

Caring for Pediatric Patients in Disasters-The Utah Approach

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Objectives

1. Participants will understand the unique characteristics of Utah's Regional Pediatric Emergency Preparedness (PEP)
2. Participants will gain an overview of Federal efforts in PEP
3. Participants will begin to apply lessons learned from recent CDC-Utah PEP Conference on creating pediatric surge to local efforts





Primary Children's Hospital

The Child First and Always



PCH History

- 1911-Children's ward at LDS Hospital opened by the Primary Association (children's program) of The Church of Jesus Christ of Latter Day Saints
- 1922-The Primary Association opened the LDS Children's Convalescent Hospital (35 beds)
 - Primary children began tradition of donating birthday pennies
- 1952-Moved to new 70 bed hospital that expanded to 170 beds over time



PCH History

- 1975-The Church of Jesus Christ of Latter Day Saints created an independent and non-profit healthcare corporation, Intermountain Healthcare including Primary Children's
- 1977-Formal Affiliation with the University of Utah School of Medicine Department of Pediatrics
- 1990-Primary Children' Medical Center moved to present location on the University of Utah.
- 2013-Rebranded as Primary Children's Hospital



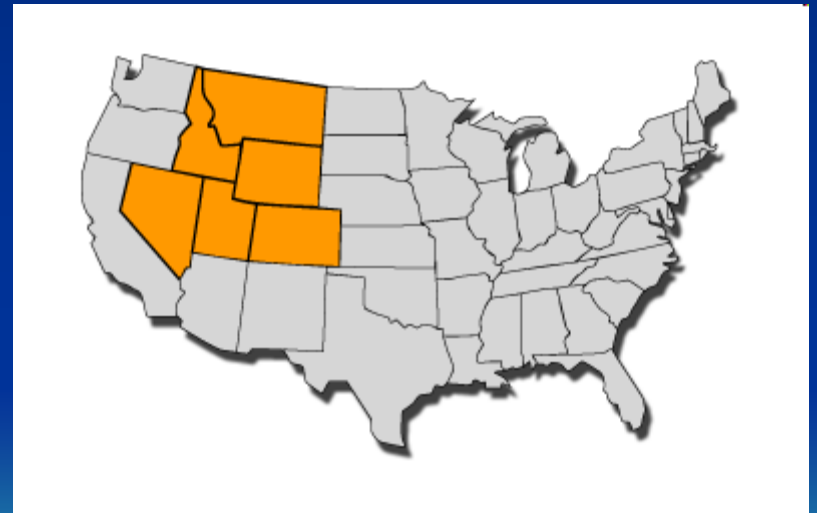
PCH

- 289 bed children's hospital, highest acuity score in state of Utah
- Admits 65-70% of Pediatric Admissions in the state (Intermountain has 90%)
 - 14,000 admissions
 - 15,000 surgeries
 - 40,000 ED Visits
- 3,800 employees
- 800 Physicians and LIPs on medical staff



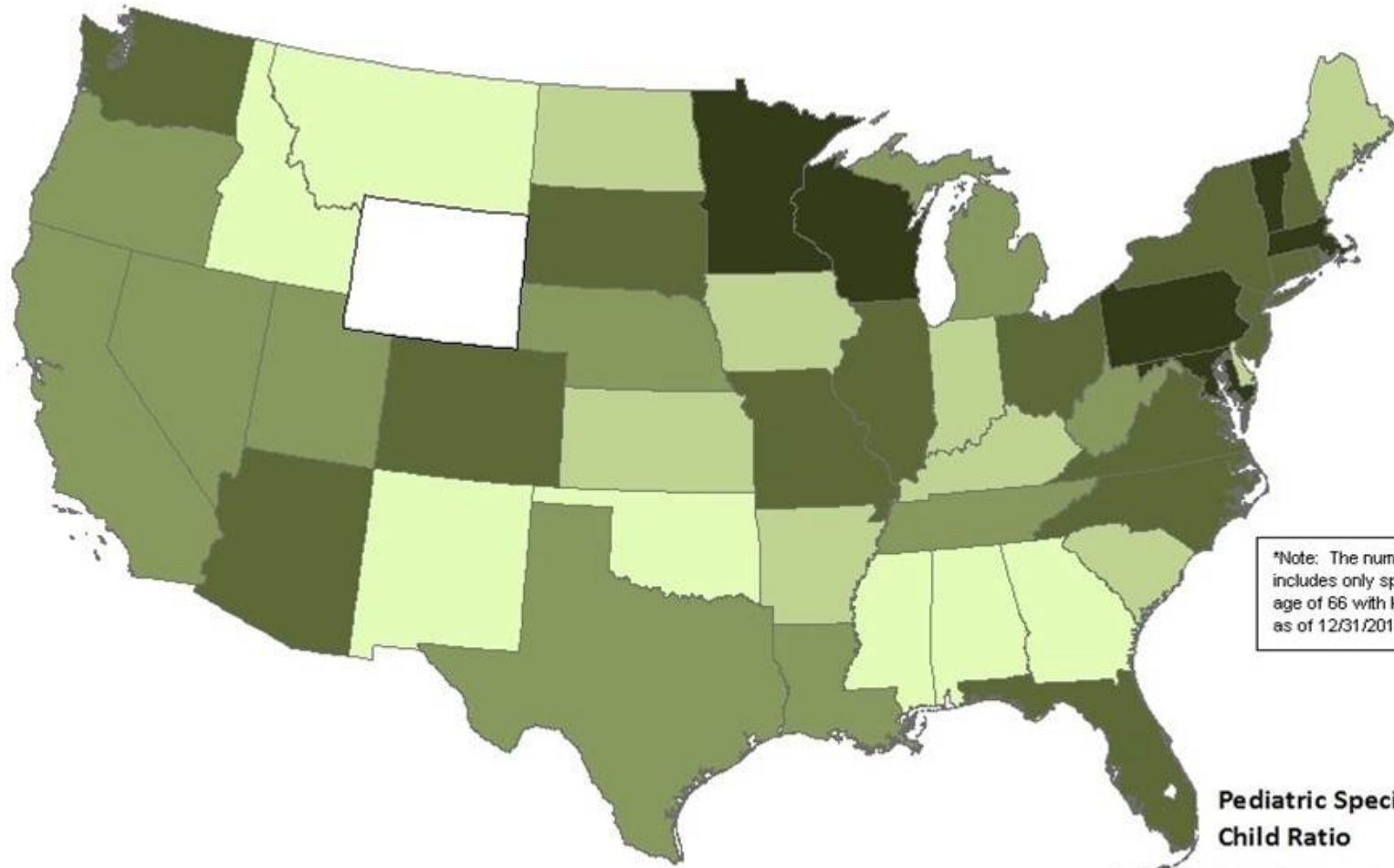
Large Geographic Area

- Coverage area is the entire Intermountain West
 - Utah
 - Wyoming
 - Idaho
 - Montana
 - Nevada



Relative Distribution of ABP Critical Care Medicine Diplomates by State

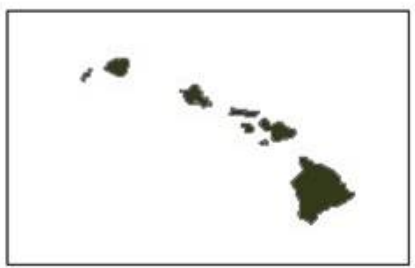
(Total Diplomates ever certified* as of 12/31/2012)



*Note: The number of diplomates includes only specialists under the age of 66 with known addresses as of 12/31/2012.

Pediatric Specialist-to-Child Ratio

- No certified specialists
- 1:60,000+
- 1:50,000-59,999
- 1:40,000-49,999
- 1:30,000-39,999
- 1:1-29,999

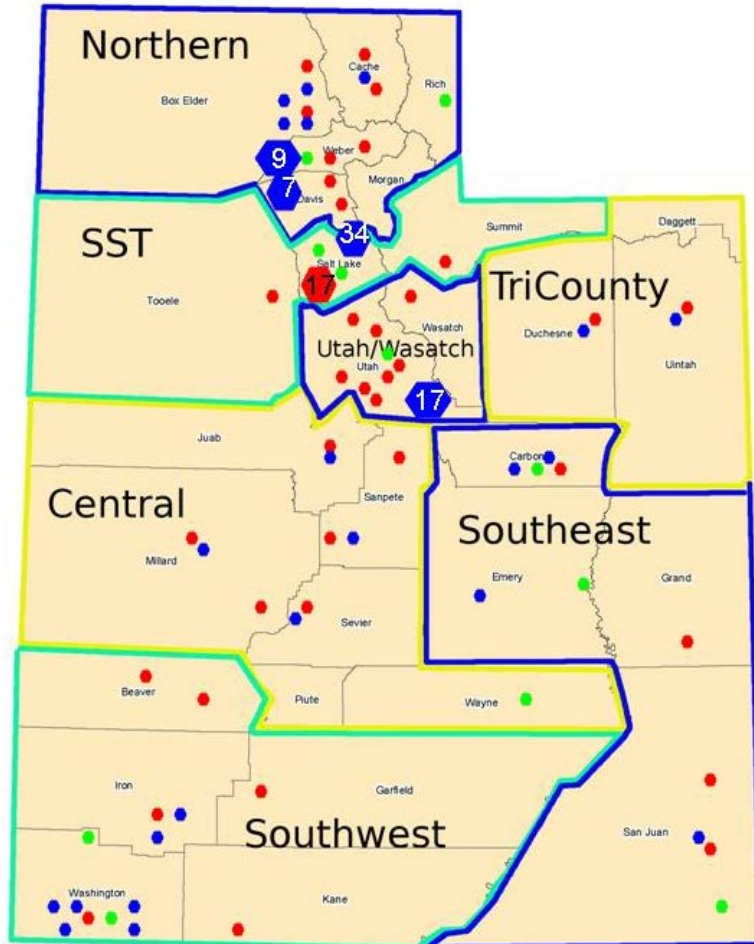





PCH Planning Efforts

- Numerous levels of planning
 - Winter Surge Planning
 - PI planning (internal and statewide)
 - Utah Burn Plan
 - Crisis standards of care
- Community Partner Planning is integrated into each of these!



Regional Medical Surge Coalitions



-  Hospitals -50
-  FQHC Community Health Centers-11
-  Long Term Care Facilities-96

- 7 Regions
 - Correlation with patient movement and access and EMS transport patterns
- 4 match LHD boundaries, 3 combine LHDs
- LHD as staff host (6 of 7)
- Funding includes staffing, training, and equipment
- All LHD are CDC Health Preparedness grantees
- Good fit with grant alignment

PCH Surge Plan

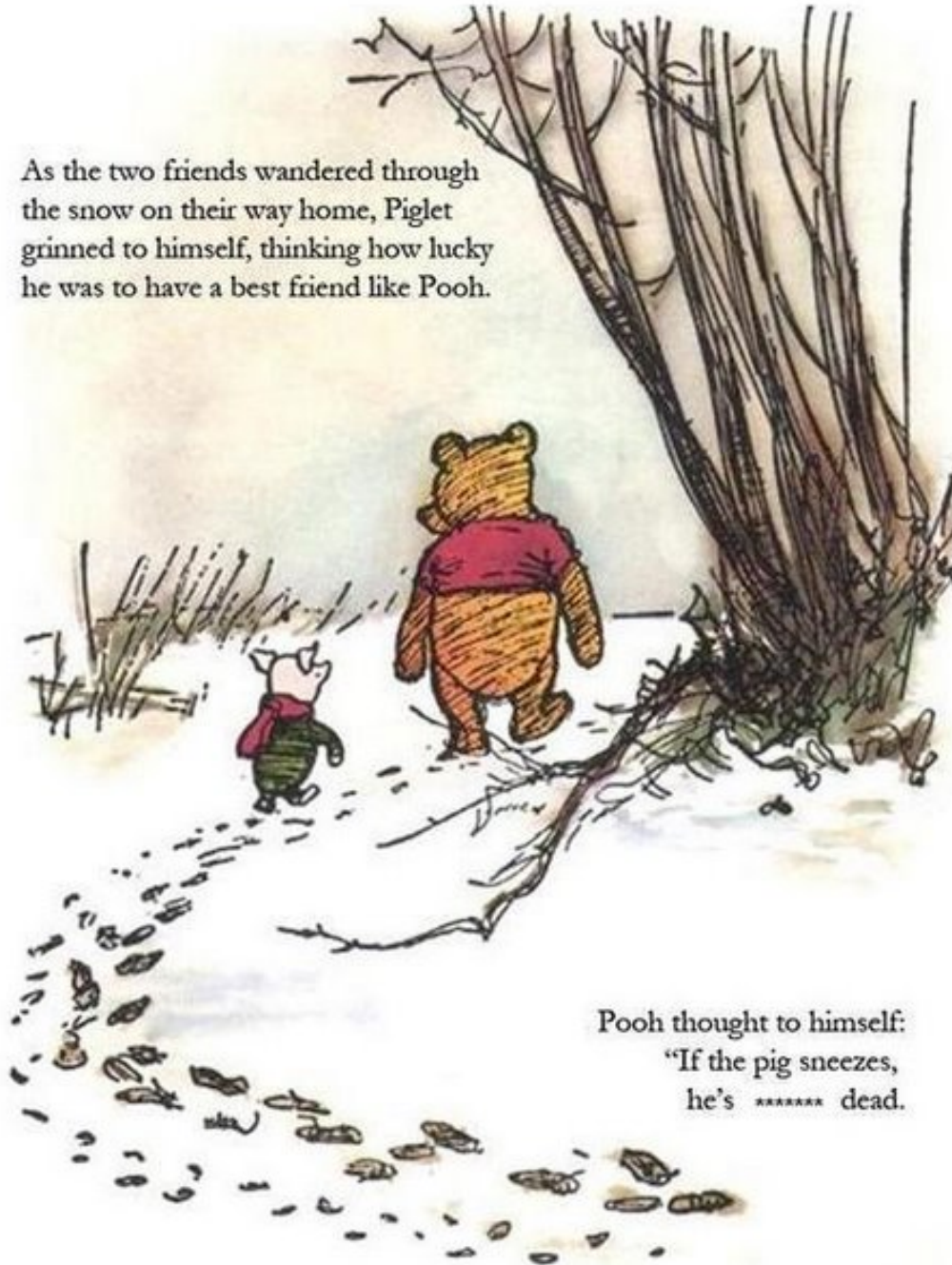
	Med-Surg (Includes Oncology) ** maximum number of beds may be adjusted for patient acuity and age	PICU	NICU	ED/RTU
Surge Level 1 “Fill The House” Who Decides: Nursing Supervisor & Medical Officer of the Day (MOD)*	SDS: use up to 8 beds for surgical inpatients PACU: hold pending admits IMSU, CMU, NTU: use cribs and shift beds and large cribs to CSU IMSU (3 rd Floor) CMU, CSU, NTU: double bunk up to 4 rooms in each unit IMSU: may take patients up to age 5 Treatment Rooms: IMSU (3 rd Floor), CSU, NTU, ICS based on pt population	Double bunk up to 55 beds	Double bunk 2 internal beds (52 beds). Evaluate for back-transport	Open Pod 3 earlier than 1600 (8 beds)
Surge Level 2 “Change Operations” Who Decides: MOD* & Nursing Supervisor. Additional: evaluate equipment & supply needs daily	Hem/Onc/BMT: begin moving RTU HemOnc sedation patients into HemOnc sedation area Med Units: cancel scheduled medical admits as needed PACU: hold up to 6 in PACU Surgery/SDS: cancel surgeries as needed <u>Small Pt Influx:</u> CSU: move post-op cardiac infants to the NICU, double bunk up to 12 rooms <u>Small or Large Pt Influx:</u> Hem/Onc/BMT Clinic: all services provided in infusion area Hem/Onc/BMT: consider transfer of patients >18 years to UofU <u>Large Pt Influx:</u> IMSU: convert Pod C on 3 rd floor to CMU beds CSU: double bunk up to 12 rooms PICU: board larger patients if beds available	Move into SDS to occupy 28 beds (83 “PICU” beds).	Double bunk parent rooms (56 beds)	Open Pod 4 at 1600 (7 beds)
Surge Level 3 “Drastic Measures” Who Decides: CEO, CNO, Chief Medical Officer, Administrator-on-Call, MOD* Nursing Supervisor. Continue to evaluate equipment & supply needs daily	ALL: refer to Mass Casualty/Surge Capacity Plan HemOnc/BMT: Utilize Outpatient Clinic space for chemo infusion HemOnc pts Med Units: Cancel all non-emergent admits Surgery: Cancel all SDS and non-emergent surgeries Transfer: Consider transferring lower acuity in-patients to Riverton’s Children’s Unit Divert: MOD may approve the diversion of patients 15 and older to an appropriate facility. Consider transferring PCMC ED admissions to Riverton Children's Unit <u>Medical/Surgical Unit Surge</u> HemOnc/BMT: utilize all of Hem/Onc clinic sedation and infusion space for inpatients Outpatient Clinics: prioritize patients and evaluate other locations Green Team Room: utilize space for patients NTU Rehab GYM: utilize space for patients	Move into NICU (patients <=6 months) to occupy 17 beds (100 “PICU” beds). NICU nursing and medical staff care for all 56 patients in NICU	Transfer patients to other facilities to free up beds for critical children <=6 months (56 beds)	ED—Expand 4-8 beds into RTU RTU—cancel all elective procedures
Divert	MOD may approve the diversion of patients > 15 years of age.			

PI Impact in Utah

- Severe pandemic influenza would create the need for 8,000 hospitalizations for influenza in the second week of the pandemic in Utah
- Utah has 5,024 staffed hospital beds
 - 70-80% of these beds are usually full



As the two friends wandered through the snow on their way home, Piglet grinned to himself, thinking how lucky he was to have a best friend like Pooh.



Pooh thought to himself:
"If the pig sneezes,
he's ~~*****~~ dead."

Utah PI Triage Planning

- Utah began pandemic planning and realized that it was not possible to care for all the potential patients using today's standards for admission and patient care
- Utah Hospital Association received a grant in 2006 to develop triage criteria for hospital admission and ICU admission/ventilator care



PI Planning Efforts



Utah PI Triage Planning

- Committee created
- Plan developed and approved
 - Admission criteria for triage
 - Ventilator allocation criteria
 - Home care and comfort care guidelines
- 1st state plan to incorporate pediatric concepts
- Initial tabletop drills made it clear that pediatric and adult patients had to be handled differently



PI Triage

STAR TRIBUNE
S&K



OVERVIEW OF PANDEMIC TRIAGE LEVELS

Triage Level 1

Early in the pandemic

- Hospitals recognize the need to surge bed capacities.
- Emergency departments are experiencing increased numbers.
- Note: In the event of a severe and rapidly progressing pandemic, start with Triage Level 2.

Triage Level 2

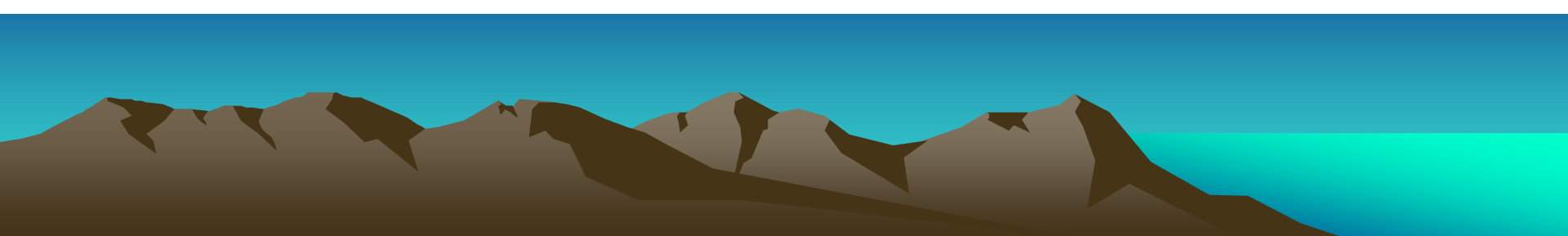
Worsening pandemic

- Hospitals have surged to maximum bed capacity, and emergency departments are overwhelmed.
- There are not enough beds to accommodate all patients needing hospital admission, and not enough ventilators to accommodate all patients with respiratory failure.
- Hospital staff absenteeism is 20% to 30%.

Triage Level 3

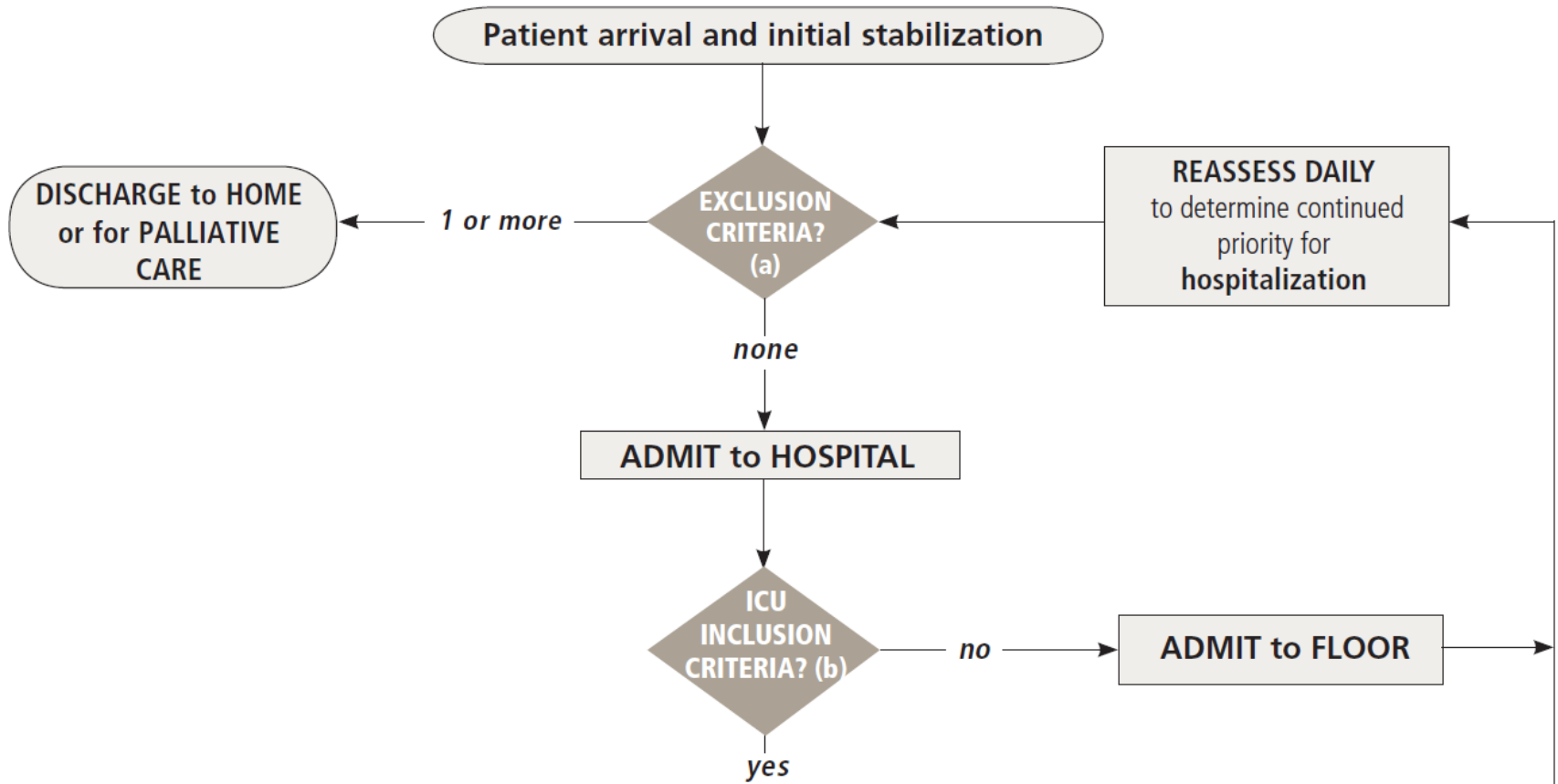
Worst-case scenario

- Hospitals have already implemented altered standards of care regarding nurse/patient ratios and have already expanded capacity by adding patients to already occupied hospital rooms.
- Hospital staff absenteeism is 30% to 40%.



ALGORITHM: HOSPITAL AND ICU/VENTILATOR ADMISSION TRIAGE

Applies at Pandemic Triage Levels 2 and 3



(a) EXCLUSION CRITERIA for Hospital Admission:

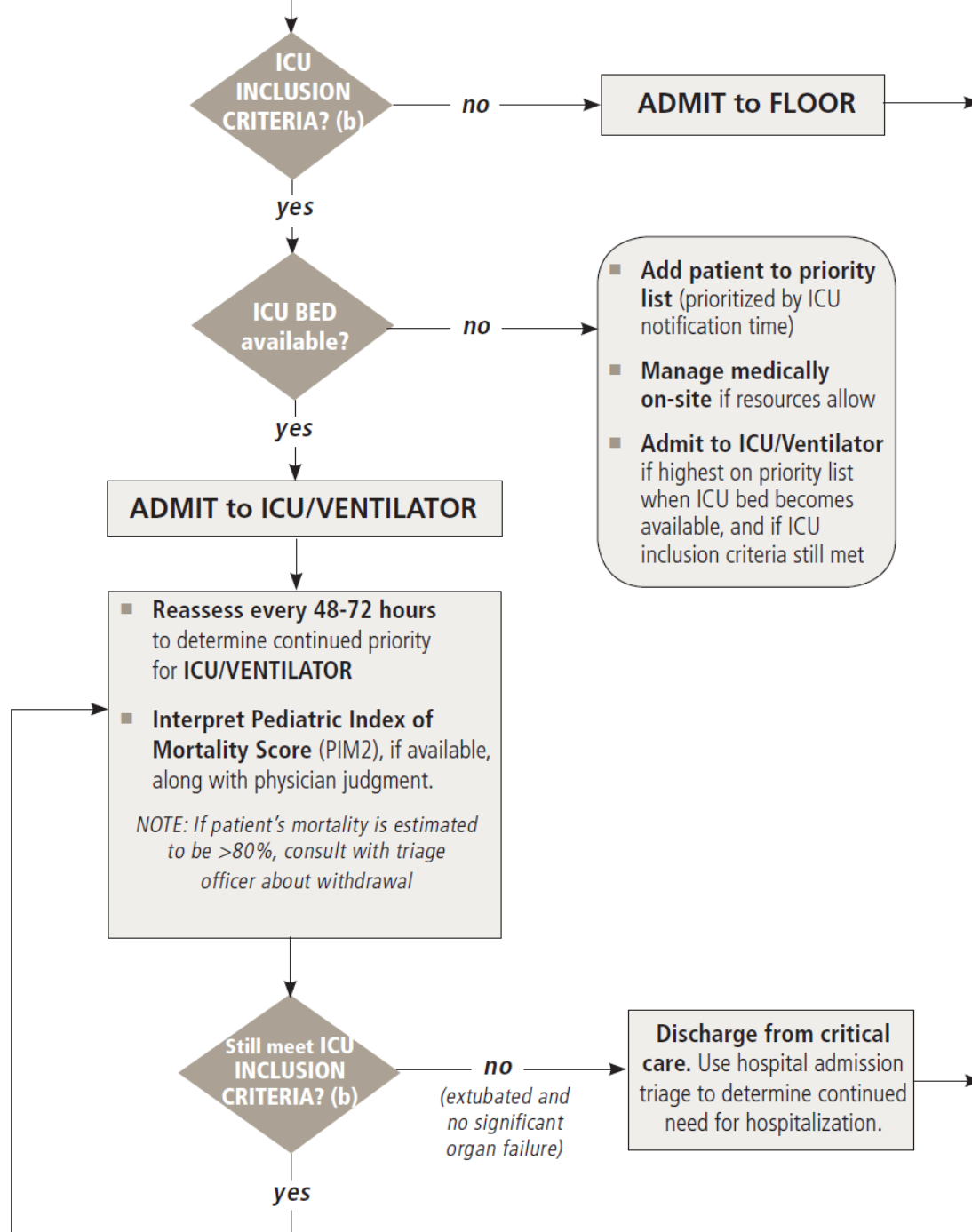
The patient is excluded from hospital admission or transfer to critical care if ANY of the following is present:

- (1) **Known "Do Not Resuscitate" (DNR) status.**
- (2) **Persistent coma or vegetative state.**
- (3) **Severe acute trauma with a REVISED TRAUMA SCORE <2 (see (d) and (e) on following pages).**
GCS: _____ SBP: _____ RR: _____
Revised trauma score: _____
- (4) **Severe burns with <50% anticipated survival** (patients identified as "Low" or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS (f)). Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Medical Center Burn Center under normal circumstances).
- (5) **Cardiac arrest not responsive to PALS interventions within 20-30 minutes.**

- (6) **Short anticipated duration of benefit**, e.g., underlying condition with >80% mortality rate at 18-24 months:
 - a) Known chromosomal abnormalities such as Trisomy 13 or 18
 - b) Known metabolic diseases such as Zellweger syndrome
 - c) Spinal muscular atrophy (SMA) type 1
 - d) Progressive neuromuscular disorder, e.g., muscular dystrophy and myopathy, with inability to sit unaided or ambulate when such abilities would be developmentally appropriate based on age
 - e) Cystic fibrosis with post-bronchodilator $FEV_1 < 30\%$ or baseline $PaO_2 < 55$ mm Hg
 - f) Severe end-stage pulmonary hypertension

OTHER CONSIDERATIONS:

- Resuscitation of extremely premature infants with anticipated mortality rates greater than 80% should not be offered. See http://www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/
- The use of ECMO will be decided on an individual basis by the Chief Medical Officer (with input from attending physician, nursing supervisor, and ECMO representative) based on prognosis, suspected duration of ECMO run, and availability of personnel and other resources. Patients should have an estimated survival of >70% with an estimated ECMO run of <7-10 days.



(b) ICU/Ventilator INCLUSION CRITERIA

- Applies to all patients except those infants not yet discharged from the NICU
- Patients must have NO EXCLUSION CRITERIA (a) and at least one of the following INCLUSION CRITERIA:

(1) Requirement for invasive ventilatory support

- Refractory hypoxemia (SpO₂ < 90% on non-rebreather mask or FIO₂ > 0.85)
- Respiratory acidosis (pH < 7.2)
- Clinical evidence of impending respiratory failure
- Inability to protect or maintain airway

(2) Hypotension* with clinical evidence of shock** refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting

* **Hypotension** = Systolic BP < 90 mm Hg for patients age > 10 years old, < 70 + (2 x age in years) for patients ages 1 to 10, < 60 for infants < 1 year old, or relative hypotension

** **Clinical evidence of shock** = altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure

Utah State Burn Disaster Plan

- Effort led by University of Utah Burn Center
- Plan developed and approved (2013)
 - Complete Toolbox
 - Triage Criteria
 - Treatment Plans
 - Adult and Pediatric guides
 - Radiation injury management
 - Consultation and Transfer guidance and agreements
- Several Drills held with pediatric focus including mobile communication consultation



Fluid Resuscitation of the PEDIATRIC < 30KG Acute Burn Patient:

STEP ONE:

Use the Calculated Fluid Resuscitation Sheet for initial LR rate

Begin LR fluid resuscitation

LR @ _____, & D5LR @ 25ml/hr

D5LR is not extra fluid on top of LR, Only titrate LR
Measure urine output hourly

Vitals unstable: HR>180 or Systolic BP < 80

Call Attending

Vital Signs Stable: HR<180, Systolic BP > 80

Pt. Wt _____ Kg's on admission

UOP < 0.9ml/kg/hr Flush Foley with 10ml sterile H2O Check UOP again	UOP 1-1.9ml/kg/hr _____ ml/hr	UOP > 2ml/kg/hr _____ ml/hr	UOP > 4ml/kg/hr _____ ml/hr
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Increase IV rate by 10%	Leave IV at current rate	Decrease IV rate by 10%
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REPEAT STEP ONE EVERY HOUR UNTIL:

UOP < 0.5ml/kg/hr for two hours despite an increase in fluid

CALL MD./CONSULT BURN CENTER and consider beginning **ALBUMIN PROTOCOL**

If patient again develops oliguria or hemodynamic instability
CALL MD/CONSULT BURN CENTER
And restart patient on LR /D5 LR. Repeat STEP ONE

Total Maintenance Fluid Rate of LR/D5LR _____ ml/hr is reached and held for two hours AND the pt. is at least 24 hours post burn

Fluid resuscitation is **COMPLETE:**

Switch to D5 0.45 NS with 20 mEq KCL
Run IV @ Calculated
Total Maintenance Fluid Rate @ _____ ml/hr
STOP LR/D5LR NOW
GOAL RATE = ALL FLUIDS/HR (INCLUDING TUBE FEEDS)

Consider decreasing IV rate every 1/2 hr by 10% Be sure to assess patients Blood Sugar, BP, HR, Lactic Acid, Hemoglobin, **before** decreasing IV rate Consult with CN first, then Attending for any questions.

ALBUMIN PROTOCOL

If patient requires > calculated fluids or has complications related to edema, consider albumin protocol

Patient may need colloid resuscitation: Call MD/Burn Clinic to discuss starting 5% albumin at one-third current hourly rate, LR/D5LR at two-thirds current rate.

Example (If Current Rate of LR/D5LR is 90ml/hr, it should be changed to 60 ml/hr LR/D5LR, and 30 ml/hr 5% Albumin.

Repeat STEP ONE until patient maintains Total Maintenance Fluid Rate with UOP Greater than 1ml/kg/hr

When combined LR and Albumin rates reach the Total Maintenance Fluid Rate change to LR for two hours

If patient maintained UOP for two hours on LR/D5LR, and is 24 hrs post burn **FLUID RESUSCITATION IS COMPLETE**
Change to D5 0.45 NS with 20 mEq KCL/L At Goal Rate (if available)

M.D. Signature _____ Date _____

RN Co-sign _____ Date _____

1. RESUSCITATION

A. Calculated Resuscitation and basal requirement

1. (4ml x _____ kg x _____ % burn) = _____ + (1500ml x _____ m2) = _____ ml/24 hours

B. Resuscitation Fluid per 8 hours

- 1st 8 hours = _____ ml. _____ ml/hr
- 2nd 8 hours = _____ ml. _____ ml/hr
- 3rd 8 hours = _____ ml. _____ ml/hr

2. MAINTENANCE FLUIDS

A. Basal fluid requirement - 1500 ml x _____ m2

1. Total body surface area _____ m2
2. 24 hours = _____ ml
3. Hour = _____ ml/hr

B. Evaporative water loss

1. Children - (35 + % burn) x _____ m2 = ml/hr.
2. Calculate evaporative water loss
A. (_____ + _____ % burn) = _____ x _____ m2 = _____ ml/hr. _____ ml/24hr

C. Total maintenance fluids = basal requirement and evaporative water loss

1. 24 hours = _____ ml.
2. Hours = _____ ml/hr

Utah Crisis Standards of Care Plan

SITUATION	Conventional	Contingency	Crisis
SURGE STATUS	Hospitals utilize normal bed capacity. Occasional and temporary surges of demand may occur that are temporary and may incur longer wait times for non-critical care as hospitals, ICUs, and emergency departments temporarily reach capacity.	Hospitals have surged beyond maximum bed capacity. Emergency Operations Plans are in effect. Elective procedures delayed. Hospitals may be adding patients to occupied hospital rooms and non-patient care areas. Community health care facilities may be requested to surge. Alternate care sites may be opened.	Expanded capacity is still not sufficient to meet ongoing demand for care. Some patients needing care cannot be admitted to hospitals and instead will be sent home or to alternate care sites. Hospitals are adding patients to occupied hospital rooms and non-patient care areas. Community health care facilities are operating beyond normal scope of practice.
RESOURCE LEVEL	Occasional, limited resource shortages may occur, typically of non-critical supplies or medications with substitution as the most common resource sparing strategy.	Some resources are becoming scarce. Attempts at conservation, reuse, adaptation, and substitution may be performed.	Some or even many critical resources are unavailable, potentially including hospital beds, ventilators, and medications. Critical resources are re-allocated to help as many patients as possible.
STAFF	Usual staffing. Hospital staff absenteeism is not a large problem.	Staff extension (increased patient/provider ratios, expanded scope of practice). Hospital staff absenteeism may be a problem.	Staffing levels at critical shortage. Staff are operating outside normal scope of practice and greatly increased patient/provider ratios. Hospital staff absenteeism may be greater than 30%.



Pediatric Considerations in Disaster Planning

- Children need to be a major consideration in disaster planning
 - 25% of the U.S. population
 - More than 20 million < 6 years
- Children may be more vulnerable physiologically and socially
- Often ignored in the planning process



Cost of PI Preparedness per Hospital

Activity or Stockpile	Cost (\$)
Development of PI Plan	200,000
Staff Education and Training	160,000
Stockpile of PPE	400,000
Stockpile of Supplies	240,000
Total	1,000,000

Estimated PI Requirements (25% attack rate over 8 weeks)

Resource	Number	Moderate PI (1958-like)	Severe PI (1918-like)
Hospital Beds	840,000	19%	191%
ICU Beds	90,000	46%	461%
Ventilators	105,000	20%	198%

Toner, et al. *Biosecur Bioterr.* 2006; 4:207-212.



Difference between ICUs

	Adult	Neonatal	Pediatric
Number of Beds	67,357	20,000	4,044
Specialty of Attendings	Many	Few	Few
Range of Equipment	Limited	Limited	Wide
Type of Patients	Moderate	Limited	Wide

Other Key Shortages

- Antivirals, vaccines, antibiotics, pressors, PPE could be in short supply
 - Just in time supply, offshore manufacturers
- Key resource shortage-personnel



Task Force for Mass Critical Care Recommendations (Chest 2008)

- Every hospital with an ICU should plan and prepare to provide Emergency Mass Critical Care (EMCC) in coordination with regional hospital planning efforts.
- Hospitals with ICUs should plan and prepare to provide EMCC for a total critically ill patient census of at least triple usual ICU capacity.
- Hospitals should prepare to deliver EMCC for 10 days without sufficient external assistance.



Pediatric Mass Critical Care (PCCM 2011)

- Every hospital with a pediatric ICU or neonatal ICU should plan and prepare to provide PEMCC in coordination with regional health planning efforts.
- Hospitals with ICUs should plan and prepare to provide PEMCC for a total critically ill patient census at least double the pediatric ICU bed capacity and at least triple usual ICU capability.
- Hospitals should prepare to deliver PEMCC for 10 days without sufficient external assistance.
 - Care should be coordinated with the emergency department for triage and transfer of patients to/from ICUs.



Task Force for Mass Critical Care Update (Chest 2014)

- Surge response levels for ICUs
 - Conventional: 20% above baseline maximal capacity
 - Contingency: 100% above baseline maximal capacity
 - Crisis: 200% above baseline maximal capacity
- Regional planning with expectation that hospitals be able to provide initial stabilization care to populations they normally don't serve:
 - Pediatrics, burn and trauma patients
- Predetermined standards that define minimal ongoing critical care capability to create the framework for patient transfer decisions



Task Force for Mass Critical Care Update (Chest 2014)

- We suggest coalitions have identified with the following pediatric disaster/pandemic designated resources including, but not limited to:
 - Pediatric consultative specialists available by dedicated phone line support and/or dedicated video or telemedicine consultation.
 - Designated pediatric surge personnel (e.g., pediatric hospitalists, others) available to non-pediatric hospitals and health systems to support surge in contingency or crisis level events.
 - Identified pediatric capable transport resources for allocation and matching of pediatric patients to available pediatric resources.
 - Knowledge of availability and location of key supplies, medications, and other pediatric assets with a defined process for how they may be accessed urgently.
 - Pediatric educational resources. If web-based, they should be found on HC/RHA websites, or with links to appropriate resources. If published, resources should be readily available to all partners.



Federal Approach National Response Framework

- Emergency Support Functions
 - ESF 6 directs FEMA to lead activities relating to mass care, emergency assistance, and human services
 - ESF 8 directs HHS to lead the public health and medical response
 - ESF 9 addresses urban search and rescue activities and is led jointly by DHS/ FEMA, DHS/US Coast Guard, the Department of the Interior/National Parks Service, and the Department of Defense/US Air Force

Health and Human Services

- Assistant Secretary for Preparedness and Response
 - Office of Preparedness and Emergency Operations
 - The Hospital Preparedness Program 2012 budget is \$347 million (0.0001% of overall National Health Expenditures)
 - National Medical Disaster System-NMDS
 - Disaster Management Assistance Teams-DMAT
 - only a few pediatric focused teams
 - Medical Reserve Corps
 - Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP)
 - Strategic National Stockpiles-SNS

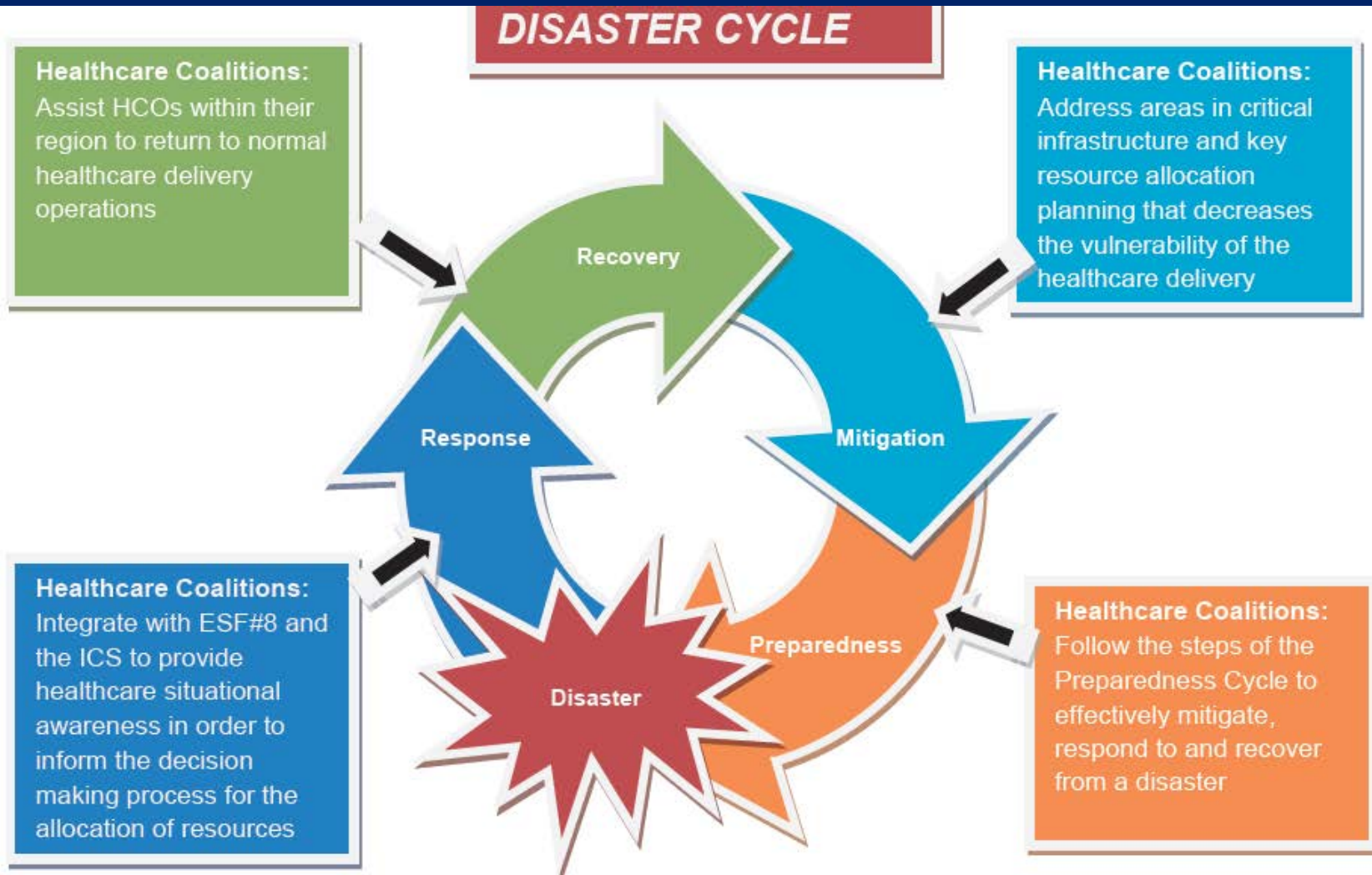


Healthcare Preparedness Capabilities

- 8 of 15 Public Health Preparedness Capabilities
 - Healthcare System Preparedness
 - Healthcare System Recovery
 - Emergency Operations Coordination
 - Fatality Management
 - Information Sharing
 - Medical Surge
 - Responder Safety and Health
 - Volunteer Management



Healthcare Preparedness Success



Progress in Pediatric Planning

- National Commission on Children and Disasters-2010
- Emergency Medical Services for Children Program Reauthorization-2010
- Pandemic and All-Hazards Preparedness Act (PAPHA) Reauthorization-2013
 - New language prioritizing pediatrics and critical care
- AAP Disaster Preparedness Advisory Council



Utah Planning Workshop for Addressing Pediatric Surge

- Joint conference on July 29-31 2014 with Utah healthcare and community partners, Centers for Disease Control and Prevention, and Oak Ridge Associated Universities
- Proposal submitted in March 2014
 - Awarded in April 2014
 - “The purpose of the *Pediatric Surge Project* is to advance planning and coordination between pediatric and general healthcare systems to address the delivery of healthcare during a pediatric surge *event*.”
- Weekly planning calls and on-site visit



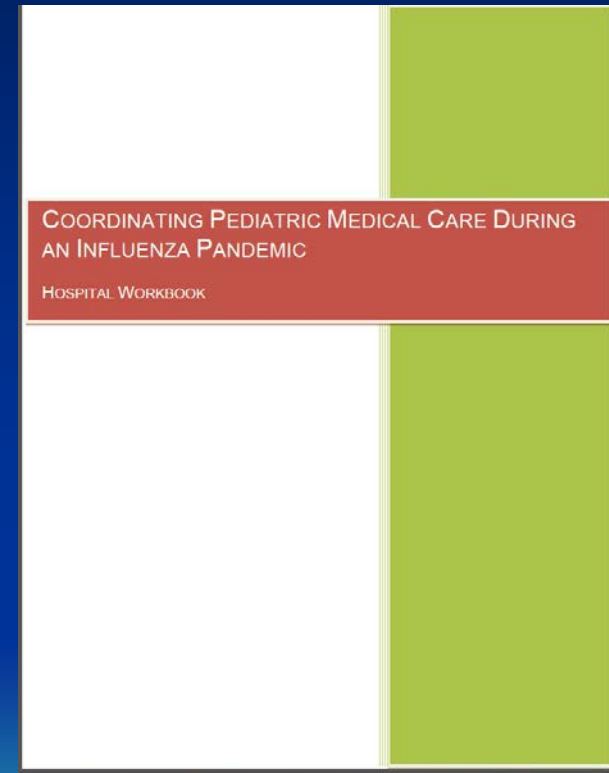
Workshop Objectives

- Select, engage, and conduct a multi-day workshop with a community whose pediatric and general healthcare systems are currently engaged in collaborative planning.
- Utilize the information gathered during the workshop to
 - Inform and advance other communities in their pediatric surge planning.
 - Inform professional organizations or others who draft policy statements or guidelines.
 - Drive additional work with partner agencies (e.g., Office of Assistant Secretary for Preparedness and Response, Institute of Medicine).
- Incorporate lessons learned from this project into future workshops and CDC-HPA and ORISE work.



Project Approach

- **Before the workshop, the selected community's core planning team will**
 - Participate in pre-workshop planning including, but not limited to, communications with community partners and review of the workshop agenda and activities.
 - Review the Coordinating Pediatric Medical Care During an Influenza Pandemic Hospital Workbook and provide feedback on its utility.



Project Approach

- **During the workshop, participants will**
 - Identify and create a flowchart of the community's current pediatric healthcare delivery based on identified healthcare roles, responsibilities, and available resources.
 - Assess the pediatric healthcare system to identify issues, gaps, opportunities, and/or obstacles encountered during a pediatric surge event
 - Develop cross-sector strategies to address the issues, gaps, opportunities, and/or obstacles identified in assessment.
 - Utilized both a no-notice (earthquake) and notice (PI) event



Project Approach

- **After the workshop, the selected community's core planning team and partners will develop a**
 - A narrative document that outlines planning history and background, challenges, processes, and strategies identified during the workshop, and proposed post-workshop preparedness work.
 - Written description that outlines planning and coordination between the pediatric and general healthcare systems and integrates issues and strategies identified during the workshop.



Participants

- PCH
- CDC
- ORISE
- ASPR
- UT HPP Manager,
- WY DOH planner,
- MT HPP Manager,
- Colorado Hospital Association
- ID and CO hospitals
- UT Hospital Association
- University of Utah
- UT hospitals (CAH and larger trauma centers)
- EMS/Fire
- UT Office of Emergency Management (state and county level)
- Pharmacies
- School system
- VA
- Behavioral Health
- Faith based community
- Hospice
- Home health

Lessons Learned

- Identify key partners
 - Pharmacy, other state coalitions, schools, VA
- Leverage unique regional characteristics
 - Faith Based organizations, existing communication channels
- Identify Gaps
 - Neonatal, media, fatality management



Next Steps

- Development of Action Plan
- Leverage existing state-wide projects to fast track progress on works in progress
 - Pediatric crisis standards of care
- Develop and refine interstate coordination for pediatric medical surge events
 - Many of the tasks identified will be best coordinated at a state level



Questions

