specific mass casualty and surge incidents, a survey was conducted involving all hospitals that routinely manage pediatric patients in their emergency departments, to better understand the preparedness levels for these facilities.
Method: This is a retrospective analysis of data collected in 2014 and repeated in 2021. Our focus included one predominantly rural state in the United States of America (USA). We examined results from surveys conducted where facilities self-reported objective criteria that resulted in a readiness score (as it relates to pediatric readiness). Reporting stratification reflected the annual pediatric ED volume with groups of; Low (<1800/year), Medium (1800-4999 /year), Medium to High (5000-9999/year), and High (>10,000/year).
Results: Low-volume hospitals scored (Mean=59/Median=56), Medium volume hospitals scored (Mean=62/Median=60), Medium to High volume hospitals (Mean=67/Median=65), and hospitals with High volumes (Mean=82/Median=83). All hospital volume ranges had outlier hospitals that scored between 82-97. The general tendency, lower volume hospitals had a lower level of readiness, and higher volume hospitals had a higher (to much higher) level of readiness.
Conclusion: Pediatric disaster readiness needs to be improved at the community level. It is encouraging that pediatric disaster readiness has been addressed in the larger medical centers. Yet, it should be noted that even very low-volume hospitals (had outliers with) scores as high as 94 indicating that with ample support, and resources, pediatric disaster preparedness is achievable in every hospital regardless of size or volume. The results point to a need to develop, improve, and distribute resources and support local hospitals with pediatric disaster readiness.

Prehosp. Disaster Med. 2023;38(Suppl. S1):s200–s201
doi:10.1017/S1049023X23005149

The New York City Pediatric Disaster Coalition Pediatric Intensive-Care Response Team (PIRT)

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Introduction: Children represent 25% of the population, have special needs, and are often over-represented in disasters. The New York City Pediatric Disaster Coalition (NYC PDC) is funded by the NYC Department of Health and Mental Hygiene (DOHMH) to improve pediatric disaster preparedness and response. PDC worked with a network of pediatric intensivists to create the Pediatric Intensive-Care Response Team (PIRT). PIRT consists of volunteer pediatric intensivists that currently practice in New York City.
Method: Secondary transport may be requested by hospitals due to a mismatch of resources to needs for patients requiring critical and/or subspecialty care. The team is activated when a disaster involves a significant number of pediatric patients. In the proposed plan, the PIRT physician on-call will triage/prioritize the patients based on acuity and need for services and relay the necessary information to the transport agency. PIRT is designated to provide subject matter expertise and resources during real-world events. PIRT maintains a 24/7 on-call schedule with backup. The PIRT system was tested in four call-down communications drills and a tabletop exercise for prioritization of pediatric mass casualty victims.
Results: The call-down drills demonstrated the ability to contact the on-call and backup physicians by email or text within 20 minutes and others within one hour. In the tabletop, PIRT members were given 15 patient profiles based on a scenario and asked to prioritize patients based on their injuries/medical needs. This was accomplished in less than 30 minutes, followed by a review and discussion of the rank order. A number of lessons learned were identified and will be presented.
Conclusion: The NYCPDC has developed and tested a PIRT that is available 24/7 to prioritize patients for secondary transport and offer subject matter expertise during pediatric mass casualty events. This model can be utilized to enhance pediatric disaster preparedness.

Prehosp. Disaster Med. 2023;38(Suppl. S1):s201
doi:10.1017/S1049023X23005150

Can Social Media cause Needed Health Care Transformation to Occur? The STRONGERR Project

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Introduction: The key cripplers of health care are:

1. Fragmented Patient chart
   Possible solutions:
   • single cloud-based chart that is owned by the patient protected by the government
   • information uploaded by a certified care provider (or they don't get paid)
   • Maintained by a patient navigator who organizes information
   • linked to self-care directions and
   • tele-support clinicians

2. Disparate and rapidly changing medical treatments of variable support with evidence
   Why can't we integrate all guidance into one set of current recommendations so that when you put your information into the patient's EMR, guidance pops up and you follow that.
   Not only will that lead to consistency, you are essentially entering a patient into a clinical trial of sorts as this data can be reviewed later.

3. CME
   • Fragmented, disparate, inconsistent.
   • Make it a paid part of our salary making it mandatory, and consistent

4. Telemedicine
   Create a Provincial or State or Regional Virtual hospital that Offers 24/7, Full hospital e-consultant services.
   a. Tier one, e-Consultants support acute care issues.They help you decide regardless of where you are working the