PEDIATRIC SURGE ANNEX

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INTRODUCTION

Purpose:

The Region 2 Healthcare Coalition Pediatric Annex applies to a mass causality event with a large number of pediatric patients. It supports Region 2 HCC Response Plan by addressing specific needs of children and supporting appropriate pediatric medical care during a disaster. This plan is intended to support, not supplant, any existing facility or agency policy or plan by providing uniform response actions in the case of an emergency that involves (or could involve) significant numbers of children.

Scope:

This plan is inclusive of HCC partners and members within, and contiguous to, Region 2 HCC: Bureau, Fulton, Henry, Henderson, Knox, LaSalle, Livingston, Marshall, McDonough, McLean, Mercer, Peoria, Putman, Rock Island, Stark, Tazewell, Warren, and Woodford. The Pediatric Surge Annex is a supplement that addresses the response actions that support a regional response. This plan supports and does not supersede actions and resources described in independent facility, agency, county of discipline specific Emergency Operations Plans. Instead, the purpose of the plan is designed to support, not supplant, existing policies in order to help protect children and provide appropriate pediatric care during a major disaster. During a disaster, it is certain that adult acute care hospitals will be providing care for children regardless of what they routinely provide.

This annex provides additional details and guidance relevant to an incident that involves significant numbers of pediatric victims. A typical use for this annex accommodates command structure, communication protocols, including process and procedures for medical resource requests.

Recognized Pediatric Age Groups

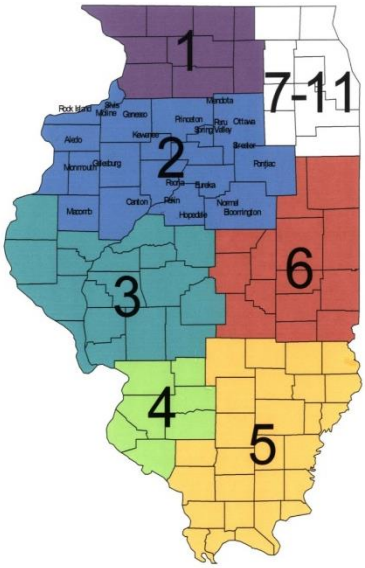
The age for children that meet the definition of a pediatric patient is typically birth through 17 years of age. During a disaster, children may comprise nearly a fourth of the victims. The following pediatric age groups were identified in order to define the pediatric population and to integrate specific age considerations into planning:

- Neonate-28 days
- Infants/toddlers (28 days - 24 months)
- Toddlers/preschoolers (2 - 5 years)
- School-aged children (6 – 13 years)
- Adolescent children over 14; unaccompanied minors, and children with underlying complex medical conditions. (Children with special needs who are over 14 and experience chronic pediatric conditions such as cystic fibrosis, cerebral palsy, and others will likely require specialized attention during a disaster.)

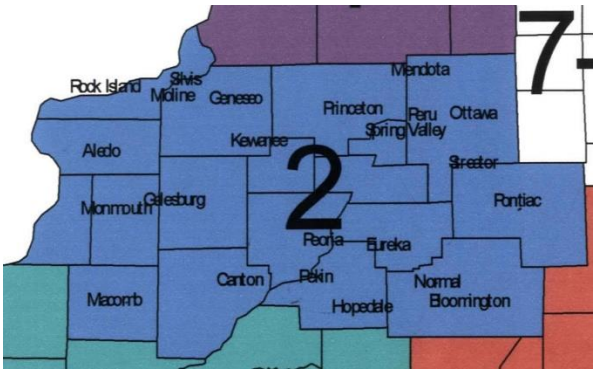
Overview/Background of Region 2 HCC:

The Region 2 Healthcare Coalition is a group comprised of Regional Hospitals, Public Health Officials, Emergency Managers of City and Counties, and other healthcare entities within IDPH EMS Region 2. The region is comprised of 18 counties and 24 hospitals, with 1 standalone emergency department, serving over 1 million persons in population. The Region 2 Healthcare Coalition also maintains Regional Response Assets housed within Regional Hospitals.

IDPH EMS Regions



IDPH EMS Region 2



Region 2 Pediatric Population Snapshot

		2000 Population	< 18 yr/O
1	Bureau	33822	7449
2	Fulton	36,047	7302
3	Henderson	6966	1335
4	Henry	49,681	11,362
5	Knox	51,752	10,301
6	La Salle	111,935	24,647
7	Livingston	37,278	8,141
8	Marshall	12,060	2,448
9	McDonough	31,727	5,274
10	McLean	173,254	38,166
11	Mercer	15,971	3,502
12	Peoria	186,818	44,665
13	Putnam	5,746	1,158
14	Rock island	146,536	32,821
15	Stark	5,840	1,231
16	Tazewell	135,400	31,264
17	Warren	17,611	3,908
18	Woodford	39,123	9,779
	TOTAL	**1097567**	**244753**
	Illinois Totals	**12,419,293**	**2,990,629**

Authorities

This plan is designed to provide a guide for Region 2 Healthcare Coalition partners to:

- Implement standardized care guidelines as needed
- Ensure associated communications processes are in place
- Support the tracking of pediatric patients throughout the incident
- Identify strategies to manage surge and scarce resources
- Assist with the coordination of transferring acutely ill/injured pediatric patients to pediatric tertiary care centers/specialty care centers
- Assist with the decompression from pediatric tertiary care centers/specialty care centers to make additional critical care beds available for acutely ill/injured pediatric patients
- The Hospital Preparedness Program (HPP) and Public Health and Emergency Preparedness (PHEP) domains addressed in this annex include, but are not limited to:
    - Community Resilience
    - Strengthen Incident Management
    - Information Management and Sharing
    - Countermeasure and Mitigation
    - Surge Management

- 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.
- 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 support local operations.
- All requests for health and medical assistance with the care of children during emergency events will be routed first through the Region 2 RHCC. If necessary the Region 2 RHCC will then route further requests to the State Emergency Operations Center (SEOC) and IEMA as indicated in the IDPH ESF-8 Plan. The request will then be directed by the SEOC manager to the IDPH SEOC liaison. IDPH will determine the best resources from the health and medical standpoint to deploy in order to fulfill the request. Resources sent to the region will be tracked and coordination of resource dissemination will be the responsibility of the RHCC.

- 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.
- The overall authority for coordinating disaster resources of facility(ies) that respond to an emergency medical incident is the Emergency Medical Services (EMS) medical director or designee.

Overview of Access, Functional Needs, & Vulnerable Populations

Children between 0-17 years of age are typically a highly vulnerable segment of the population during and following a disaster. Children in this age group consist of nearly 25 percent of the U.S. population and has significant and complex planning or emergency response requirements. Under routine conditions, there are components at the governmental, private, and non-profit level, which form networks on which children depend upon to support development and protection from harm. Children typically fall under the supervision of their parents, guardians, and primary caregivers; however, most or all these foundations in a child's life may collapse during a disaster. The American Academy of Pediatrics has determined children have unique physical and emotional needs following a tragedy but also at an increased risk of physical detriment. Children respond to illness, injury, and treatment inversely than adults, relying on stable routines in their daily lives. Disasters can cause drastic changes to their world. Disasters not only endanger their safety, but also frighten them as well. A disaster can cause profound physical trauma as well as compounding psychological trauma(s). To ensure physical security and emotional stability of children in disasters, organizations and agencies must adjust their emergency planning efforts to include children's unique needs during disasters. Disasters involving a large populous of pediatric patients present unique challenges. The challenges involve a labor-intensive response, but also, a very sensitive response resulting in expansive needs for mental/behavioral health supports for all responders, families, and children.

CONCEPT OF OPERATIONS

- 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 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.
- While appropriate and established communication and/or notification processes during an incident are important, providing emergency medical care to pediatric patients initially takes priority. Once the incident and patients are more stabilized, health care facilities must communicate with IDPH to relay what processes (e.g., increased bed capacity beyond licensure) occurred as indicated in the IDPH ESF-8 Plan. For those incidents that build more gradually or are preplanned incidents, the established external

authorization and communication processes must occur as indicated in this annex and the IDPH ESF-8 Plan.

- Regardless of the pathway to activate the 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).
- 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.

Activation and Triggers

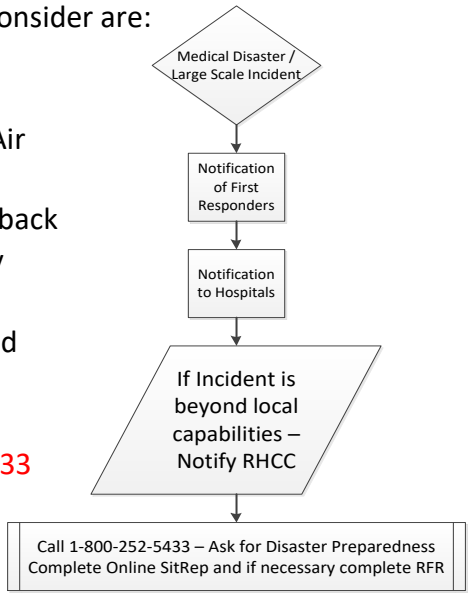
- The Pediatric Surge Annex should be activated in response to any emergency that has a disproportionate number of pediatric patients relative to the capacity of the area hospitals' space, staffing, and resources to care for those patients. Each hospital will determine which surge strategies to implement to meet the surge of pediatric patients based on their facility's bed capacity and capabilities
- 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.
- This annex can be partially or fully activated during any emergency event that involves pediatric casualties and leads to the exhaustion of pediatric resources to care for these casualties at the local, regional or, state level for the Pediatric and Neonatal Surge Annex Activation Pathway. The circumstances of the incident that leads to the activation of the annex can range from a large, unexpected, potentially life-threatening incident involving the pediatric population (e.g., earthquake) to a slow, gradually building or preplanned incident (e.g., epidemic, pandemic, partial or full planned evacuation).
- Incidents that could prompt the activation of the Pediatric and Neonatal Surge Annex include, but are not limited to:
    - Activation of the IDPH ESF-8 Plan
    - Overwhelming influx or surge of pediatric and neonatal patients
    - Inadequate pediatric health care facility resources (e.g., inpatient monitored beds, ventilators, isolation beds)
    - Damage or threats to health care facility(ies)
    - Staffing limitations (e.g., qualified and trained staff to care for pediatric or neonatal patients)

- Activation of health care facility(ies) disaster plan when surge capacity for pediatric patients has been exceeded
- Requests from border states to assist with a surge of pediatric patients

Notification

- **EMS/Pre-Hospital Request:** The ranking on scene medical provider (possibly the incident commander) will notify their local Emergency Management Agency (EMA) of a medical disaster. In addition, the ranking on scene medical provider will contact their designated Resource Hospital and notify them of the medical disaster. Contact must be made with the Medical Control Physician or ECRN (Emergency Communications Registered Nurse) on duty.

- **Hospital Request:** Upon notification that a hospital will activate their Hospital Emergency Operations Plan. The Medical Control Physician, Hospital Administrator or designee at the Hospital will determine if the local medical community has the appropriate resources to deal with the medical disaster. Items to consider are:
  - Hospital bed availability
    - Update current bed availability in EMResource
  - Availability of EMS transportation resources (BLS, ALS, and Air transportation resources)
  - Current staffing models and the ability to perform staff call-back
  - Medical supply inventories and additional supply availability
  - Blood supplies
  - If a Medical Disaster is declared the impacted hospital should immediately notify
    - Regional Hospital Coordination Center 1-800-252-5433 ask for Disaster Preparedness. Give the information requested and await a call back from the RHCC/Disaster Preparedness
    - Complete the online SitRep (Situation Report) and RFR (Request For Resources) available electronically on the website (www.osfsaintfrancis.org/disaster) under the RHCC tab
    - EMS Systems should also complete the EMS System wide Crisis Form available on the website.



The RHCC Hospital may:

- Dispatch a medical response team (RMERT) to the impacted hospital or to the scene of the incident(s) to decompress the medical community affected by the disaster
- If it is determined the impact of the incident has exceeded the availability of resources in the region, the RHCC will:
  - Make a request to the Illinois Emergency Management Agency for additional supplies, resources, and/or additional staff.
  - Serve as a resource center for the contacting hospital
  - In the event a medical facility requires evacuation. The RHCC, working in unison with the Illinois Department of Public Health and/or the Illinois Emergency Management Agency, will work to determine the best destination for the evacuated patients.

Roles and Responsibilities

This annex calls for all hospitals with the capability and experience in caring for acute pediatric patients to expand capacity to accommodate a surge of pediatric patients. This may require shifting non-critical patients from these facilities so that the most critically ill children are cared for by hospitals most accustomed to caring for and treating critically ill children. The remainder of hospitals will be called upon to meet the remaining need. As the emergency unfolds, there may be a need for secondary transfers of patients to move more stable patients to alternate locations.

This section provides general guidance to support the distribution of pediatric patients throughout the region during a pediatric medical surge. These guidelines are intended to supplement, not supplant, existing plans and processes. This should be used in conjunction with facility-specific Emergency Operations Plans. Pediatric medical (SME) subject matter experts should also be consulted in the triage and distribution of pediatric patients. SME can be accessed through the RHCC.

The tiered model below outlines the capabilities of partners who may be involved in a response to a pediatric medical surge. The tiered structure is based upon pediatric trauma designations and other capabilities of the listed facilities. Patients should be distributed to an appropriate level of care given the specific circumstances of the emergency. This tiered model can be used in addition to facility-specific plans and other transfer guidelines to determine which facilities to request care for pediatric patients of specific ages and triage levels (red, yellow, or green).
For the purposes of this Annex:

- **Red-triaged patients**: critical/unstable; immediate life threat; presents clinically with altered mental status/respiratory distress/signs of shock/truncal penetrating injury
- **Yellow-triaged patients**: moderately injured or ill/potentially unstable; potential life threat (within hours); presents as generally non-ambulatory with injury that may become life-threatening if left untreated
- **Green-triaged patients**: minor or non-injured/stable; no immediate life threat; generally ambulatory with isolated injuries that should not be life or limb-threatening

Resources:
Illnois EMSC – Regional Pediatric Resource Directory
(https://www.luriechildrens.org/globalassets/documents/emsc/home-page/regionalpediatricresourcedirectory_july_2020.pdf)

Illinois EMSC – Neonatal Intensive Care Unit (NICU) Evacuation Guidelines

(https://www.luriechildrens.org/globalassets/documents/emsc/disaster/other/nicuevacuationguidelines20093.pdf)

Florida Department of Health – Hospital Emergency Evacuation Toolkit

(http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/healthcare-system-preparedness/discharge-planning/_documents/%20evac-toolkit.pdf)

Tier	Partner	Role/Responsibility During Pediatric Medical Surge
1	Designated Level 1 Pediatric Trauma Hospital: • OSF Saint Francis Medical Center Resources outside of the region • HSHS St Johns (Peds Level 2 Trauma) • Saint Louis Children's Hospital (Peds Level 1 Trauma) • Deaconess Evansville, IN (Peds and Adult Level 2 Trauma) • Ascension St. Vincent Evansville, IN (Peds and Adult Level 2 Trauma) • Lurie Childrens Hospital of Chicago (Peds and Adult Level 1 Trauma) • John H. Stroger Hospital of Cook County (Peds and Adult Level 1 Trauma) • UIC Medical Center (Peds and Adult Level 1 Trauma)	• Hospitals that currently care for pediatric intensive, acute, neonatal, and trauma patients • These facilities may be requested to treat the most critically injured children throughout the region • Provide treatment and care per trauma level designation for: any Neonate or Pediatric patient up to scope of license; priority age 0-8; patients triaged as Red (most acute injuries); burn patients, as appropriate
2	Designated Level 2 Trauma Hospitals(w/ EDAP): • OSF Healthcare Saint Mary Medical Center • Unity point Health Methodist • OSF Healthcare Saint Joseph Medical Center • Genesis Health Silvis • Unity Point Health Trinity • Galesburg Cottage Hospital • Carle BroMenn Medical Center	• These Hospitals hold a Level 2 Adult Trauma designation and are EDAP accredited. • Provide initial treatment and stabilization for pediatric and adult trauma patients

3	Designated Level 2 Trauma Hospitals(without any pediatric accreditation) • Hopedale Medical Complex	• These Hospitals hold a Level 2 Adult Trauma designation, but do not hold any type of pediatric accreditation • Provide initial treatment and stabilization for adult trauma patients
4	All other hospitals and critical access hospitals: • Perry Memorial Hospital • St. Margaret's Hospital • St. Margaret's Health - Peru • Genesis Health Aledo • OSF Healthcare Holy Family Medical Center • Unity Point Health Pekin • Hammond Henry Hospital • OSF Healthcare Saint Paul Medical Center • OSF Healthcare Saint James Medical Center • McDonough District Hospital • OSF Healthcare Saint Luke Medical Center • OSF Healthcare Saint Elizabeth Medical Center • Advocate Eureka Hospital	• Hospitals that do not provide inpatient pediatric services • These facilities may be requested to stabilize and provide care for any patient regardless of acuity based on incident needs (especially any Pediatric patients triaged as yellow or green ages 9 or older) • May be used for transfer once a patient is stable based on their capabilities

Logistics

Every hospital in Region 2 HCC must be prepared to provide supportive care services to all patients regardless of age. This section of the plan identifies strategies for facilities to address critical resource shortages and the corresponding regulatory considerations that may impact essential resource allocation decision making. The plan intends to provide guidelines for healthcare providers to continue to provide treatment ethically to pediatric patients, when there may be a significant imbalance between the needs of the patients and the resources available to the healthcare provider.

Supporting Surge: Space Requirements

- Utilize licensed space for other types of patients
- Use outpatient beds for in-patient care
- Use internal skilled beds as acute patient areas
- Convert adult space into pediatric space
- Convert pediatric space into an adult space
- Open hospital floors that are vacant if safe to do so
- Use non-traditional areas of the hospital for inpatients
- Use tents to create additional patient care areas
- Request relaxation of nurse/patient ratios to allow occupancy of all licensed bed

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

Contingency capacity - affects the ability for hospital daily practices to be consistent but has minimal impact to usual patient care. At this point, the demand for resources has not exceeded community resources. The spaces, staff and supplies (resources) used are not consistent with daily practices, but provide care that is functionally equivalent to usual patient care.

Crisis capacity - may require adjustments in care not consistent with daily practices, but the standard of care is coherent within the setting of an emergency. The best possible care is provided to patients under these circumstances. Adaptive spaces, staff and supplies (resources) used are not consistent with usual standards of care, but provide sufficiency of care in the context of a catastrophic disaster (ie. Provide the best possible care to patients given the circumstances and resources available).

Supporting Staffing Requirements

Sources of staff with potential pediatric subject matter expertise may include providers (physicians, nurses, physician assistants, nurse practitioners, and others) working in emergency medicine, pediatrics, family medicine, anesthesia, ENT, pediatric surgery, trauma surgery,

general surgery, orthopedics, urology, neurosurgery, thoracic surgery, the OR, PACU, ICUs, inpatient units and outpatient clinics, pharmacy, or respiratory therapy.

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

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

Resource Coordination & Management

This section outlines strategies for the coalition and member facilities to address resource shortages and resource allocation. This section is specifically for resources needed after local agency supply and vendor ability to fulfill orders have been expended. Whether requesting a supply or personnel resource the request must be clear and quantifiable. To support resource and bed coordination, EMResource will continue to be incorporated into area operations as supported by IDPH. EMS, hospitals, public health agencies, and emergency management agencies in the Region 2 jurisdiction maintain routine preparedness supplies. In an emergency, unique quantities and specific supplies may be needed. EMA, EMS, hospitals, and public health agencies have identified primary and back up vendor contacts. Hospitals have mechanisms in place to request supplies from other hospitals in their respective networks.

Requests for Resources (RFR)

This standard operating procedure (SOP) addresses healthcare facilities in the Region 2 Healthcare Coalition will request regional assets following an incident or in anticipation of significant regional event.

The Region 2 Healthcare Coalition is a group comprised of Regional Hospitals, Public Health Officials, Emergency Managers of City and Counties, and other healthcare entities within IDPH EMS Region 2. The region is comprised of 18 counties and 24 hospitals serving over 1 million persons in population. The Region 2 Healthcare Coalition also maintains Regional Response Assets housed within Regional Hospitals.

This SOP guides the Requests for Regional Assets in support of:

- A catastrophic incident or event involving multiple jurisdictions—especially incidents or events in which regional resource requests are anticipated and/or the activation of a Mutual Aid Agreement (MAA) is likely.
- Situational awareness and planning support for a regional response to ensure that all actions are accomplished within the procedures and priorities established

Situation

- A serious incident or event has occurred that has affected multiple jurisdictions within Region 2.
    - Regional resources are needed to facilitate the treatment or transport of patients
    - Or, Local Resources are extinguished and Regional Resources are requested to support a healthcare facility in the region.

Assumptions

- All Regional Assets will be requested by members of the Region 2 Healthcare Coalition

Requesting Regional Resources

The following steps are intended to guide you step-by-step for requesting resources.

- Regional Assets will be requested only after local resources have been extinguished, or in planning of extinguishing local resources during an event or incident.
- All Regional Asset Requests will be made to the RHCC or RHCC staff.
- When making requests for regional resources please use the following order:
    - Make contact the RHCC or RHCC Staff by phone
        - Contact OSF Emergency Services at 1-800-252-5433
        - Once contact has been made, complete the Request for Resources (RFR) form on the OSF Disaster Preparedness Website under the RHCC Login
- The RHCC or RHCC Staff is responsible for processing the requests and the dissemination of equipment
- Any Regional Resources that are requested and delivered then become the responsibility of the requesting facility or agency.
- Any consumable resources requested, delivered, and used during an event must be replaced before being returned. Or a documented plan must be developed for the replacement of the consumed good.
- Any Maintenance costs, fuel/consumable costs associated with the use of requested assets are the responsibility of the requesting facility or agency
- Any Regional Resources that are damaged, stolen, or found to be unusable or inoperable upon return will be replaced or associated replacement costs will be paid by the Requesting Agency
- The RHCC staff will be notified as soon as possible when surplus resources are to be deactivated.
- Once the resource is deactivated it is the responsibility of the Requesting Facility to make contact with the RHCC to Demobilize the Regional Assets. (see. *Region 2 Asset Demobilization Plan*)

AREAS OF RESPONSIBILITIES

- Requesting Facility or Agency
  - Must make the request for Regional Assets to the RHCC
  - Is responsible for the use, maintenance, security, and replacement of consumables while using the requested assets
  - Is responsible for cleaning and returning the asset back to delivered state
- RHCC
  - Is responsible for processing the request
  - Is to coordinate the shipment or delivery of the requested resource
  - Is to coordinate with the Requesting Facility to demobilize the regional resources

Pediatric and Neonatal Care Guidelines

During a large-scale incident, normal inter-facility transfer patterns may be disrupted. Health care facilities that typically transfer their acutely ill/injured pediatric patients or children with special health care needs to pediatric tertiary care centers/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. These documents provide support and guidance to those practitioners caring for children during the initial 96 hours following an incident.

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

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 or any other trigger occurs as listed under "Activation and Triggers), pediatric and/or neonatal tertiary care

centers/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 health care facilities that outline pediatric/neonatal capabilities should be considered:

- 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.
- 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 year of age or older.
- 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 transferring physician and/or the PCMS or other IDPH pediatric representative within the PHEOC with the practitioners receiving the patient will need to take place.

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 to care for those seeking or currently receiving care at their facility.

Support Agencies / Facilities / Organizations

- ILLINOIS EMERGENCY MANAGEMENT AGENCY
  - Coordinate collection, receipt, compilation and development of situational reports on damage impacts to services, facilities, sites and programs at the federal, state and local levels.
  - Collaborate with IDPH on the requests for pediatric specific resources.
  - Collaborate with IDPH to coordinate the activation of medical mobile support teams including activating IMERT and their PCMS team.
  - Request disaster declaration (state and federal) as indicated.
  - Facilitate EMAC requests as indicated
- ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN (EMSC)
  - Assist with the notification of stakeholders listed in the Pediatric and Neonatal Surge Annex during the activation of the annex.
  - Assist with revising and maintaining the Pediatric and Neonatal Surge Annex in accordance with timelines defined by IDPH.
  - Assist in maintaining the PCMS database.
  - Maintain and update the *Pediatric and Neonatal Care Guidelines* associated with this annex to ensure compliance with current treatment recommendations.
  - Continue to develop materials to assist in the education of health care providers regarding the care of pediatric patients.
- ILLINOIS MEDICAL EMERGENCY RESPONSE TEAM (IMERT)
  - Maintain a PCMS team of pediatric experts that can be activated and serve as PCMS (Pediatric Care Medical Specialist) when this annex is activated.
- REGIONAL HOSPITAL COORDINATING CENTER (RHCC)
  - Provide care for neonatal and pediatric patients and children with special health care needs that arrive at their health care facility to the best of the facility and practitioners' ability.
  - Provide patient families at their facility with information about the event and education about components of the response that may involve their child's care (e.g., system decompression, coordination of care statewide and transfer processes).
  - Provide necessary situational awareness communications to/from the affected and/or assisting health care facility(s) within the region and to/from IDPH.
  - Inform IDPH, as appropriate, when Regional ESF-8 Plan has been activated.
  - Inform IDPH, as appropriate, when regional pediatric resources have been depleted.
  - Assist with the communication and RFR for pediatric specific resources as indicated in this annex .
  - Assist health care facilities with accessing Illinois Helps.
  - Function as a liaison between IDPH, IEMA and the health care facilities, and EMS providers within their region.

- RESOURCE HOSPITALS
    - Provide care for neonatal and pediatric patients and children with special health care needs that arrive at their facility to the best of the facility and practitioners' ability.
    - Provide patient families at their facility with information about the event and education about components of the response that may involve their child's care (e.g., system decompression, coordination of care statewide and transfer processes).
    - 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.
    - Function as a liaison between the EMS associate and participating health care facilities within their system, and the RHCC.
    - Assist with the communication with EMS providers within their EMS system.
- ALL OTHER HOSPITALS
    - Provide care for neonatal and pediatric patients and children with special health care needs that arrive at their facility to the best of the facility and practitioners' ability.
    - Provide patients' families at the facility with information about the event and education about components of the response that may involve their child's care (e.g., system decompression, coordination of care statewide and transfer processes).
    - 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.
- LOCAL HEALTH DEPARTMENTS
    - Assist health care facilities 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 and the RFMR process outlined in the IDPH ESF-8 Plan.
    - Maintain communication and provide situational awareness updates, specific to pediatrics, to health care facilities and to IDPH, as indicated.

Special Considerations

Children with Special Healthcare Needs

- If a hospital or EMS System receives a specific request for assistance from a family with a child with special healthcare needs and the request is beyond the capabilities of the hospital or EMS System, contact the RHCC / OSF Saint Francis Medical Center-Hospital Command Center for additional assistance.
- Resources needed for the child will be arranged through the RHCC / OSF Saint Francis Medical Center- 1-800-252-5433.
- Assistance for Medical Transportation for the child can be arranged through the RHCC / OSF Saint Francis Medical Center -Hospital Command Center.
- Assistance for specific sheltering requirements may be arranged through the American Red Cross or a local shelter.

Behavioral/Mental Health

During emergencies, it is given that hospital facilities will receive and shelter at-risk children with behavioral/mental health issues. All staff working at a healthcare facility that may receive children have the potential to become the initial point of contact for delivery of Psychological First Aid (PFA).

The Pediatric Symptom Checklist (PSC) is a brief screening questionnaire used by pediatricians and other health professionals to recognize psychosocial problems and improve treatment in children. Ensuring availability of behavioral/mental health assets entails more than assessing the availability of mental health professionals. Staff should be trained to recognize that the impact and effect of a disaster event will manifest differently in children than in adults and will vary based on factors including: age, gender, ethnicity, proximity to the disaster, and, the direct impact of the disaster to the child.

Staff should be expected to undertake the following, within reasonable limits:

- Role of Hospital EM staff a. Ensure adequate resources in place and mechanism exists to assess incoming children & parents for mental health resources
- Staff Responsibilities
    - Make efforts to reduce psychological stress
    - Remain Positive
    - Provide age-appropriate play and activities
    - Have children supervised by individuals who are trained in child care
    - Re-establish child care and a normal routine as soon as possible
    - Allow pets to stay with the family when feasible
    - Answer questions without providing unnecessary details
    - Watch for presence of or developing signs of increased anxiety and stress

*You can download the PSC here

Decontamination

- Pediatric considerations during the process of hospital-based decontamination should include:
    - Avoiding separation of families during decontamination, especially under conditions that involve large numbers of patients in a chaotic situation; however, medical issues take priority.
    - Older children may resist or be difficult to handle due to fear, peer pressure and modesty issues (even in front of their parents or caregivers).
    - Since parents or caregivers may not be able to decontaminate both themselves & their children at the same time, decontamination (“hot zone”) personnel may be needed to assist.
    - Incorporating high-volume, low-pressure water delivery systems (e.g., handheld hose sprayers) that are “child-friendly” into the hospital decontamination showers.

- Risk of hypothermia increases proportionally in smaller, younger children when the water temperature in the decontamination shower is below 98°F. Recommended temperature is 100 °F
- Attention to airway management, a priority in decontamination showers.
- The smaller the child, the bigger the problem regarding any of the above considerations (hypothermia, airway management, separation of families and the ability to effectively decontaminate the child).

The following recommendations are based on the child's estimated age based on appearance, since asking may be impractical due to the limitations of personal protective equipment (PPE) worn by decontamination team members and/or due to a large influx of patients. In these recommendations, children are divided into three groups by ages—infants and toddlers (typically 0 to up to 2 years of age), preschool children (children approximately older than two to six to eight years of age) and school aged children (approximately 8 to 18 years of age).

Infants and Toddlers (Children Typically Younger than Two Years of Age) Infants and toddlers are the most challenging group to treat; special needs considerations are of the utmost importance in this group. Follow the guidelines below during treatment.

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

Preschool-Aged Children (Typically Two to Eight Years of Age) Children ages two to eight years are able to walk and speak, yet (with considerable variations in physical characteristics), are clearly children.

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

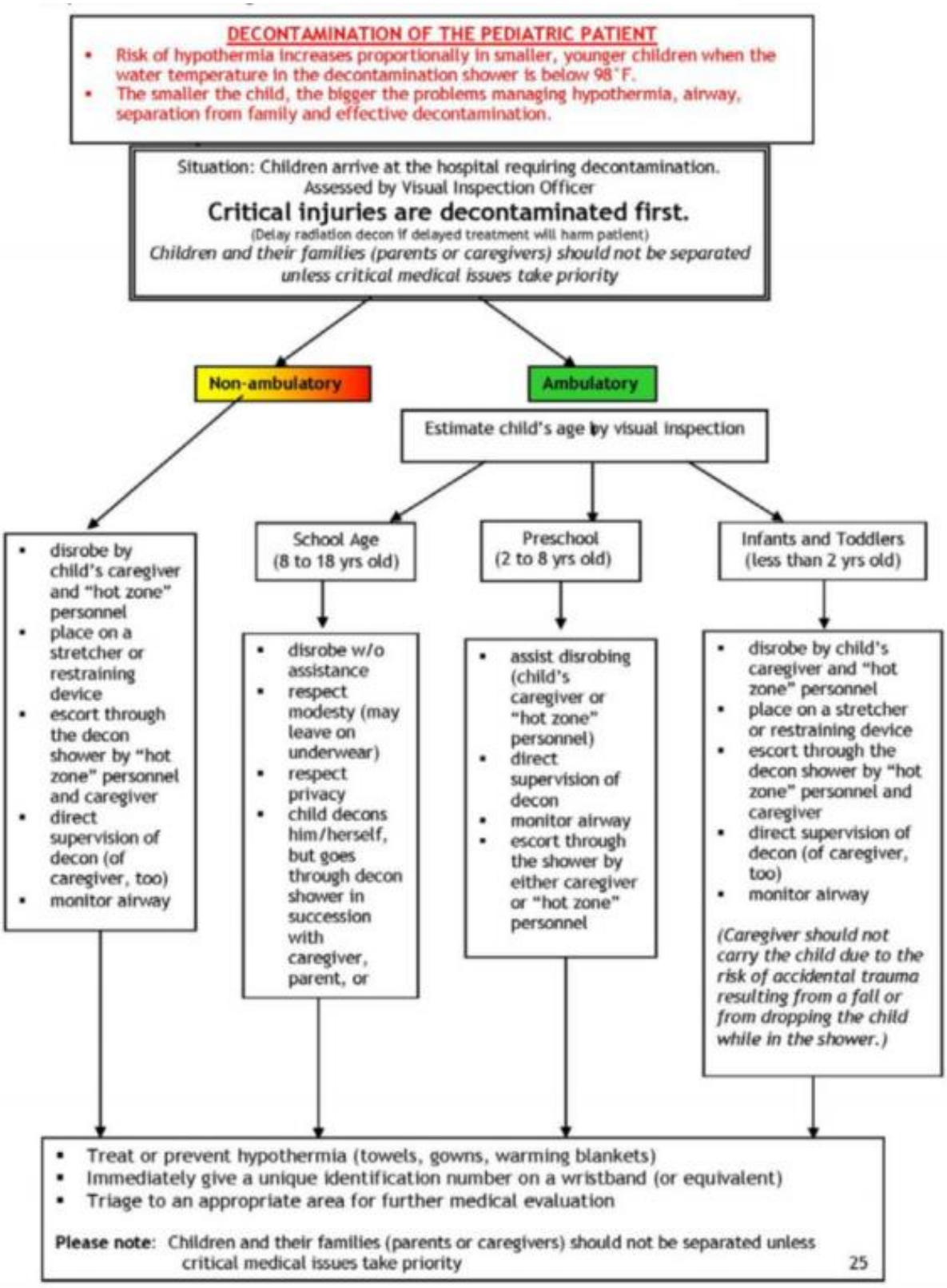
School-Aged Children (Typically 8 to 18 years of age) At the age of eight years and older, children's airway anatomy approximates that of an adult. Although it is tempting to regard this age group as "small adults" there are special needs unique to this age group.

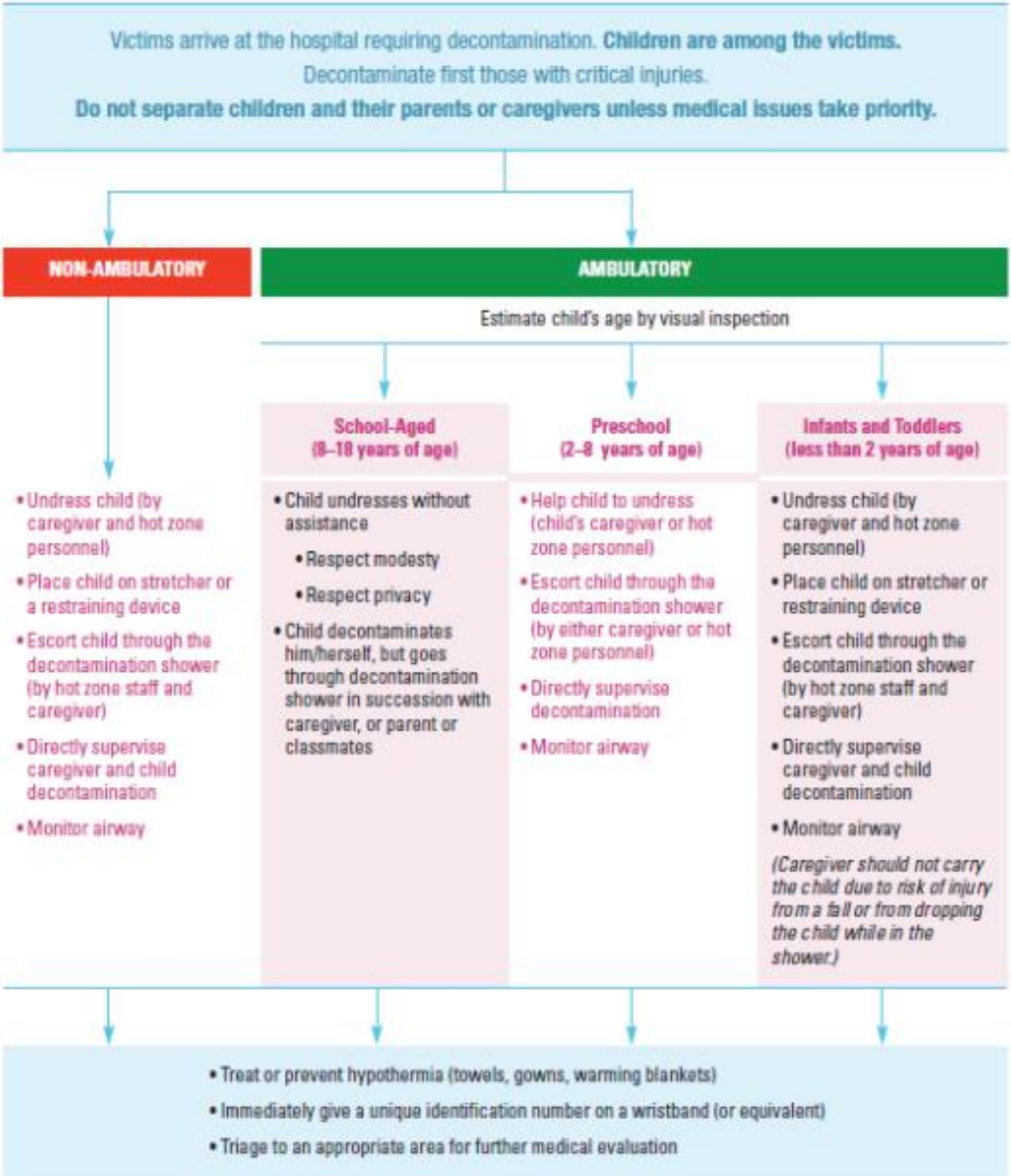
- Ambulatory children should undress as instructed by hot zone personnel. All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
- Each child should then walk through the decontamination shower, preferably in succession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

Decontamination for Children with Functional Access Needs (CFAN) There are a variety of special circumstances that may apply to these children and the following information should serve as a guide during decontamination:

- CFANs should not be separated from their family/caregivers (they live and care for the child on a daily basis and are the experts when comes to interacting with him/her.
- Consideration should be made for non-porous and non-motorized devices to remain with the child when suitable going through the decontamination facility/process. Examples include walkers, canes, some wheelchairs, and prosthetic devices that lack leather components.
- Children with mobility impairment should be allowed to ambulate through the line with assistance from either their parents, staff members, or caregivers.
- Decontaminating Children in their wheelchairs may be impractical depending on the situation. However, the child should be moved to an alternative device that would facilitate movement through the decontamination process such as wheeled shower chairs, backboards, or a scoop stretcher.
- Removing assistive devices may take away certain levels of independence or necessary spine supports.
- For children with impaired vision who wear corrective lenses, their glasses may be decontaminated effectively and they should be allowed to retain possession of them.
- Children with profound visual impairment (i.e. legally blind) require additional time and effort and may require positive contact from caregiver during the process.
- Service animals should be processed with the child. This reduces stress and may assist in reducing stress on the animal. It has also been suggested by the National Center for Disaster Preparedness (NCDP) that even though service animals possess good dispositions, it might be beneficial to decontaminate them and their owners in a separate location form others to reduce any potential for an untoward event.
- Ensure staffing supports and makes considerations for hearing and language impairments. Hearing aids may need to be removed, and dry decontaminated (situation dependent) and sealed to ensure they return to the child was decontaminated.
- Technologically dependent children (i.e. children with Tracheotomy support, ventilators, central lines, ports, gastrostomy support, ostomy support, total parenteral nutrition, and insulin pumps) especially need parents/caregivers to support them through the process. Process of temporary disconnection or removal of devices for basic hygiene is best understood by family or care providers.
- Ensure availability of lift equipment, infant carriers, and ambulatory equipment that can be decontaminated.

*For further reference, see Pediatric Decontamination Checklist


DECONTAMINATION OF THE PEDIATRIC PATIENT
Risk of hypothermia increases proportionally in smaller, younger children when the water temperature in the decontamination shower is below 98°F.
The smaller the child, the bigger the problems managing hypothermia, airway, separation from family and effective decontamination.
Situation: Children arrive at the hospital requiring decontamination.
Assessed by Visual Inspection Officer
Critical injuries are decontaminated first.
(Delay radiation decon if delayed treatment will harm patient)
Children and their families (parents or caregivers) should not be separated unless critical medical issues take priority
Non-ambulatory
Ambulatory
Estimate child's age by visual inspection
disrobe by child's caregiver and "hot zone" personnel
place on a stretcher or restraining device
escort through the decon shower by "hot zone" personnel and caregiver
direct supervision of decon (of caregiver, too)
monitor airway
School Age (8 to 18 yrs old)
disrobe w/o assistance
respect modesty (may leave on underwear)
respect privacy
child decons him/herself, but goes through decon shower in succession with caregiver, parent, or
Preschool (2 to 8 yrs old)
assist disrobing (child's caregiver or "hot zone" personnel)
direct supervision of decon
monitor airway
escort through the shower by either caregiver or "hot zone" personnel
Infants and Toddlers (less than 2 yrs old)
disrobe by child's caregiver and "hot zone" personnel
place on a stretcher or restraining device
escort through the decon shower by "hot zone" personnel and caregiver
direct supervision of decon (of caregiver, too)
monitor airway
(Caregiver should not carry the child due to the risk of accidental trauma resulting from a fall or from dropping the child while in the shower.)
Treat or prevent hypothermia (towels, gowns, warming blankets)
Immediately give a unique identification number on a wristband (or equivalent)
Triage to an appropriate area for further medical evaluation
Please note: Children and their families (parents or caregivers) should not be separated unless critical medical issues take priority
25


Victims arrive at the hospital requiring decontamination. Children are among the victims.
Decontaminate first those with critical injuries.
Do not separate children and their parents or caregivers unless medical issues take priority.
NON-AMBULATORY
AMBULATORY
Estimate child's age by visual inspection
School-Aged (8–18 years of age)
Preschool (2–8 years of age)
Infants and Toddlers (less than 2 years of age)
• Undress child (by caregiver and hot zone personnel)
• Place child on stretcher or a restraining device
• Escort child through the decontamination shower (by hot zone staff and caregiver)
• Directly supervise caregiver and child decontamination
• Monitor airway
• Child undresses without assistance
• Respect modesty
• Respect privacy
• Child decontaminates him/herself, but goes through decontamination shower in succession with caregiver, or parent or classmates
• Help child to undress (child's caregiver or hot zone personnel)
• Escort child through the decontamination shower (by either caregiver or hot zone personnel)
• Directly supervise decontamination
• Monitor airway
• Undress child (by caregiver and hot zone personnel)
• Place child on stretcher or restraining device
• Escort child through the decontamination shower (by hot zone staff and caregiver)
• Directly supervise caregiver and child decontamination
• Monitor airway
(Caregiver should not carry the child due to risk of injury from a fall or from dropping the child while in the shower.)
• Treat or prevent hypothermia (towels, gowns, warming blankets)
• Immediately give a unique identification number on a wristband (or equivalent)
• Triage to an appropriate area for further medical evaluation

Evacuation

When discussing "surge", we often think of an "Influx" of patients (mass casualties flooding into ED or pandemic), but surge cannot be discussed or managed without the mirror image…URGENT EVACUATION or MOVEMENT OUT of patients…evacuation vs. rapid discharge or alternative care site. Surge, as referenced in this plan could indicate an evacuation or rapid discharge.

In the event of an immediate threat, anyone within the pediatric treatment area(s) will be mobilized to help. Clinicians will care for and move patients. Non-clinicians and any parents in the vicinity will help push isolettes, supplies, or other necessary equipment and track patients as they travel from the staging or alternate area. Individual facilities should maintain an Evacuation Plan referencing the specific plans and resources available to them, and how to manage patient movement, tracking and care during an evacuation.

The RHCC maintains a cache of MedSleds and other evacuation supplies at their warehouse. Upon the request of the facility for these supplies, they could be transported to the requesting facility.

In the even

Evacuation Actions/Considerations

***Facilities should reference their own evacuation plans for specific procedures relating to evacuation of pediatrics**

- Inform the nursing supervisor and most senior pediatric physician on-site of the threat.
- Identify where the threat is coming from.
- Initiate patient tracking in the Pediatric treatment/care areas.
- Evacuate patients closest to the hazard, regardless of acuity.
- Evacuate patients most likely to be adversely affected by the threat (i.e., patients in cribs during a smoke condition).
- Evacuate stable babies with a 1:2 patient to nurse ratio until all are evacuated.
- Evacuate critical patients with a 1:4 patient to clinician ratio.
- An attending physician must be part of the evacuation team for patients on oscillators.
- Initiate patient tracking at the staging area.

- Horizontal/Vertical Evacuation Activities Limit access and close non-essential entry points to the entire facility
- Staff essential areas.
- Post security guards at all Pediatric/Neonatal entrance and exit points.
- Clear all unauthorized personnel from secure patient care areas.
- If relocating to a non-secure area, partition area from public view and unauthorized access.
- Reroute foot traffic as needed.
- Escort patients with serious mental health problems to a secure treatment area.
- Screen all family members prior to letting them into patient care, mental health or FISC areas.

- Call 911 if an emergency requiring immediate police, fire or EMS response is needed.
- Obtain current situational awareness and share with first responders as they arrive on scene.
- Make all internal notifications as stated in general emergency operations plan. Total or Full Evacuation Activities
- If applicable, close off any roads that may disrupt the evacuation and direct all vehicular traffic to appropriate areas.
- Post security guards at all NICU entrance and exit points.
- Clear all unauthorized personnel from the evacuation staging area.
- Total or Full Evacuation Activities
    - If applicable, close off any roads that may disrupt the evacuation and direct all vehicular traffic to appropriate areas.
    - Post security guards at all NICU entrance and exit points.
    - Clear all unauthorized personnel from the evacuation staging area.

Infectious Diseases

It is beyond the scope of this document to go into detail about infection control and epidemic management. Facility-specific infectious disease plans should account for pediatric-specific issues.

Pediatric Safe Spaces

Please refer to facility-specific emergency operations plans regarding the set-up and use of pediatric safe areas for the purposes of patient safety and security.

MEDICAL OPERATIONS

Triage:

In the event of a pediatric surge incident, EMS will triage patients in the field according to their standard of care. In the field, triage decisions will be left up to EMS at the time of the incident. JumpSTART is the specifically identified process for triage of pediatric patients according to the IDPH ESF-8 Plan. It is the responsibility of all hospitals to perform secondary triage to determine the best setting for a patient to receive definitive care.

Treatment:

Region 2 facilities should refer to facility specific plans and protocols for guidelines regarding pediatric patient treatment. In the event regional facilities that lack certain pediatric specialty resources become tasked with caring for acutely ill and injured children, specialists could potentially be arranged for consultation on patient care using a telemedicine platform available. The Region 2 RHCC has telemedicine platforms available. The regional facilities should contact the RHCC to coordinate this resource. Requests for SME (Subject Matter Experts) should be arranged through the RHCC or internally within the facilities healthcare system (if available).

Transportation Resources

In the event of an emergency that produces a volume of pediatric patients that is beyond the scope of a single receiving hospital, the RHCC will be used to efficiently coordinate the

distribution of all affected patients to appropriate points of care. The role of the RHCC will be to identify the appropriate clinical match for the patient to receive the most appropriate care that will ensure the safety and health of the patient. Transportation resources can also be requested and coordinated through the RHCC. These transportation resources can include flight medical services, ground ambulance transport (ALS/BLS), fixed wing medical transportation assets and non-medic transportation such as buses and wheelchair vans.

Patient Tracking and Reunification

Assure pediatric patients are tracked to facilitate timely situational awareness and determine and document patient identity, location, and involvement in the incident. Attempt to keep families together when possible and provide transfer information to Family Assistance Center as soon as possible for the purposes of family reunification. Please refer to facility-specific plans regarding special pediatric tracking and information disclosure considerations. The state of Illinois has access to a patient tracking system called EMTrack. Faculties and EMS agencies can also consider the use of ICS and HICS forms regarding patient tracking.

Deactivation and Recovery

- Deactivation: Prior to plan deactivation, ESF-8 will request updated situation reports to ensure there unaddressed issues are resolved. Following deactivation, ESF-8 will request After-Action Evaluations from all participating agencies. Long-term recovery plans will be activated upon establishment of regional/jurisdictional response. Incident Action Plans (IAPs) will be developed for recovery, reconstitution, and restoration.
- Post-Event Recovery: Returning children to their normal school or day care routine is a significant part of the normalization process and post-event recovery. Open and functioning schools are critical for post-event recovery. Normalization occurs for children when functional/operational schools provide children with a sense of stability and structure. Open and functioning schools further support a sense of normalcy and stability for parents and caregivers. Normal, day-to-day activities such as school allows parents to return their normal routines and begin work to rebuild their communities. As children need a sense of structure and stability, school may be their only source of meals or health care following a disaster. Region 2 Emergency Management Agencies work closely with schools and licensed day care facilities to assist them in developing emergency plans for their facility and to ensure they have planned and prepared for the ability to restore operations as soon as possible following a disaster.
- Normalization Planning, the following considerations are in place:
    - Facilitate post-disaster recovery activities that facilitate healing (children being around children)
    - Facilitate children's resiliency
    - Support all members of crisis response team
    - Ensure access to sufficient levels of mental health resources
    - Identify children and youth who are high risk and plan interventions. Reference Disaster Mental Health for the Youth Pediatric Symptoms Checklists

- Ensure a sense of structure and stability
- Support teachers, school staff and daycare providers As the emergency subsides to normal activities, Region 2 Healthcare Coalition, in collaboration with member agencies, will determine the need to deactivate or "demobilize" the Healthcare Coalition Multi-Agency Coordination System. This may occur in a tiered fashion as certain functions/organizations return to normal operations or all at once. Intentions to demobilize should be communicated to all applicable stakeholders. The HCC delegate/representative, in collaboration with community response organizations, should consider the following criteria when determining the need to demobilize the HCC MACS:
- Projected end of an outbreak
- Ability to provide inpatient care without surge activities
- Ability to provide emergency services without surge activities
- Resumption of normal operations is imminent/completed

Appendices:

Hyperlinks

HICS Forms

(HICS 254 – Disaster Victim/Patient Tracking)

(HICS 255 – Master Patient Evacuation Tracking)

EMtrack

Pediatric Symptom Checklist

Region 2

Region 2 RFR (Request for Resources) [Form] [Plan]

Region 2 SitRep (Situation Report) [Form] [Plan]

Region 2 System Wide Crisis Form

Region 2 Asset Demobilization Plan

EMSC:

Pediatric and Neonatal Care Guidelines

Planning and Care Guidelines

Regional Pediatric Resource Directory

NICU Evacuation Guidelines

Patient Evacuation – Identification Tracking Form

Patient Decontamination Checklist

Florida Department of Health

Hospital Evacuation Toolkit