recommendations. Understanding hazard-exposure dynamics are vital for advancing emergency health responses toward early intervention and health protection from future hazards that threaten functioning of whole health systems.

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Towards a Multidisciplinary Guideline for Psychosocial Crisis Management

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Introduction: The Dutch Multidisciplinary Guideline for Psychosocial support during Disasters and Crises (2014) contains general principles and recommendations for mental health and psychosocial support (MHPSS) to those affected by disasters, crises or other potentially traumatic events. Changes in the field of MHPSS, 'new' types of crises (such as social unrest and long-term crises) as well as new (scientific) knowledge have been identified. A revision of the guideline is therefore necessary to ensure that the document is in line with the current scientific evidence and practice.
Method: The aim of the revision is to regain national consensus on the updated recommendations for providing optimal MHPSS in the event of disasters and crises. Needs and challenges identified in the national field formed the basis for the revision, together with the existing recommendations from 2014. The setup of the revised guideline is in accordance with the Dutch EBRO method [Evidence Based Guideline Development]. The knowledge input was twofold: first, a systematic literature search was conducted in PsycINFO, Ovid Medline, Embase en PTSDpubs. Further, a multidisciplinary working group was formed with representatives from the domains of practice, policy and research. A consensus process was followed to test and revise the guideline.
Results: The literature search yielded 3,845 unique articles and 180 met the inclusion criteria. Based on the scoping review, supplemented with literature and expert knowledge, the recommendations have been updated and revised. The majority of the recommendations are still valid. They have been adapted based on current literature. Knowledge of the two new themes: 'long-term and creeping crises' and 'social media' is translated into recommendations in the field of MHPSS.
Conclusion: The revision will lead to a more complete starting point for additional guidelines, perspective for action and protocols for specific users and applications.

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Mental Health and Psychosocial Support for Ukrainian Refugees in the Netherlands from Fragmentation to Integration

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Introduction: More than 7.8 million people fled Ukraine since the invasion of Russia and are registered as refugees in Europe (as of November 1, 2022). Almost 89,000 of them are registered to the Netherlands (as of November 3, 2022). It is expected that this number will rise. Appropriate and accessible Mental Health and Psychosocial Support (MHPSS) is essential for conflict survivors to address psychological harm from traumatic events and distress both during the escape and after, while trying to adjust to an unfamiliar place. Receiving countries have the obligation to provide MHPSS as part of their international commitment to the right to health. This is recognized in the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of Persons with Disabilities (CRPD). Nevertheless, the Netherlands is failing to honor this commitment with fragmented services that do not seem to fit support needs. The longer it takes to put a comprehensive approach in place, the greater the damage to the refugees will be. This interactive session aims to shed light on practical challenges and opportunities for the implementation of appropriate, accessible and integrated MHPSS. What is needed to go from a fragmented to an integrated approach?
Method: Being active as advisors in the field of Disaster Health and MHPSS in the Netherlands, the presenters review their experienced challenges thereafter opportunities and good practices are explored together with the participants.
Results: Experienced challenges include complexity, fragmented organization, lack of ownership and inadequate access to knowledge and information about support needs.
Conclusion: More is needed to meet the commitment to the right of health and to provide adequate MHPSS to refugees in the Netherlands and beyond. International exchange and learning can help us to understand and overcome implementation challenges.

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Pediatric Disaster Readiness and Community Hospitals in a Rural American State

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Introduction: Pediatric patients represent a small (but important) subset of the patient population routinely visiting emergency departments (ED) each year. With the aim of better understanding the disaster preparedness level for pediatric-

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.

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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.

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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