Southwest Florida Healthcare Coalition

Pediatric Surge Annex

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Record of Changes

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TABLE OF CONTENTS

Health Care Coalition Pediatric Surge Annex

1. Introduction

1.1 Purpose

The purpose of the Southwest Florida Healthcare Coalition Pediatric Surge Annex is to support the *Florida's Comprehensive Emergency Management Plan (CEMP) Appendix VIII: ESF8- Public Health and Medical Services- Patient Movement Support Standard Operating Guideline* (hereafter referred to as: FDOH ESF8- Patient Movement Support SOG), by providing a functional annex for all stakeholders involved in an emergency response within Region 6 which consists of Charlotte, Collier, DeSoto, Glades, Hendry, Highlands, Lee, Okeechobee, and Sarasota Counties in order to protect children and to provide appropriate pediatric medical care during a disaster. This annex is an adjunct to the States annex that guides the state level response on patient movement, system decompression, and resource allocation during a surge of pediatric patients that overwhelms the local healthcare system. This annex is intended to support, not replace, any agencies' existing policies or plans by providing coordinated response actions in the case of pediatric emergency.

The purpose of Health Care Coalitions (HCC's) are to ensure that local providers and other health care partners plan collaboratively for the risks facing the health care community and identify available local resources.

1.2 Scope

This plan is designed to provide a guide for county and local health care partners to:

- Enhance pediatric triage decision-making to prioritize transfers/treatment.
- Enhance standardized care guidelines as needed.
- Ensure coordinated and consistent communications processes are in place.
- Support the tracking and placement of pediatric patients throughout the incident.
- Identify strategies to manage surge and scarce resources.
- Assist with the coordination of transferring acutely ill/injured pediatric patients to pediatric tertiary care centers/specialty care centers.
- Assist with the decompression from pediatric tertiary care centers/specialty care centers to make additional critical care beds available for acutely ill/injured pediatric patients.

For this plan, the following pediatric age groups were used to define the pediatric population and determine special age group related considerations:

- Infants/toddlers (0 - 24 months)
- Toddlers/preschoolers (2 - 5 years)
- School aged children (6 - 13 years)
- Adolescent children (14 - 17 years); and children with underlying complex medical conditions. (It is important to note that some children with special needs who are over 15 and experience chronic pediatric conditions such as cystic fibrosis, cerebral palsy, and others will likely require specialized attention during a disaster.)

1.3 Background

The Florida Public Health Risk Assessment Tool (FPHRAT)– The FPHRAT captures information in a residual risk matrix that produces a risk, capability, and resources gap analysis for each hazard by county. Access is managed to allow county planner(s) to rank capability functions, resources, and hazards.

The FPHRAT is a collaborative project involving local, regional, and state partners. This tool helps planners to create jurisdictional risk assessments by assessing the 15 Centers for Disease Control and Prevention (CDC) Preparedness Capabilities and local resources, producing gap analyses; estimating the impacts of hazards to public health; healthcare, and mental health; measuring the positive effect of mitigation factors such as community resilience; producing a final matrix of residual risk; and exploring county, state and regional data queries.

HCC's use the FPHRAT to inform their annual planning and develop training and exercises to meet the gaps and risks outlined in the Joint Risk Assessment (JRA).

The HCCs collaborate with state and local public health, as well as Emergency Management officials and organizations to develop their annual JRA.

The goal of this project was to develop a statewide pediatric disaster surge plan for the management of an unusual incident or event that overwhelms a local healthcare system's capacity to triage, stabilize, and transfer pediatric patients to a treatment facility outside of the affected hospital's area.

EMSC: Enhancing the pediatric readiness of Emergency Departments (EDs) and Emergency Medical Services (EMS) agencies to care for children is important to improve quality of care and outcomes for ill or injured children. To achieve this objective, the United States (US) Health Resources and Services Administration (HRSA) EMS for Children (EMSC) Program and the EMSC Innovation and Improvement Center (EIIC) partners with the American Academy of Pediatrics, American College of Emergency Physicians, and the Emergency Nurses Association. Florida receives HRSA EMSC State Partnership funds to support 9 key performance measures related pediatric readiness and preparedness. (https://emscimprovement.center/programs/partnerships/performance-measures/)

At the state level, Florida EMSC named the collaborative ***Florida PEDReady.*** Florida EMSC collaborates with EMLRC to host the *Florida PEDReady* website and a monthly newsletter and disseminates resources and educational opportunities. The Florida PEDReady program aims to collaborate with other pediatric, emergency, EMS, trauma, disaster, rural and hospital stakeholders.

Florida PEDReady will primarily focus on pediatric readiness in non-children's hospitals and all EMS agencies, especially in rural areas. Nationally, the majority (80-85%) of children and adolescents access emergency care in non-pediatric facilities and have different clinical presentations and needs compared to adults.

Florida is the third most populous state in the US and the most moved to state in 2023, where almost 20% of residents are children less-than 18 years of age. Our state has approximately 215 Integrated ED's, 84 Stand Alone ED's and 17 children's hospitals, compared to other states that may only have one to two children's hospitals. Access or transfer to pediatric care is usually easily accommodated by in-state children's hospitals, as well as burn and trauma centers, although certain areas of the state have minimal EDs and pediatric resources.

According to the Agency for Health Care Administration's (AHCA) flhealthcharts.gov, in 2021 there were 8,159,134 ED visits (including 1,513,379 offsite/ freestanding) with children 0- 17 years of age accounting for 1,297,064 or 19% of those visits. Unintentional injury followed by malignancy, homicide and suicide are the leading causes of death in Florida's children over one year of age.

Children have unique physiologic, developmental, and medical needs that differ from those of adults. Furthermore, pediatric patients require size-specific equipment and caregivers trained to use that equipment. These characteristics also present the caregiver with significant challenges.

Characteristic	Causation/ Origin	Consequences
Larger head for a given body weight	High center of gravity	More likely to suffer head injuries and falls
Greater skin surface for body	Evaporative heat and water losses	Hypothermia and dehydration
Closer proximity of solid organs with less bony	Relative size with younger age	Greater chance of multi-organ injuries
Wide range of normal vital signs	Large differences in size, weight, and normal values	Difficult to determine normal values for a given individual, particularly for clinicians more accustomed to caring for adult patients
Rapid heart and respiratory rate	Normal physiologic variables based on age and weight	Faster intake of airborne agents and dissemination to tissues
Wide range of weight across pediatric age range	Normal physiologic variables based on age and weight	Greater likelihood of medication errors
Shorter height	Closer to the ground	Greater exposure to chemical and biologic toxins that settle near the ground due to higher density
Often found in groups	Daycare and school	More likely to see multiple casualties
Immature cognitive and coping skills	Age and experience, psychological development	Less likely to flee from danger, inability to cope, inability to care for themselves, find sustenance, and avoid danger
Small blood vessels	Relative size with younger age	Difficult venous access, more difficult fluid, and medication delivery

1.4 Access and Functional Needs

Caring for pediatric patients, as opposed to adults, may include several unique needs such as:

- Family/guardians being present while pediatric patients receive care.
- Ensuring pediatric patients are not left alone.
- Consent for health care may need to be granted before pediatric patients are transported/treated.

1.5 Planning Assumptions

This annex has been designed with the following assumptions in mind and includes, yet is not limited to, the following. These are non-binding assumptions that should be addressed at the beginning of a response and determined if applicable.

- The decision to activate this annex is based upon a real or perceived lack of capacity of a singular area hospital to support a response to a Health Care Coalition Pediatric Surge Annex without additional support.
- Planning and response under the Health Care Coalition Pediatric Surge Annex will be coordinated with the local Health Care Coalition, and local and State ESF-8, as needed.
- Planning and response under the Health Care Coalition Pediatric Surge Annex will be coordinated with other facility-specific response and emergency operations plans, as needed.
- Activation of this annex will be communicated with the Health Care Coalition, as needed.
- If a hospital's Emergency Operations Plan (EOP) has been activated, the Hospital Incident Command System (HICS) will be used throughout the duration of the hospital's emergency response.
- All hospitals providing emergency services are equipped to initially treat and stabilize pediatric patients in accordance with their available resources. All hospitals have differing capacities and capabilities of treating and stabilizing pediatric patients; however, all hospitals can at minimum provide initial triage and resuscitation for pediatric patients.
- Each hospital has an updated medical surge plan to fully maximize and leverage their facility and organization.
- Each hospital has pediatric patient transfer agreements in place.
- Whether a child meets pediatric age will be determined at the time of the incident and follow both organizational definitions and assessment of physical maturity and anatomical characteristics of the patient.
- After an incident, many loved ones will immediately call or self-report to the hospital where they believe their children may have been taken. Appropriate measures will be taken to handle the high demand for information and effectively coordinate information.

- Hospitals will plan for reunification in collaboration with other critical partner organizations' plans and systems within the community as needed (e.g., local health jurisdictions and emergency management).
- Critical access hospitals may not be able to treat critically injured pediatric patients long-term and will likely need to transport them to a higher trauma level hospital.
- In large incidents, or when access to the facility is an issue, critical access hospitals may be asked to provide ongoing care - pending availability of other transportation or treatment resources.

2. Concept of Operations

2.1 Activation

In accordance with the FDOH ESF-8 Patient Movement Support SOG, this plan may be activated in response to any incident with a disproportionate number of pediatric casualties. The plan may also be activated prior to a declared or proclaimed emergency. In cases where the plan is activated prior to a declaration or proclamation, the gathering of information, assessment of the situation, and notification of healthcare facilities and providers will be emphasized to provide a basis for the full implementation of the plan should an emergency be declared, and surge required.

The declaration of an emergency along with other actions taken by the Governor's Office has significant impact on the ability to meet the demands created by a surge incident. Specifically, healthcare regulations may be relaxed during a declared emergency. This allows the healthcare system to meet these demands in ways it cannot when regulations are in effect.

2.2 Notifications

Upon activation of a hospital's surge plan, the hospital will be responsible for notifying local Emergency Management to request support (as outlined in the County's Comprehensive Emergency Management Plan and the facility's Emergency Operations Plan).

Notifications and requests for support from the Florida Department of Health- ESF-8 will be made as outlined in the FDOH ESF-8 Patient Movement Support SOG.

2.3 Information Management

In the aftermath of a disaster, people immediately try to seek information. The lack of timely, credible information to the public about the incident can result in more chaotic circumstances, such as increased crowds in or near the affected area, call volume to emergency officials and services, and the presence of anxious family members seeking their loved ones. Hospital communications plans and plans for information sharing should ensure the hospital is able to gather, verify, and timely disseminate- both internally and externally, the best possible information to affected families, staff, and others. Ensuring all families are provided regular updates to the status of the incident, and the hospital's response that is relevant to them will help minimize potential psychological and security concerns generally associated with these incidents.

Some considerations for information sharing include:

- How and what kinds of critical information can be shared considering the Health Insurance Portability and Accountability Act (HIPAA) and other laws, regulations, or policies.
- How to rapidly implement communication processes, including pre-scripted messaging.
- How local emergency management and public health communities will coordinate their public messaging with hospitals.
- How to inform hospital staff regarding what information they can or cannot share.
- How best to establish good relationships with local, regional, statewide, national, and international news organizations.

Hospitals must be able to manage the ways in which family members will use their existing public-facing infrastructure (i.e., Information Desk, Emergency Department Reception Area, Hospital Phone Operator) as they inquire whether a loved one is present within the facility. If hospitals manage these points of contact effectively, they can support the facilitation of rapid identification of survivors by family members whose presence is confirmed at the hospital. Internal sharing of information among response roles is paramount to ensure a common operating picture for the facility. Hospitals should consider the following approaches to help maintain situational awareness among response roles:

- Establish a process for the Reunification Branch Director to obtain updated lists of patients at regular, prescribed intervals, and distribute these lists to all appropriate staff aiding in reunification efforts.
- Frontline staff must know when to expect the next update (i.e., every 30 minutes).
- Maintain consistency by ensuring family members and loved ones seeking information receive the same credible information (when they have a legal right to know), whether they present in person or call on the telephone to speak with an operator.
- Designate key points of contact for information collection and sharing in each area, including the Emergency Department (ED), the Hospital Reunification Center (HRC), the Pediatric Safe Area (PSA), the Reunification Site, and the Information Desk, to ensure proper oversight and communication among involved locations.
- When family members and/or loved ones cannot definitively be told their relative is not present at a hospital, family members and/or loved ones should then be directed to the HRC to wait, or to other appropriate municipal reunification resources. Hospitals should include detailed contact information for municipal reunification resources (if available) in all their communications to the public and affected families and loved ones to assist with the reunification process.

2.4 Roles and Responsibilities

During an incident with significant numbers of pediatric casualties, resources at healthcare facilities with pediatric critical care capabilities will quickly become exhausted. Therefore, developing a system that outlines how all healthcare facilities and supporting entities can assist with providing care to children is crucial to the response. The table below illustrates common responsibilities of local healthcare facilities and supporting entities.

Facility/ Entity Type	Responsibilities
Disaster Control Facility (most impacted)	• Initial notifications • Initiate identification system for reunification • Patient dispersal/ decompression • Tracking patient destinations • Decontamination (if needed) • Triage and treatment • Provide security for a Pediatric Safe Area (PSA) • Provide a controlled ingress/egress route for EMS
Department of Children and Families (DCF)	• Collect victim/casualty information. • Provide temporary care for unaccompanied minors. • Coordinate reunification of families
EMS/Fire Rescue Agency(ies)	• Coordinate EMS resources • Triage patients • Field decontamination (if needed) • Transport to healthcare facilities • Provide staff and supplies (if permitted)
Hospitals	• Triage and treatment • Decontamination (if needed) • Tracking secondary facility transfers • If not impacted, provide staff/space/supply support. • Reunification of families (with DCF/Law Enforcement) • Create a PSA for medically cleared, yet unaccompanied minors
Law Enforcement/Sheriff	• Coordinate with DCF to ensure the safety of all unaccompanied children. • Aid in identification/reunification of children in a disaster • Conduct investigations (as needed) • Notification to families of victims/casualties • Provide a secured PSA
Healthcare Coalition	• Assist local and state EOC as needed or requested. • Revise/ update their plan, as needed. • Assist impacted hospital(s) by providing guidance outlined within this plan
Specialty Clinics/Organizations (pediatrics)	• Provide pediatric consultation services to hospitals. • Provide staff/space/supplies (if permitted)

Disaster/Incident County's Emergency Management Agency/ Department/Office	• Coordinate requests for mutual aid resources • Process medical health mutual aid requests • Request aid from the State EOC forunmet needs • Notify the State Watch Office (SWO)/State ESF-8 of the incident
Skilled Nursing Facilities	• Respond to bed poll (if requested) • Provide surge relief to hospitals
Disaster/Incident County's Health Department (CHD)	• Develop medical health situation report, provide notifications/updates regularly • Provide public health officer(s) for ESF-8 (if needed) • Assist local EM, as needed
Medical Examiners/Fatality Management	• Collection and storage of deceased • Identification of deceased • Notification of death to family • Maintain accurate records
Specialty Organization (i.e., Language Line)	• Language interpretation

2.5 Logistics

In a disaster or incident, a large number of patients presenting for care may cause a "surge". Surge is determined by the number of patients a hospital can receive while maintaining usual standards of care. For each of the critical system components (space, staff, and supplies) needed to respond to a surge incident, there are three measurements that provide guidance to overall surge capacity at each of the tiered levels. An incident does not have to overwhelm assets in all three categories to have an impact on healthcare.

Conventional Capacity is the ability to manage a surge while operating daily practices with little or no impact to the patients or facility. The spaces, staff, and supplies (resources) used are consistent with daily practices within the institution.

Contingency Capacity affects the ability for daily practices to be consistent yet has minimal impact to usual patient care. At this point, the demand for resources has not exceeded local resources. The spaces, staff, and supplies (resources) used are not consistent with daily practices; however, they do provide care that is functionally equivalent to usual patient care.

Crisis Capacity may require adjustments in care not consistent with daily practices, yet the standard of care is coherent within the setting of an emergency. The best possible care is provided to patients under these circumstances. Adaptive spaces, staff, and supplies (resources) used are not consistent with usual standards of care; however, they do provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available).

Table 1 below demonstrates how each stage of surge capacity could potentially be managed as the number of pediatric patients increase.

Table 1 Pediatric Medical Surge Response Strategies

	Conventional Capacity	Contingency Capacity	Crisis Capacity
Supplies	• Facilities are able to order more supplies through normal channels.	• Stockpiled supplies are being used. • Supplies are being ordered through rushed delivery methods. • Resource requests to local health jurisdictions and Emergency Management.	• If local partners cannot fill demand, requests may be made up to the state level.
Space	• Cancel elective procedures. • Use in-place elective procedures. • Begin surge discharge.	• Clear patients from pre-induction and procedure areas. • Fill all available beds. • Begin bed availability reporting.	• Decompress hospitals. • Request state support of transportation resources. • Place patients in hallways or lobby areas, as needed. • Set up temporary structures in order to increase space capacity. • Request use of other facilities.
Staff	• Use all staff trained to care for pediatrics to provide care.	• Request additional pediatric trained staff from other hospitals.	• Request staff support from the state. • Utilize staff not trained for pediatric care after providing just-in-time training.

2.5.1 Supplies

Most emergency departments have some pediatric supplies, yet they are limited in availability and may have issues sustaining pediatric patients if they are unable to acquire more supplies or transfer the patients. Children 14 years of age and older (or of certain size) may be able to use adult medical supplies as directed by pediatric specialists.

The HCC supports members and/or partner agencies with healthcare resource management. When county and local response partners are unable to meet the need for additional resources, the partners at the state-level work to fill the gap.

A new 2020 Pediatric Readiness in the ED checklist is now available based on the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), and Emergency Nurses Association (ENA) 2018 joint policy statement "Pediatric Readiness in the Emergency Department". The checklist and toolkit

(https://emscimprovement.center/domains/hospital-based-care/pediatric-readiness-project/readiness-toolkit/) may be a useful document when developing and maintaining readiness for pediatric patients. Hospitals are encouraged to use the checklist to determine if their emergency department (ED) is prepared to care for children.

2.5.2 Space

Spaces conducive to pediatric care are identified and further categorized here:

- *Conventional spaces* are areas where care is normally provided.
- *Contingency spaces* are areas where care could be provided at a level functionally equivalent to usual care.
- *Crisis spaces* are areas where sufficient care could be provided when usual resources are overwhelmed.

2.5.3 Staff

Sources of staff with potential pediatric subject matter expertise may include medical providers (physicians, nurses, physician assistants, nurse practitioners, and others) working in emergency medicine, pediatrics, family medicine, anesthesia, Otolaryngology or Ear/Nose/Throat (ENT), pediatric surgery, trauma surgery, general surgery, orthopedics, urology, neurosurgery, thoracic surgery, the Operating Room (OR), Post-Anesthesia Care Unit (PACU), Intensive Care Units (ICUs), inpatient units and outpatient clinics, pharmacy, or respiratory therapy.

Additionally, staff in other categories/areas may have experience with pediatric care that provides them with a level of comfort and expertise, allowing them to assist in care during a disaster. They should be encouraged to keep current with pediatric topics and enroll in available courses and offered trainings to maintain their skills and confidence.

Just-in time training may need to be provided to train additional staff to care for pediatric patients. As needed, receiving hospitals should video call medical providers at hospitals that traditionally provide specialized care for pediatric patients.

At some hospitals, staff trained in pediatric emergency medicine and trauma care may be hard to find. In the event of an emergency that causes a surge of pediatric patients which overwhelms the hospital's normal capabilities, those few pediatric-trained personnel may be called upon to act more as directors rather than clinicians. Each facility should identify those internal staffing resources that could be utilized during a pediatric surge to triage, coordinate care, and prioritize the transfer sequence (this/these person(s) should be certified in a pediatric medical/trauma course [Pediatric Advanced Life Support (PALS), Pediatric Emergency Assessment, Recognition and Stabilization (PEARS), Pediatric Education for Prehospital Professionals (PEPP), Advanced Pediatric Life Support (APLS), Neonatal Resuscitation Program (NRP), Pediatric International Trauma Life Support (PITLS), etc.] or a residency-trained physician [Emergency Medicine, Pediatrics, etc.]).

Primary Goal: Increase the ability to maintain staffing levels and/or expand the workforce.

Strategies	Considerations
• Cross-train clinical staff	• Malpractice coverage • Medical Direction/Orders • Scope of Practice constraints
• Contact Nurse Staffing Agencies (registries/ traveling nurses) to assist with supplemental staffing needs.	• Just-in-time training/hospital familiarization. • Pediatric experienced staff may be limited.
• Use non-conventional staff or expand scope of practice. • Student nurses • Medical students • Military licensed staff	• Regulations to expand clinical professionals' scope of practice may require a FDOH waiver and Governor's Executive Order. Seek clarification from professional boards. • Nurse ratios
• Use of non-conventional staff • Volunteers • Paramedics/ Emergency Medical Technicians (EMT's) • Dentists • Veterinarians • Retired health professionals with an active license	• Professionals with inactive licenses will need to go through the process of reactivation. • Liability/licensing regulations.
• Utilize pediatric trained/skilled nurses to supervise adult-only trained/skilled nurses.	• Liability regulations and insurance limitations.
• Implement and/or develop just-in-time training for clinical staff normally assigned to non-direct patient care positions.	• None

2.6 Special Considerations

2.6.1 Behavioral Health

Children may respond to disaster and hospitalization in similar ways to adults, yet will also experience, process, and communicate trauma in unique ways characteristic of their developmental levels. Hospital staff should consider this when helping children cope with their hospital stay after a disaster. Staff can help children feel safer in the unfamiliar environment of a hospital by including familiar people, things, and routines as part of their care. Hospitals should also prepare staff for the different ways culture impacts a child's response to trauma.

Developmental Level-Specific Guidelines for Treating Children in the Hospital

Infants

- Let a parent or caregiver stay with and, when possible, hold the infant during medical procedures using comfort positioning and distraction techniques.
- Use familiar objects from the baby's home such as stuffed animals, blankets, music boxes or toys for comfort before, during and/or after a procedure.

Toddler and Preschool-aged Children

- Avoid discussing toddler or preschoolers' care in their presence unless you include them in the conversation. Children overhear much more than adults realize and without any explanation, information may seem terribly frightening.
- Let a parent or caregiver stay overnight with the child if possible and let other family members, including brothers and sisters, visit (if appropriate).
- Reassure the child that the hospitalization is not a punishment. Avoid applying good or bad labels to the child, particularly during a procedure. For example, instead of saying "See, you were so good, the doctor only had to do this once," you can say, "You did such a good job of sitting still I know that was hard."
- Allow children to handle medical equipment such as stethoscopes, blood pressure cuffs, etc. and to practice procedures on a doll. Children learn best through play. "Medical play" can be particularly useful.
- Allow the child to make choices whenever possible; however, do not offer a choice when none exist. For example, do not say, "Would you like to come into the treatment room now, so the doctor can look at you?" Instead say, "Do you want to bring your bear or blanket with you to the treatment room?"

School-aged Children

- Avoid discussing a child's care in their presence unless you include them in the conversation. Children overhear much more than adults realize and, without any explanation, information may seem terribly frightening.
- You can give school-aged children more specific information about what they will experience; however, many medical terms can be confusing. For example, the term "I.V." could be confused with the word "ivy," or "dye" with "die." Give simple, specific explanations for procedures and use non-technical language.
- This is a great age for medical play (communicating understanding, fears, etc. through play with medical equipment). Let the child reenact events through play with different kinds of toys or art materials. This will help school-aged children express their feelings and gain a sense of control over what is happening to them.
- Encourage all staff to respect the child's privacy by knocking before entering his or her room and by being sensitive to who is around when examinations are in progress.
- Children this age may regress or revert to behaviors that they had outgrown (thumb sucking, bed wetting, etc.) during stressful situations such as hospitalization. Do not berate (e.g., say, "come on, you're a big girl now…") or punish children for such behavior; instead, encourage them to express their feelings and discharge emotions through play.

Adolescents

- Avoid discussing teenagers' care in their presence unless they are included in the conversation. Adolescents can understand much more about their bodies and what is happening to them than younger children and may resent being excluded from discussions.

- Do not assume teens manage their emotions the same way as adults. Give teens opportunities to talk to staff about what is happening and to ask questions, both with and without parents or caregivers present.
- Encourage all staff to respect teens' privacy by knocking before entering exam rooms and by being sensitive to who is around during examinations.
- Adolescents are particularly concerned about body image and do not want to be perceived as "different" than peers because of an illness or injury. Be especially sensitive to the physical change's adolescents may experience when explaining any procedures, injuries, or treatments.

How to Help Children During and After a Disaster

There are many ways to help children both before, during, and after a disaster, especially if their age is considered.

Children Younger than Five Years of Age

- Maintain their normal routines and favorite rituals as much as possible.
- Limit exposure to TV programs and adult conversations about the events.
- Ask what makes them feel better.
- Give plenty of hugs and physical reassurance.
- Provide opportunities for them to be creative and find other ways to express themselves.

Children Older than Five Years of Age

- Do not be afraid to ask them directly what is on their minds and answer their questions honestly.
- Talk to them about the news and any adult conversations they have heard.
- Make sure they have opportunities to talk with peers, if possible.
- Set gentle but firm limits for "acting out" behavior.
- Encourage expression, verbally and through play, of thoughts and feelings.
- Listen to their repeated retellings of the event.

When to Consult a Mental Health Professional

Seek psychiatric consultation if children exhibit any of the following behaviors:

- Excessive fear of something terrible happening to their parents or loved ones.
- Excessive and uncontrollable worry about unfamiliar people, places, or activities
- Fear of not being able to escape if something goes wrong.
- Suicidal thoughts or the desire to hurt others.
- Hallucinations
- Feelings of being helpless, hopeless, or worthless

2.6.2 Infection Control

The purpose of this section is to guide health care partners involved with a major communicable disease emergency in managing exposure risks between and among differentially affected children (contacts, suspected cases) and their adult caregivers. The local County Health Department (CHD) maintains the county's infectious disease

emergency response plan.

Activation of the infectious disease emergency response plan will be coordinated with and through the disaster county's County Health Department. Hospital Incident Command Centers may also be activated in response to an infectious disease emergency and will coordinate response activities with the Florida DOH, as outlined in the disaster county's Comprehensive Emergency Management Plan (CEMP).

2.6.3 Decontamination

The following recommendations are intended to facilitate decontamination of all children presenting to any hospital during a disaster in a timely manner. Children require special considerations that may not be addressed in a general Hospital Decontamination Plan.

General Guidelines

Infants and children have unique needs that require special consideration during the process of hospital-based decontamination, such as:

- Avoiding separation of families during the decontamination process
- Older children may resist or be difficult to handle due to fear, peer pressure and modesty issues.
- Since parents or caregivers may not be able to decontaminate both themselves and their children at the same time, decontamination personnel may need to assist them.
- Incorporating high-volume, low pressure water delivery systems that are "child- friendly" into the hospital decontamination showers.
- Risk of hypothermia increases proportionally in smaller, younger children when the water temperature in the decontamination shower is below 98°F
- Pay attention to airway management, a priority in decontamination showers.
- The smaller the child, the bigger the problem regarding any of the above considerations

Decontamination Recommendations Based on Child's Age

The following recommendations are based on the child's estimated age of appearance, since asking may be impractical due to the limitations of personal protective equipment (PPE) and/or due to a large influx of patients. These recommendations are divided into three groups by ages – infants and toddlers (0-2 years), preschool children (2-8 years), and school-aged children and adolescents (8-17 years).

Infants and Toddlers (0-2 years)

Infants and toddlers are the most challenging group to treat; special needs considerations are of the utmost importance in this group. In accordance with the hospital policy, follow the guidelines below during treatment.

- All infants and toddlers should be placed on a stretcher, a bassinet, or a laundry basket with holes and undressed by either the child's caregiver or hospital decontamination personnel. All clothes and items should be placed in appropriate containers or bags provided by the hospital and labeled.

- Each child should then be accompanied through the decontamination shower by either the child's caregiver or hospital decontamination personnel to ensure the patient is properly and thoroughly decontaminated. It is not recommended the child be separated from family members or adult caregivers. Caregivers should not carry the child because of the possibility of injury from a fall, or from dropping a slippery and squirming child. Special attention must be given to the child's airway while in the shower.
- Non-ambulatory children should be placed on a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated (glasses, hearing aids, or other devices) should be placed in appropriate containers or bags as provided by the hospital and labeled.
- All non-ambulatory children should then be escorted through the decontamination shower by the child's caregiver (if available), and decontamination personnel to ensure the patient is properly and thoroughly decontaminated. Special attention must be paid to the child's airway while in the shower.
- Once through the shower, the child's caregiver or post-decontamination personnel will be given a towel and sheets to dry off the child, and a hospital gown. The child should immediately be given a unique identification number on a wristband and then triaged to an appropriate area for medical evaluation.
- Children and their parents or caregivers should not be separated unless critical medical issues take priority.

Preschool-Aged Children (2-8 years)

Children ages two to eight years can walk and speak, yet (with considerable variations in physical characteristics) are clearly children. In accordance with the hospital policy, follow the guidelines below during treatment.

- Ambulatory children should be assisted in undressing with help from either the child's caregiver or hospital decontamination personnel. All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
- Each ambulatory child should be directly accompanied through the shower by either the child's caregiver (if available) or hospital decontamination personnel to ensure the entire patient is properly and thoroughly decontaminated. The child should not be separated from family members or the adult caregiver.
- Non-ambulatory children should be placed in a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
- Each non-ambulatory child on a stretcher should be escorted through the decontamination shower and assisted with decontamination to ensure the patient is thoroughly and properly decontaminated.
- Once through the shower, each child should be given a towel and sheets to dry themselves, and a hospital gown. The child should immediately be given a unique identification number on a wristband and then triaged to an appropriate area for medical evaluation and treatment.
- Children and their parents or caregivers should not be separated unless critical medical issues take priority.

School-aged Children and Adolescents (8-17)

At the age of eight years and older, children's airway anatomy approximates that of an adult. Although it is tempting to regard this age group as "small adults" there are special needs unique to this age group. In accordance with the hospital policy, follow the guidelines below during treatment.

- Ambulatory children should undress as instructed by hospital decontamination personnel. All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
- Each ambulatory child should then walk through the decontamination shower, preferably in succession with their parent or caregiver, and essentially decontaminate him or herself.
- Non-ambulatory children should be placed on a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
- Each non-ambulatory child should be escorted through the decontamination shower and assisted with decontamination to ensure the entire patient is properly and thoroughly decontaminated.
- Once through the shower, each child should be given a towel and sheets to dry themselves, and a hospital gown. The child should then immediately be given a unique identification number on a wristband and triaged to an appropriate area for medical evaluation.
- Children and their parents or caregivers should not be separated unless critical medical issues take priority.

2.7 Operations- Medical Care

2.7.1 Triage

Disaster triage is a method of quickly identifying victims who have life-threatening injuries and who also have the best chance of survival. Identification of such victims serves to direct other rescuers and health care providers to these patients first when they arrive on the scene. The use of disaster triage involves a change of thinking from everyday care to:

- High intensity care should go to the sickest patient and doing the greatest good for greatest number.
- Identify victims with the best chance of survival for immediate intervention, focusing care on those with serious and critical injuries, yet who are salvageable.
- Identify victims at extremes of care by sorting those who are lightly injured and those who are so severely injured they will not survive.
- Provide immediate treatment to only those victims that procedure or intervention may make a difference in survival. Altered standards of care will be based on resource availability.

Disaster triage must be dynamic and fluid in its execution. Primary triage is done at the scene by first responders; the triage category is assigned rapidly and is based on physiologic parameters and survivability. Secondary triage occurs typically at the facility where the patient is transported. The initial triage assignments may change and evolve as the patient's condition changes, so reassessment is crucial. It is essential that medical personnel prioritize transport and treatment based on level of injury and available resources.

In the State of Florida, the primary pre-hospital triage of adult and pediatric patients is accomplished using the Simple Triage and Rapid Treatment (START) and JumpStart methods. Lee County Emergency Medical Services are utilizing RAMP as their triage method. The first arriving medical personnel will use a their method to categorize the victims by the severity of their injury. The victims will be easily identifiable in terms of what appropriate care is needed by the triage ribbons/tags they were administered. Once the evaluation is complete, the victims are labeled with one of the four color-coded triage categories:

- Minor (Green) – delayed care/can delay up to three hours
- Delayed (Yellow) – urgent care/can delay up to one hour
- Immediate (Red) – immediate care/life threatening
- Deceased (Black) – victim is dead, or mortally wounded/no care required

During some large-scale mass casualty disasters, it is important to realize that only a portion of victims may present via "traditional" methods (i.e., ambulance, walking wounded); the first wave of victims will often self-present at facilities and require the healthcare facility to conduct the primary triage. Hospitals should be well practiced in whichever triage methodology they use and be prepared to establish a triage, treatment, and transport sector on site. Two excellent resources for hospitals to use in developing surge plans are the *15 'til 50 Publications* and the 2017 *Las Vegas Mass Shooting Case Study*.

2.8 Treatment

HCC partners should refer to facility specific plans, protocols, and training for guidelines regarding pediatric patient treatment.

2.9 Transportation

All hospitals should be prepared to provide extended care to children during a disaster. As part of this care, hospitals may need to transport children from one clinical area to another (including inpatient units) or to diagnostic testing locations (such as radiology, computed tomography, and ultrasound areas).

Hospitals lacking specialized pediatric services may need to transfer children, after initial evaluation and stabilization, to centers with advanced pediatric capabilities. Keep in mind; however, that transfer (or evacuation, if necessary) might be impossible due to local conditions, safety concerns, lack of appropriate transport vehicles or personnel, or lack of capacity at specialty children's hospitals.

For more information, including interfacility transfer guidelines and template, visit: http://www.floridahealth.gov/provider-and-partner-resources/emsc-program/index.html

Even when transfer to pediatric centers is possible, usual staff and equipment may be stretched thin by the disaster; therefore, hospitals should develop alternative

mechanisms for safely transferring children based on the following guidelines:

2.9.1 Stable Children

Arrange for child car safety seats, including:

- Rear-facing seats for children younger than two years of age or who weigh less than 40 pounds.
- Forward-facing seats for children two to four years of age or who weigh more than 40 pounds or are more than 40 inches tall.
- Booster seats for children four to eight years of age or taller than 4 feet 9 inches.
- Rear seats with seat belts for children eight to twelve years of age; children younger than thirteen years should not ride in the front seat.

To obtain appropriate car seats:

- Purchase them through retail/ commercial locations.
- Request them through donations from non-government organizations (NGO's).
- Survey employees to identify car seats available in personal vehicles.
- Contact the local EMS agencies for availability.

2.9.2 Unstable Children or Potentially Unstable Injured or Ill Children

Potential transport vehicles include ambulances staffed with emergency medical technicians or paramedics, which may also include:

- Hospital staff skilled in pediatric airway care and resuscitation.
- Equipment appropriate for the child's age and acuity.
- Specialty pediatric transport vehicles and teams from referral pediatric institutions.
- For less critical patients only, Advanced Life Support (ALS) ambulances with no additional hospital staff.
- Ambu-buses staffed by hospital and EMS personnel.

If ambulances are not available, appropriate transport possibilities include:

- Cars, vans, and city/private buses may be appropriate for children who can sit up (car seats may be necessary).

School buses may be used for children aged five years and older who can sit up. Considerations for this strategy include:

- Drivers must be able to communicate with hospital emergency command centers by cell phone or radio.
- Appropriate medical personnel (emergency medical technicians, paramedics, nurse practitioners, physician assistants, nurses, physicians, etc.) must accompany children during transport.
- Ideally, mental health personnel or staff trained in children's psycho-social needs should accompany children.

When transporting children, the following guidelines are recommended to ensure compliance with Section 316.613, Florida Statutes regarding child safety seats:

- Children 5 years or younger- use a crash-tested, federally approved child restraint device.

- For children aged through 3 years, such a restraint must be a separate carrier or a vehicle manufacturer's integrated child seat.

For children aged 4 through 5 years, a separate carrier, an integrated child seat, or a child booster seat may be used. However, the requirement to use a child restraint device does not apply when a safety belt is used and the child:

- Is being transported gratuitously by an operator who is not a member of the child's immediate family.
- Is being transported in a medical emergency involving the child; or
- Has a medical condition that necessitates an exception as evidenced by appropriate documentation from a health care professional.

2.10 Tracking

Hospitals have historically served as safe havens for displaced persons during a disaster. Abandoned children are also often brought first to a hospital emergency department for evaluation. During a disaster, hospitals may again serve as safe havens and may find themselves host to displaced and unaccompanied children. As an example, Hurricane Katrina and the ensuing floods and chaos caused more than 3,000 children to be displaced throughout the United States. These displaced children, if unaccompanied, are at increased risk for maltreatment, neglect, exploitation, and subsequent psychological trauma. Hospitals and medical clinics therefore need to be especially alert to the safety and mental health issues of these children.

Hospitals, especially those that do not routinely take care of the pediatric population, need to pay special attention to the specific security needs of this group and take the necessary precautions to ensure proper care of these individuals while they are in the hospital.

There are two populations of accompanied children during a disaster that should be addressed:

- The pediatric patient who is a patient of the hospital because of the disaster and who may become separated from the responsible adult; for example, if the responsible adult is also a patient.
- The pediatric visitor who is not a patient of the hospital yet may be accompanying an adult person who is a patient (e.g., a critical adult patient who was caring for a minor at the time of the disaster prevent).

A possible solution to tracking these persons is to use a system of identification bands for the minors and corresponding responsible adults that are distributed as soon as these individuals contact the Emergency Department (ED) area. Care must be taken to place bands or other identification devices quickly and correctly on both parties.

Special attention needs to be taken to ensure this measure is completed as soon as possible at the entry point to the hospital to reduce the possibility of human error during the matching and placing of the bands.

There are hospital policies in place for the tracking of minors from pediatric and maternity wards. These identification bands are used on all patients as they enter the hospital. The specific concern raised here is minors accompanying the adults during a disaster-level event who could easily be lost during the chaos of a disaster event.

The identification bands used should include the following information, which will be useful in maintaining a tight link between pediatric patient/visitor and adult:

- Name of pediatric patient/visitor + Date of Birth (DOB)
- Name of adult + DOB
- Admission date of adult
- Admission date of pediatric patient
- Date of visit of pediatric visitor

In addition, a more sophisticated approach to tracking could be implemented using bar-coded bracelets as identifiers that can be affixed to the pediatric patient/visitor and to the adult at the time of entry to the ED or other entry point of the hospital. In this manner, the same bar code is assigned to the adult and the pediatric patient/visitor(s) with the adult.

2.11 Reunification

Rapid identification and protection of displaced children (less than 18 years of age) is imperative to reduce the potential for maltreatment, neglect, exploitation, and emotional injury. A critical aspect of pediatric disaster response is effectively addressing the needs of children who have been displaced from their families and legal guardians. The separation of children from significant others is a recognized factor influencing the psychological responses of children after a disaster.

All hospitals, medical clinics, and shelters providing care to child survivors of disasters should immediately implement appropriate child-safety measures in direct response to this crisis. Initiatives such as *"ReUnite"* implemented in Lee, Hendry, and Glades Counties has provided a rapid, systematic protocol for successfully identifying and protecting displaced children. ReUnite is a community-based collaborative between United Way and law enforcement agencies in Lee, Hendry, and Glades Counties. It is offered free of charge for children and vulnerable adults who may be prone to wandering or becoming lost. ReUnite is a multi-layered program that incorporates the Lee County Sheriff's Office Aviation Unit, drones, and a group of certified Bloodhounds – specifically designated for search and rescue operations. The primary objective is to reduce search time when an individual is reported missing by a caregiver. This program provides families with a free scent kit which will aid search and rescue operations by equipping them with critical information in the event the at-risk individual becomes lost.
For more information on the program, please email ReUnite@UnitedWayLee.org or call (239) 433-7583.

Protocol to Rapidly Identify and Protect Displaced Children

Survey all children in your hospital, medical clinic, or shelter to identify children who are not accompanied by an adult; these children have a high probability of being listed as missing by family members. Find out where they are sleeping/being held and the name and age of person(s) who is/are supervising them, if available.

Place a hospital-style identification bracelet (or ideally a picture identification card) on the child and a matching one on the supervising adult(s), if such an adult is available. Check frequently to make sure that the wrist band matches that of the adult(s) seen with the child in the hospital or shelter. Some children may also have a triage tag number that will accompany the child from the field to the hospital that must not be removed. If there is no supervising adult, the child should be taken to the hospital's pre-determined

Pediatric Safe Area (as identified within the hospitals EOP) where he/she can be appropriately cared for until a safe disposition or reunification can be made.

The names of all children identified through the survey as not being with their legal guardians or who are unaccompanied should be considered at high-risk and immediately reported to the Hospital's Incident Command Center (HICC). Additional reporting should also be made to the disaster county's Department of Children and Families (DCF) Emergency Response Division, notifying them there are unaccompanied minors at the facility.

The DCF will coordinate with local law enforcement to identify the child and the child's parent(s) or guardian(s). If a guardian cannot be identified, DCF will take actions to assume emergency custody of the child, so they may be discharged from the hospital.

Unaccompanied children and those who are not with their legal guardian(s) should undergo a social and health screening taking into consideration an assessment of the relationship between the child and the accompanying adult, ideally performed by a physician with pediatric experience.

Reunification

It is essential that children are definitively identified and matched to their legal custodial parent/guardian before release from the hospital. Accurate identification of children before releasing them from the hospital is key to preventing harm. Mistaken identity may lead to:

- Release of a child to the wrong family
- Release of a child to an unauthorized noncustodial parent
- Delay of reunification with the child's actual family (this affects both the child and the family)
- Failure to identify significant medical and other conditions important to the care of the child.

Most children will be able to self-identify verbally, as well as identify their parents. Children who can identify both themselves and their parents can typically be released to their parents following standard hospital policies.

For those children who cannot be definitively identified, it is recommended that hospitals develop procedures to safely maintain care for all unidentified children until they can later be definitively reunited with their families. This includes planning for a Pediatric Safe Area (PSA), as identified later in this document. Children may not be able to self-identify if they are nonverbal due to developmental age, illness, or ability. In addition, it is possible that some children's usual guardians may have experienced an extreme loss of resources and may be unable to safely care for the child at the time of release from the hospital.

For children unable to be reunited with a parent or legal guardian, the Department of Children and Families (DCF) should be notified to take emergency custody. Protective services will work with law enforcement personnel to continue the search for the legal custodians and will work with hospital personnel to arrange temporary placement for the child, as either a temporary social admission to the hospital or placement with a child's relatives or a foster family. The timeline for transferring unaccompanied minors to foster care or specialized care, when applicable, differs depending on specific state criteria and details of the disaster.

Service options could range from immediate transfer to foster care, to delayed transfer following an extended period. To expedite the reunification process for children placed into foster care, courts may choose to issue an order stating that children may be immediately released from foster care back into their parents or legal guardians' care once they are located and identification is confirmed. Health care facilities should familiarize themselves with state laws regarding unaccompanied minors in advance of a disaster and adjust planning efforts accordingly.

The Hospital Reunification Center (HRC)

It is recommended all hospitals have a plan in place to manage a surge of concerned family members, loved ones, guardians, and friends that may present following a disaster, especially if large numbers of unaccompanied pediatric patients could be involved in the incident. This is recommended as the volume of family members presenting to the hospital looking for their loved ones will typically overwhelm hospital lobbies and other care areas and could adversely affect clinical operations. This place where families and others may gather is often called a Hospital Reunification Center (HRC). The HRC is meant to:

- Provide a private and secure place for families to gather, receive, and provide information regarding children and other loved ones who may have been involved in the incident.
- Provide a secure area for these families away from media organizations and curiosity seekers.
- Facilitate efficient information sharing among hospitals and other response partners to support reunification.
- Identify and support the psychosocial, spiritual, informational, medical, and logistical needs of family members to the best of the hospital's ability.
- Coordinate death notifications, when necessary.

Hospitals should consider locations in their facility that are best suited to establish a reunification center effectively and respectfully. Some considerations to keep in mind are:

- Locate the HRC away from the hospital Emergency Department and media staging sites as well as away from the designated pediatric safe area (see security section below).
- Ensure there is sufficient space to accommodate many individuals.
- Adequate space facilitates communication between designated hospital personnel and family members.
- Provide nearby access to smaller rooms that may be used for confidential discussions, notifications, and provision of other support.
- Distraught family members, loved ones, guardians, friends may need additional space; alcoves or additional rooms may help both psychologically and with security.
- Ensure the space has an area for food and beverages.
- Ensure restrooms are easily accessible.
- Ensure the space is accessible to patients and family members with considerations for access and functional needs.
- Access to the HRC can be controlled and security can be assured within the site.

The Reunification Site (RS)

Once identification and verification of a child and family is complete, there should be a separate area to facilitate the actual reunification of the family and child. The physical place where pediatric patients are reunited with their legal caregivers should be located away from the HRC as well as the PSA. This is to permit the reunification to occur in a safe, well-controlled area located well away from the noise and distractions of the other areas. The reunification site should allow for secure and simple departure from the hospital. Hospitals should also plan for reunification of patients who have been admitted to the hospital and for escorting of parents or guardians to other areas of the hospital.

Separation of the Reunification Site from the HRC is also important to prevent creating additional trauma for families still waiting in the HRC, who are not yet reunited with their children yet would otherwise be watching reunifications happening in front of them.

Families, guardians, loved ones, friends arriving at the hospital will be under a tremendous amount of stress and may have limited ability to process instructions or other information while they are looking for their children. Therefore, staff members in the HRC must have experience in helping people under stressful conditions. Hospital staffing may include, yet are not limited to, the following departments:

- Security
- Social Work
- Nursing
- Chaplaincy
- Psychiatry or Psychology
- Pediatrics
- Family Medicine
- Child Life

Pediatric Safe Area

To ensure the pediatric patients' safety, as well as to help patients cope, a Pediatric-Safe Area (PSA) should be established in an appropriate area that allows children to play and move about safely. Therefore, the hospital should pre-plan for, and be able to securely operate a PSA. The PSA is a controlled and supervised space where children can play and wait safely and securely while awaiting reunification with their families. This space should be in an area separate from both the Emergency Department and the HRC. The following are some issues to consider when determining a PSA location:

- The PSA should be away from the hospital Emergency Department and media staging sites as well as the HRC.
- Ensure there is sufficient space to accommodate children of different ages with age-appropriate activities for each group; consider leveraging an existing infrastructure such as a childcare center.
- Provide nearby access to smaller rooms or adjacent spaces that may be used for younger children such as babies or for children with sensory integration issues.
- Ensure restrooms are easily accessible and appropriate for pediatric patients.
- Ensure the space has an area for food and beverages; ensure attention to patients with possible food allergies.

Access to the PSA and restrooms must be able to be controlled, and security must be around and within the site.

Security

Security will play an integral role in any emergency requiring the activation of a hospital's reunification plan. Many of these incidents could involve increased security risks, such as in the case of an active shooter scenario or terrorist activities. In addition, as families attempt to find their loved ones, crowds will form requiring an increased need for security personnel. As such, it is important to engage the institution's security leadership early in the planning process. At a minimum, the hospital reunification plan should include the creation of a security leader within its command structure. Hospital security personnel can also assist with coordination of interface between the institution and outside law enforcement. Ideally, an individual with preexisting relationships with law enforcement on local and regional levels, including relevant federal entities (e.g., Federal Bureau of Investigation; Bureau of Alcohol, Tobacco, Firearms and Explosives), may fill this position. There will need to be a security presence in the HRC and the PSA.

2.12 Deactivation and Recovery

Deactivation of this annex will depend upon whether the HCC Pediatric Surge Plan has been activated or not. To deactivate:

- Deactivate patient tracking (if applicable).
- Notify partners the pediatric medical surge response has been completed.
- Refer to public health and emergency management officials for more information regarding recovery, such as reunification, mental and behavioral health following trauma follow-up, etc.

2.13 Training and Exercises

The Florida Department of Health, Bureau of Preparedness and Response (BPR), Training and Exercise (T&E) Section annually brings together representatives from the BPR, 10 Health Care Coalitions, County Health Department representatives from all seven (7) regions, representatives from the Florida Division of Emergency Management Training and Exercise (T&E) Unit, Florida Hospital Association, and bureau capability leads.

The purpose of the Integrated Preparedness Planning Workshop (IPPW) is to determine State and local training and exercise gaps, including those that impact pediatric surge, identify priorities, and discuss inputs for the annual Integrated Prepared Plan (IPP).

The IPPW provides an opportunity for participants from across the state to share strategies and coordinate plans for emergency preparedness and response, including planning for pediatric surge, if applicable. The setting also enhances coordination among jurisdiction officials, as well as shared proven strategies and practices, and the ability to apply lessons learned from past incidents.

The BPR T&E staff compiles the group's preliminary work into one document for discussion during the workshop. No CHD, capability lead, or HCC is expected to meet every individually identified training or exercise priority.

The format allows participants an opportunity to better understand the many resources available to them and provides for small group discussions to promote collaboration.

During these small group discussions, HCC representatives, bureau capability leads, and regional CHD representatives are encouraged to collaborate within their own and neighboring regions to address training and exercise gaps and needs.

Groups then select the top three (3) training and tabletop exercises for the BPR, T&E Section to develop during the next grant cycle.

3. Appendices

3.1 Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies

Adapted from *Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies*.

Children have unique, often complex physiological, psychosocial, and psychological needs that differ from adults, especially during disaster situations; and, unfortunately, children are often involved when disasters occur. These essential pediatric domains and considerations are intended to support every hospital's disaster preparedness policies, not replace them. The domains were developed as tools to help hospital administrators and leadership incorporate essential pediatric considerations into existing hospital disaster plans and policies.

- What it is designed to do: This tool was designed to complement and augment existing disaster resources, both pediatric-specific and general, rather than to serve solely as a stand-alone document. Users may find the entire checklist useful or may focus on specific domains, depending on their unique needs and resources. The relative importance assigned to any given consideration is unique to each facility based on their specific risk assessments.
- What it is not designed to do: This is not a step-by-step guide to implementing policies. Instead, resources are provided for each domain to offer more details and help implement the considerations.

The following domains are priority planning areas for healthcare facilities:

- Essential Resources – Space, Staff, Supplies
- Care and Shelter
- Transportation, Tracking, and Reunification
- Triage, Infection Control, Decontamination
- Behavioral Health

Each of these essential pediatric domains are organized into functional appendices of this plan and are intended to be used as quick reference guides for healthcare facilities.

It is the consensus of national subject matter experts that the pediatric domains and considerations in this checklist be well integrated into existing all-hazards hospital disaster preparedness policies or guidelines. For example, this checklist can be used to supplement the eight healthcare preparedness capabilities, so the pediatric domains are addressed by healthcare coalitions funded by the *Hospital Preparedness Program*. Furthermore, hospital disaster plans are unique to each facility and community; hence hospital administrators and managers are encouraged to work closely with their local, regional, and state healthcare systems and healthcare and/or disaster coalitions, national disaster partners, and their corresponding local chapters to adapt recommendations to their local needs, strategies, and resource availability. A comprehensive compendium of pediatric disaster resources and searchable databases is now available from the U.S. National Library of Medicine- Disaster Information Management Research Center's Health Resources About Children in Disaster and Emergencies.

Background

Children comprise 22.1 percent of the U.S. population[1] and account for about 22 percent of all hospital emergency department visits[2]. The findings by Bennett et al[3] highlighted that, although the numbers of pediatric EM physicians and fellowship training programs have increased, the numbers of pediatric EM subspecialists who are clinically active are nowhere near the quantity needed to staff every ED in the United States. The report noted deficiencies in the availability of pediatric equipment, supplies and medications, training for medical staff, and policies incorporating the unique needs of children. Furthermore, in the wake of Covid-19 (2020), the report noted that such deficiencies in everyday operational readiness are exacerbated during a disaster, calling the nation's emergency care system "poorly prepared for disasters."[3]

While there have been marked improvements in many areas of pediatric emergency care over the past decade[4]. A June 2022 study found high ED pediatric readiness was associated with reduced in-hospital and 1-year mortality among injured and medically ill children receiving emergency care in 11 states, which appeared to be largely due to the prevention of early deaths. The findings of this study suggest that more than 1000 pediatric deaths may have been prevented in these states over 6 years by increasing the level of pediatric readiness among all EDs[5].

In 2013, the American Academy of Pediatrics, the American College of Emergency Physicians, the Emergency Nurses Association, and the Emergency Medical Services for Children (EMSC) Program collaborated jointly on a quality improvement initiative, the National Pediatric Readiness Project. The project initiated an assessment of more than 5,000 U.S. emergency departments and more than 4,100 facilities responded (83 percent). Preliminary results illustrated that less than half of all U.S. hospitals reported having written disaster plans addressing issues specific to the care of children. Based on these findings, the National Pediatric Readiness Project stakeholder group recommended convening a multidisciplinary workgroup to develop a tool to assist hospitals to assure pediatric considerations are included in existing or future disaster plans.

The primary goal of the workgroup was to build on existing resources, with a particular focus on best practice guidelines and checklists from local geographic regions, to come to consensus on essential domains of pediatric considerations that should be incorporated into disaster policies for all hospital types in the United States. While this checklist takes an all-hazards approach to pediatric hospital preparedness, it is designed primarily to identify the personnel, resources, equipment, and supplies that will be useful for rapid onset pediatric surge planning, as well as for disaster response involving pediatric patients. Specific references and links to more robust resources for disaster and pandemic incidents for each domain are provided at the end of the document.

[1] Census Bureau Releases New 2020 Census Data on Age, Sex, Race, Hispanic Origin, Households and Housing, May 25, 2023 https://www.census.gov/newsroom/press- releases/2023/2020-census-demographic-profile-and-dhc.html

[2] Centers for Disease Control and Prevention, Ambulatory and Hospital Care Statistics Branch. National Hospital Ambulatory Medical Care Survey:2020 https://www.cdc.gov/nchs/data/nhamcs/web_tables/2020-nhamcs-ed-web-tables-508.pdf

[3] Bennett CL, Espinola JA, Sullivan AF, et al. Evaluation of the 2020 pediatric emergency physician workforce in the US. JAMA Net Open. 2021;4(5):e2110084. doi:10.1001/jamanetworkopen.2021.10084

[4] American Academy Of Pediatrics, Access to Optimal Emergency Care for Children, Volume 147, Issue 5, May 2021. https://publications.aap.org/pediatrics/article/147/5/e2021050787/180819/Access-to-Optimal-Emergency-Care-for-Children?autologincheck=redirected

[4] National Pediatric Readiness Project. National Results. Revised July 7, 2023. from https://emscimprovement.center/domains/pediatric-readiness-project/assessment/2021/

[5] Emergency Department Pediatric Readiness and Short-term and Long-term Mortality Among Children Receiving Emergency Care. Craig D. Newgard, MD, MPH1; Amber Lin, MS1; Susan Malveaux, MS1; et al. 2023 Published: January 13, 2023. doi:10.1001/jamanetworkopen.2022.50941

Domain 1: Staff coordinator to champion pediatric disaster coordination and response - roles and responsibilities

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Professionals with pediatric training in medical content and disaster response, or willing to learn about disaster response (e.g., Incident Command System (ICS) courses)	Yes No	
Non-pediatric professionals who could advocate for and integrate the needs of children in planning and impact pediatric disaster response (e.g., neurosurgeon, trauma surgeon, other surgical subspecialists, infectious disease, adult emergency medicine physicians, etc.)	Yes No	
Formal designation of advocates with defined roles/responsibilities/authority, including: • Incorporates pediatric-specific considerations within the hazard vulnerability analysis and planning goals. • Plans and coordinates disaster drills that include pediatric patients. • Serves as liaison for pediatric patients/concerns on hospital committees (e.g., medical, trauma, disaster, etc.) • Assures pediatric considerations and priorities are included in all staff disaster education and training. • Assures pediatric considerations and priorities are included in disaster education for prehospital providers. • Assists with development and review of the hospital disaster policies, ensuring that pediatric needs are addressed. • Serves as liaison representing children to regional facilities, EMS agencies, healthcare coalitions, and organizations to promote community disaster preparedness inclusive of children. • Collaborates with disaster program manager. • Promotes pediatric disaster awareness in the community	Yes No	

Domain 2: Partnership building to facilitate surge capacity

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Coalition-building and relationships (pact among hospitals and other healthcare facilities) with hospital and nonhospital stakeholders (e.g., primary care, churches, medical homes, EMS, schools, daycare centers, Red Cross, etc.) to support pediatric care and families	Yes No	
Process/plan to measure, prioritize, and expand pediatric surge capacity and capabilities based on resource availability	Yes No	
Process to facilitate the triage of patients including children for transport from the prehospital setting to the appropriate destination	Yes No	
Defined pediatric transfer processes, i.e., agreements and guidelines to facilitate movement of children needing pediatric specialty facilities as well as those more stable children needing to be moved to increase surge capacity of specialty centers	Yes No	
Telemedicine/telephone consultation agreements, processes, and equipment to facilitate provision of pediatric care in facilities not typically caring for children	Yes No	
Method to integrate facility disaster policy with community and regional disaster plans, including prehospital systems of care	Yes No	

Domain 3: Essential resources necessary for building pediatric surge capacity

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Plan for expanded and alternative space for pediatric surge for key services: • Alternative care sites (including sites for the provision of general inpatient and outpatient overflow and specialty care, such as critical care, technology dependent care, surgery, etc.) • Decontamination showers and mass decon areas • Family, guardians, loved ones staging/waiting	Yes No	
Pediatric equipment (e.g., ventilators, isolettes; consider equipment and supplies to support children with special health care needs) Memorandum of Understandings (MOUs) to obtain additional equipment for surge	Yes No	
Pharmaceutical needs and drug administration aides (pediatric appropriate drugs, dosing, and administration guidelines including specific pediatric antidote dosing requirements for exposure to chemical/biological agents, access to pharmaceutical caches and stockpiles, Pediatric length-based tapes/systems or equivalent, kilogram scales, etc.)	Yes No	
Dietary needs: regular formula, special formula (non-dairy, lactose free), infant foods, and equipment (bottles, feeding tubes) to meet surge	Yes No	
Supplies and accommodations (e.g., cribs, diapers, recliner for parents) Inventory of items attached. Memorandums of Understanding (MOUs) to obtain additional supplies for surge	Yes No	
Needs for prolonged patient stays in your facility when transfer not immediately possible (shelter in place)	Yes No	

Domain 4: Triage, infection control, and decontamination

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Pediatric disaster triage processes that include defined process when infectious disease or exposure suspected	Yes No	
Temperature- and pressure-regulated water controls for pediatric decontamination, especially for small children	Yes No	
Process for keeping families together during decontamination	Yes No	
Disposable pediatric-sized face masks	Yes No	
Pediatric isolation capabilities (e.g., contact, airborne)	Yes No	
Process for disinfection of communally available toys in the facility	Yes No	
Shelter in place and evacuation procedures for children	Yes No	

Domain 5: Family tracking, security, support, and reunification

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Child identification (ID) forms and ID bands for all children arriving at the hospital listing information available from verbal children (name, age, parent name, address/phone, and possibly allergies) and identifying characteristics and intake source (where did they arrive from and who brought them in) of nonverbal children	Yes No	
Central transfer/tracking tool with capacity to record children's photos/ID information. This should include digital camera and photo printing capabilities	Yes No	
Processes defined to support family togetherness and reunification during triage, care, and post disaster	Yes No	
Procedures/staff/volunteers to care for unattended children brought into the hospital	Yes No	
Process for maintaining or increasing adequate security for existing pediatric patients in all areas of the hospital in addition to the emergency department	Yes No	
Specialized, separate spaces for injured/ill and non-injured/non-ill unaccompanied children with security guard and appropriate staff	Yes No	
Defined security, support, and reunification processes for non-verbal children	Yes No	
Obstetrics/Gynecologic (OB/GYN) – the unique considerations of disasters on pregnant women, delivery, breastfeeding, and care of newborns	Yes No	
A plan to establish an Information and Support Center (which could include staffing by volunteers)	Yes No	

Domain 6: Legal/ethical issues

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Policies and education regarding assents/consents for pediatric assessment, testing, or treatment with or without a parent in a disaster situation	Yes No	
Review and understand ability to require vaccination, testing, or treatment notwithstanding parental or other consent.	Yes No	
Coordinate with credentialing bodies for healthcare personnel and understand scope of practice for all healthcare providers.	Yes No	
Procedures/staff/volunteers to care for unattended children brought into the hospital	Yes No	
Process for rapid credential verification and privileges. Does the state participate in volunteer license reciprocity programs?	Yes No	
Reporting of pediatric adverse events, including maltreatment/violence	Yes No	
Plan addressing allocation of scarce resources for children and adolescents (e.g., mechanical ventilators and pumps, etc.)	Yes No	
Understand the process for obtaining and impact of a waiver of Emergency Medical Treatment and Labor Act (EMTALA), Florida's Children's Health Insurance Program (CHIP), or other federal or state laws during declared emergencies.	Yes No	
Legal requirements to plan and prepare for pediatric needs during emergencies	Yes No	
Liability and protections related to the implementation of crisis standards of care during declared emergencies/ disasters	Yes No	

Domain 7: Behavioral health

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Pediatric psychological first aid protocols and training for all responders/staff	Yes No	
Waiting area and discharge information sheets with tips for pediatric mental health/stress responses and resources	Yes No	
Mental health and child life professionals incorporated into pediatric care-review process – Performance Improvement/Quality Improvement/After Action Report (PI/QI/AAR)	Yes No	
Pediatric mental health screening procedures and staff education to identify at-risk individuals based on nature and degree of exposures potentially needing additional behavioral health services and follow-up (e.g., death of family member)	Yes No	
Assessment and identification of pediatric mental health resource availability in the facility and the community	Yes No	
Death notification and bereavement support	Yes No	
Policies and processes to reduce unnecessary exposure of children (and caregivers) to television and other potentially sensitizing stimuli (e.g., curtains to reduce exposure to injured patients and other traumatic images)	Yes No	
Rapid access to urgent evaluation and treatment services when indicated	Yes No	

Domain 8: Children and youth with special health care needs

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Care considerations specific to neonates	Yes No	
Care considerations specific to children with developmental disabilities and/or physical limitations and disability	Yes No	
Specialized equipment (e.g., wheelchairs, ventilators, pediatric feeding tubes, pediatric suction catheters, tracheostomy, portable source of electricity, etc.) or MOUs to obtain. (See Domain 2: Resources)	Yes No	
Medications and related dietary needs	Yes No	
Process to estimate hospital surge demands for children and youth with special health care needs (CYSHCN). Consider: • An estimate of the number of CYSHCN in community (may want to work with state to identify number and types of special needs in catchment area to assure they can be addressed in a disaster; for example: The STARS Program • Resource availability (e.g., special equipment, facilities) • Health Care professionals and other potential caretakers with which to partner (e.g., pre-hospital personnel, home health, and parent support organizations, such as Family Voices)	Yes No	

Domain 9: Staffing, exercises, drills, and training

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Pediatric victims are incorporated into regular exercises that test the system's ability to handle a surge in or evacuation of a variety of pediatric patients (e.g., infants, special needs). Lessons learned, after action reports, and improvement plans are incorporated into and drive improvement of hospital policy	Yes No	
Staffing needs during disasters and identification/ prioritization of pediatric staff/expertise to care for children or pediatric champions within institution	Yes No	
Triage protocols and training to identify patients to be considered for immediate transfer (critically ill/injured or those sufficiently stable to move to another care center) and transferring patients with appropriate pediatric specific equipment and personnel	Yes No	
Pediatric care-review process - Process Improvement/ Quality Improvement/After Action Report/Corrective Action Plans (PI/QI/AAR/CAP, etc.)	Yes No	
Curriculums and training opportunities that address gaps and increase skills specific to pediatric patients	Yes No	

Domain 10: Recovery and Resiliency

Pediatric Specifics to Consider/Discuss	Established?	Notes/Implementation Plan
Discharge disposition of children (including a tracking process and tool to assure that providers can readily communicate when and where children have been discharged or transferred to other facilities)	Yes No	
Short and long-term mental health assessment and continuity of care for children's behavioral health needs	Yes No	
Culturally tailored and developmentally focused user- friendly parent information sheets	Yes No	
Partnerships with primary care and community medical homes to promote pediatric resiliency	Yes No	
Bereavement support	Yes No	
Professional self-care	Yes No	
Partnerships with community sites, such as childcare centers, schools, preschools, etc., where services can be provided, including screening, primary prevention, and treatment	Yes No	

3.2 Legal Authorities

Federal and State Authorities/Legislation

CMS and Disasters: Resources at Your Fingertips. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. ASPR TRACIE. (Updated May 2023)
The Centers for Medicare & Medicaid Services issued the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule to establish consistency for Health Care providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and human-caused disasters. This document provides links to numerous related resources applicable to a variety of providers and suppliers.

EMTALA and Disasters. ASPR TRACIE (2018)
This fact sheet addresses several frequently asked questions regarding the Emergency Medical Treatment and Labor Act (EMTALA) and disasters and provides links to resources for more information but is not intended to be used as regulatory guidance or in place of communications with or guidance from the Centers for Medicare & Medicaid Services (CMS) which oversee EMTALA compliance.

HIPAA and Disasters: What Emergency Professionals Need to Know. ASPR TRACIE (2017).
Knowing what kinds of patient information can be released, to whom, and under what circumstances, is critical for healthcare facilities in disaster response. This guide is designed to answer frequently asked questions regarding the release of information about patients following an incident.

Final Rule for Control of Communicable Diseases: Interstate and Foreign. Centers for Disease Control and Prevention. (2017)
This webpage discusses the updates to the law about quarantine and CDC's authority. The final rule improves CDC's ability to protect against the introduction, transmission, and spread of communicable diseases while ensuring due process. Details of the final rule, and links to relevant legislation are included.

Selected Federal Legal Authorities Pertinent to Public Health Emergencies. Centers for Disease Control and Prevention, Public Health Law Program. (2017)
This document summarizes a selection of key federal legal authorities pertaining to public health emergencies.

Hospital Legal Preparedness: Relevant Resources. Centers for Disease Control and Prevention. (2016)
The resources on this webpage compiled by the Public Health Law program and sorted into categories (e.g., EUA and countermeasures, HIPAA, liability, and immunity) provide many resources for incorporation of legal and regulatory considerations into hospital and jurisdiction emergency plans. The page was last updated in 2016.

Emergency Authority and Immunity Toolkit. Association of State and Territorial Health Officials. (2013)
This toolkit contains a review of key emergency authority and immunity concepts; a summary of federal laws and policies pertaining to emergency planning and response; and a series of fact sheets addressing fundamental issues or legal authorities, issue briefs, and state analysis guides.

Further information may be found at: https://asprtracie.hhs.gov/technical-resources/83/healthcare-related-disaster-legal-regulatory-federal-policy/1#federal-and-state-authorities-legislation

3.3 Resources/ References

1. *REDi- Regional Emergency and Disaster Healthcare Coalition (Feb 13, 2020).* "Pediatric Medical Surge Annex." https://srhd.org/media/documents/REDi-HCC-Pediatric-Medical-Surge-Annex.pdf
2. *Florida Department of Health (Dec 2019).* "Emergency Support Function 8 Public Health and Medical- Patient Movement Support Standard Operating Guideline". http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/preparedness-planning/_documents/patient-move-support-sog.pdf
3. *Stanislaus County Healthcare Emergency Preparedness Coalition (2019).* "Pediatric Surge Plan." https://files.asprtracie.hhs.gov/documents/stanislaus-calif-pediatric-disaster-surge-plan-draft-1-23-19.pdf
4. *Nevada Hospital Association (Oct. 2018)*. "A Day Like No Other- A Case Study of the Las Vegas Mass Shooting". https://nvha.net/a-day-like-no-other-case-study-of-the-las-vegas-mass-shooting/
5. *Illinois Department of Health ESF-8 Plan (March 2017)*. "Pediatric and Neonatal Surge Annex Public Version". http://www.dph.illinois.gov/sites/default/files/publications/peds-neo-surge-annex-final-march2017-public-complete-file-031417.pdf
6. *Florida Department of Health (Feb 2015)*. "Mass Casualty Incident Response Playbook".
7. *Minnesota Department of Health*. "Minnesota Pediatric Surge Primer". https://www.health.state.mn.us/communities/ep/surge/pediatric/primer.pdf
8. *U.S. Department of Health and Human Services (Sept. 2007).* "Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies". https://www.phe.gov/preparedness/planning/mscc/handbook/documents/mscc080626.pdf
9. *EMSC IIC*. "Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies". https://emscimprovement.center/documents/144/Checklist_HospitalDisasterPrepared2125.pdf
10. *HHS- ASPRTRACIE*, "Healthcare Coalition Pediatric Surge Annex Template"; https://files.asprtracie.hhs.gov/documents/aspr-tracie-hcc-pediatric-surge-annex-template-final-508.pdf
11. *Florida Department of Health*, "Alternate Care Site Local Plan Development Guide"; http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/_documents/alternate-care-site-ops.PDF
12. *California Department of Public Health.* "15 'til 50 – Mass Casualty Incident Toolkit". http://cdphready.org/15-til-50-mass-casualty-incident-toolkit/
13. *Florida Agency for Health Care Administration. Florida Health Finder.* https://quality.healthfinder.fl.gov/Facility-Provider/

3.4 Acronyms/ Abbreviations

AAR	After Action Report
ALS	Advanced Life Support
BVM	Bag-Valve-Mask
C.A.T.	Combat Applied Tourniquet
CDC	Center for Disease Control
CEMP	Comprehensive Emergency Management Plan
CHD	County Health Department
CYSHCN	Children and Youth with Special Health Care Needs
DCF	Department of Children and Families
Decon	Decontamination
DOB	Date of Birth
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
EOP	Emergency Operations Plan
ER (ED)	Emergency Room (Emergency Dept.)
ESF	Emergency Support Function
F.A.C.	Florida Administrative Code
FDEM	Florida Division of Emergency Management
FDOH	Florida Department of Health
HCC	Health Care Coalition
HRC	Hospital Reunification Center
HICC	Hospital Incident Command Center
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
IOM	Institute of Medicine
I.V.	Intravenous
IBA	Immediate Bed Availability
ID	Identification
LEOC	Local Emergency Operations Center
MOU	Memorandum of Understanding
NICU	Neonatal Intensive Care Unit
NRP	Neonatal Resuscitation Program
OB/ GYN	Obstetrics/ Gynecologic
OR	Operating Room
PALS	Pediatric Advanced Life Support
PAT	Pediatric Assessment Triangle
PEPP	Pediatric Emergencies for Pre-Hospital Professionals
PI	Process/ Performance Improvement
PICU	Pediatric Intensive Care Unit
PITLS	Pediatric International Trauma Life Support
PPE	Personal Protective Equipment
PSA	Pediatric Safe Area
RS	Reunification Site
SALT	Sort, Assess, Lifesaving treatment, Transport
SCHIP	State Children's Health Insurance Program
SEOC	State Emergency Operations Center
START	Simple Triage and Rapid Treatment
QI	Quality Improvement

3.10 Region 6- Southwest Florida Health Care Coalition

Contact Information:

Name	Phone #	Email
Brian Massey	239-270-1041	brianmassey@HPCSWF.com

Demographics/ Description of the Health Care Coalition (HCC)
The Region 6 Southwest Florida Health Care Coalition encompasses nine (9) Counties which consists of Charlotte, Collier, Desoto, Glades, Hendry, Highlands, Lee, Okeechobee, Sarasota counties The SWFHCC includes both urban/suburban and rural areas. The SWFHCC region is bordered on the west by the Gulf of Mexico, likewise, Lake Okeechobee is a major feature on the eastern border.

Region 6 breakdown by age (2021):

County	0-4	5-18	0- 18	All Age Totals	% Pedi Pop (0-18)
Charlotte	5,380	20,046	25,426	194,764	13%
Collier	15,914	55,083	70,097	385,428	18%
Desoto	1,691	5,432	7,123	34,408	21%
Glades	340	1,614	1,954	12,234	16%
Hendry	2,813	8,993	9,544	38,051	25%
Highlands	4,233	14,965	19,198	103,324	19%
Lee	35,036	116,140	151,176	787,976	19%
Okeechobee	2,468	7,052	9,520	30,764	31%
Sarasota	14,771	54,966	69,767	447,087	16%
Total:	**82,646**	**284,291**	**363,805**	**2,034,036**	**18%**

Description of Health Care System
The Southwest Florida Health care Coalition has 25 health care facilities designated as Acute Care Hospitals and 7 free-standing Emergency Departments; All of these facilities provide 24-hour emergency care services. The Coalition has no pediatric trauma centers. Depending on the severity of the pediatric trauma, the adolescent will either be airlifted or taken by ground to the nearest pediatric trauma facility. In most cases, this would be Johns Hopkins All Children's Hospital in Pinellas County or Joe DiMaggio Childrens Hospital in Broward County.

Most hospitals within the Coalition have limited capability to provide comprehensive medical care to pediatric populations with traumatic injuries. There are 21 within the HCC that have limited capability to provide comprehensive medical care to some pediatric populations. While some hospitals may provide care services to pediatric populations, Two (2) (Golisano Children's Hospital and NCH) of the acute care hospitals in the Coalition has the capability of a Pediatric Intensive Care Unit (PICU), and Four (4) (Golisano Children's Hospital, Sarasota Memorial Hospital, ShorePoint, and NCH) offer Neonatal Intensive Care Units (NICU).

Identified **triggers, gaps, capabilities, and processes** by facility and hazard type that could lead to a pediatric surge emergency:

Hurricanes/ Tropical Storms

County	Action by HCC: Communication, information sharing, work with county Emergency Manager to share information on resources, assist with connecting partners and resources.
All	Post-storm impacts (injuries, displacement of medically fragile pediatric patients, disease due to unsanitary conditions or group living environments) from severe tropical weather and hurricanes have the potential to create pediatric surge in acute care medical facilities, as pediatric resources are limited in most counties. Specialty facilities are not evenly distributed throughout the region; they are located in coastal counties, more susceptible to storm surge and access issues. Traditionally, a planning trigger for medical surge is 20 percent of licensed capacity for receiving and stabilizing patients. This number is likely lower (closer to 5 percent) for long-term, definitive care. Coalition support includes communication coordination, inter-county resource coordination and provision of some assets from developed mission-ready packages (shelter support, emergency lighting, etc.). Pediatric SMEs will be consulted in coalition response strategy development and implementation.
Coastal Counties (Charlotte, Collier, Lee, Sarasota)	Significant evacuations of population (i.e., Level C or higher) would include significant levels of both general and special needs pediatric populations. Charlotte County has limited capabilities for pediatrics overall. Golisano Children's Hospital, Sarasota Memorial, and NCH have NICU beds that could serve pediatric patients.
Inland Counties (DeSoto, Hendry, Highlands, Okeechobee)	Inland counties have the potential for hosting evacuated populations from coastal counties, which would include pediatric populations that may impact hospitals. Two of these counties have limited to no pediatric resources in acute care facilities (Highlands, Hendry).
Inland County (Glades)	Even low-level impacts from severe tropical weather at any level have the potential to create a pediatric surge, especially in rural counties with no pediatric acute care capability.

Biological Disease Outbreaks

County	Action by HCC: Communication, information sharing, work with county Emergency Manager to share information on resources, assist with connecting partners and resources. Working with the Florida Infectious Disease Transportation Network (FIDTN) team to mitigate surge.
ALL	Biological disease outbreaks are perhaps the most likely hazards to trigger a pediatric surge emergency/event in area hospitals. Possible diseases are numerous and range from vaccine-preventable

	diseases from unvaccinated cohorts to severe seasonal influenza, to novel pathogens. Traditionally, a planning trigger for surge is 20 percent of licensed capacity for receiving patients. This number may be lower (closer to 5 percent) for long-term, definitive care. These triggers could be even lower in an outbreak scenario, if response activities are significantly resource-intensive (i.e., requiring ventilators). Golisano Children's Hospital could provide communication coordination, inter-county resource coordination and provision of supplies from infectious disease cache. Pediatric SMEs will be consulted in coalition response strategy development and implementation.
Hendry, Okeechobee	Even limited numbers of pediatric casualties due to an outbreak would cause a surge emergency/event, due to extremely limited pediatric capability (one hospital with no pediatric inpatient beds).
Glades	Even limited numbers of pediatric casualties due to an outbreak would cause a surge event, due to no hospital in the county.

Conventional Terrorism

County	**Action by HCC: Communication, information sharing, work with county Emergency Manager to share information on resources, assist with connecting partners and resources.**
ALL	See ALL boxes below in Mass Casualty Incidents section for triggers and HCC role.
Charlotte	Active shooter at school
Collier	Active shooter at school, Incident at theme park or event area (concert venues, convention centers)
DeSoto	Active shooter at school, Incident at event area (fairgrounds)
Lee	Active shooter at school, Incident at theme park or event area (fairgrounds, festival, parade route, concert venues, sports stadiums/arenas, convention centers)
Highlands, Okeechobee, Sarasota	Active shooter at school
Glades, Hendry	Even low-level impacts from at any type of active aggressor event any level have the potential to create a pediatric surge, especially in rural counties with no pediatric acute care capability.

Mass Casualty Incidents

Facility	Action by HCC: Communication, information sharing, work with county Emergency Manager to share information on resources, assist with connecting partners and resources.
ALL	Possible MCIs that would result in pediatric surge in any county include active shooter/active assailant incidents at a school, as well as school bus accidents. Traditionally, a planning trigger for MCI surge is 20 percent of licensed capacity for receiving and stabilizing patients. This number may be lower (closer to 5 percent) for long-term, definitive care and shrink to 1 percent above current bed capacity for burn beds. Many counties have limited pediatric capacities, and an MCI involving pediatrics would require outside assistance at a fairly low level. Golisano Children's Hospital could provide communication coordination, inter- county resource coordination and provision of supplies from limited caches (as relevant). Pediatric SMEs will be consulted in coalition response strategy development and implementation.
Charlotte, Collier, Highlands, Lee, Okeechobee, Sarasota	Active shooter at school, School Bus Crash
DeSoto, Hendry	Active shooter at school, School Bus Crash would have limited resources
Glades	Active shooter at school, School Bus Crash. Even low-level impacts from severe tropical weather at any level have the potential to create a pediatric surge, especially in rural counties with no pediatric acute care capability.

Mass Population Surges

Facility	Action by HCC: Communication, information sharing, work with county Emergency Manager to share information on resources, assist with connecting partners and resources.
ALL	No triggers for pediatric surge have been identified specifically for mass population surge. Gaps in pediatric capabilities related to other incident types would apply here, should medically care needs within the surging population reach those levels.

Local individuals or organizations within the HCC's that can act as a Coalition **pediatric subject matter expert** in the event of a pediatric surge (e.g., local pediatrician and nursing staff, pediatric home health nurses, etc.).

Pediatric SME	Contact Information	Associated Agency	Specialty
Kathleen Selby RN	863-532-3831	Raulerson Hospital	ED and pediatrics
Nichole Shimko RN	239- 343-6333	Golisano Children's Hospital	Transportation and pediatrics
Marshall A. Frank, DO, MPH, FACEP, FAEMS	813-259-8700	Medical Director, Sarasota County Fire Department,	ED Physician
Jeremiah Rabish	941-861-5000	Sarasota County Fire Department	EMS Operations Captain SCFD PECC
Sally Kreuscher	239-343-8319	Community Programs Coordinator Community Affairs Lee Health	Instructor for child passenger safety technician
Julie Noble	(239) 343 - 5101	Golisano Children's Hospital of Southwest Florida	Safe Kids Coordinator

*Due to the nature of roles, positions and names changing, contact the SWFL HCC for the most up to date information.

Identified **gaps in equipment/ supplies** for the categories listed above for each of the 24-hour emergency care hospitals in the Coalition. Includes the most commonly deficient items and the identified strategies to address them:

SUPPLY/ EQUIPMENT GAPS	
Supply / Equipment	**Strategies to fill gaps**
Most hospitals that do not have a pediatric focus – as a whole, are limited on pediatric supplies. They have enough supply on hand for daily emergencies that may arrive in their ED yet question how quickly they may "burn" through their supply in a "surge" emergency/event.	• The Coalition is currently polling hospitals and hospital systems to their regional capabilities, and availability of pediatric supplies. • The Coalition is also considering a pediatric supply cache. • Some hospital facilities have agreements in place with local resupply. This may be with a vendor or corporate hospital supply chain.

Identified **unique risks** for pediatric-specific mass casualty incident/events (e.g., evacuation of a pediatric hospital, etc.) by county.

County	Risk	Number of Potential Patients	Gaps
ALL	Possible MCIs that would result in pediatric surge in any county include active shooter /active assailant incidents at a school, various youth focused events that occur throughout our region, and school bus accidents. Traditionally, a planning trigger for MCI surge is 20% of licensed capacity for receiving & stabilizing patients. This number may be lower (closer to 5%) for long-term, definitive care and shrink to 1% above current bed capacity for burn beds. As many counties have limited pediatric capacities, an MCI involving pediatrics would require outside assistance at a fairly low level.	Varies	• Pediatric supplies are available at all of our regional hospitals. Some hospitals expressed concern of enough needed supplies, dependent on the nature of the event if they reach "surge" capacity. • Transportation

The table below outlines the hospital's classification; total number of beds; total number of beds broken down to acute care and specialty pediatric beds for NICU, PICU, and trauma patients. This is not an exhaustive list as details change often.

Provider Name	Hospital Classification	Onsite Children's Hospital	Trauma Center Designation	City	County	Total Capacity	Acute Care	Child Psych	Child Substance Abuse	Total NICU Beds
SARASOTA MEMORIAL HOSPITAL	ACUTE		Level II	SARASOTA	SARASOTA	901	722	22	8	33
SARASOTA MEMORIAL HOSPITAL - VENICE	ACUTE			VENICE	SARASOTA	110	110		0	0
HCA FLORIDA SARASOTA DOCTORS HOSPITAL	ACUTE			SARASOTA	SARASOTA	155	139		0	0
HCA FLORIDA ENGLEWOOD HOSPITAL	ACUTE			ENGLEWOOD	SARASOTA	100	100		0	0
DESOTO MEMORIAL HOSPITAL	RURAL			ARCADIA	DESOTO	49	49		0	0
ADVENTHEALTH LAKE PLACID	ACUTE			LAKE PLACID	HIGHLANDS	33	33		0	0
ADVENTHEALTH SEBRING	ACUTE			SEBRING	HIGHLANDS	171	171		0	0
HCA FLORIDA HIGHLANDS HOSPITAL	ACUTE			SEBRING	HIGHLANDS	126	126		0	0
HCA FLORIDA RAULERSON HOSPITAL	RURAL			OKEECHOBEE	OKEECHOBEE	100	100		0	0
HCA FLORIDA FAWCETT HOSPITAL	ACUTE			PORT CHARLOTTE	CHARLOTTE	253	233		0	0
SHOREPOINT HEALTH PORT CHARLOTTE	ACUTE			PORT CHARLOTTE	CHARLOTTE	254	247		0	7
SHOREPOINT HEALTH PUNTA GORDA	ACUTE			PUNTA GORDA	CHARLOTTE	208	156		0	0
CAPE CORAL HOSPITAL	ACUTE			CAPE CORAL	LEE	291	291		0	0
LEE MEMORIAL HOSPITAL	ACUTE		Level II	FORT MYERS	LEE	414	336		0	0
GULF COAST MEDICAL CENTER LEE MEMORIAL HEALTH SYSTEM	ACUTE			FORT MYERS	LEE	699	624		0	0

Provider Name	Hospital Classification	Onsite Children's Hospital	Trauma Center Designation	City	County	Total Capacity	Acute Care	Child Psych	Child Substance Abuse	Total NICU
HEALTHPARK MEDICAL CENTER	ACUTE	Golisano Children's Hospital of Southwest Florida		FORT MYERS	LEE	461	391		0	70
HENDRY REGIONAL MEDICAL CENTER	CRITICAL ACCESS HOSPITAL			CLEWISTON	HENDRY	25	25		0	0
NAPLES COMMUNITY HOSPITAL	ACUTE			NAPLES	COLLIER	391	368		0	0
NCH HEALTHCARE SYSTEM NORTH NAPLES HOSPITAL CAMPUS	ACUTE			NAPLES	COLLIER	322	249		0	19
PHYSICIANS REGIONAL MEDICAL CENTER - COLLIER BOULEVARD	ACUTE			NAPLES	COLLIER	130	130		0	0
PHYSICIANS REGIONAL MEDICAL CENTER - NORTH	ACUTE			NAPLES	COLLIER	50	20		0	0
PHYSICIANS REGIONAL MEDICAL CENTER - PINE RIDGE	ACUTE			NAPLES	COLLIER	177	177		0	0