Access the recorded webinar here:
https://attendee.gotowebinar.com/recording/6057161584090898178

Access speaker bios here:
https://files.asprtracie.hhs.gov/documents/aspr-tracie-pediatric-surge-annex-webinar-speaker-bios.pdf

Contact ASPR TRACIE for a copy of the NHCPC 2019 Pediatric Workshop Summary.

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Developing a Healthcare Coalition Pediatric Surge Annex

February 26, 2020

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ASPR TRACIE: Three Domains

- Self-service collection of audience-tailored materials
- Subject-specific, SME-reviewed "Topic Collections"
- Unpublished and SME peer-reviewed materials highlighting real-life tools and experiences

asprtracie.hhs.gov

- Personalized support and responses to requests for information and technical assistance
- Accessible by toll-free number (1844-5-TRACIE), email (askasprtracie@hhs.gov), or web form (ASPRtracie.hhs.gov)

1-844-5-TRACIE

- Area for password-protected discussion among vetted users in near real-time
- Ability to support chats and the peer-to-peer exchange of user-developed templates, plans, and other materials

askasprtracie@hhs.gov

Resources

- ASPR TRACIE
  - Pediatric Topic Collection
  - HCC Pediatric Surge Annex Template
  - HCC Pediatric Surge TTX Toolkit
  - Healthcare Coalition Select Resources Landing Page
  - Family Reunification and Support Topic Collection
  - Pediatric Issues in Disasters Webinar
- AAP Resources:
  - Pediatric Disaster Preparedness and Response Topical Collection: Pediatric Preparedness Exercises chapter
  - Pediatric and Public Health Exercise web page and Resource Kit

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HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Jack Herrmann, MSEd, NCC, LMHC
Acting Director, National Healthcare Preparedness Program, HHS ASPR

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Pediatric Surge Annex Requirements

2019-2023 Hospital Preparedness Program Funding Opportunity Announcement

HCCs must develop complementary coalition-level annexes to their base medical surge/trauma mass casualty response plan(s) to manage a large number of casualties with specific needs

In addition to core elements required for all annexes, the Pediatric Surge Annex must consider:

- Local risks for pediatric-specific mass casualty events
- Age-appropriate medical supplies
- Mental health and age-appropriate support resources
- Pediatric/Neonatal Intensive Care Unit (NICU) evacuation resources and coalition plan
- Coordination mechanisms with dedicated children's hospital(s)

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HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

John Hick, MD
Hennepin Healthcare & ASPR Moderator

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Webinar Objectives/ Setting Stage

- This webinar supplements the Pediatric Annex Planning Workshop at the 2019 National Healthcare Coalition Preparedness Conference
- Presenters will discuss guidance, resources, and lessons learned to help HCCs develop a pediatric surge annex
- Agenda:
  - Overview of AAP and Pediatric Centers of Excellence
  - **Deanna Dahl-Grove, MD, FAAP**, Associate Professor, Pediatric Emergency Medicine, Rainbow Babies and Children's Hospital; Member, AAP CoDPR Executive Committee
  - **Christopher Newton, MD**, Associate Professor of Surgery, Division of Pediatric Surgery, Director of Trauma Care, UCSF Benioff Children's Hospital Oakland
  - **Sarita Chung, MD, FAAP**, Director of Disaster Preparedness, Division of Emergency Medicine, Children's Hospital Boston; Member, AAP Council on Disaster Preparedness and Recovery

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HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Overview of AAP and Pediatric Centers of Excellence

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American Academy of Pediatrics (AAP)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

American Academy of Pediatrics

- Most important contributions:
  - Pediatric disaster focus since 2005
  - Pediatric experts who will review draft annexes or certain sections
  - Models from other states (Chapter Contacts for Disaster Preparedness)
  - Pediatric Disaster Care Centers of Excellence
  - Assistance with pediatric-focused exercises
- ***NEW*** Council on Disaster Preparedness and Recovery
  - Those interested in membership can e-mail AAP staff at DisasterReady@aap.org

www.aap.org/disasters

AAP Policy Statements

- Ensuring the Health of Children in Disasters
- Medical Countermeasures for Children in Public Health Emergencies, Disasters, or Terrorism
- Providing Psychosocial Support to Children and Families in the Aftermath of Disasters and Crises
- Chemical-Biological Terrorism and Its Impact on Children
- Supporting the Grieving Child and Family
- Disaster Preparedness in Neonatal Intensive Care Units
- Radiation Disasters and Children

Is Your ED Pediatric Ready?

National PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

Children and their families rely on the nearest ED to be ready to provide outstanding care. Working together we can ensure that all EDs are pediatric ready. It is simple - participate in the upcoming 2020 assessment and learn how your ED can be pediatric ready.

START NOW to be PedsReady before taking the assessment starting June 2020.

You can help now by doing the following:

- Bookmark the **PedsReady.org** website
- Download the 2018 guidelines: **https://tinyurl.com/PedsReady**
- Like & share the PedsReady Facebook page: **@PedsReady**

ASSESSMENT 2020

National PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

GET PEDSREADY

The unique needs of children and their families are often left out of hospital disaster plans. To integrate pediatric disaster preparedness into your ED, download the EMSC Disaster Preparedness Checklist: **https://tinyurl.com/PedsReadyDisasterPreparedness**

Prepare now to be PedsReady before taking the assessment starting in June 2020. **pedsready.org**

Supported by:

American College of Emergency Physicians® ADVANCING EMERGENCY CARE

ENA EMERGENCY NURSES ASSOCIATION

EMSC Emergency Medical Services for Children

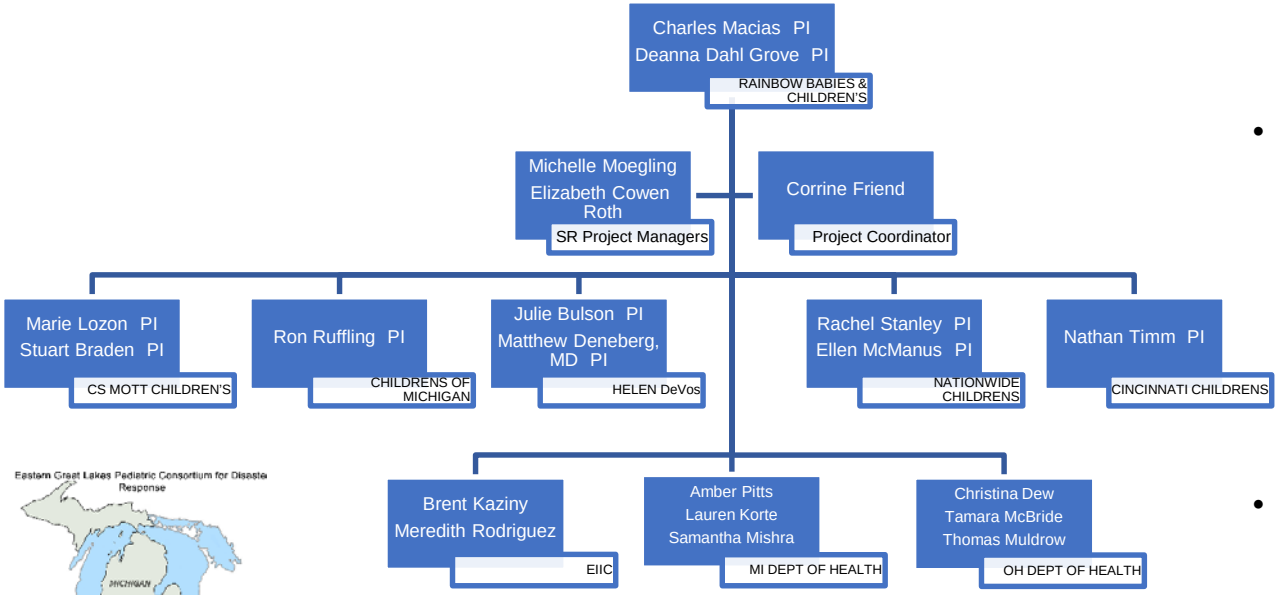
American Academy of Pediatrics DEDICATED TO THE HEALTH OF ALL CHILDREN®

Supported in part by the US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Emergency Medical Services for Children (EMSC) Program (cooperative agreement number UJ5MC30824).

ASPR - Pediatric Disaster Care Center of Excellence

- One of 2 awardees - **Eastern Great Lakes**
- Goal: to harness the best practices around disaster preparedness and response shared with children and non-children's hospitals and affiliates
- Multi faceted approach working with hospitals and state partners to improve individual hospital preparedness, regional pediatric capability expansion and alignment of state systems and programs

Organization Chart



Key Partners

- Departments of Health, Emergency Medical Services and Emergency Management among other key state partners
- EIIC - Emergency Services for Children Innovation and Improvement Center

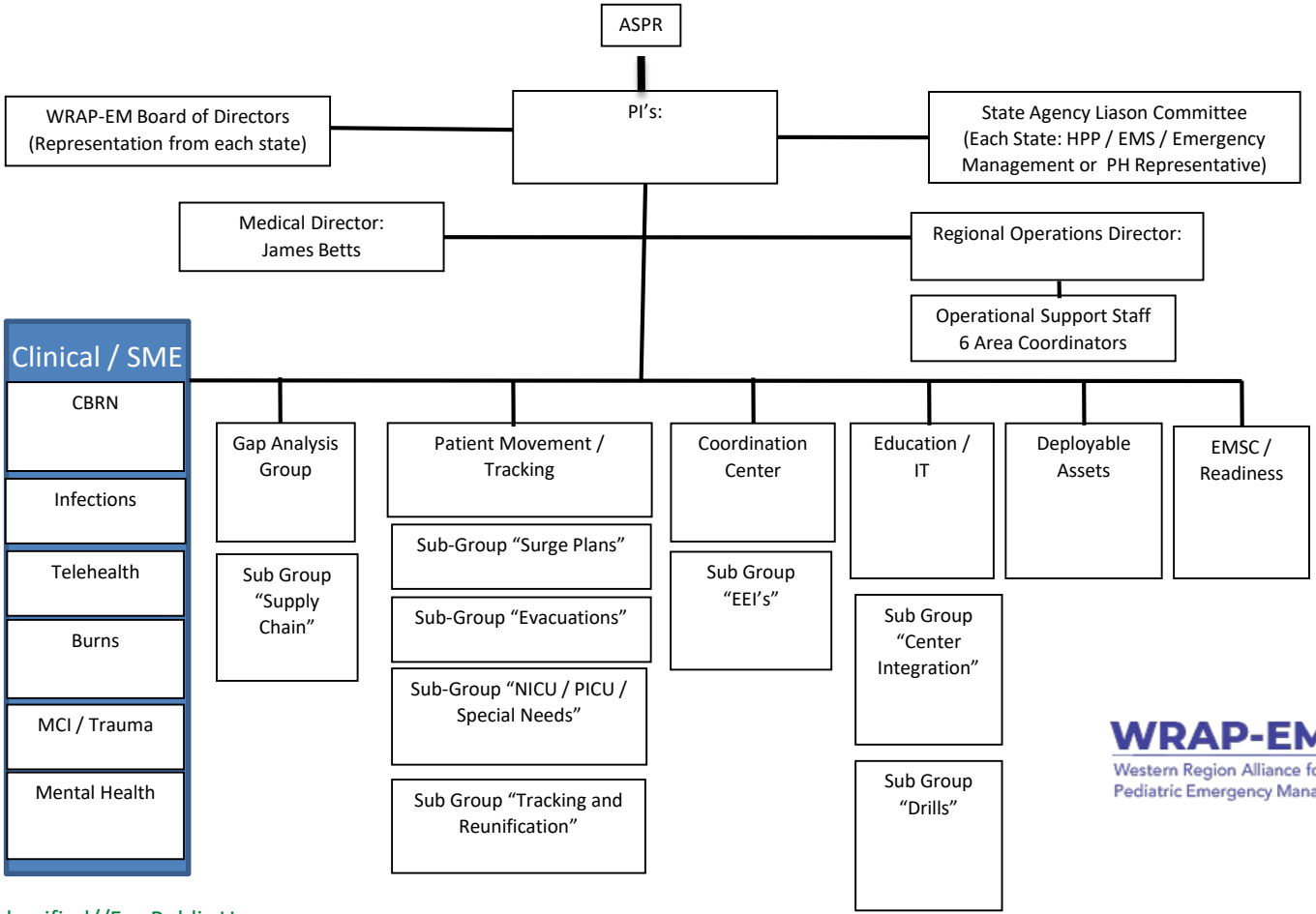
Universities / Facilities

Seattle Children's (UW)
University of Oregon (OHSU)
UC Davis
UCSF
Stanford
Valley Children's Hospital (Fresno)
Loma Linda University
CHLA (USC)
Lindquist Institute (Harbor-UCLA)
Cedars Sinai
Rady Children's (UCSD)
University Medical Center (UNLV)
Phoenix Children's (ASU)

Agency / Consortium / Corporate

State Departments of Health
State EMS and EM
Health Care Coalitions (HCC's)
Western Peds Preparedness Partnership (WPPP)
Poison Control Centers
Burn Centers Consortium
Ebola Biocontainment Centers (NETEC)
AMR Ambulance
Reach / Calstar Air Medical Ambulance
Kaiser Permanente
Providence Healthcare

13 Million Children
~150 Active participants



WRAP-EM
Western Region Alliance for Pediatric Emergency Management
AZ CA NV OR WA

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Deanna Dahl-Grove, MD, FAAP
Associate Professor, Pediatric Emergency Medicine, Rainbow Babies and Children's Hospital; Member, AAP CoDPR Executive Committee

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Eastern Great Lakes Pediatric Consortium for Disaster Response - Helping Coalitions Prepare to Care for Children in Disasters

Michigan and Ohio Region serving nearly 7 million children and their families

Components of the Annex

- Concept of Operations: activation, notification and roles with responsibility, logistics (staff, space, supplies), special considerations (behavioral health, decontamination, etc.)
- Operations for Medical Care: triage, treatment
- Transport
- Tracking
- Reunification

Why is this important?

- >80% of children are seen in community hospitals and 1/3 of those are remote or rural hospitals
- Unique characteristics and needs of children (weight based medication dosing; imaging and radiation exposure; equipment sizes by age or weight)
- Caring for a critically ill child is rare for most providers
- Day to day readiness to care for children:
  - Makes it that much easier to respond in a disaster involving children
  - Appropriate child diagnoses can stay in the community (less travel for families)
  - Increased healthcare provider knowledge regarding pediatric emergency care may decrease provider burnout

Eastern Great Lakes Workgroups

- Pediatric Assets Map
  - Regional Coalition Surveys
  - Children's Hospital Survey
  - EMS Survey
  - Facility Recognition
  - Supply Chain Survey
- Telemedicine
- Legal and Policy Review
- Behavioral Health
- Hazard/Vulnerability Analysis
- Education Collaboration with the other COE
- Quality Collaboration with the other COE
- Pediatric Strike Teams
- Exercise Development
- Information Technology Integration

Regional Healthcare Coalitions and Pediatric Annex

- Healthcare Coalition Partners: EMS (Fire and First Responders), EMA, healthcare, public health; in addition may include schools/child care programs, ambulatory health and long-term care, behavioral health, businesses
- Creating the Pediatric Annex: across the community with a lens on children and families
- Emergency Spectrum of Care from first responders to emergency departments first line healthcare; followed by the support from healthcare facilities to create a web of response to respond to needs day to day and in a disaster

Pediatric Annex in Rural areas

- Connecting the community partners (revealing the pediatric assets and defining the challenges)
- Prehospital Pediatric Champion within emergency services (shared resource) to improve transport asset
- Contacting the Pediatric Center (where the more critical children are referred)
- Identifying a Pediatric Champion within a healthcare institution (shared resource)
- Pediatric Center can offer education, quality and tele (-medicine -health) support to increase the capability of staff day to day
- Community can feel more empowered to support children and families in a crisis and increase the resilience to withstand a large event

Eastern Great Lakes Pediatric COE and Pediatric Annex

- Creating a common facility recognition in the region using common language to assist pediatric champions at the institutions
- Pediatric Champions to be supported by education and quality initiatives enhance the capability and capacity to care for children day to day and preparing for a disaster (https://emscimprovement.center/)
- Connecting the initiatives of prehospital Pediatric Champions in communities to create collaborative educational and quality opportunities across the emergency spectrum (https://www.ems.ohio.gov/emsc-pediatric-care.aspx)

Pediatric Readiness Enhanced by the Presence of a Pediatric Emergency Care Coordinator (Champion)

- Who is a Pediatric Emergency Care Coordinator (PECC) - physician, nurse, mid-level (or other healthcare provider) with desire to improve pediatric emergency care at their institution with the support of hospital administration
- What is the role of a PECC - support and identify education for staff, quality improvement, patient safety, works collaboratively with EMS and ensure disaster plans incorporate children
- May be a shared resource with small community facilities
- Collaboration with Prehospital Pediatric Care Coordinators

https://emscimprovement.center/domains/hospital-based-care/pediatric-readiness-project/readiness-toolkit/guidelines-administration-and-coordination-ed-care-children/

Facility Recognition for the Region

Tier I	*Tier II*	*Tier III*	*Tier IV*
Children's Hospital	**Pediatric Ready**	**Pediatric Capable/Stand by**	**General**
Children's Hospital with PICU & Pediatric Trauma Verification	**Hospital with Pediatric ED and or Pediatric Unit staff by Pediatric Nursing and Providers**	**Trauma Hospitals (non pediatric providers)**	**Non- Trauma Hospitals without any Pediatric In-Patient Beds**
Hospital:	**Hospital:**	**Hospital:**	**Hospital:**
· Accredited as a Pediatric Hospital and/or a Verified Pediatric Trauma Center	· Pediatric providers 12 hr/day at minimum	· Adult Trauma Center accreditation	· All non-tertiary hospitals must be prepared to care for and accept pediatric patients
· Annually Regional Pediatric Disaster drills	· Annually incorporates pediatric patients as a part of a regional exercise	· Annually incorporates pediatric patients as a part of a regional exercise	· Annually incorporates pediatric patients as a part of a regional exercise
Conventional Care Benchmarks	**Conventional Care Benchmarks**	**Conventional Care Benchmarks**	**Conventional Care Benchmarks**
The hospital exhibits the highest level of preparedness exhibiting the ability to:	The hospital exhibits the highest level of preparedness exhibiting the ability to:	The hospital maintains a high level of preparedness exhibiting the ability to:	The hospital maintains a base level of preparedness exhibiting the ability to:
	· Provide initial assessment and stabilization (airway management, initial fluid resuscitation and pain management) for pediatric patients; and preparation of patient(s) for safe transfer to a designated facility as indicated	· Provide initial assessment and stabilization (airway management, initial fluid resuscitation and pain management) for pediatric patients; and preparation of patient(s) for safe transfer to a designated facility	· Provide initial assessment and stabilization (airway management, initial fluid resuscitation and pain management) for pediatric patients; and preparation of patient(s) for safe transfer to a designated facility
· Offer expert support and consultation to non-pediatric hospitals providing care for seriously injured/ill patients.	· Offer expert support and consultation to non-pediatric hospitals providing care for seriously injured/ill patients.		
Disaster Trigger/Contingency Care Indicator:	**Disaster Trigger/Contingency Care Indicator:**	**Disaster Trigger/Contingency Care Indicator:**	**Disaster Trigger/Contingency Care Indicator:**
· For Burn victims consult State Burn Surge Plan	· For Burn victims consult State Burn Surge Plan	· For Burn victims consult State Burn Surge Plan	· For Burn victims consult State Burn Surge Plan
· The hospital RPAT has developed appropriate contingency policies & processes to increase bed capacity by 50%.	· The hospital RPAT has developed appropriate contingency policies & processes to increase bed capacity by 50%.	· The hospital RPAT has developed appropriate contingency policies and processes to increase pediatric surge capacity by 25%.	· The hospital RPAT (Regional Preparedness & Allocation Team) has developed contingency policies/processes to sustain stabilizing care for up to 23 hours.
Training Resources:	**Training Resources:**	**Training Resources:**	**Training Resources:**
· PALS/ENCP	· PALS/ENCP	· PALS/ENCP	· PALS/ENCP
· FEMA disaster training	· Basic Disaster Training	· Basic Disaster Training	· Basic Disaster Training
· TNCC		· TNCC	
· ATLS	· ATLS	· ATLS	· ATLS

Education

- Collaborating with the WRAP-EM (Pediatric COE)
- Delphi process of items to be included in competencies related to pediatric disaster preparedness
- Creating a crosswalk of competencies based on the information from 2014 NCDMPH for healthcare professions
- Vetting national resources to match the competencies and thus identify gaps
- Create materials to close the gaps
- Identify materials to be adapted for JIT and telemedicine support and including behavioral health
- Education to be available on the EIIC website and ASPR TRACIE

Strategy-Telemedicine Workgroup in a Disaster

- HUBS- 6 pediatric specialty centers
- Each HUB will select a SPOKE center
- Collaborative selection process:
  - Project fulfillment
  - Network specifications
  - Personnel capabilities

Pediatric Disaster Preparedness Quality Collaborative (PDPQC)

Aim

By September 30, 2020, 100% of participating hospitals will have a hospital disaster plan that includes pediatric-specific needs.

Targeted Hospitals

Rural, Critical Access, Community, Suburban, Non-Pediatric Urban

Time Commitment

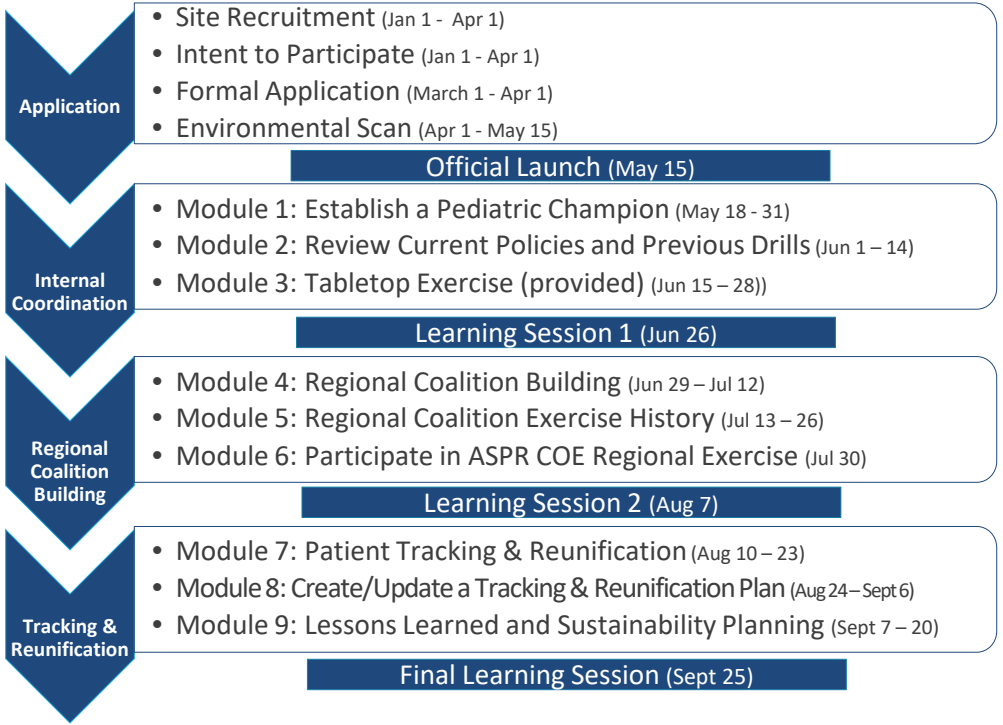
Nine, 2-week modules including participation in the ASPR COE Regional Exercise (July 30th)

1-2 hrs./week for ~20 weeks (40 hours total)

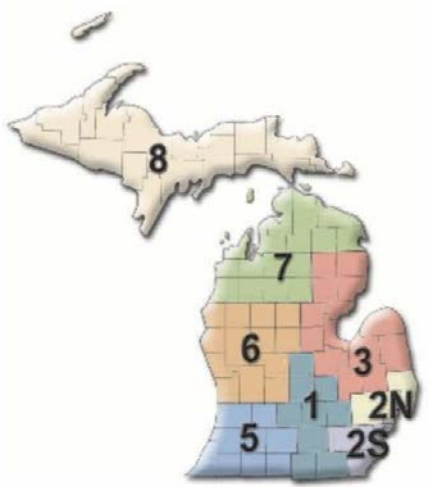
Links

Intent to Participate Link (RedCap): https://tch-redcap.texaschildrens.org/REDCap/surveys/?s=TYHJTNWPPE

For more information visit:
https://emscimprovement.center/collaboratives/pediatric-disaster-preparedness-quality-collaborative/



Harnessing Regional Coalitions



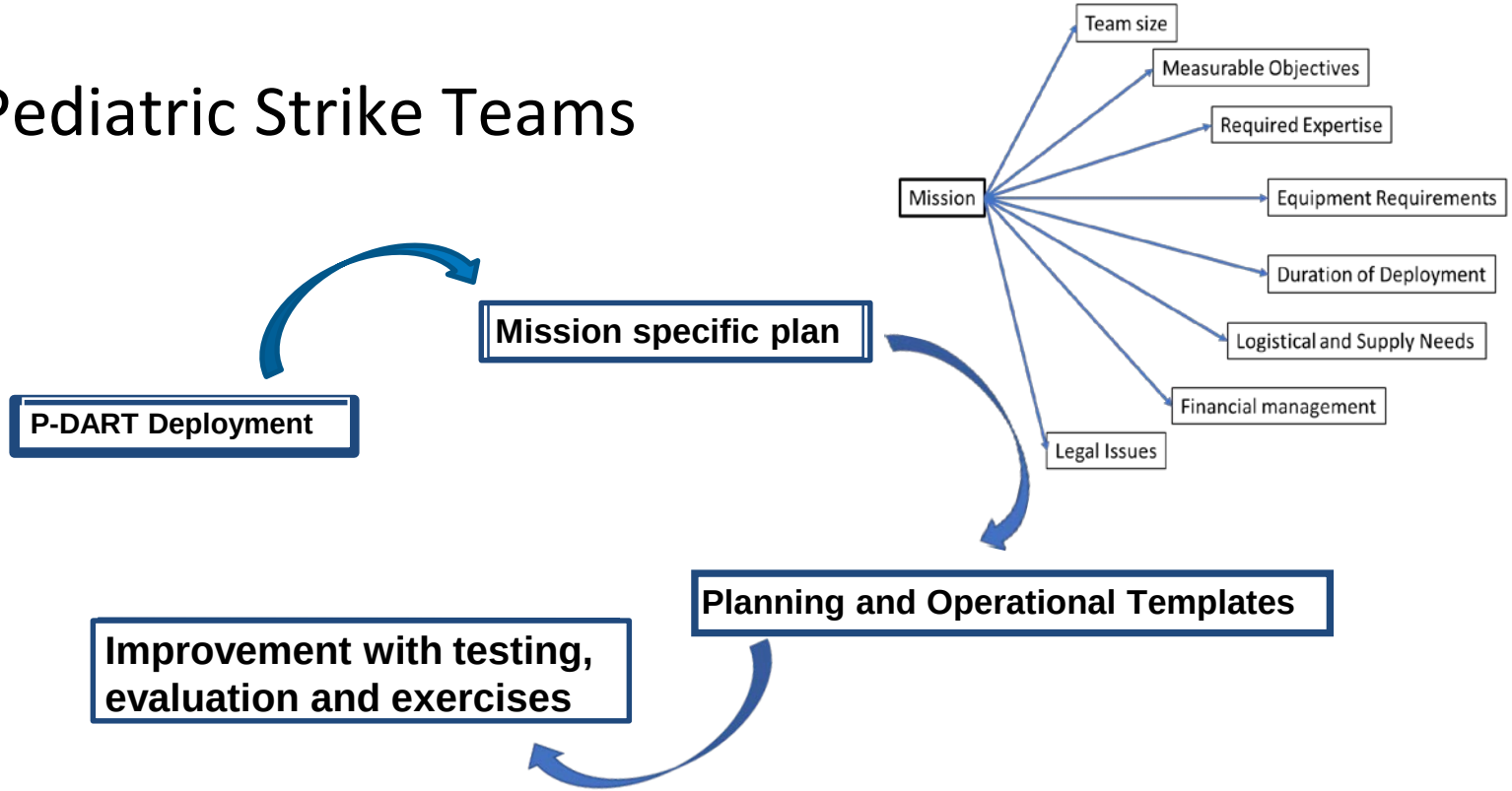
Michigan Emergency Preparedness Regions Map

- 8 regions/state
- Ohio: home-rule state, plans are regional (and county based)
- Information: prehospital triage, reunification, HVA, # of children, and # of schools

Mapping Pediatric Assets

- Hospitals
  - Identify each hospital's current capacity for pediatrics (NICU, medical floor, ED etc.)
  - Assign hospitals to facility tier based on current capacity
  - Apply the concepts of Pediatric Readiness to the tiering - pediatric capability expansion
- Supply vendors for pediatric specific equipment
- Transport (EMS and specialized transport capabilities)
- Behavioral health resources
- Long term care facilities that care for children

Pediatric Strike Teams



Eastern Great Lakes Pediatric Consortium for Disaster Response

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HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Christopher Newton, MD

Associate Professor of Surgery, Division of Pediatric Surgery,
Director of Trauma Care, UCSF Benioff Children's Hospital Oakland

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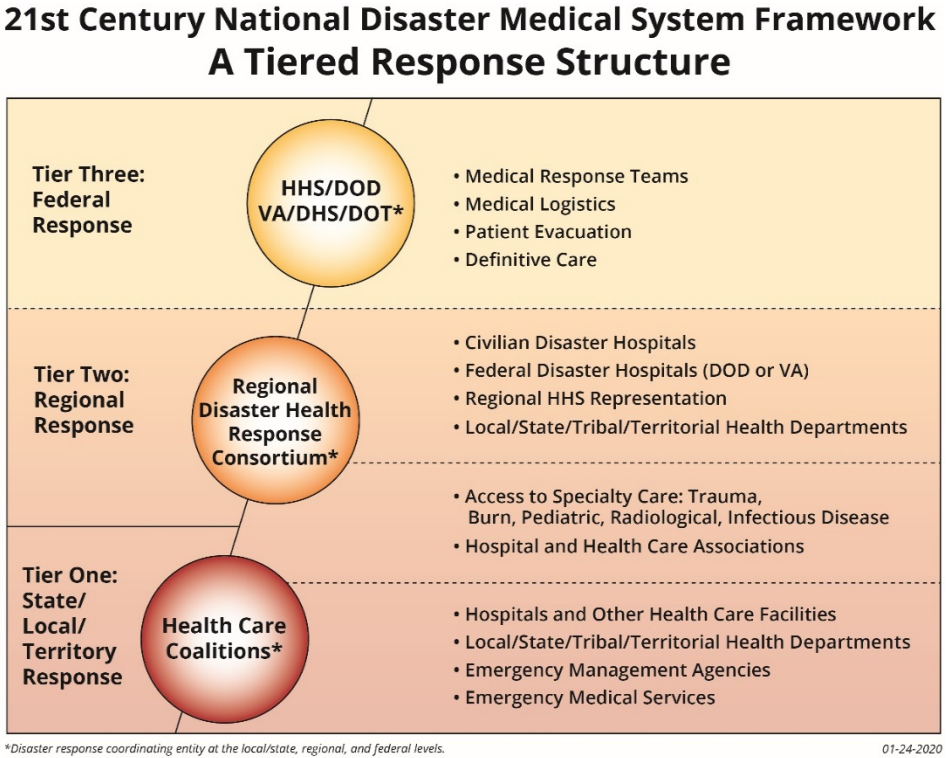
COE: Overview of ASPR Project Plan

- Plans (summary)
  A. Gap Analysis
  B. Infrastructure (plans, policy and system alignment)
  C. “Access the experts”
  D. Education
  E. “Readiness” projects

Project Status – *In Process*

- Focus groups established
- Operational staff: Area coordinators and regional manager
- Website / Library
  - Policies / plans / drill templates / educational material
  - EMSC-EIIC / TRACIE / AAP integration
- Expanded scope and collaborations:
  - Interstate communication and coordination
  - Integration with state level EOC‘s
  - Agency steering committee
  - Interstate legal and policy challenges

Where Does the Peds COE Fit in?



Courtesy – Kevin Yeskey, MD, Principal Deputy Assistant Secretary for Preparedness and Response

Pediatric Surge Annex Template

- Purpose and Scope
- Overview / HCC Resources
- Access and Functional Needs
- CONOPS
  - Activation, notification, roles, logistics (staff, space, supplies), special considerations, operations.
- Transportation, Tracking, Reunification
- Deactivation and Recovery
- Appendices

What Are the Key Outcomes?

- Determining "surge" inpatient/referral resources
- Determining "surge" pediatric transport resources
- Preparing to provide care-in-place at non-pediatric centers
  - Awaiting transportation
  - Delays: weather, access issues (flooding, road damage, etc.)
- Process for involving pediatric experts in transport prioritization and care in-place decisions
- Establishing pediatric "safe area" and reunification process
- Assuring children's needs are recognized and met throughout the response

PEDIATRIC UNIQUE CHALLENGES

- Medical Issues
  - Resource limited!
  - Familiarity with kids:
    - pharmacy, anesthesia, vents, etc.
  - Specialty equipment needs
  - “High expectations” medical care

PEDIATRIC UNIQUE CHALLENGES

- "Two for the price of one" phenomena
  - Injured parents that will not leave their child
- Expectations of immediate treatment for the child
- "Expectant" and "delayed" become very difficult categories

PEDIATRIC UNIQUE CHALLENGES

- Whose child is this phenomena??
  - Separated family members
    - Transport to different facilities
  - No history and no consents
  - No “home” for discharge
  - No one to help care for the child
  - Need for security and child safe space
  - Difficult reunification if child does not know where he/she lives!

Three Tiers to Consider:

1. What happens *every day* in all phases of care? Limits?
2. What current pediatric resources can be flexed or supplemented?
3. What are the things you would usually NOT consider, unless in a crisis?

What Happens Every Day?

- How are sick / injured children handled in the coalition EVERY DAY?
  - Where are they taken?
  - Who provides care and what training do they have?
  - What equipment is available?
  - Where are they transferred to?
  - How are transfer decisions made/who is involved?
  - What transport assets do we use?

- Public Health
- Primary Care Offices
- Specialty Clinics
- Mental Health Services
- Social Services / CPS
- School Health Services

Pediatric Experience / Training

- Critical Care
- ALS
- BLS

Tier 2: Flex

- Then, scale up – and figure out your breaking points when systems have to change from daily to disaster
- Advice:
  - Do not exaggerate your daily capabilities and resources
  - “Embrace your gaps!”
  - What can be developed that is NOT currently robust

National PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

- Trauma Center Level (including pediatric)
- Pediatric Verification/Recognition System
- Pediatric Emergency Care Coordinator
- Equipment and Medications
- Pediatricians on Staff
- Pediatric Ward
- Family Medicine
- Nursing Training in Pediatric Care

<u>Capacity AND Capabilities</u>

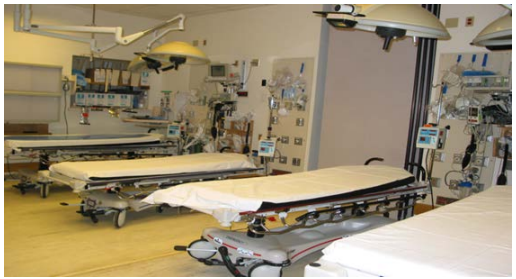
- NICU/PICU Level
- ED/NICU/PICU Capabilities: ECMO, ventilator, noninvasive
- Tertiary Specialty: anesthesia, surgery
- Transfer Capability

Tier 3: Crisis

- Outside of standard practice:
  - Adult care resources
  - “Cross trained” healthcare workforce
    - APP’s, clinic staff, school nurses, etc.
  - Altered timetables and flow
    - Facility decompression, follow up plans, return precautions
- Transport out of area
- Mutual aid teams
- Telehealth

Discussion

- Logistics
  - Space
  - Staff
  - Stuff



Space

- Conventional pediatric care
  - Consider outpatient sector as well
- Contingency pediatric care
  - Adult care areas
  - Procedural and post-op areas
- Crisis pediatric care
  - Cot-based care

- Bed considerations
- Safety considerations
- Space is *usually* NOT the limiting factor in pediatric planning!

Staff

- Conventional
  - Pediatric nursing and physician staff
- Contingency
  - Other appropriate providers with Just in Time training / support
- Crisis
  - Most appropriate provider with external expertise (e.g. family physician providing pediatric critical care)
- Training
  - Pre-event vs Just in Time
- Support
  - Telemedicine / telehealth
  - Parents / caregivers / volunteers
- Supplemental
  - Staff sharing / supplementation
  - Agreements with other facilities
  - Know the options and priorities!
- Extension
  - Numbers of patients
  - Patient selection (age, conditions)
  - Type of care provided
  - "Top of license" practice
  - “Crisis Credentialing” process

Staff

- What is important in the Annex?
  - Usual staffed pediatric inpatient resources
  - Community pediatric staff/personnel – summary
  - MRC/other resources – summary and activation process
  - Coalition staff sharing agreements
  - Other staff sharing agreements/potential resources
  - Sources of telemedicine/telehealth pediatric support for staff
  - Coalition-level training resources (if any)

Stuff (Supplies)

- <8 years is critical cut-off for pediatric-sizing *(or weight based)*
- Many supplies CANNOT be substituted for (e.g. endotracheal tubes)
- Baseline planning – how many patients from infant to children <8 years should hospitals be prepared to manage (based on trauma level)?
- AAP and other lists (Preparedness Planning in Specific Practice Settings)
- Drug formulation considerations
- Dietary considerations *(infant formula)*
- Annex:
  - Baseline expectations of facilities
  - Regional resources – equipment caches, etc.

Special Considerations: COE Programs

- Behavioral Health
  - Psychological support provisions (telehealth access?)
  - “Psy-Start” screening tool
- Decontamination / ID
  - Subject matter expert access
  - Poison control centers
- Evacuation
  - “TRAIN” tool (needs to resource matching)
  - SME triage and matching support
- Special Needs Children Plans
  - Family / school supported plans and education

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HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

Sarita Chung, MD, FAAP

Director of Disaster Preparedness, Division of Emergency Medicine, Children's Hospital Boston; Member, American Academy of Pediatrics (AAP) Council on Disaster Preparedness and Recovery

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Pediatric Identification and Tracking

- Coalition process/system for patient tracking
- EEI for tracking
- Unidentified patient process – EEI – (clothing, hair/eye color, age/height/weight, gender, scars/birthmarks, tattoos, jewelry)
- Interface with Family Assistance Center

Parent's Name(s)
Contact Number
Family's Address
Child's Name
Child's Medical Record Number
Child's Birth Date
Child's Age
Patient Identifiers
Hair Color
Eye Color
Clothing
Shoes
Jewelry
Other
Name of School/Grade
Teacher's Name(s)
Pets – Name, Type of Animal(s)

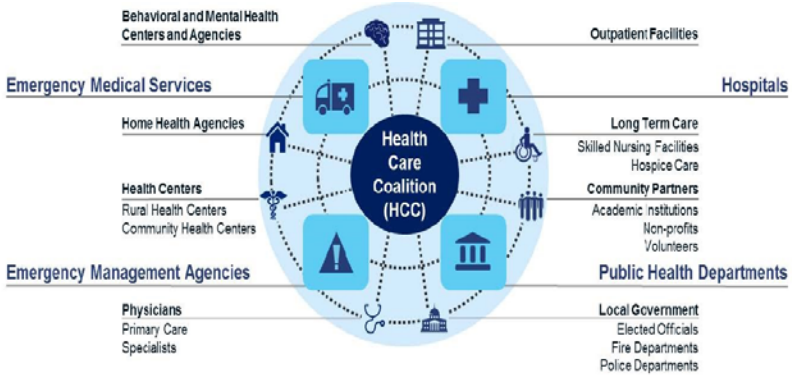
Pediatric Reunification

- Process
  - Intake and information collected
  - Caregiver notification – hospital vs. school vs. public process (FAC)
  - Threshold / policy for associating child and family member/caregiver
  - Release process
  - Documentation
  - County/parish services interface

www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/family-separation-reunification.aspx

Community Reunification Partners

- Goal is to prevent duplication of effort

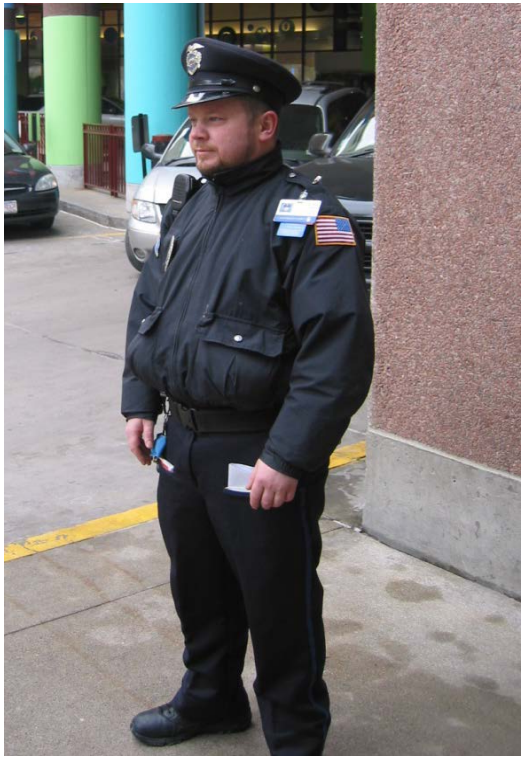


Pediatric Safe Area

- Secure unidentified area for unaccompanied pediatric patients who are medically cleared
- Secure location, away from but close to the ED (and near bathrooms)
- Staff
  - Reassure children
  - Medical presence
- Age appropriate
  - Supplies
  - Food

Pediatric Security

- Ensure scene safety
- Anticipate 4-5 family members per child – need for crowd control
- Security reinforcement at
  - Pediatric safe areas
  - Reunification centers



Pediatric Behavioral Health

- Annex
  - Resources – community, regional, strike teams
  - Access – how do patients/families access services
  - Coordination – who is responsible for disaster-related BH services and how do coalition partners integrate with that entity?
- Consider
  - Psychological support provision
  - Identification/triage/assessment of at-risk individuals
  - Risk communication/anticipatory guidance

Pediatric Decontamination

- Expectations of all facilities
- Capabilities of facilities (emphasis on pediatric facilities when present)
  - Factors to address:
    - Supervision / direction
    - Safety – carrying, slips/trips
    - Privacy
    - Hypothermia
    - Age-appropriate support / anxiety reduction (keep children w/parents)

Pediatric Infectious Outbreaks

- Consistent with regional plans
- Coalition expectations and capabilities
  - Including frontline facilities
- Assessment and treatment centers for pediatric patient
- Referral and transport process
- Parent/caregiver issues – PPE, accompanying during transport, etc.
- Pandemic/epidemic considerations as needed

Pediatric Evacuation

- Consistent with overall coalition plans
  - Pediatric-specific issues based on coalition baseline capability
- Emphasis on PICU and NICU support – relocation and evacuation
  - Horizontal and vertical
- Level 2/3 NICU require significant planning!
- Transport resources
  - Car seats
  - Pediatric immobilization – ambulances
  - Isolettes
  - Neonatal baskets, sleds, etc.
  - Critical care transport – pediatric specialty, general

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INFORMATION GATEWAY

Moderator Roundtable
John Hick, MD

ASPR
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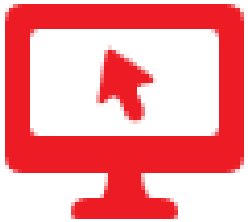
Question & Answer

Contact Us



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askasprtracie@hhs.gov