ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ESF-8 PLAN:

PEDIATRIC AND NEONATAL SURGE ANNEX

September 2014

Table of Contents

Attachments

ACRONYMS/DEFINITIONS

ACS	Alternate Care Site
APA	American Pharmaceutical Association
APLS	Advanced Pediatric Life Support
APN	Advanced Practice Nurse
ARC	American Red Cross
ATS	Alternate Treatment Site
CEMP	Comprehensive Emergency Management Program
CHUG	Collaborative Healthcare Urgency Group
CSHCN	Children with Special Health Care Needs
DCFS	Illinois Department of Children and Family Services
DPR	Division of Disaster Planning and Readiness
DSCC	Division of Specialized Care for Children
ED	Emergency Department
EDAP	Emergency Department Approved for Pediatrics
EMAC	Emergency Medical Assistance Compact
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EMTrack	Commercial electronic multi-functional tracking system
ENPC	Emergency Nursing Pediatric Course
EOC	Emergency Operations Center
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FGM	Fiscal and Grants Managment
HAM	Amateur radio
GLHP	Great Lakes Healthcare Partnership
HAv-BED	Hospital Available Beds for Emergencies and Disasters
HBPPC	Indiana State Department of Health, Hospital Bioterrorism Preparedness Planning Committee
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
IA	Iowa
IAACCT	Illinois Association of Air and Critical Care Transport
IAFP	Illinois Academy of Family Physicians
ICAAP	Illinois Chapter of American Academy of Pediatrics
ICAHN	Illinois Critical Access Hospital Network
ICEP	Illinois College of Emergency Physicians
ID	Identification
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
Illinois ENA	Illinois Emergency Nurses Association

Illinois Helps	Illinois ESAR-VHP Program
IMERT	Illinois Medical Emergency Response Team
IMT	Incident Management Team
IN	Indiana
IPA	Illinois Pharmacists Association
ISBE	Illinois State Board of Education
ISMS	Illinois State Medical Society
KY	Kentucky
KYEM	Kentucky Emergency Management
LHD	Local health department
LTC	Long-term Care
LTC for U-22	Long-term Care for Under 22 Years of Age
MACS	Multiple Agency Command System
MCI	Mass Casualty Incident
MO	Missouri
MOU	Memorandum of Understanding
NCMEC	National Center for Missing and Exploited Children
NICU	Neonatal Intensive Care Unit
NIMS	National Incident Management System
NRP	Neonatal Resuscitation Program
OPR	Office of Preparedness and Response
PA	Physician Assistant
PALS	Pediatric Advanced Life Support
PCCC	Pediatric Critical Care Center
PCMS	Pediatric Care Medical Specialist
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health and Emergency Preparedness
PHMSRR	Public Health and Medical Services Response Regions
PICU	Pediatric Intensive Care Unit
POD	Point of Distribution
REMSC	Regional Emergency Medical Services Coordinator
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SEDP	Standby Emergency Department Approved for Pediatrics
SEOC	State Emergency Operations Center
SIRC	State Incident Response Center
SIREN	State of Illinois Rapid Electronic Notification
SMOC	St. Louis Medical Operation Center
SNS	Strategic National Stockpile
T and E	Training and Exercise
TMTS	Temporary Medical Treatment Stations
WHEPP	Wisconsin Hospital Emergency Preparedness Program
WI	Wisconsin
WI-TRAC	Wisconsin's Hospital Available Beds for Emergencies and Disasters

PRIMARY AGENCY

Illinois Department of Public Health

SUPPORT AGENCIES AND ORGANIZATIONS

Illinois Emergency Management Agency
Illinois Emergency Medical Services for Children
Regional Hospital Coordinating Centers
EMS Resource Hospitals
Hospitals
Border States (Indiana, Iowa, Kentucky, Missouri, Wisconsin)
Pediatric Care Medical Specialists
Long-term Care Facilities with Pediatric Capabilities
Illinois Chapter of American Academy of Pediatrics
Illinois Helps
Illinois College of Emergency Physicians
Illinois Critical Access Hospital Network
Illinois Emergency Nurses Association
Division of Specialized Care for Children
Illinois Department of Children and Family Services
Illinois Department of Human Services

1.0: INTRODUCTION

1.1 PURPOSE

The purpose of this Pediatric and Neonatal Surge Annex is to support the Illinois Department of Public Health (IDPH) ESF-8 Plan, by providing a functional annex for all stakeholders involved in an emergency response within the state of Illinois and/or adjacent states in order to protect children and to provide appropriate pediatric medical care during a disaster. This annex guides the state level response and gives local medical services guidance on the care of children, including patient movement, system decompression, recommendations for care, and resource allocation during a surge of pediatric patients that overwhelms the local health care system. This annex is intended to support, not replace, any agencies' existing policies or plans by providing uniform response actions in the case of pediatric emergency.

1.2 ASSUMPTIONS

1.2.1 The IDPH ESF-8 Plan has been activated, either partially or fully at the discretion of the IDPH director.

1.2.2 The Public Health and Medical Services Response Regions (see Attachment 1) serve as the primary regional geographical organizational structure for the IDPH ESF-8 Plan and the Pediatric and Neonatal Surge Annex response.

1.2.3 The local health care system has exhausted its capacity to care for pediatric patients and has implemented and exhausted any mutual aid agreements, therefore requiring assistance from the other regions and/or the state.

1.2.4 Requests for assistance with medical consultation, system decompression and coordination of pediatric patient movement will be considered once a Request for Medical Resources (RFMR) has been made to the Regional Hospital Coordinating Center (RHCC) in the Public Health and Medical Services Response Region (PHMSRR) where the requesting hospital(s), or health care provider(s) reside (as in the Regional ESF-8 Plan) or through request patterns indicated in the IDPH ESF-8 Plan.

1.2.5 In the initial stages of a mass casualty event that includes large numbers of ill and/or injured children, all hospitals may have to provide care to pediatric patients until adequate resources become available to allow for transport to pediatric tertiary care centers/pediatric specialty care centers.

1.2.6 The age range for children that meet the definition of a pediatric patient in this annex is birth through 15 years of age. Since children within this age range comprise approximately a quarter of the population within Illinois, it should be assumed children may comprise approximately a quarter of the victims during a disaster.

1.3 SCOPE:

The Pediatric and Neonatal Surge Annex is designed to provide the command structure, communication protocols, RFMR process, and the procedure for inter-regional and interstate transfer as related to pediatric patients. The Pediatric and Neonatal Surge Annex is designed to:

1. Enable safe pediatric transfer decision making
2. Implement standardized care guidelines as needed
3. Ensure associated communications processes are in place
4. Support the tracking of pediatric patients throughout the incident
5. Assist with the coordination of transferring acutely ill/injured pediatric patients to tertiary care centers/pediatric specialty care centers
6. Assist with the decompression from pediatric tertiary care centers/pediatric specialty care centers in order to make additional critical care beds available for acutely ill/injured pediatric patients

The Hospital Preparedness Program (HPP) capabilities addressed in this annex include, but are not limited to:

1. Health care system preparedness (#1)
2. Emergency operations coordination (#3)
3. Medical surge (#10)

The Public Health and Emergency Preparedness (PHEP) capabilities related to this Annex include but are not limited to:

1. Community preparedness and health care system preparedness (#1)
2. Emergency operations coordination (#3)
3. Medical surge (#10)

1.4 SITUATION:

The IDPH ESF-8 Plan and its corresponding annexes are activated when the State Incident Response Center (SIRC) is activated and/or at the discretion of the IDPH director when circumstances dictate. It can be partially or fully implemented in the context of a threat, in anticipation of a significant event or in response to an incident. Scalable implementation allows for appropriate levels of coordination.

1.5 AUTHORITIES:

1.5.1 Within Illinois, the overall authority for direction and control of the response to an emergency medical incident rests with the governor. Article V, Section 6, of the Illinois Constitution of 1970 and the Governor Succession Act (15 ILCS 5/1) identify the officers next in line of succession in the following order: the lieutenant governor, the elected attorney general, the elected secretary of state, the elected comptroller; the elected treasurer, the president of the senate, and the speaker of the House of Representatives. The governor is assisted in the exercise of direction and control activities by his/her staff and in the coordination of the activities by Illinois Emergency Management Agency (IEMA). The State Emergency Operation Center (SEOC) is the strategic direction and control point for Illinois response to an emergency medical incident (see Attachment 2)

1.5.2 IDPH is the lead agency for all public health and medical response operations in Illinois. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to local operations

1.5.3 All requests for health and medical assistance with the care of children during emergency events will be routed through the State Incident Response Center (SIRC) and IEMA as indicated in Request for Medical Resources process in the IDPH ESF-8 Plan. The request will then be directed by the SIRC manager to the IDPH SIRC liaison to address. IDPH will determine the best resources from the health and medical standpoint to deploy to fulfill the request.

1.5.4 The overall authority for direction and control of IDPH's resources to respond to an emergency medical incident is the Department's director. The line of succession at IDPH extends from the director to the assistant director, forward to the appropriate deputy directors of the IDPH offices.

1.5.5 The overall authority for coordinating the resources of the disaster RHCC hospital(s) that respond to an emergency medical incident is the Emergency Medical Services (EMS) medical director or designee.

2.0. CONCEPT OF OPERATIONS

2.1 GENERAL:

2.1.1 Throughout the response and recovery periods, the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex will provide the framework to evaluate and to analyze information regarding medical, health, and public health assistance requests for response; develop and update assessments of medical and public health status in the impact area; and provide contingency planning to meet anticipated demands as they relate to children.

2.1.2 When an incident affects large numbers of children, subject matter expertise will be provided to advise and/or to direct operations as it pertains to pediatric patient movement, system decompression, care guidelines and resource allocation within the context of the Incident Command System structure. Pediatric subject matter experts throughout the state and surrounding border states will be utilized.

2.1.3 Incidents that could prompt the activation of the Pediatric and Neonatal Surge Annex include, but are not limited to:

1. Activation of the IDPH ESF-8 Plan
2. Overwhelming influx or surge of pediatric and neonatal patients
3. Inadequate pediatric hospital resources (e.g., inpatient monitored beds, ventilators, isolation beds)
4. Damage or threats to hospital(s)
5. Staffing limitations (e.g., qualified and trained staff to care for pediatric or neonatal patients)
6. Activation of hospital(s) disaster plan when surge capacity for pediatric patients has been exceeded
7. Requests from border states to assist with a surge of pediatric patients

2.1.4 This annex can be activated based on any of the following circumstances: (see Attachment 3 for the Pediatric and Neonatal Surge Annex Activation Pathway)

2.1.4.1 Type 2 or Type 1 Health and Medical Emergency Event that involves pediatric casualties

A. Immediate Event
   1. Large, unexpected, potentially life-threatening incident involving the pediatric population (e.g., earthquake)
   2. While appropriate and established communication and/or notification processes during an incident is important, providing emergency medical care to pediatric patients initially takes priority over any external bed authorization, communication and/or notification processes. Once the incident and patients become more stabilized, hospitals must communicate with IDPH to relay what processes (e.g., increased bed capacity beyond licensure) occurred as indicated in the IDPH ESF-8 Plan.

B. Controlled Event
   1. Slow, gradually building or preplanned incident (e.g., epidemic, pandemic, partial or full planned evacuation)
   2. Necessary and established external authorization and communication processes must occur as indicated in this annex and the IDPH ESF-8 Plan.

2.1.5 Regardless of the pathway to activation of the Pediatric and Neonatal Surge Annex, the health care entities involved with the incident function independently and may activate the necessary internal resources and policies to successfully respond to the needs of the pediatric patient (e.g., early or expedited inpatient discharge).

2.1.6 Within the IDPH ESF-8 Plan, multiple annexes exist that address the needs of specialty populations (i.e., pediatric and neonatal patients, burn patients). Depending on the scope of the disaster, multiple annexes or components of each

may need to be activated simultaneously in order to thoroughly address the specific needs of the victims (e.g., pediatric burn patients). Efforts have been made to ensure consistency between annexes that address the needs of specialty populations. It is the recommendation that the experts for the specialty populations involved in the mass casualty incident (MCI) work together to address any conflicts that may occur.

2.2 NOTIFICATION:

2.2.1 Upon the activation of the Pediatric and Neonatal Surge Annex, the *Pediatric/Neonatal Medical Incident Report Form* (see Attachment 4) will be utilized to communicate necessary information about the annex activation with affected entities and those entities that may be called upon to assist during the incident. See Section 2.2.3 for a listing of possible stakeholders that should be notified during the activation of the Pediatric and Neonatal Surge Annex. This form may be sent and received via any available communication method (e.g., SIREN, e-mail, fax). When the *Pediatric/Neonatal Medical Incident Report Form* is utilized during an event, the communication method that will be utilized for stakeholders to reply will be indicated on the form in the "Reply/Action Required" section.

2.2.2 Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information internally and externally from their facility. Information should be shared in the preferred and most expected method (i.e., SIREN). However, depending on the type of incident, the typical alert and messaging systems may or may not be available and alternate methods will be utilized to communication. Some of the possible established methods for communication that can be used include:

1. Telephone (landline)
2. Telephone (cellular)
3. Fax
4. Radio systems (StarCom, HAM/Amateur, MERCI, telemetry)
5. E-mail
6. Electronic emergency management systems
7. SIREN
8. HAv-BED Tracking System in each state
9. WebEOC®
10. Social media
11. Comprehensive Emergency Management Program (CEMP) (For information sharing, including access to documents and resources)

2.2.3 Communication during an incident that involves large numbers of children is vital and information sharing needs to occur with health care facilities/agencies and non-health care entities where children are typically located. The *Pediatric/Neonatal Medical Incident Report Form* should be utilized to assist with ensuring consistent communication between stakeholders and to provide a mechanism to request pediatric medical resources and identify availability of resources at a facility. On the next page are facilities/agencies/entities/individuals that either play a role in caring for children or are part of the incident response and should be notified and receive ongoing communication from the time the

Pediatric and Neonatal Surge Annex is activated until normal operations resume. See Attachment 5 for the *Pediatric/Neonatal Communication Pathway.* To ensure flexibility of this annex, the following list is not all inclusive, nor are entities listed in any priority order. Depending on the type of incident that has occurred, additional stakeholders should be included in the information sharing process as needed and appropriate.

1. Hospitals
    a. Acute care hospitals
    b. Pediatric specialty hospitals
    c. Psychiatric hospitals
    d. Rehabilitation hospitals
2. Regional Hospital Coordinating Centers (RHCC)
3. County Emergency Management Agencies (EMA)
4. Local health departments (LHD)
5. Local Emergency Medical Services (EMS) agencies
6. IDPH Regional Emergency Medical Services Coordinator (REMSC)
7. Illinois Department of Public Health (IDPH)
8. Illinois Emergency Management Agency (IEMA)
9. Professional medical organizations
    a. Illinois Chapter of American Academy of Pediatrics (ICAAP)
    b. Illinois College of Emergency Physicians (ICEP)
    c. Illinois State Medical Society (ISMS)
    d. Illinois Academy of Family Physicians (IAFP)
    e. American Pharmaceutical Association (APA)
    f. Illinois Pharmacists Association (IPA)
    g. Illinois Emergency Nurses Association (ENA)
10. Illinois Critical Access Hospital Network
11. Division of Specialized Care for Children (DSCC)
12. Long-term Care Facilities for Under Age 22 Years (U-22)
13. Collaborative Healthcare Urgency Group (CHUG)
14. Border state agencies (Refer to Section 2.3.3 for specific notification details)
    a. Great Lakes Healthcare Partnership through the Minnesota Department of Health, Office of Emergency Preparedness
    b. Indiana - Indiana State Department of Health, Hospital Bioterrorism Preparedness Planning Committee (HBPPC) (see Attachment 6)
    c. Iowa - Iowa Department of Public Health duty officer
    d. Kentucky - Duty officer in the Commonwealth Emergency Operation Center (see Attachment 7)
    e. Missouri - St. Louis Medical Operations Center (SMOC)-state of Missouri (see Attachment 8)
    f. Wisconsin - Wisconsin Hospital Emergency Preparedness Program (WHEPP)- state of Wisconsin (see Attachment 9)
15. Illinois State Board of Education (ISBE), Regional Offices of Education.
16. Health care coalitions

17. Any alternate treatment sites, alternate care sites and/or temporary medical treatment stations that have been established during the incident.

2.3. ORGANIZATION:

2.3.1 Hospital Response Structure

1. During a MCI with significant number of pediatric casualties, resources at hospitals with pediatric critical care capabilities will quickly become exhausted. Therefore, developing a system that outlines how all hospitals can assist with providing care to children is crucial to the response. Dividing the hospitals into categories based on their pre-event pediatric and neonatal capabilities can assist with decompressing pediatric and neonatal specialty care centers during an event to ensure children are treated at the best possible facility. See Section 2.4: *Patient Care and Movement* and Section 2.4.6. *System Decompression* for more information on this coordination of care.
2. When this annex is activated, all hospitals within Illinois will fall into one of the following four categories to assist with the coordination of care during a burn mass casualty incident. See Section 3.2.6 for additional information on the following categorization:
    a. Category 1: Pediatric Specialty Centers (pediatric intensive care unit {PICU} and/or neonatal intensive care unit {NICU})
    b. Category 2: Community Hospitals with Some Pediatric Services
    c. Category 3: Community Hospitals with no Pediatric/Neonatal Services
    d. Category 4: Community Hospitals with Level I, II, and/or II-E (II+) nurseries, but no other pediatric services

2.3.2 Regional Response Structure

1. Each region will respond as indicated within its regional ESF-8 plan.

2.3.3 State Response Structure

1. State emergency management officials will activate the SIRC to coordinate state and/or federal support to local jurisdictions. The public health emergency operations center (PHEOC) will be activated by IDPH. Requests for Medical Resources (RFMR) will be processed in accordance with the IDPH ESF-8 Plan.
2. Upon receiving requests for pediatric medical resources, the SIRC manager will notify the IDPH SIRC liaison. The IDPH SIRC liaison will notify the IDPH duty officer, who will request from IEMA that the Illinois Medical Emergency Response Team (IMERT) be activated to deploy the Pediatric Care Medical Specialists. The Emergency Medical Services for Children (EMSC) manager (or designees) will be activated to assist with the Pediatric Care Medical Specialist role and the coordination and notification of stakeholders.
3. During an activation of the SIRC in the event of a large number of pediatric casualties, pediatric subject matter experts from the IMERT Pediatric Care Medical Specialist Team will be integrated into the incident command structure to fill the Pediatric Care Medical Specialist role and will allow for an

appropriate, coordinated and timely response to the needs of children during the incident.

4. When this annex is activated, the request for pediatric specific medical resources by a hospital, hospital or regionally based alternate care site (ACS), hospital or regionally based alternate treatment site (ATS), and/or state temporary medical treatment station (TMTS) will follow the same pathway as the request for other medical resources as outlined in the IDPH ESF-8 Plan. These pediatric resources can include, but are not limited to:
    a. Pediatric equipment, supplies and medications
    b. Medical consultation
    c. Placement of pediatric patients in tertiary care centers/pediatric specialty care centers or hospitals with pediatric services
    d. System decompression processes outlined in this annex

    See the *IDPH ESF-8 Request for Medical Resources Process.*
5. The IDPH Regional EMS Coordinators (REMSC) will assist with the communication between IDPH, Pediatric Care Medical Specialist (PCMS) and the RHCCs. The REMSC(s) should be involved in the situational awareness briefings throughout the event during which the PCMS will provide updates on interactions/ communication with hospitals and their medical consultation and transfer coordination requests. The REMSC should then relay this information to their RHCC to assure loop closure and awareness of the response activities within their region.
6. IDPH, in conjunction with support agencies, develops and maintains this annex and accompanying operational guidelines that govern response actions related to large scale events involving children. However, support agencies may develop and maintain their own operational guidelines for internal use, which must be compatible with and in support of this Annex.

2.3.4 Multi-State Response Structure

1. The incident may require accessing pediatric resources that exist outside Illinois. The SIRC may consider requesting out-of-state resources through normal request patterns, methods indicated within this annex and the IDPH ESF-8 Plan, and/or interstate mutual aid agreements, including Emergency Medical Assistance Compact (EMAC). Border states will be contacted as indicated below to identify pediatric resource availability, send information about the event and to assist with the coordination of transfers:
    1) Great Lakes Healthcare Partnership
        a) A consortium of jurisdictions, including Minnesota, Wisconsin, Illinois, city of Chicago, Indiana, Michigan and Ohio, located within the Federal Emergency Management Agency (FEMA) Region V that can provide communication and resource assistance in the first 24-72 hours of a significant incident in the region when other resources are being activated through conventional channels. To access Great Lakes Healthcare Partnership resources, call the Minnesota Department of Health, Office of Emergency Preparedness at 651-201-5735 and specifically ask for the Great Lakes Healthcare Partnership (GLHP).

2) Indiana
   a) Indiana State Department of Health, Hospital Bioterrorism Preparedness Planning Committee (HBPPC) District Leads will serve as the primary contact for Indiana. Districts 1, 4, 7 and 10 border Illinois and will serve as liaisons to identify pediatric resource availability, send information to Indiana hospitals and assist with coordination of transfers. See Attachment 6 for contact information list.
3) Iowa
   a) Iowa Department of Public Health Duty Officer will serve as the primary contact for Iowa at 866-834-9671 or Duty.Officer@idph.iowa.gov. Once contacted, the duty officer will serve as the point of contact to identify pediatric resource availability (hospitals, transport and EMS) and assist with communication with Iowa hospitals/agencies.
4) Kentucky
   a) The on-call Kentucky Emergency Management (KYEM) duty officer in the Commonwealth Emergency Operations Center will serve as the primary contact for Kentucky at (800)255-2587. Once contacted, the KYEM duty officer will notify the KYEM Manager on call, one of the ESF-8 Public Health/Kentucky Health Association Partners and the Kentucky Board of EMS based on the requested needs to assist with patient placement and transportation (see Attachment 7).
5) Missouri
   a) St. Louis Medical Operations Center (SMOC) will serve as the primary contact for Missouri. Contact the Central County 911 Center at 636-394-2212 and request the SMOC duty officer be contacted. Once contacted, they will serve as liaisons to identify pediatric resource availability, send information to Missouri hospitals, and assist with coordination of transfers (see Attachment 8)
6) Wisconsin:
   a) WI-TRAC will be used to identify bed availability at hospitals and send out communication notifications to Wisconsin hospitals. Illinois and Wisconsin have established access to each state's HAv-BED System. Representative(s) from IDPH will access the WI-TRAC and send alerts to hospitals that border Illinois and identify pediatric resource availability. The individual hospitals can then be contacted to assist with coordination of transfers.
   b) Wisconsin Hospital Emergency Preparedness Program (WHEPP). WHEPP regional managers from Region 5 and 7 also can assist in the process of identifying pediatric resource availability, sending information to Wisconsin hospitals and assisting with coordination of transfers (See Attachment 9 for the WHEPP Regional Manager Contact Information Map).

2.3.5 Federal Response Structure

1. When response to a disaster or emergency incident exceeds the resources and capabilities of Illinois to manage, IEMA will notify officials at FEMA Region V of the governor's forthcoming request for federal assistance and a presidential disaster declaration. FEMA authorities will deploy a FEMA liaison officer to the SIRC when a presidential disaster declaration appears imminent.

2.4. PEDIATRIC PATIENT CARE AND MOVEMENT:

The Pediatric and Neonatal Surge Annex is designed to help coordinate the following components of care as related to children during an incident:

2.4.1 Pediatric Care Medical Specialist (PCMS)

1. Definition
   a. Pediatric experts from Illinois and its border states who volunteer pre-event as part of the IMERT Pediatric Care Medical Specialist Team to be called upon by IDPH during a large scale event in which there are numerous pediatric casualties leading to the activation of this annex. These volunteers will function as subject matter experts for the state by providing guidance on the coordination of care and medical consultation for pediatric patients.
2. Types
   There are three types of Pediatric Care Medical Specialists
   a. Group 1 Specialists: Includes pediatric intensivists, pediatric emergency physicians and/or pediatric physicians with transport expertise who will be called upon during all events in which the annex is activated to assist with patient triage, coordination of transfers and system decompression.
   b. Group 2 Specialists: Includes pediatric specialty physicians, primary care physicians and neonatal subspecialists who will be activated to serve in a medical consultation role based on the specific needs of the event and the affected population.
   c. Group 3 Specialists: Includes pediatric specialty advanced practice providers (e.g., nurse practitioners) and support resources (e.g., child life specialists, pediatric Pharm D/pharmacists) that will be activated to serve in a consultation role based on the specific needs of the event and the affected population.
3. Roles and Responsibilities
   a. Triage pediatric patients to pediatric specialty hospitals utilizing the information submitted by non-pediatric specialty hospitals based on the Pediatric Triage Guidelines
   b. Assist with system decompression as requested from tertiary care centers
   c. Address requests for medical consultation from hospitals
   d. Assist with coordination of pediatric transport needs
   e. Document all coordinated pediatric patient transfers in the Pediatric Patient Tracking Log

2.4.2 Pediatric Patient Tracking

As pediatric patient movement occurs throughout Illinois and its border states, both for the acutely ill/injured being transported to tertiary care centers/pediatric specialty care centers and for those patients being decompressed from tertiary care centers/pediatric specialty care centers, tracking the location of the pediatric patient is crucial in aiding in the reunification of these children with their families. Electronic patient tracking may be available in certain regions. Manual tracking of patient movement through the methods listed below will be necessary until all regions have electronic systems.

1. *Patient Identification Tracking Form*: (see Attachment 10)
    a. Purpose: To assist in identifying, tracking, and reunification of pediatric patients during a disaster.
    b. Responsibility: The primary physician and/or nurse at every health care facility.
    c. Instructions: This form will be completed to the best of the ability given the information/resources available on ALL pediatric patients who arrive at a health care treatment facility (hospital, clinic, ACS, ATS, TMTS), regardless if they are accompanied by a parent/guardian. This form records demographic information, description of the child, a place to attach a photo of the child, patient tracking log, accompanied and unaccompanied child information, medical history and disposition. The form should be copied. The original of this form will accompany the patient if/when the patient is transferred to another facility and a copy should be kept as part of the facility's medical record. Each receiving facility will add their facility's information in the Patient Tracking Log section. **NOTE: All attempts should be made to keep patient identification (ID) bands from previous facilities and triage tags from EMS on the patient.** If ID bands need to be removed, attach the removed band to this form under the Patient Tracking Log section. If triage tags are removed, ensure all information on the tag is incorporated into the patient's medical record or, if possible, place a photo copy of the tag in the patient's medical record.
2. *Pediatric Patient Tracking Log:* (see Attachment 11)
    a. Purpose: To assist with tracking pediatric patients during a disaster.
    b. Responsibility: Pediatric subject matter expert (i.e. PCMS or other IDPH pediatric representative) who is assisting with the coordination of patient movement.
    c. Instructions: This form will be completed by the PCMS or other IDPH pediatric representative when they assist with transfer coordination of pediatric patients between health care facilities. Any issued tracking number, name, gender, date of birth and age shall be recorded on all patients, and each hospital's name, location and the arrival/departure date from each hospital. This document will be kept in the PHEOC and stored in the same manner as other incident related command documents after the PHEOC closes.
3. Additional Pediatric Patient Tracking Resources:
    a. American Red Cross (ARC) Patient Connection Program:

The Patient Connection Program may be available during a large-scale event throughout Illinois and northwest Indiana. The program is activated when a local incident sends 10 or more people to hospitals. A call center is opened for inquires about those who may have been hospitalized. Hospitals should follow the procedure outlined in their memorandum of understanding (MOU) with the ARC.

b. National Center for Missing and Exploited Children (NCMEC) Unaccompanied Minor Registry: The Unaccompanied Minors Registry is a tool that will enable NCMEC to provide assistance to local law enforcement and to assist in the reunification of displaced children with their parents or legal guardians. The registry may be available to assist providers with unaccompanied minors. The program allows the public to report information related to children who have been separated from their parents or legal guardians as a result of a disaster. For more information or to enter information on an unaccompanied minor: https://umr.missingkids.com/umr/reportUMR?execution=e2s1

2.4.3 Pediatric Patient Triaging and Transfer Coordination

During MCIs with significant numbers of pediatric casualties, resources at hospitals with pediatric critical care capabilities will quickly become exhausted. The *Pediatric Triage Guidelines* were developed to assist with statewide triage during a disaster to identify the type of pediatric specialty resources needed so pediatric patients will be transferred to the most appropriate hospital, based on their pre-event capabilities (through the self-assigned decompression categories), to receive proper pediatric care.

1. Pediatric Triage Guidelines (see Attachment 12)

a. Purpose: To provide guidance to the transferring facility and the PCMS during statewide triage of patients to identify the most appropriate facility to transfer pediatric patients to.

b. Responsibility: The physician responsible for the care of the pediatric patient at the originating hospital, and who has identified that a higher level of care is needed than what can be provided at the current location.

c. Instructions: The transferring facility will use these guidelines to triage their pediatric patients based on the criteria (includes interventions, conditions and perinatal considerations) listed in the *Pediatric Triage Guidelines*. The criteria list within the guidelines is not inclusive and does not replace clinical judgment. Once the transferring provider has determined what triage category the pediatric patient(s) are, this information should be communicated to the PCMS via the *Pediatric/Neonatal Medical Incident Report Form*. This form should be sent to the PCMS via the mechanism identified in the "Reply/Action Required" section. The initials of the patient, age, triage category and diagnosis should all be listed on the form to help guide the PCMS in identifying the most appropriate facility. The PCMS will determine placement for the child based on the information provided and send the accepting hospital, physician and any additional transfer information back

to the transferring facility via the *Pediatric/Neonatal Medical Incident Report Form.*

2. *Pediatric Patient Transfer Form* (see Attachment 13)
   a. Purpose: To provide a method of communicating medical and treatment information on pediatric patients during a disaster when the patients are being transferred to tertiary care centers/pediatric specialty care centers/pediatric specialty care centers. This information will provide the PCMS or other IDPH pediatric representative additional information to assist with patient placement, be shared with the physician at the accepting tertiary care centers/pediatric specialty care centers, and assist with ensuring continuity of care for pediatric patients when they arrive at the receiving facility.
   b. Responsibility: The physician responsible for the pediatric patient at the originating hospital, and who has identified that a higher level of care is needed than what can be provided at the current location.
   c. Instructions: This form will be completed at the originating hospital and sent to the PCMS or other IDPH pediatric representative in the PHEOC through the RFMR process described in this annex and the IDPH ESF-8 Plan and forwarded to the accepting physician at the tertiary care centers/pediatric specialty care centers. This form provides the PCMS or other IDPH pediatric representative with basic demographic information, past medical history, clinical assessment and treatments, request for services at tertiary care centers/pediatric specialty care centers/pediatric specialty care centers, transport needs and any telemedicine management recommendations received and performed. This form also will be sent with the patient at the time of transfer.

2.4.4 Pediatric Transport

The transportation needs during a large-scale incident involving children may be quite extensive. The sending physician and staff, the PCMS or other IDPH pediatric representative and accepting/receiving physician will work together to identify the resources needed to transport the pediatric patient(s) in the most efficient and safe manner available at the time. The PCMS or other IDPH pediatric representative can assist hospitals in identifying known transport companies that have pediatric capabilities, and available alternative methods for transporting pediatric patients. The Illinois Association of Air and Critical Care Transport (IAACCT) maintains an *Illinois Aircraft Resource Guide* and an *Illinois Critical Care Ground Resource Guide* that may assist with identifying transport resources throughout the state. This list may not be inclusive. This information can be found at: http://iaacct.org/resources/

2.4.5 Pediatric and Neonatal Care Guidelines

During a large-scale incident, normal interfacility transfer patterns may be disrupted. Hospitals that typically transfer their acutely ill/injured pediatric patients or children with special health care needs to tertiary care centers/pediatric specialty care centers may need to care for these patients for longer periods of time until they are able to transfer these patients to a higher level of care. The PCMS or other IDPH pediatric representative can be accessed for medical

consultation. In addition, *Pediatric and Neonatal Care Guidelines* are available as an adjunct to this annex for common pediatric medical issues, such as respiratory; shock; burn injury; trauma and blast injury; pandemic; newborn care; premature newborn care; obstetrical (OB) care; radiation exposure; and inpatient treatment and monitoring interventions. They provide support and guidance to those practitioners caring for children during the initial 96 hours following an incident.

1. Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster.
2. Responsibility: These guidelines are not meant to be all inclusive, replace an existing policy and procedure at a hospital or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.
3. Instructions: Practitioners may use the *Guidelines* as a reference and to assist with care of pediatric patients during a disaster. These *Guidelines* will be updated and maintained by Illinois EMSC.

2.4.6 System Decompression

In a large scale incident that leads to a significant number of ill or injured children, the need for pediatric and neonatal critical care resources may exceed what is available. If this occurs or any other trigger occurs as listed in Section 2.1, pediatric and/or neonatal tertiary care centers/pediatric specialty care centers will need to decompress their less critically ill/injured pediatric/neonatal patients to other health care facilities that have the capabilities to care for them in order to have space to accept and treat more acutely ill or injured children. Ideally, facilities should decompress to a similar or higher level of care facility. However, in a large scale disaster, this may not be possible. If there is a need to decompress to another health care facility, the following categories for hospitals that outline pediatric/neonatal capabilities should be considered:

1. Category 1: Specialty Centers (pediatric intensive care unit {PICU} and/or neonatal intensive care unit {NICU}) (includes Pediatric Critical Care Centers {PCCC}) able to provide complex pediatric care to ages 0 through 15 years.
2. Category 2: Community Hospitals with Some Pediatric Services (includes Emergency Departments Approved for Pediatrics {EDAP}) and accepts 0-12 year-old patients.
3. Category 3: Community Hospitals with no Pediatric/Neonatal Services (can include Standby Emergency Departments Approved for Pediatrics {SEDP}) and accepts 12 year of age or older.
4. Category 4: Community Hospitals with Level I, II, and/or II-E (II+) nurseries, but no other pediatric services (can include Standby Emergency Departments Approved for Pediatrics {SEDP}) and accepts 0-1 year old patients.

Whenever decompressing to a facility, phone consultation between the sending physician and/or the PCMS or other IDPH pediatric representative within the PHEOC with the practitioners accepting the patient will need to take place. The Decompression Category for every Illinois hospital can be found in the Regional Pediatric Resource Directory through Illinois EMSC at http://www.luhs.org/depts/emsc/allregionalgrids.pdf, and in SIREN.

2.4.7 Resource Allocation

In a large scale event involving significant numbers of pediatric casualties, resources (e.g., equipment, medications, trained staff and available space) needed to care for pediatric patients may quickly be depleted. This could lead to health care providers having to adapt normal standards of care and to implement resource allocation strategies or crisis standards of care for those seeking or currently receiving care at their facility. Illinois EMSC's *Resource Allocation Strategies for the Pediatric Population*, which is an adjunct to this annex, can assist health care providers, hospitals, regions, IDPH and the PCMS with identifying possible strategies to assist with this task.

3,0 ROLES, RESPONSIBILITIES AND RESOURCE REQUIREMENTS

3.1 PRIMARY AGENCY:

3.1.1 ILLINOIS DEPARTMENT OF PUBLIC HEALTH

3.1.1.1. Role and Responsibility

1. Provide leadership in directing, coordinating and integrating overall state efforts to provide public health and medical assistance to affected areas and the pediatric populations within those areas.
2. Coordinate and direct the activation and deployment of this Pediatric and Neonatal Surge Annex as part of the IDPH ESF-8 Plan either partially or in its entirety as indicated by the pediatric needs following an incident.
3. Collaborate with IEMA on the RFMRs for pediatric specific resources from hospitals, public health departments, alternate care sites, alternate treatment sites and temporary medical treatment stations.

3.2 SUPPORT AGENCIES/FACILITIES/ORGANIZATIONS

3.2.1 ILLINOIS EMERGENCY MANAGEMENT AGENCY

3.2.1.1 Role and Responsibility

1. Work with specific agency(ies) within jurisdiction(s) to gain a situational awareness of the incident.
2. Collaborate with IDPH on the RFMRs for pediatric specific resources from hospitals, public health departments, alternate care sites, alternate treatment sites and temporary medical treatment stations.
3. Collaborate with IDPH to fulfill the request for PCMS by activating IMERT and their PCMS team.
4. Proceed with established procedures for requesting disaster declaration (state and federal) as indicated.
5. Proceed with established procedures for facilitating EMAC requests as indicated.

3.2.2 ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN (EMSC)

3.2.2.1 Role and Responsibility

1. Assist with the notification of stakeholders listed in the Pediatric and Neonatal Surge Annex during the activation of the annex.

2. Assist with revising and maintaining the Pediatric and Neonatal Surge Annex in accordance with timelines defined by IDPH.
3. Assist in maintaining the PCMS database.
4. Maintain and update the *Pediatric and Neonatal Care Guidelines* associated with this annex to ensure compliance with current treatment recommendations.
5. Continue to develop materials to assist in the education of health care providers regarding the care of pediatric patients.

3.2.3 ILLINOIS MEDICAL EMERGENCY RESPONSE TEAM (IMERT)

3.2.3.1 Role and Responsibility

1. Maintain a PCMS team of pediatric experts that can be deployed and serve as PCMS when this annex is activated.

3.2.4 REGIONAL HOSPITAL COORDINATING CENTER (RHCC)

3.2.4.1 Role and Responsibility

1. Provide care for neonatal and pediatric patients and children with special health care needs that arrive at the facility to the best of the facility and practitioners' ability.
2. Provide patient families with information about the event and education about components of the annex that may involve their child's care (e.g., system decompression, coordination of care statewide and transfer processes).
3. Provide necessary situational awareness communications to/from the affected and/or assisting hospital(s) within the region and to/from IDPH.
4. Inform IDPH, as appropriate, when Regional ESF-8 Plan has been activated.
5. Inform IDPH, as appropriate, when regional pediatric resources have been depleted.
6. Assist with the communication and RFMR for pediatric specific resources as indicated in this annex (see Attachment 5 and 9).
7. Assist hospitals with accessing Illinois Helps.
8. Function as a liaison between IDPH, IEMA and the hospitals, and EMS providers within their region.

3.2.5 RESOURCE HOSPITALS

3.2.5.1 Role and Responsibility

1. Provide care for neonatal and pediatric patients and children with special health care needs that arrive at the facility to the best of the facility and practitioners' ability.
2. Provide patient families with information about the event and education about components of the annex that may involve their child's care (e.g., system decompression, coordination of care statewide and transfer processes).
3. Assist with the communication and RFMRs for pediatric specific resources as indicated in the Regional ESF-8 Plan, the IDPH ESF-8 Plan and in this annex (see Attachment 5 and 9).

4. Function as a liaison between the EMS associate and participating hospitals within their region, and the RHCC.
5. Assist with the communication with EMS providers within their EMS system.

3.2.6 ALL OTHER HOSPITALS

3.2.6.1 Role and Responsibility

1. Provide care for neonatal and pediatric patients and children with special health care needs that arrive at the facility to the best of the facility and practitioners' ability.
2. Provide patients' families with information about the event and education about components of the annex that may involve their child's care (e.g., system decompression, coordination of care statewide and transfer processes).
3. Communicate and submit RFMR for pediatric resources as necessary as indicated in the Regional ESF-8 Plan, the IDPH ESF-8 Plan and in this annex (see Attachment 5 and 9).

3.2.7 LOCAL HEALTH DEPARTMENTS

3.2.7.1 Role and Responsibility

1. Assist hospitals in obtaining supplies from the Strategic National Stockpile (SNS), specific to pediatrics, as requested, through the processes that are currently identified and incorporated into their existing plans.
2. Maintain communication and provide situational awareness updates, specific to pediatrics, to hospitals and to IDPH, as indicated.

3.2.8 BORDER STATES

3.2.8.1 Great Lakes Healthcare Partnership (GLHP)

3.2.8.1.1 Role and Responsibility

a. The PCMS or other IDPH pediatric representative will notify the Minnesota Department of Health, Office of Emergency Preparedness at 651-201-5735 and ask for the Great Lakes Healthcare Partnership contact who can then assist with the communication and resource assistance in the first 24-72 hours of an incident involving a large number of pediatric casualties.

3.2.8.2 Indiana

3.2.8.2.1 Role and Responsibility

a. The PCMS or other IDPH pediatric representative will notify the Hospital Bioterrorism Preparedness Planning Committee (HBPPC) District Leads for Districts 1, 4, 7, and/or 10 regarding the situation who can then assist with the identification and coordination of available pediatric resources (see Attachment 6).

3.2.8.3 Iowa

3.2.8.3.1 Role and Responsibility

a. The PCMS or other IDPH pediatric representative will notify the on call Iowa Department of Public Health duty officer at 866-834-9671/ Duty.Officer@idph.iowa.gov, regarding the situation and

pediatric resource needs. The duty officer can then assist with the identification of pediatric resource availability in hospitals, transport services and EMS, and assist with communication with Iowa hospitals/agencies.

3.2.8.4 Kentucky

3.2.8.4.1 Role and Responsibility

a. The PCMS or other IDPH pediatric representative will notify the on call KYEM duty officer in the Commonwealth Emergency Operations Center at 800-255-2587 regarding the situation and pediatric resource needs. The KYEM duty officer can then assist with the identification and coordination of available pediatric resources (hospital and transport) (see Attachment 7).

3.2.8.5 Missouri

3.2.8.5.1 Role and Responsibility

a. The PCMS or other IDPH pediatric representative will contact the SMOC duty officer by calling the *Central County 911* (St Louis area) at 636-394-2212 and requesting to be connected to the duty officer. IDPH and/or the PCMS will notify the duty officer of the situation, who can then assist with the identification and coordination of available pediatric resources (see Attachment 7).

3.2.8.6 Wisconsin

3.2.8.6.1 Role and Responsibility

a. The PCMS or other IDPH pediatric representative will access the WI-TRAC HAv-BED system to identify bed availability at Wisconsin hospitals and communicate status messages to hospitals.
b. The PCMS or other IDPH pediatric representative also will notify the WHEPP regional project coordinators for Region 5 and/or 7 regarding the situation, which can then assist with the communication, identification and coordination of available pediatric resources (see Attachment 8).

3.2.9 PEDIATRIC CARE MEDICAL SPECIALISTS

3.2.9.1 Role

1. Function as subject matter experts to the state of Illinois (IDPH and/or IEMA) as members of IMERT's PCMS team by providing guidance on triaging pediatric and neonatal patients to tertiary care centers/pediatric specialty care centers when the Pediatric and Neonatal Surge Annex is activated during a multiregional or statewide disaster.
2. Provide medical consultation to those hospitals caring for pediatric and neonatal patients waiting to be transferred to tertiary care centers/pediatric specialty care centers, as members of IMERT's PCMS team
3. Assist with the coordination of system decompression as members of IMERT's Pediatric Care Medical Specialist Team

3.2.9.2 Responsibility

1. Serve in a consultant capacity to provide advice in the areas of pediatric emergency, surgical, medical, psychological, neonatal and transport care per their training, qualifications and within their scope of practice.
2. Be an active member in compliance with IMERT requirements.

3.2.10 LONG-TERM CARE FACILITIES for Under Age 22 Years (U-22)

3.2.10.1 Role and Responsibility

1. Illinois has skilled pediatric long-term care facilities that have the capabilities to provide extensive medical care to children under the age of 22 with chronic medical and behavioral conditions. Two agencies within Illinois oversee and regulate these types of facilities: IDPH Office of Health care Regulation and the Illinois Department of Children and Family Services (DCFS). During a large scale incident in which the annex is activated, these facilities can assist hospitals with system decompression and early discharge for children who are less acutely ill or injured, but still require medical care.
2. To access facilities regulated by the IDPH, Office of Health care Regulation, the IDPH duty officer will contact the Long-term Care (LTC) bureau chief who can assist with sharing information about the event with facilities and identifying facilities able to assist with system decompression. After the initial contact with the Long-term Care bureau chief by the duty officer, the PCMS will work closely with IDPH through the EMSC designee on the coordination of patient transfers.
3. To access facilities associated with the DCFS, the PCMS or other IDPH pediatric representative can contact DCFS to obtain a list of facilities with capacity to assist with system decompression.
4. Collaborative Health Care Urgency Group (CHUG)
    a. Some LTC for U-22 with pediatric capabilities are members of CHUG. CHUG may be utilized to help provide information to its members and possibly coordinate patient movement during the system decompression process. CHUG may be contacted at: 847-803-2484.

3.2.11 ILLINOIS CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS (ICAAP)

3.2.11.1 Role and Responsibility:

1. Assist with the pre-activation recruitment of PCMS Specialists, including, but not limited to:
    a. pediatric intensivists
    b. emergency physicians with pediatric expertise
    c. pediatric surgeons
    d. neonatologists
    e. pediatric psychologists/psychiatrists
    f. pediatric physicians with transport experience
2. Provide a method to communicate information with its members about the incident and recommendations for care and action.

3.2.12 ILLINOIS HELPS

The Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) system for Illinois (Illinois HELPS) supports the pre-registration, management and mobilization of clinical and non-clinical volunteers to help in responding to all types of disasters. The volunteer management system is part of a nationwide effort to ensure that volunteer professionals can be quickly identified and their credentials checked so that they can be properly utilized in response to a disaster.

3.2.12.1 Role and Responsibility

1. Provide a method to track credentials, qualifications, certifications, contact information and training of the PCMS throughout the state .

3.2.13 DIVISION OF SPECIALIZED CARE FOR CHILDREN (DSCC)

3.2.13.1 Role and Responsibility

1. Provide a method to communicate information to CSHCN, their families and its members about the incident and recommendations for care and action.

3.2.14 DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS)

3.2.14.1 Role and Responsibility

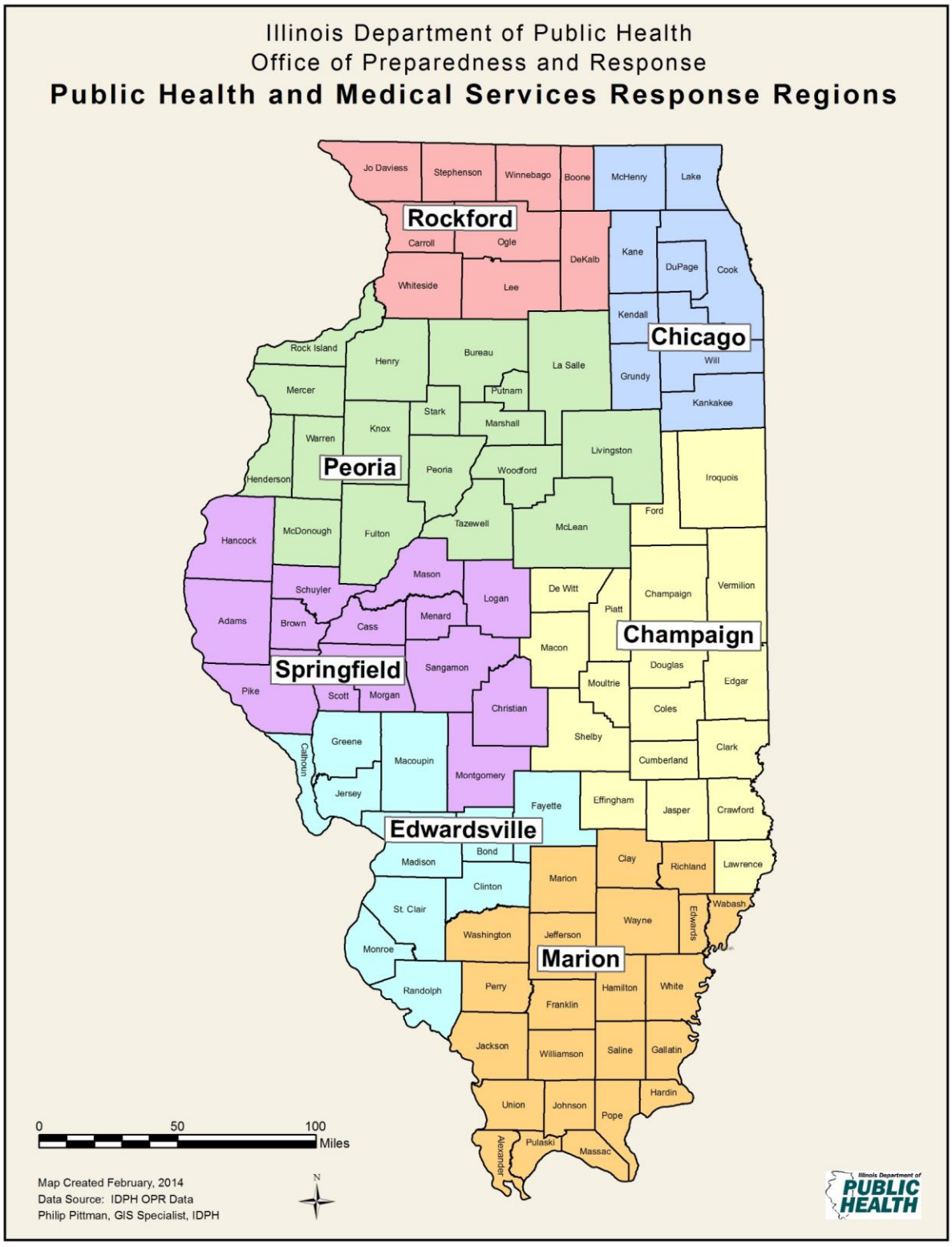
1. To provide assistance to hospitals, hospital or regionally based ACS, hospital or regionally based ATS, and/or state TMTS with:
   a. Securing placement for non-injured/ill children who have been unable to be reunited with their families.
   b. Providing consent for treatment for those children in need of medical care who are wards of the state.
   c. Providing consent for patient transfer during the decompression process for those children who are wards of the state.
   d. Verifying guardianship of unaccompanied minors who are in the DCFS database.
2. Report any missing children/youth whom the department is legally responsible for to the local law enforcement agency, the child's case manager and the Child Intake and Recovery Unit (312-328-2345 or 866-503-0184).
3. The Child Intake Recovery Unit provides child specific information and advocacy intervention services to law enforcement officials, the National Center for Missing and Exploited Children, child care workers and supervisors, and assistance to any child whom the department has legal responsibility for.
4. Hospitals, hospital or regionally based ACS, hospital or regionally based ATS, and/or state TMTS can contact the DCFS Hotline (800-252-2873) for questions and/or concerns about unaccompanied minors and children who are wards of the State or to report suspected abuse or neglect.

3.2.15 ILLINOIS DEPARTMENT OF HUMAN SERVICES (DHS)

3.2.15.1 Role and responsibility:

3.2.15.1.1 To assist IDPH in their communication with day care centers/child care centers throughout the state.

ATTACHMENT 1: PUBLIC HEALTH AND MEDICAL SERVICE RESPONSE REGIONS MAP



ATTACHMENT 2: IDPH OPR IMT ORGANIZATIONAL CHART

Chart of IDPH Office of Preparedness and Response Incident Management Team (IMT)

Command Staff

Incident Commander
Title
OPR Deputy
EMS Chief
FGM Chief

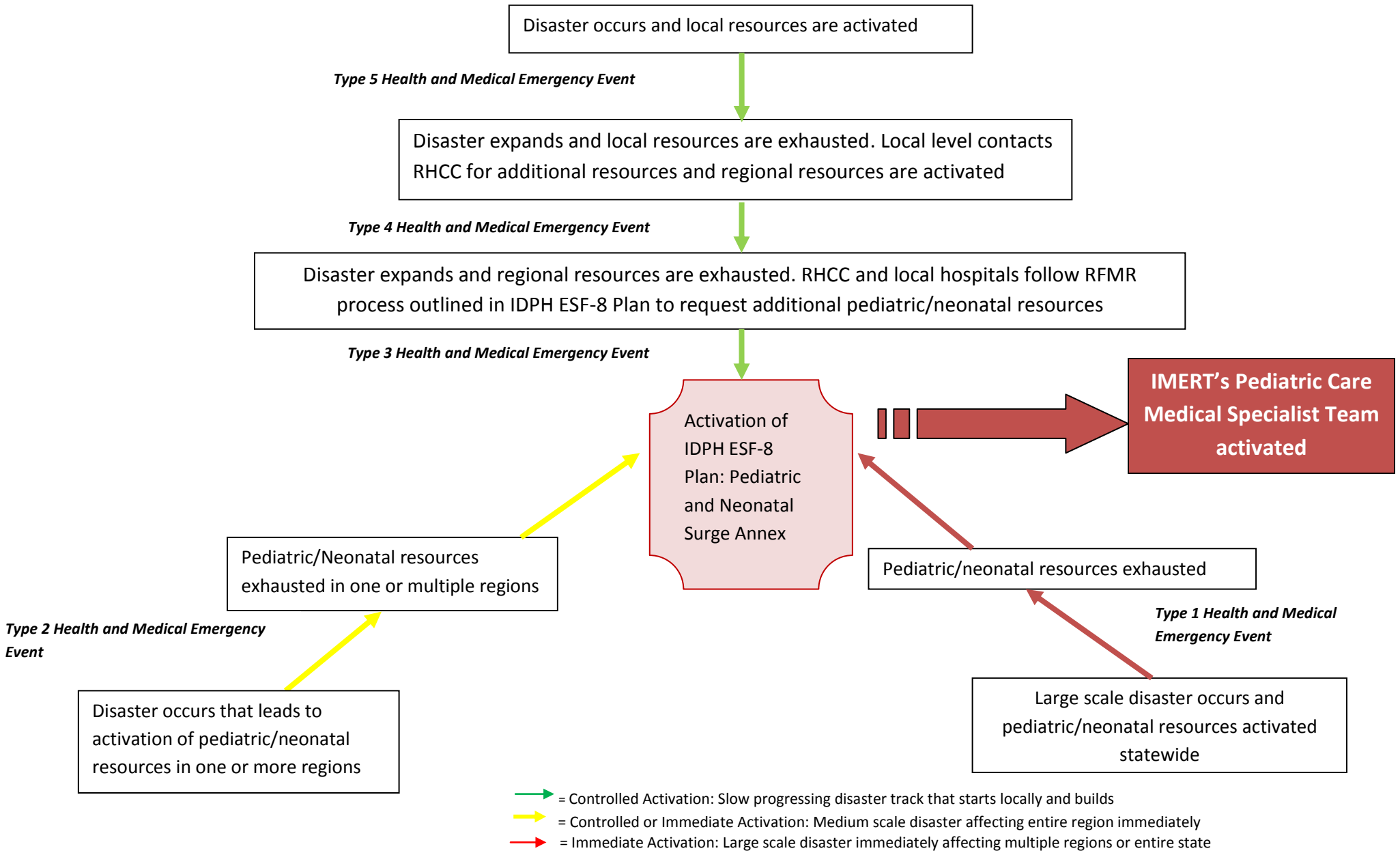
Safety Officer	Liaison Officer	Public Information Officer	State ESF-8 Lead State Incident Response Center (SIRC)
Title	Title	Title	Title
T & E Safety Officer	OPR Administrative Assistant	Communications Manager	DPR Chief
EMS Special Programs Coordinator	DPR Administrative Assistant	Communications Manager	All-Hazards Planning Section Chief
	EMS Administrative Assistant		

General Staff

Operations Section	Planning Section	Logistics Section	Finance and Administration Section
Title	Title	Title	Title
EMS Chief	All-Hazards Planning Section Chief	PHEOC Coordinator	FGM Chief
ERC Regional Supervisor	Evaluation Coordinator	Accounting Technician	HPP Grants Manager
HPP Program Manager			PHEP Grants Manager

ATTACHMENT 3: PEDIATRIC AND NEONATAL SURGE ANNEX ACTIVATION PATHWAY

Purpose: To outline the types of incidents that prompt the activation of the Pediatric and Neonatal Surge Annex



ATTACHMENT 4: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

INCIDENT NAME:			
DATE/TIME PREPARED	**DATE/TIME RECEIVED**	**OPERATIONAL PERIOD**	**RECEIVED VIA** □ Phone □ Radio □ Fax □ Other
FROM (SENDER)	**TO (RECEIVER)**	**REPLY/ACTION REQUIRED?** □ YES □ NO If YES, reply to (if different from sender)	
PRIORITY: □ Urgent/High □ Non-urgent/Medium □ Informational/Low			

DATE/TIME PHEOC ACTIVATED	**REASON FOR PHEOC ACTIVATION**
DATE/TIME ANNEX ACTIVATED	**REASON FOR ANNEX ACTIVATION**
ACTIVATION LEVEL □ IMMEDIATE □ CONTROLLED	
DATE/TIME PEDIATRIC CARE MEDICAL SPECIALISTS ACTIVATED	**REASON FOR PEDIATRIC CARE MEDICAL SPECIALISTS ACTIVATION**

CURRENT INCIDENT INFORMATION

CURRENT NUMBER OF PEDIATRIC/NEONATAL BED NEEDS DUE TO A FACILITY REQUIRING SYSTEM DECOMPRESSION

NUMBER OF PATIENTS	**HOSPITAL CATEGORY**
	Category 1: Specialty centers (pediatric intensive care unit {PICU} and/or neonatal intensive care unit {NICU}) able to provide complex pediatric care to ages 0 through 15 years (includes Pediatric Critical Care Centers {PCCC})
	Category 2: Community hospitals with some pediatric services (includes Emergency Departments Approved for Pediatrics {EDAP}) and accepts 0-12 year-old patients
	Category 3: Community hospitals with no pediatric/neonatal services (can include Standby Emergency Departments Approved for Pediatrics {SEDP}) and accepts 12 years old and older patients
	Category 4: Community hospitals with Level I, II and/or II-E (II+) nurseries, but no other pediatric services and accepts 0-1 year-old patients (can include Standby Emergency Departments Approved for Pediatrics {SEDP})

*Adapted from HICS 213 Form

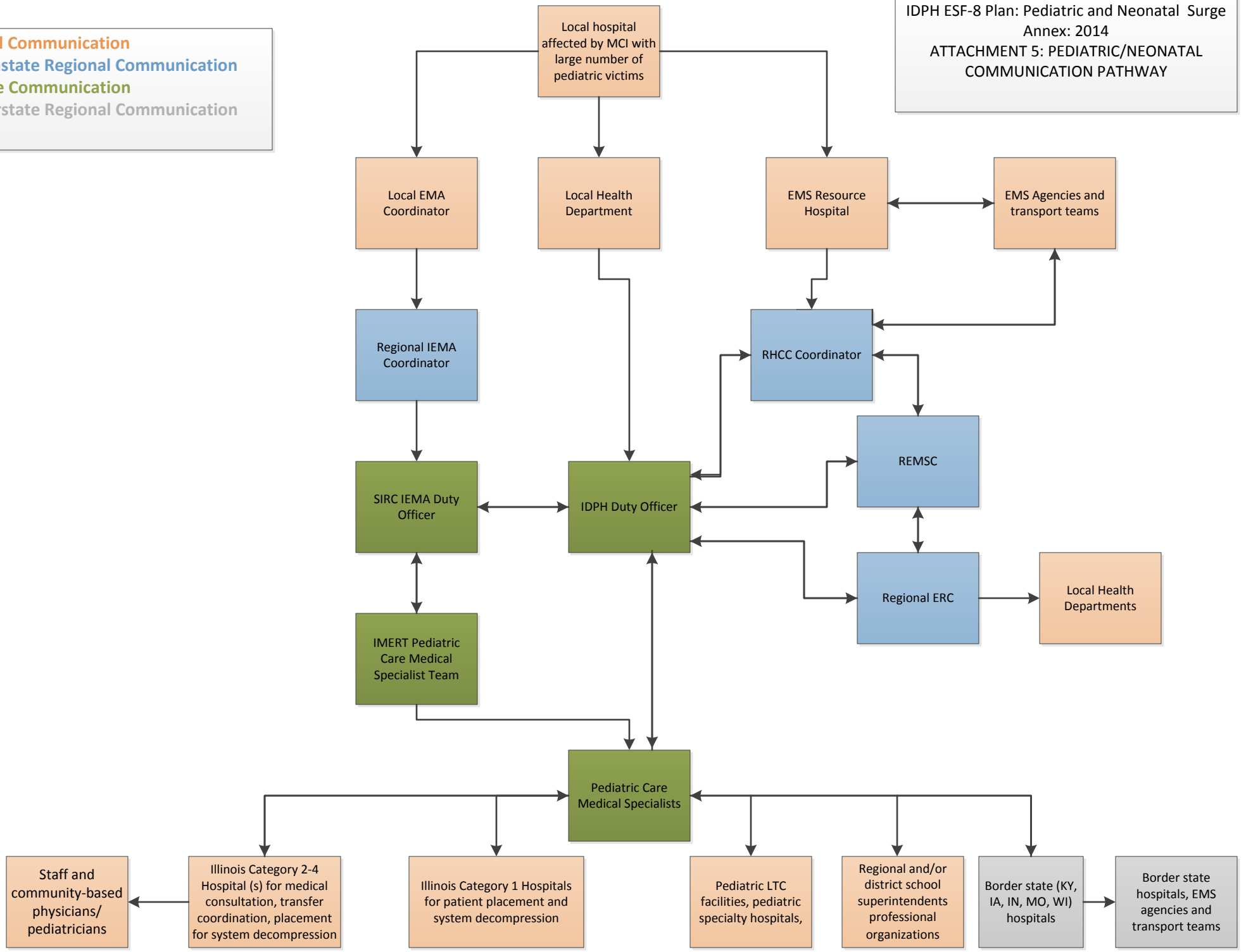
ATTACHMENT 4: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

REQUIRED/REQUESTED ACTIONS AT THIS TIME		
RECEIVED BY	**TIME RECEIVED**	**FORWARD TO**
COMMENTS		
FACILITY NAME/LOCATION		

*Adapted from HICS 213 Form

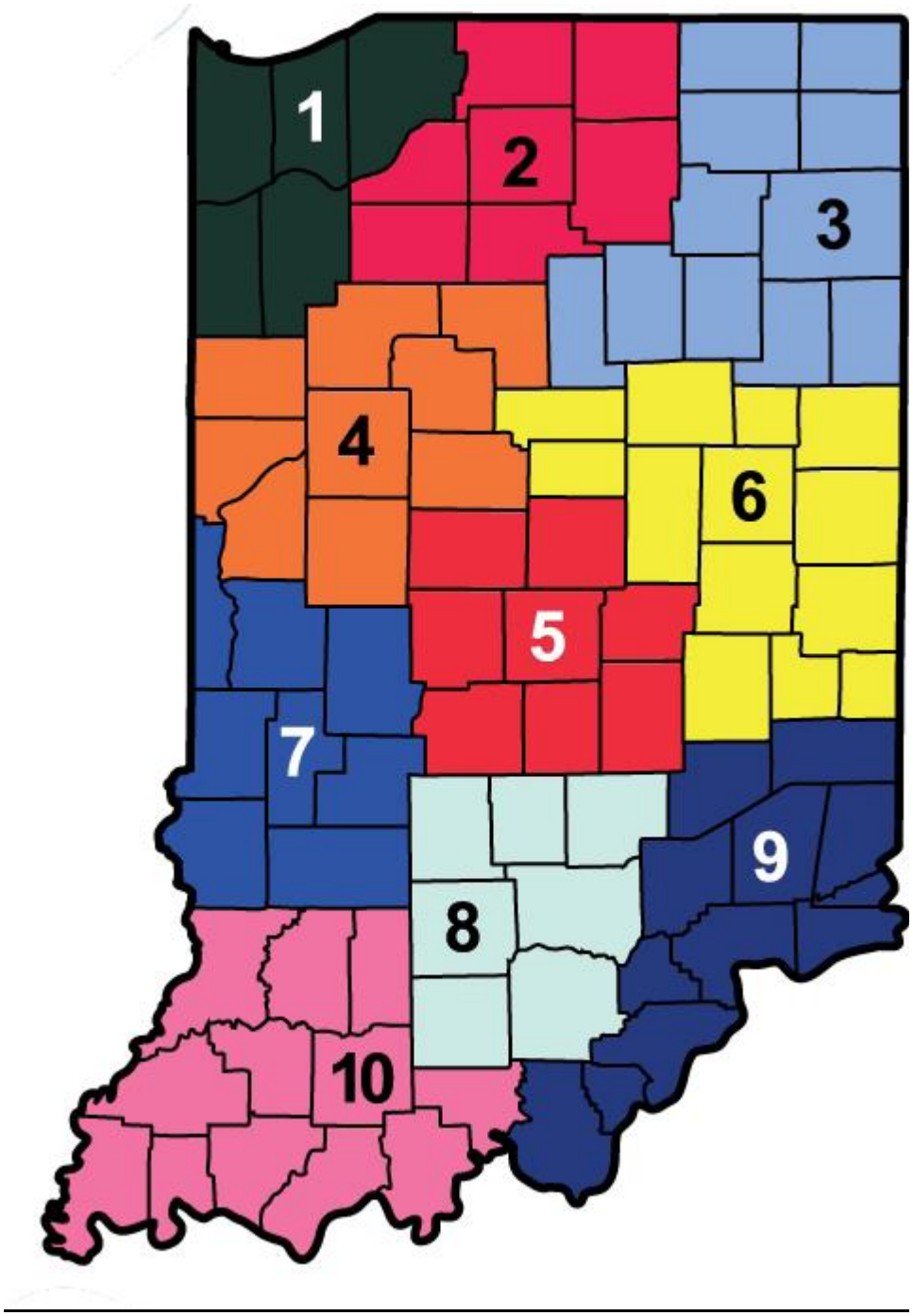
IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex: 2014
ATTACHMENT 5: PEDIATRIC/NEONATAL COMMUNICATION PATHWAY

Local Communication
Intrastate Regional Communication
State Communication
Interstate Regional Communication



ATTACHMENT 6: INDIANA HBPPC DISTRIC LEAD CONTACT INFORMATION

Hospital Bioterrorism Preparedness Planning Committee
Indiana State Department of Health
District Leads



ATTACHMENT 6: INDIANA HBPPC DISTRIC LEAD CONTACT INFORMATION

Hospital Members:

Emery Garwick, LPM, PI (BT District 1)
EMS/Emergency Preparedness Coordinator
The Methodist Hospitals
2269 W. 25th Ave.
Gary, IN 46404
Cell: 219-670-7443
Phone: 219-881-3717
E-mail: emery.garwick@yahoo.com

Kelly Jolliff (BT District 2)
Memorial Hospital of South Bend
615 N. Michigan St.
South Bend, IN 46601
Phone: 574-647-2238
E-mail: kjolliff@beaconhealthsystem.org

Troy Jester (BT District 3)
Safety Coordinator
Parkview Noble Hospital
401 Sawyer Rd.
Kendallville, IN 46755
Phone (office): 260-347-8504
Phone (cell): 260-438-5892
E-mail: troy.jester@parkview.com

Tom Fuson, BSRT CHEC
Director, Environment of Care and Emergency Preparedness (BT District 4)
Indiana University Health Arnett
5165 McCarty Lane
Lafayette, IN 47905
Phone (office): 765-838-5074
Phone (cell): 765-426-7753
Fax: 765-838-4699
E-mail: FusonT@iuhealth.org

Ron Reitenour, MT (ASCP) (BT District 5)
Area Coordinator Microbiology, HAZMAT, Disaster Preparedness
Riverview Health
395 Westfield Rd.
Noblesville, IN 46060
Phone: 317-776-4264
Phone (cell): 317-503-6859
E-mail: rreitenour@riverview.org

ATTACHMENT 6: INDIANA HBPPC DISTRIC LEAD CONTACT INFORMATION

Angie Miller (BT District 6)
Community Hospital of Anderson and Madison County
1515 N. Madison Ave.
Anderson, IN 46011
Phone: 765-298-1651
Phone (cell): 765- 208-0538
Fax: 765-298-5850
E-mail: amiller@ecommunity.com

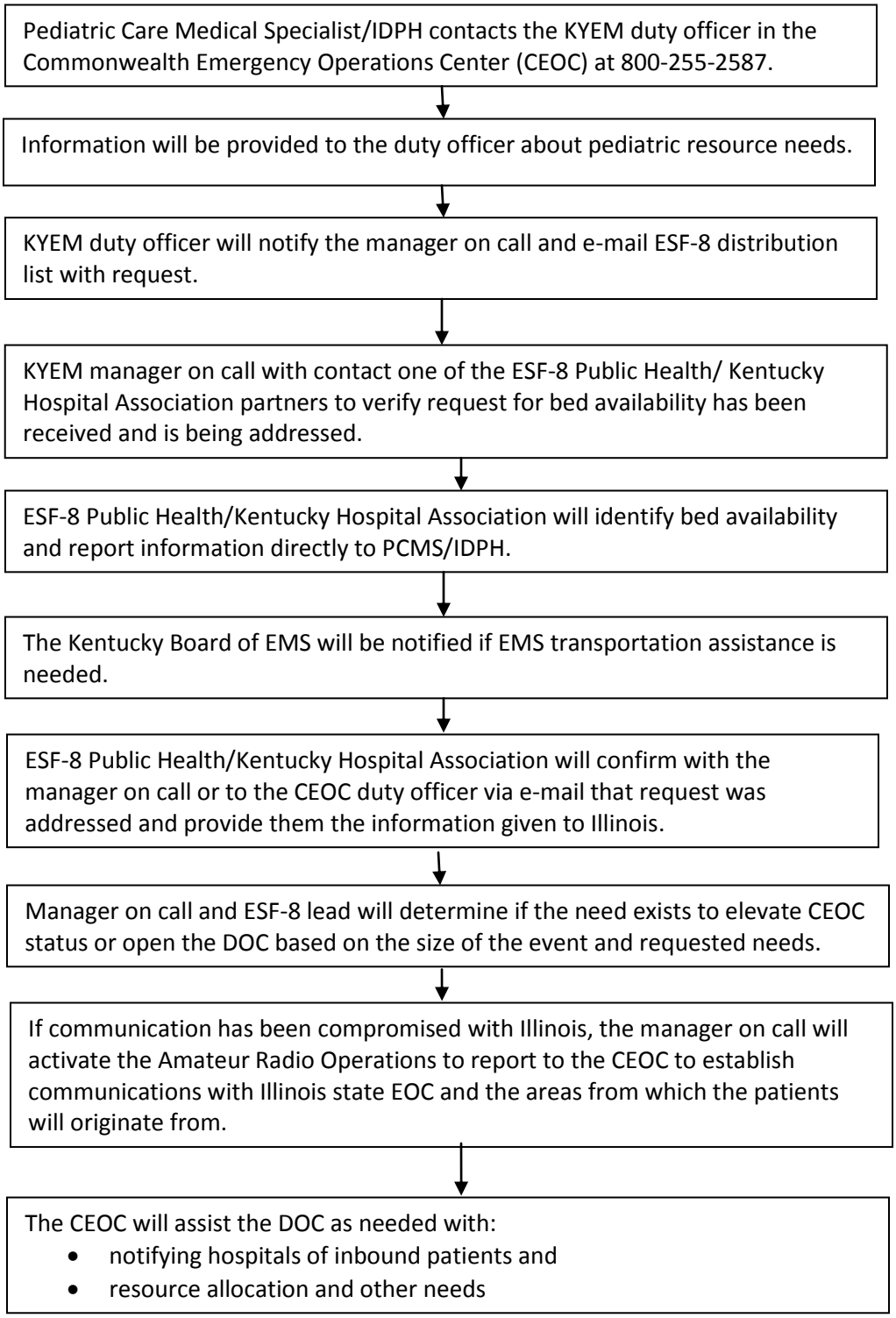
Mindy Young (BT District 7)
Terre Haute Regional Hospital
3901 S. 7th St.
Terre Haute, IN 47802
Phone (office): 812-237-1140
Phone (cell): 812-230-3205
Fax: 812-237-9974
E-mail: mindy.young@HCAhealthcare.com

Michael Hutchins (BT District 8)
Disaster Preparedness Asst.
Schneck Medical Center
411 W. Tipton St.
Seymour, IN 47274
Phone (cell): 812-786-5424
Fax: 812-522-5424
E-mail: mhutchins@schneckmed.org

Andrew Williams (BT District 9)
Floyd Memorial Hospital & Health Services
1850 State St.
New Albany, IN 47150
Phone: 812-948-6741
E-mail: awilliams@fmhhs.com

Keith Kahre (BT District 10)
EMS Coordinator
St. Mary's Medical Center
3700 Washington Ave.
Evansville, IN 47750
Phone: 812- 485-4191
Fax: 812-485-7676
E-mail: kkahre@stmarys.org

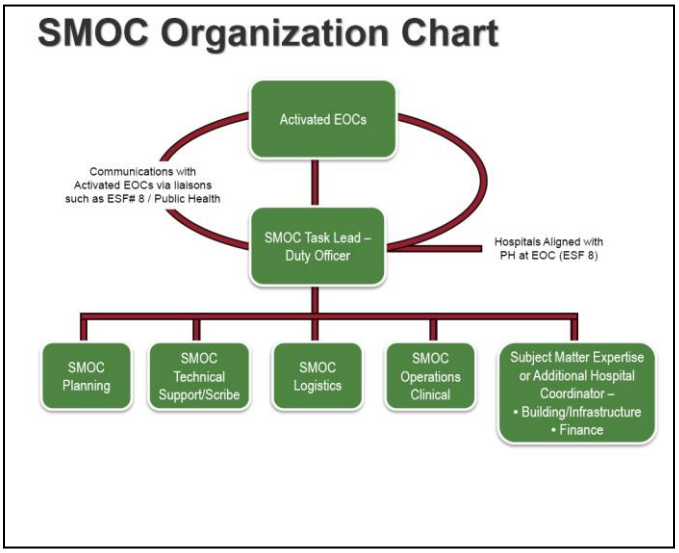
ATTACHMENT 7: KENTUCKY PEDIATRIC RESOURCE REQUEST PROCESS

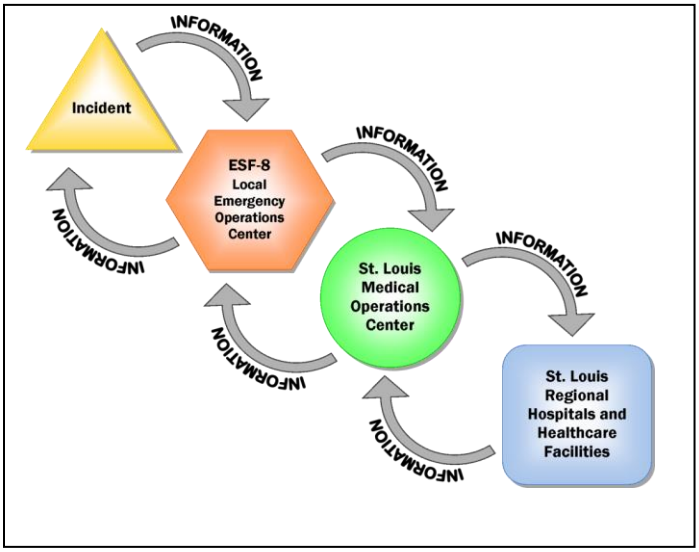


ATTACHMENT 8: ST LOUIS MEDICAL OPERATIONS CENTER REQUEST PROCESS

St. Louis Medical Operation Center (SMOC)

- Regional coordination entity supported and staffed by health care organizations to help coordinate decision making for hospitals when hospitals need assistance beyond their walls.
- Supported by volunteers from the medical community (administrative, clinical, non-clinical.
- During an emergency:
  - Serves as central point of contact among healthcare facilities, state and local emergency management agencies, and other governmental and non-governmental agencies as needed.
  - Collects and disseminates current situational information about incident and facility status.
  - Accesses health care resources and needs (e.g., equipment, bed capacity, personnel, supplies, etc.).
  - Develops priority allocations.
  - Tracks disbursement of resources.
  - Manages relevant health care response and communication.
  - Serves as advisors to other emergency support functions (ESF's) within the EOC.

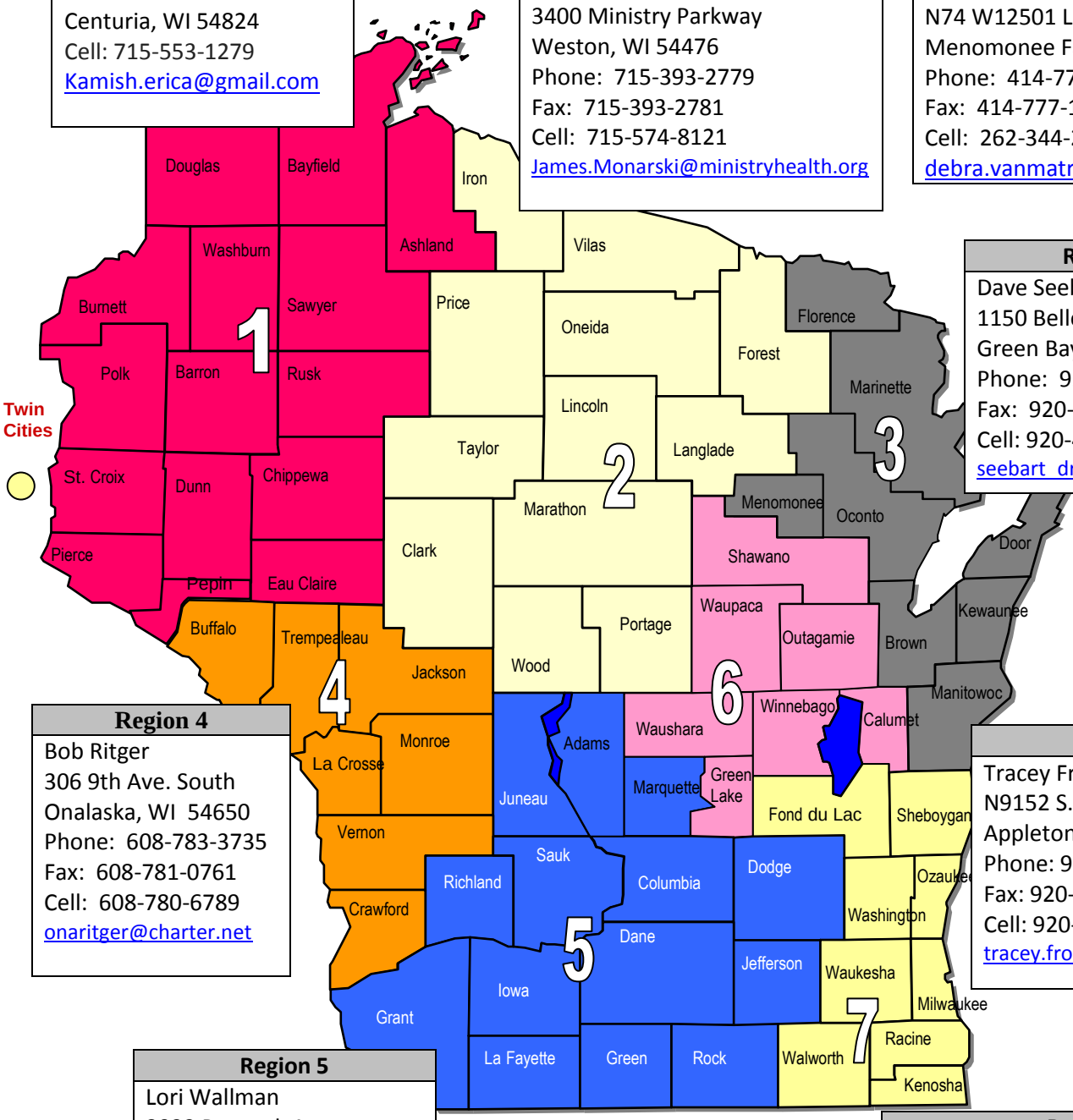




Process for Communication:

- PCMS/IDPH contacts the Central County 911 Center at 636-394-2212 and request SMOC duty officer be contacted.
- The duty officer will then serve as the liaison to identify pediatric resource availability, send information to Missouri hospitals and assist with the coordination of transfers.

ATTACHMENT 9: WHEPP REGIONAL MANAGER CONTACT INFORMATION MAP



Region 1

Erica Kamish
1689 200th Ave.
Centuria, WI 54824
Cell: 715-553-1279
Kamish.erica@gmail.com

Region 2

Jim Monarski
3400 Ministry Parkway
Weston, WI 54476
Phone: 715-393-2779
Fax: 715-393-2781
Cell: 715-574-8121
James.Monarski@ministryhealth.org

WI-Trac

Deb Van Matre
400 Woodland Prime
N74 W12501 Leatherwood Ct.
Menomonee Falls, WI 53051
Phone: 414-777-5094
Fax: 414-777-1921
Cell: 262-344-2119
debra.vanmatre@froedtert.com

Region 3

Dave Seebart
1150 Bellevue St.
Green Bay, WI 54302
Phone: 920-448-6476
Fax: 920-448-6449
Cell: 920-465-0361
seebart_dr@co.brown.wi.us

Region 4

Bob Ritger
306 9th Ave. South
Onalaska, WI 54650
Phone: 608-783-3735
Fax: 608-781-0761
Cell: 608-780-6789
onaritger@charter.net

Region 6

Tracey Froiland
N9152 S. Kernan Ave.
Appleton, WI 54915
Phone: 920-427-2229
Fax: 920-720-7290
Cell: 920-427-2229
tracey.froiland@thedacare.org

Region 5

Lori Wallman
3922 Paunack Ave.
Madison, WI 53711
Phone: 608-467-7222
Fax: 608-467-7221
Cell: 608-669-3510
lwallman@grantregional.com

Carolyn Strubel
WHEPP Manager
Phone: 608-267-0247
Fax: 608-266-7089
Cell: 608-225-4778
carolyn.strubel@wi.gov

Region 7

Elizabeth Corneliuson
400 Woodland Prime
N74 W12501 Leatherwood Ct.
Menomonee Falls, WI 53051-4480
Phone: 414-777-0146
Fax: 414-777-1921
Cell: 262-853-3289
elizabeth.corneliuson@froedtert.com

ATTACHMENT 10: PATIENT IDENTIFICATION TRACKING FORM

Purpose: To assist in identifying, tracking and reunifying patients during a disaster.

Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

Date of Arrival _____/_____/_____	Time of Arrival AM/PM	Tracking number
Patient's Name (Last, First)		Patient's Phone
Patient's Full Home Address		
(For Minors) Parent/Guardians' Names		Presented with patient? □ Yes □ No
Patient's DOB / / □ Unknown	Age ___Years ___Months □ Estimated	Gender □ Male □ Female
Race, if known □ White non-Hispanic □ Black, non-Hispanic □ Asian □ Hispanic □ Middle Eastern □ Native American □ Other □ Unknown		Language □ English □ Spanish □ Nonverbal □ Other _____

□ Accompanied □ Unaccompanied How patient arrived at hospital (list name if available) □ EMS_____ □ Private medical transport service (ambulance/flight)_____ _____ □ Law Enforcement _____ _____ □ Private Vehicle □ Walk-in □ Other_____	Describe where patient was found (be as specific as possible, including neighborhood/street address).	Items worn by or with patient when found (describe color, pattern, type) □ Pants_____ □ Shirt_____ □ Dress _____ □ Shoes _____ □ Socks _____ □ Coat/Jacket _____ □ Jewelry_____ □ Glasses_____ □ Medical Devices_____ □ Other _____ □ Other _____ □ Other _____

DESCRIPTION OF THE PATIENT

Skin color_____ Hair Color □ Blonde □ Brown □ Black □ Bald □ Other_____ Eye Color □ Brown □ Blue □ Green □ Other_____ Height □Estimated Weight □Estimated Other markings □ Scars_____ □ Moles_____ □ Birthmarks _____ □ Tattoos_____ □ Missing teeth_____ □ Braces_____ □ Other_____ □ Other_____ □ Other_____	Attach photo here

PATIENT TRACKING LOG

Hospital/Facility Name Location (city, state)	Phone Number Fax Number	Arrival Date Departure Date	ID Band #/ ID Band *(If patient has ID bands from other facilities and they need to be removed to provide care, attach ID band in this area)*
	( )	____/____/____	Attach ID Band Here
	( )	____/____/____	
	( )	____/____/____	Attach ID Band Here
	( )	____/____/____	
	( )	____/____/____	Attach ID Band Here
	( )	____/____/____	

MEDICAL HISTORY AND TREATMENT WHILE AT THIS FACILITY

Does the patient have any pre-existing medical conditions/medical problems/previous surgeries/special needs?
□ No □ Unknown □ Yes (list)

Is the patient on any medications? □ No □ Unknown □ Yes (list)

Does the patient have any allergies? □ No □ Unknown □ Yes (list)

Did the patient receive medical care for an injury/illness while at this facility?
□ No □ Yes (list)

COMPLETE FOR MINORS: CHILD ACCOMPANIED BY PARENT/GUARDIAN

Name of Person Accompanying Child □ Adult □ Child/Minor

Relationship to Child
□ Parent □ Guardian □ Sibling □ Grandparent
□ Aunt/Uncle/Cousin □ Unknown
□ Other _____

Attach Copy of ID

ID Checked? □ Yes □ No
Form of ID (list)_____

If accompanied by adult, was child living with this adult prior to the emergency? □ Yes □ No
Does this adult have any proof of legal guardianship or relationship? □ Yes □ No
If yes, make copy and attach to this form.

If child and adult were separated after arrival at current facility, where is accompanying adult now?

If accompanied by someone other than parent/guardian, what is known about the parent/guardian's current whereabouts?
□ Nothing at this time □ Their current location is:

Is it known if there are orders of protection or other custody issues? □ No known custody/protection issues
□ Issue(s) identified

COMPLETE FOR MINORS: CHILD UNACCOMPANIED BY PARENT/GUARDIAN

Are the whereabouts of the parent/guardian currently known? □ No □ Yes
Is information about parent/guardian known? □ No □ Yes
Name Phone
Location
E-mail Address

Where and when was the parent/guardian last seen

Has the parent/guardian been contacted □ No □ Yes
Contacted by_____ Date __/__/____ Time _____

Plans for reuniting child with parent/guardian

Agencies Used to Assist with Reunification (Date/Person Contacted)
□ American Red Cross _____
□ Department of Children and Family Services_____
□ Law enforcement_____
□ National Center for Missing and Exploited Children
_____
□ Other_____

Additional steps to verify guardianship if reunited at hospital
□ Does parent/guardian describe child accurately?
□ Does parent/guardian pick correct child out from a group of pictures?
□ Does parent/guardian have a picture of them with the child?
□ Does the child respond appropriately when reunited with parent/guardian?

DISPOSITION

□ Admitted to_____ □ Discharged □ Expired
□ Patient was released to an individual □ Parent □ Guardian □ Other_____
Name Phone
Address □ Permanent □ Temporary
Was consent obtained from parent/guardian if released to another adult? □ Yes □ No (explain)_____

□ Patient was transferred to another facility/agency (Name)_____
Address Phone
Contact Name
Transported by

Signature of patient/individual patient released to	Date:__ / __/ ____ Time	Name of Person Completing Form
		Signature of Person Completing Form

ATTACHMENT 11: PEDIATRIC PATIENT TRACKING LOG

Purpose: To assist with tracking of pediatric patients during disasters.

Pediatric Patient Tracking Log

Incident Name	**Date/Time Prepared**	**Operational Period (Date/Time)**
Submitted By:		

Tracking Number	**Name (Last, First)**	**Sex**	**DOB** / **Age**	**Initial hospital** / **Location (city/state)** / **Transported by**	**Arrival Date** / **Departure Date**	**Receiving hospital #1** / **Location (city/state)** / **Transported by**	**Arrival date** / **Departure Date**	**Receiving hospital #2** / **Location (city/state)** / **Transported by**	**Arrival Date** / **Departure Date**
		M F	__/__/__		__/__/__		__/__/__		__/__/__
		M F			__/__/__		__/__/__		__/__/__
		M F	__/__/__		__/__/__		__/__/__		__/__/__
		M F			__/__/__		__/__/__		__/__/__
		M F	__/__/__		__/__/__		__/__/__		__/__/__
		M F			__/__/__		__/__/__		__/__/__

ATTACHMENT 11: PEDIATRIC PATIENT TRACKING LOG

				__/__/__		__/__/__		__/__/__		__/__/__
		M	F			__/__/__		__/__/__		__/__/__
				__/__/__		__/__/__		__/__/__		__/__/__
		M	F			__/__/__		__/__/__		__/__/__
				__/__/__		__/__/__		__/__/__		__/__/__
		M	F			__/__/__		__/__/__		__/__/__
				__/__/__		__/__/__		__/__/__		__/__/__
		M	F			__/__/__		__/__/__		__/__/__
				__/__/__		__/__/__		__/__/__		__/__/__
		M	F			__/__/__		__/__/__		__/__/__

ATTACHMENT 12: PEDIATRIC TRIAGE GUIDELINES

Purpose: To provide guidance to the transferring facility and the Pediatric Care Medical Specialist during statewide triage of patients to identify the most appropriate facility to transfer pediatric patients to.

TRIAGE CATEGORY	POSSIBLE CRITERIA* INTERVENTIONS	CONDITIONS	PERINATAL CRITERIA
GREEN (Pediatric/ Neonatal General Medical Care/ Category 2 and 3 Hospitals)	Intermittent monitoring (e.g., pulse oximetry)	Pediatric Burns <10%	Level I or II Perinatal Center Criteria • Active labor in mothers >35 gestation • Stable gestational hypertension • Premature rupture of membranes >35 weeks gestation • Rule out rupture of membranes (ROM)
	Maintenance IV fluids or saline lock	Inpatient psychiatric resources	
	Low flow oxygen (up to 4L)	Fever (Stable)	
	Nebulizer treatments q 2 hrs or greater	Other condition(s) requiring pediatric specialty care	
	PO/IV meds		
YELLOW (Pediatric/ Neonatal Intermediate Care/ Category 2 and 4 Hospitals)	IV drip x 1 (e.g., insulin, inotropes, TPN, etc.)	Shock, responding adequately to treatment (compensated)	Level II-E Perinatal Center Criteria • Active labor in mothers >30 and <35 weeks gestation • Multiple gestations (no more than twins) in active labor • Decreased fetal movement • Abdominal pain • Preterm rupture of membranes >30 and <35 weeks gestation
	Central lines (IJ, Subclavian, Femoral)	Stable cardiac rhythm disturbances	
	Intermittent cardiac, NIBP and/or pulse oximetry monitoring	Dehydration, electrolyte imbalances and/or metabolic disturbances (stable)	
	Continuous nebulizer treatments	Respiratory distress (responding adequately to treatment)	
	Conventional ventilator, CPAP/BiPAP/Hi flow oxygen (stable)	Trauma (stable): Head injury, pelvic fractures, spinal cord injuries, blunt injury to chest or abdomen	
	Non-emergent hemodialysis for chronic renal failure (chronic)	Trauma (stable): Fractures and deep penetrating wounds to an extremity with neurovascular or compartment injury	
		Trauma: Patient with chest tube, hemovac (stable)	
		Burns >10% but < 20% TBSA	
		Other condition(s) requiring pediatric specialty care	
RED (Pediatric/ Neonatal Intensive Care/ Category 1 Hospitals)	Invasive monitoring (either present or needed) (e.g., A-line, CVP, ICP)	Active seizures/status epilepticus	Level III Perinatal Center Criteria • Post cardio-pulmonary failure/arrest • Eclampsia • Active hemorrhage/heavy bleeding • Fetal parts or foreign bodies protruding from vagina • Diabetic coma/DKA • Altered level of consciousness • Multiple gestations (greater than twins) in active labor • Active labor in mothers <30 weeks gestation • Preterm rupture of membranes <30 weeks gestation • Laboring mother with known antenatal fetus defect (e.g., cardiac, pediatric surgery) • Pre-eclampsia or Hemolysis, Elevated Liver Enzymes, and Low Platelets (HELLP) syndrome • Other life threatening conditions to mother or fetus
		Post cardiac arrest patients	
	Continuous cardiac, NIPB and/or pulse oximetry monitoring	Dehydration, electrolyte imbalances and/or metabolic disturbances (unstable)	
	Immediate/emergent dialysis for acute or chronic renal failure	Shock responding inadequately to treatment (uncompensated)	
		Respiratory distress (responding inadequately to treatment)	
	IV drips >2 (e.g., insulin, inotropes, TPN, etc.)	Unstable vital signs	
		Unstable cardiac rhythm disturbances	
	Highly specialized equipment needs (HFOV-high frequency oscillator ventilators, ECMO, Berlin Heart, LVAD)	Trauma (unstable): Spinal cord injuries; major pelvic fractures; blunt injury to chest or abdomen; significant penetrating wounds to head, neck, thorax, abdomen or pelvis	
	Conventional ventilator/BiPAP/CPAP/Hi flow oxygen (unstable)	Trauma: Head injury with any of the following: cerebrospinal fluid leaks, open head injuries (excluding simple scalp injuries), depressed skull fractures, decreased level of consciousness	
	Externally paced	Trauma: Amputation proximal to the wrist or ankle	
	Other highly specialized services needed	Trauma (unstable): Fractures and deep penetrating wounds to an extremity with neurovascular or compartment injury	
		Pediatric burns >20% TBSA	
		Other condition(s) requiring pediatric critical care specialty	
			Pregnant women with >20% TBSA Burns

* This list is not meant to be all inclusive and is to be used ONLY during disasters

ATTACHMENT 13: PEDIATRIC PATIENT TRANSFER FORM

Purpose: To provide a method of communicating medical and treatment information on pediatric patients during a disaster when pediatric patients are being transferred to pediatric specialty care centers.

Note: Information contained within this form is confidential and should not be shared except, with those assisting in the care of the patient.

Form completed by	Title	Date / /	Time :
Patient Name (Last, First)	DOB / / Age _____Years _____Months □ Estimated		Sex □ Male □ Female
Parent/Guardian present □ No □ Yes If yes, please provide Name Phone Custody/legal status Documentation provided □ No □ Yes	If no Known whereabouts? Efforts to contact		
Interpreter needed? □ No □ Yes Language_____	Primary care provider notified? □ No □ Yes Phone_____		

INITIAL STATUS

Referring hospital Unit at hospital Full Address Phone	Referral physician Specialty □ ED □ Pediatrician □ Family Practice □ Neonatologist □ Obstetrician □ Other (list) _____ Referring physician/hospital contact's phone
Preliminary Diagnosis	Reason for transfer

Acuity Level □ Stable/Non-emergent □ Stable/Emergent □ Unstable/Emergent

Requested services □ ED □ Trauma □ PICU □ NICU □ Burn □ In-patient services □ Other specialty services (list): _____
_____

PATIENT HISTORY

Weight	**Allergies (list)**	**Home medications (list)**
_____kg □ actual □ estimated	□ NKDA □ Unknown	□ None □ Unknown □ See attached medication reconciliation form

Relevant Medical/Surgical History (list) □ See attached

CLINICAL ASSESSMENT AND TREATMENTS

Vital signs (time)	T	HR	RR	BP	SaO2
(initial)					
(most recent)					

Intake/Output (time)	INTAKE	OUTPUT

Vascular Access □ Arterial □ IO □ PICC □ PIV □ UVC
□ Indwelling Venous Catheter □ Central Venous Line
Site _____
Fluid Type_____ Rate_____
Bolus? □ No □ Yes: Type_____
Total Volume _____ Time given _____:_____

Physical Findings

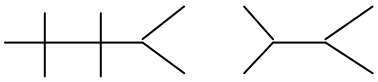
Current Medications: □ See attached	**X-Ray/CT/MRI/Ultrasound Results** □ See attached

ATTACHMENT 13: PEDIATRIC PATIENT TRANSFER FORM

Blood Gas □ See attached

Time	Site	pH	pCO_2	pO_2	HCO_3	BD/BE

Labs □ See attached



Other (include critical lab values):

Airway

Intubated □ No □ Yes
ETT/TR Size_____ Depth_____
Vent settings
CXR □ No □ Yes

O_2 Mask □ No □ Yes
Nasal Cannula □ No □ Yes
O_2 Liters/Min_____
Bi-PAP/CPAP □ No □ Yes
Settings _____

	+	-	Pending	Isolation
Flu				
RSV				
MRSA				
Cough				

Other Treatments

Treatment Summary

TRANSPORT NEEDS

Type of transport service needed □ BLS □ ALS □ Critical Care □ Ground □ Air □ Other_____

Type of transport service available at referring hospital? □ No □ Yes

Equipment needed for transport □ oxygen □ ventilator □ C-PAP □ cardiac monitor □ IV pump □ invasive monitoring □ spine immobilization □ restraints □ isolette □ car seat □ Other (list)_____

MEDICAL MANAGEMENT

Management Discussion/Recommendations □ Telemedicine Capabilities Used

RECEIVING HOSPITAL INFORMATION

Receiving hospital
Address

Bed assignment_____
Phone _____

Receiving physician

Specialty □ ED □ Pediatrician □ Family Practice
□ Neonatologist □ Obstetrician □ Other (list)
_____
Receiving physician phone

Assignment Date	Assignment Time	Person contacted at referring hospital
/ /	:	

ADDITIONAL NOTES