SPARC
SHAWNEE PREPAREDNESS AND RESPONSE COALITION

SHAWNEE PREPAREDNESS AND RESPONSE COALITION

Regional Response and Recovery Plan:

Pediatric Surge Annex

November 2024

Version 3.0

Shawnee Preparedness and Response Coalition

556 N. Airport Road, Murphysboro, IL 62966

Signature Page

This Pediatric Surge Annex has been reviewed and accepted by the SPARC Executive Board and the coalition member organizations with authority to approve. This plan addresses the domains set forth by the Hospital Preparedness Program (HPP) and is compliant with the principles outlined in the National Incident Management System (NIMS); this plan relies on strong working relationships, and effective networking efforts between all coalition member organizations and partners to manage incidents.

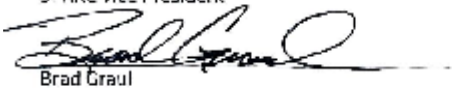
Version 3.0 Approved by the SPARC Executive Board on November 12, 2024.

Todd Carr

SPARC President

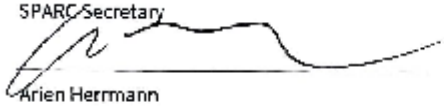
Bill Trauverin

SPARC Vice President



Brad Graul

SPARC Secretary



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RHCC Manager

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Record of Revision and Distribution

This document reflects the ongoing work and mission of the Shawnee Preparedness and Response Coalition (SPARC) regional strategies for emergency preparedness and disaster response. Proposed changes shall be reviewed and approved by the SPARC Executive Board. This document will be revised annually or as needed after exercises, planned events and real-world incidents to identify gaps and to define strategies to address gaps with a collaborative whole community approach.

This document will be distributed electronically to each SPARC Executive Board member. A copy of this document will be posted for the general membership on the Coalition's website http://www.sparccoalition.com

When a change is made, an entry will be made in the following log:

Version Number	Description of Change	Date of Change	Individual Making Change
002	Update Regional Pediatric Resource Directory: Added link	8/10/2023	Tamara Caffey-Bey
002	Signature Page; Update SPARC Executive Board Members	1/5/2024	Tamara Caffey-Bey
002	Replace MYTEP with Integrated Preparedness Plan (IPP) across	1/5/2024	Tamara Caffey-Bey
003	Update entire Annex	10/12/2024	Tamara Caffey-Bey

Person/Title/Agency	Method of Delivery	Date
Arien Herrmann, RHCC Manager	Email	August 10, 2023
SPARC Planning Action Team	Email	October 22, 2024
SPARC Executive Board	Email	November 5, 2024

Introduction

Children are a designated vulnerable population requiring special planning and response. This annex is to assist in addressing the unique needs and challenges presented by the pediatric population during disasters and to guide the coalition's response procedures. In the event of a disaster or emergency, all hospitals, including those that are not necessarily pediatric trauma centers or specialized pediatric hospitals, may receive critically ill or injured patients.

This annex is aligned with and supports SPARC's compliance with the HPP Capabilities, Capability 4: Medical Surge; Objective 2: Respond to a Medical Surge; Activity 4; Provide Pediatric Care during a Medical Surge Response. It outlines the response roles, responsibilities, and provide the concept of operations for a coordinated regional response for use during a surge involving a large number of pediatric patients. The activation of this annex allows resources to be mobilized at the necessary level to support the incident.

The goal of this annex is to develop a pediatric surge plan for the management of a mass casualty incident or event that overwhelms the local healthcare system's capacity to triage, stabilize, and transfer pediatric patients for treatment.

1.1 Purpose

This annex applies to a mass casualty event with a large number of pediatric patients. It supports the SPARC Regional Response and Recovery Plan by addressing specific needs of children and supporting appropriate pediatric medical care during a disaster. This annex is intended to support, not replace, any existing facility or agency policy or plan by providing coordinated response actions in the case of an emergency that involves (or could involve) significant numbers of children.

1.2 Scope

The Pediatric Surge Annex is applicable for pediatric events necessitating local and/or regional healthcare response coordination among partners within jurisdictions encompassed by SPARC.

There are different ways for defining the pediatric patient. For the purposes of this annex, the age range for children that meet the definition of a pediatric patient is birth through 15 years of age in accordance with the Emergency Medical Services and Trauma Center Code adopted by the Illinois Department of Public Health.

1.3 Background and Planning Assumptions

The United States Census Bureau demographics for 2020 indicate the SPARC pediatric population under the age of 18 is 98,999. Children under the age of five make up 26,052. The SPARC membership includes 22 hospitals. There are very limited to none dedicated children's hospitals in the region. Only 3 hospitals provide inpatient pediatric acute care services.

Access or transfer to pediatric care is accommodated by border states, as well as burn and trauma centers. Refer to Section 3.2 for a list of inter-facility transfer agreements with designated Pediatric Tertiary Care Centers in St. Louis and Indiana. For a complete list of EMS Regional Pediatric Resources visit EMSC Pediatric Directory - Smartsheet.com

In the event of a mass casualty incident (MCI), all hospitals should be prepared to receive, stabilize, and manage pediatric patients. Additionally, pediatric practitioners may be able to help identify patients who are appropriate for transfer to non-pediatric facilities. SPARC member hospitals can refer to the Hospital Pediatric Disaster Preparedness Checklist to be better prepared to meet the unique needs of children in times of crises and disasters.

Planning assumptions include, but are not limited to the following:

1. The age range for children that meets the definition of a pediatric patient in this annex is birth to 15 years of age. Pediatric victims will be encountered in a disaster response since the typical pediatric population is about 25% of the total population in a given community.
2. All hospitals providing emergency services are equipped to initially treat and stabilize pediatric patients in accordance with their available resources. All hospitals have differing capacities and capabilities of treating and stabilizing pediatric victims; however, all hospitals should at minimum provide initial triage and resuscitation for pediatric patients.
3. Critical access hospitals may not be able to treat critically injured pediatric patients long-term and will likely need to transport them to a facility capable of offering specialized critical care. In large incidents, or when access to the facility is an issue, critical access hospitals may be asked to provide ongoing care - pending availability of other transportation or treatment resources.
4. Priority is to transfer the most critical as early as possible to an appropriate referral center.
5. The pediatric surge response will use existing National Incident Management System / Hospital Incident Command System (NIMS/HICS) response frameworks.
6. Each designated pediatric tertiary facility has pediatric transfer agreements in place.
7. Facilities impacted by disaster have activated their emergency operations plan (EOP) and staffing of their facility operations centers.
8. The local and/or regional health care system has exhausted its capacity to care for pediatric patients and has implemented and exhausted any mutual aid agreements, therefore, requesting assistance from the other regions and/or the state.
9. This annex supports the IDPH Pediatric and Neonatal Surge Annex.
10. Requests for assistance with medical consultation, system decompression and coordination for pediatric patient movement will be considered once a request for medical resources (RFMR) has been made as outlined in the SPARC Regional Response and Recovery Plan, IDPH ESF-8 Plan and Pediatric and Neonatal Surge Annex.
11. An effort has been made to be realistic in terms of available resources and capabilities that are subject to change. Flexibility is therefore built into this plan.

1.3.1 Pediatric Risks

In addition to the regional risks identified in the annual hazard vulnerability assessment (HVA), potential causes of a surge of pediatric patients could include a pandemic that significantly impact

children or a pediatric mass casualty event (e.g., school shooting, intentional terrorist attack, accidental release from a chemical plant, or transportation accident).

These vulnerabilities place children at increased risk during a disaster. The table below identifies some of the unique problems and issues children in a disaster pose for the healthcare community.

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

Branson, R. (2011). Disaster planning for pediatrics. Respiratory Care, 56(9), 1457-1465.

1.3.2 Pediatric Surge Capacity

Surge capacity for optimization of access to hospital beds is a limiting factor in response to an MCI. Hospitals within the SPARC region do not routinely admit pediatric patients. Hospitals that admit pediatrics but do not have dedicated inpatient pediatric beds, admit to a mixed unit. These facilities' pediatric admissions are limited by both bed and staff availability, subject to change on a daily basis. Refer to the table below.

Table 1-1. SPARC Regional Pediatric Bed Surge Capacity

EMS REGION V HOSPITALS	PEDS LEVEL*	PERINATAL LEVEL**	PEDS	PICU BEDS	NICU BEDS	SURGE CAPACITY
Carle Richland Memorial	None	Level II	0	0	0	
Clay County	None	Level Ø	20	0	0	
Deaconess Illinois Crossroads	SEDP	Level Ø	0	0	0	

Fairfield Memorial	SEDP	Level Ø	0	0	0	
Ferrell Hospital	None	Level Ø	0	0	0	
Franklin Hospital	SEDP	Level Ø	0	0	0	
Hamilton Memorial	None	Level Ø	0	0	0	
Hardin County General	None	Level Ø	0	0	0	
Harrisburg Medical	None	Level Ø	0	0	0	
Deaconess Illinois Medical Center	SEDP	Level Ø	0	0	0	
Marshall Browning	None	Level Ø	0	0	0	
Massac Memorial	None	Level Ø	0	0	0	
Pinckneyville Community	None	Level Ø	0	0	0	
Salem Township	None	Level Ø	0	0	0	
SIH Harrisburg Medical	None	Level Ø	0	0	0	
SIH Herrin Hospital	SEDP	Level Ø	0	0	0	
SIH St. Joseph Memorial	SEDP	Level Ø	0	0	0	
SIH Memorial Hospital of Carbondale	EDAP	Level II-E	8	0	0	
SSM Health Good Samaritan Hospital	EDAP	Level II	0	0	0	
SSM Health St. Mary's	EDAP	Level Ø	0	0	0	
Deaconess Illinois Union County	None	Level Ø	0	0	0	
Wabash General	None	Level Ø	0	0	0	
Washington County	None	Level Ø	0	0	0	

PEDIATRIC DESIGNATION

EDAP: Emergency Department Approved for Pediatrics

SEDP: Standby Emergency Department Approved for Pediatrics

ILLINOIS PERINATAL LEVELS

Level Ø: Non-Birthing Center

Level I: General Nursery

Level II: Intermediate Care Nursery

Level II-E: Special Care Nursery with Extended Capabilities

Level III: Neonatal Intensive Care

Source: EMResource

1.3.3 Pediatric Surge Gaps

The following gaps were identified in pediatric surge capacity and capability as a result of after-action reports (AARs). Strategies are being built to address them.

1. Limited Pediatric Bed Capacity on a Daily Basis
2. Very Limited PICU or NICU Capability
3. Limited Peds Unit
4. Limited Pediatric Specialty Resources
5. Varying Availability of Pediatric Trained Staff (e.g., respiratory therapists and neonatologist)
6. Less Availability of Pediatric Crucial Care Supplies (e.g., pediatric sized resuscitation equipment, ventilators, monitors) to accommodate pediatric patients
7. Limited Transportation Resources for Transporting Pediatric Patients
8. Lack of Pediatric Mental Health Services
9. Family Reunification and Managing Uninjured/Unaccompanied Minors

1.4 Access and Functional Needs

There are many groups of individuals who will require special assistance during an MCI or medical surge resulting from access and functional needs/disabilities. Some of these include:

- Medical equipment requiring electricity (ventilators, various pumps, wheelchairs, etc.)
- Behavioral/mental health
- Chronic conditions
- Limited English
- Lack of transportation

NOTE: The Social Vulnerability Index and the emPOWER provide data on vulnerable populations in a community which can be used during the planning process.

2. Concept of Operations

Introduction

The guidance outlined in this annex will be considered anytime the SPARC Regional Response and Recovery Plan is activated and there are pediatric patients or victims involved. The Pediatric Surge Annex is applicable for pediatric events necessitating local and/or regional healthcare response coordination among partners within jurisdictions encompassed by the Coalition.

2.1 Activation

Activation of this annex will follow the existing protocols outlined in the SPARC Regional Response and Recovery Plan with the following additions:

2.1.1. Indication/Triggers

Incidents that could prompt the initiation of a surge or decompression process may include, but are not limited to the following:

- Overwhelming influx or surge of pediatric and neonatal patients;
- Inadequate pediatric healthcare facility resources (e.g., inpatient monitored beds, ventilators, isolation beds)
- Scope and magnitude of the incident includes more than one jurisdiction;
- Local resources have been exhausted;
- Request from border states to assist with a surge of pediatric patients
- Staffing limitations (e.g., qualified and trained staff to care for pediatric or neonatal patients)

2.2 Notifications

Notification of a pediatric surge incident will follow the existing protocols outlined in the SPARC Regional Response and Recovery Plan. The Pediatric/Neonatal Medical Incident Report Form (Attachment A) is a tool within the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex can be utilized to communicate necessary information about the Annex activation with affected response partners and those entities that may be called upon to assist during the incident.

For ongoing communications during a disaster, the RHCC will provide situational awareness with other SPARC partners as requested.

2.3 Roles and Responsibilities

Roles and responsibilities for all stakeholders to include hospitals, LHDs, EMS, EMA, RHCC, state, local and federal partners will be consistent with those outlined in the SPARC Regional Response and Recovery Plan.

Specific pediatric roles and responsibilities may include local law enforcement coordinating with the National Center for Missing & Exploited Children, as needed.

2.4 Logistics: Pediatric resources

A. Pediatric Resource Requests

Requests for pediatric specific supplies will follow resource request procedures outlined in the ESF-8 Plan and the SPARC Regional Response and Recovery Plan.

Upon request, the RHCC has a Mobile Hospital trailer and an Access and Functional Needs trailer with age-appropriate supplies to assist during a disaster. Refer to Attachments B & C.

B. Crisis Standards of Care (CSC)

When an event overwhelms the healthcare system, resources will become scarce. Each hospital within the SPARC region will determine what surge strategies to implement to meet the surge of pediatric patients based on their facility's capacity and capabilities. SPARC members can refer to the Regional Crisis Standards of Care Annex which identifies strategies for health care providers in each tier to

address resource shortages and resources allocation for those seeking or currently receiving care at their facility.

2.5 Special Considerations

The Administration for Strategic Preparedness and Response (ASPR) has recognized five areas of special concern in regard to pediatric patients. These five concerns are addressed below and have been integrated into coalition planning efforts.

2.5.1 Behavioral Health

Disasters are mentally traumatic for all. The effects on behavioral health as a result of an MCI, medical surge or public health emergency involving children can have negative impacts among families, communities, and healthcare workers. In the SPARC region, access to mental health care is limited.

- Upon request, the American Red Cross can provide individual disaster care (Disaster Health Services, Mental Health and Disaster Spiritual Care) for the affected population and disaster workers.
- Employee Assistance Programs (EAPs) for frontline workers, clinical staff and others can provide access to counseling or therapy services.

Recognizing the need for additional support during debriefings after critical incidents, the integration of a Critical Incident Stress Management (CISM) Service Dog ("Tovy") is a resource available to SPARC regional partners. "Tovy" aims to provide emotional comfort and stress relief to affected personnel. To request "Tovy" the requesting entity will complete a 213RR requesting "Tovy" and her handler.

2.5.2 Decontamination

It's the responsibility of each facility to have their own system or plan for decontamination, with protocols specific to children.

2.5.3 Evacuation

The decision to evacuate is the responsibility of each facility and their plans. Local emergency management agencies may be called to help coordinate evacuation efforts. All facilities shall maintain and exercise their own internal evacuation plans.

Healthcare facilities that need to evacuate should take the following into consideration with respect to pediatric patients under their care:

- Identifying staff roles and responsibilities
- Ensuring the availability of evacuation equipment and supplies suitable to support the movement of pediatric patients.
- Ensuring the availability of resuscitation equipment/supplies (e.g., jump bags).
- Ensuring the availability of appropriate transportation capabilities.
- Family notification of evacuation
- Ensuring appropriate placement of pediatric patients in other healthcare facilities

Providers can refer to EMSC Hospital Evacuation Guidelines for Pediatric & Neonatal Patients in their planning and preparation for evacuations.

2.5.4 Special Pathogens

Facilities should refer to their internal plans and policies for incidents that stem from an infectious disease outbreak to ensure appropriate infection control practices are implemented. Refer to the SPARC Regional Infectious Disease Annex for additional infectious disease considerations.

In the event that a high-consequence disease or other special pathogen is the source of infection (e.g., Ebola) refer to the IDPH High Consequence Infectious Disease Plan.

2.5.5 Security and Safety

It is conceivable that an incident involving large numbers of pediatric patients may also involve security concerns, whether stemming from the incident itself (e.g., terrorism, active shooter) or from concerned parents and family members.

Facilities caring for pediatric patients are encouraged to coordinate with their security personnel to ensure appropriate protection of the facility and its personnel, patients, and visitors. Additional assistance should be requested from local law enforcement, if necessary.

2.6 Operations-Medical Care

Caring for children require continued training especially for those who do not routinely care for children. In the event of a disaster involving children, Emergency Medical Services (EMS) and hospitals will play a crucial role in providing immediate and stabilizing care. In large-scale incidents, some facilities may be required to continue care for the pediatric patient beyond initial stabilization until sufficient resources become available for transport.

The region has established relationships and transfer agreements with pediatric tertiary care/specialty care centers to facilitate the transfer process in a surge event. Refer to Section 3.2.

2.6.1 Triage

For pediatric patients in a prehospital setting, on-scene EMS will provide triage per existing protocol. The JumpSTART Algorithm and training materials are available on the Illinois EMSC website.

2.6.2 Treatment

The treatment of pediatric patients even during a mass casualty or surge is the responsibility of the hospital and treating practitioners.

During a large-scale medical emergency, critically ill or injured children will present to any and all hospital, therefore, all hospitals should be prepared to receive, stabilize, and manage pediatric patients. SPARC hospital members should refer to facility specific plans, protocols, and training for guidelines regarding pediatric patients. The EMSC Pediatric & Neonatal Disaster/Surge Guide can be utilized as a resource to assist health care providers with addressing the medical needs of children during a disaster.

NOTE: Telemedicine can be considered when a facility is not able to transfer the pediatric patients to a higher level of care.

2.7 TRANSPORTATION

The transport of the pediatric patients requires specific equipment and appropriately trained staff. Facilities have proper procedures in place to transport pediatric patients safely to the appropriate facility. On-scene transportation will be coordinated by EMS per existing plans and protocols. The RHCC will support coordinating transportation resources as requested.

It is understood that there are limited EMS vehicles in the SPARC region with pediatric capabilities, primarily due to lack of appropriately trained staff. However, all ambulances have basic pediatric supplies and equipment on board to provide pediatric patient care.

It may be necessary to transport pediatric patients with staff from the referral institution in order to provide staff transport. Alternate means of transportation such as transit buses, facility shuttles and vans, private vehicles etc. should also be considered and equipped with appropriate safety measures and staff when transporting children.

2.8 Patient Tracking

Tracking the location of the pediatric patient is crucial in reunification with their families, caregivers or guardians. Electronic patient tracking is available and maybe used (e.g., EMTrack). Manual tracking of patient movement through pre-identified forms or used in conjunction with the electronic system (EMTrack) is necessary to ensure families stay together whenever possible and are reunified promptly if separated. The Patient Identification Tracking Form (Attachment D) is a tool within the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex can be utilized to track pediatric patients during a medical surge event.

2.9 Reunification

Every healthcare facility should maintain internal procedures for family reunification as well as planning for a pediatric safe area (PSA) to ensure appropriate safety precautions before release of minors to an appropriate custodial adult. The American Academy of Pediatrics (AAP) has a Reunification Toolkit that can be referenced to establish the Pediatric Safe Area. Visit https://downloads.aap.org/AAP/PDF/AAP%20Reunification%20Toolkit.pdf

The National Center for Missing and Exploited Children (NCMEC) Unaccompanied Minor Registry can provide assistance to local law enforcement to help reunify displaced children with their parents or legal guardians.

2.10 Deactivation and Recovery

Deactivation and Recovery/Return to a Pre-Disaster state will follow those established procedures in the SPARC Regional Response and Recovery Plan.

2.11 Training and Exercises

Training on roles and responsibilities of this Annex will be exercised with the SPARC membership and hot-washed to identify lessons learned and areas for improvement.

SPARC conducts an annual training and exercise workshop to provide an opportunity for members to provide input on trainings and exercises that support emergency preparedness and response activities, including planning for a pediatric surge.

Pediatric formal training and certification maintenance:

- Pediatric Advanced Life Support (PALS) – American Red Cross and American Heart Association
- Advanced Pediatric Life Support (APLS)- American Academy of Pediatrics
- Neonatal Advanced Life Support (NALS) – American Red Cross, American Heart Association
- Emergency Nursing Pediatric Course (ENPC) – Emergency Nurses Association
- Pediatric Emergency Assessment, Recognition and Stabilization (PEARS) – American Heart Association – American Heart Association
- Advanced Trauma Life Support (ATLS) – American College of Surgeons
- Neonatal Resuscitation Program (NRP) – American Academy of Pediatrics
- Pediatric Education for Prehospital Professionals (PEPP) – American Academy of Pediatrics
- Disaster Mental Health – American Red Cross, CDC, FEMA
- Emergency Disaster for Nurses – National Healthcare Disaster Certification – NHDP/DC
- School Nurse Emergency Care (SNEC) -

2.12 Plan Maintenance and Review

Review of the Annex will be, at minimum, annually; or as needed after exercises, planned events and real-world incidents or in coordination with Improvement Plans. Major revisions to this Annex and its processes will be reviewed by the SPARC Planning Action Team prior to final Board approval and implementation. Minor corrections, edits, updates, or adjustments to this document might occur on occasion without a formal review. All changes are tracked in the Record of Revision and Distribution log.

Coalition partners are responsible for maintaining and reviewing their own internal plans.

3. Appendices

3.1 Authorities

1. The SPARC coalition has provided the RHCC the authority to coordinate supply/equipment caches and services (other than EMS licensed providers) as outlined in the approved Regional Disaster Preparedness Plan and within the scope of the HPP Program.
2. Illinois Compiled Statues 210 ILCS 50, Emergency Medical Services (EMS) Systems Act, as amended.
3. IEMA-OHS is Authority Having Jurisdiction (AHJ) for the state of Illinois and is responsible for coordinating the State's response and recovery programs and activities and supporting local EMAs when response efforts far exceed local capabilities.
4. EMA is the lead agency for response coordination in their jurisdiction.

5. IDPH is the lead agency for public health and medical response operations. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to support local operations such as the Illinois Medical Emergency Response Team (IMERT), the Strategic National Stockpile (SNS), temporary medical treatment stations (TMTS), etc. Additional resources may be available on the local and regional levels to assist (e.g. Regional Medical Emergency Response Team [RMERT]).
6. The LHD serves as the lead local agency for public health and medical response operations in its local jurisdiction.

3.2 Transfer Agreements with Pediatric Tertiary Care Centers

HOSPITAL NAME	PEDS DESIGNATION	TRAUMA CENTER LEVEL	PERINATAL LEVEL	PEDS	PICU BEDS	NICU BEDS
Ascension St. Vincent Evansville	EDAP	Level II & Pediatric Level II	Indiana III NICU	13	5	24
Deaconess Gateway Hospital*	EDAP	Level II & Pediatric Level II	Indiana III NICU			
SSM Health Cardinal Glennon Children's Hospital	PCCC	Pediatric Level I	III NICU	103	86	65
St. Louis Children's Hospital	PCCC	Pediatric Level I	III NICU	212	77	150

PEDIATRIC DESIGNATION

PCCC: Pediatric Critical Care Center **(Only available by transfer)**

EDAP: Emergency Department Approved for Pediatrics

SEDP: Standby Emergency Department Approved for Pediatrics

ILLINOIS PERINATAL LEVELS

Level Ø: Non-Birthing Center

Level I: General Nursery

Level II: Intermediate Care Nursery

Level II-E: Special Care Nursery with Extended Capabilities

Level III: Neonatal Intensive Care

3.3 Additional Pediatric Resources

Caring for the Non-injured and Non-Ill Children in a Disaster
https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-and-other-resources/practice-guidelinestools/caringchildrendisasterbookmay20164.pdf

Children with Special Health Care Needs Quick Reference Guide

https://www.luriechildrens.org/globalassets/documents/emsc/disaster/other/childrenwithspecialhealthcareneedsreferenceguide.pdf

IDPH Emergency Medical Services for Children – Pediatric Resources Directory

https://app.smartsheet.com/b/publish?EQBCT=19846c2a1a6e4e52beaa5903a989dec3

Family Reunification Toolkit

https://downloads.aap.org/AAP/PDF/AAP%20Reunification%20Toolkit.pdf

Pediatric Disaster Preparedness Guidelines
https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-and-other-resources/practice-guidelinestools/00_peddisasterguide3ed_jan2019final.pdf

Pediatric and Neonatal Care Guidelines
https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-and-other-resources/practice-guidelinestools/pediatricneonatalcareguidelinesjune20172.pdf

Pediatric Reference Pocket Card:
https://www.luriechildrens.org/globalassets/documents/emsc/resourcesguidelines/guidelines-tool-and-other-resources/practice-guidelinestools/emscpedspocketcard2019.pdf

PEDIATRIC SURGE STATE PLAN REFERENCES

Illinois Department of Public Health ESF-8 Plan: Pediatric and Neonatal Surge Annex 2020

https://dph.illinois.gov/content/dam/soi/en/web/idph/files/publications/peds-neo-surge-annex-revisionsjuly-2020final-july-2020publicversioncombined.pdf

IMPORTANT TELEPHONE NUMBERS

Illinois Department of Children and Family Services **24/7 Hotline: 1-800-25-ABUSE (22873)**

Illinois Poison Control Center **24/7 Hotline: 1-800-222-1222**

National Center for Missing and Exploited Children **24-Hour Call Center: 1-800-THE LOST (843-5678)**

4. Attachments

Attachment A: Pediatric/Neonatal Medical Incident Report Form

Attachment B: RHCC Mobile Hospital Trailer Pediatric Supply List

Attachment C: RHCC Access and Functional Needs Trailer Pediatric Supply List

Attachment D: Patient Identification Tracking Form

Attachment A: Pediatric/Neonatal Medical Incident Report Form

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ATTACHMENT 5: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

Purpose: Assist with ensuring consistent communication between stakeholders and provide a mechanism to request pediatric medical resources and identify availability of resources at a health care facility.

Instructions: When the annex is activated, this form will be utilized by **all** stakeholders (e.g. health care facilities, LHDs, IDPH, PCMS) to communicate necessary information about the incident, annex activation, and pediatric patient transfer resource needs/requests. For pediatric care equipment needs/requests, complete the ICS 213RR form and submit it through the Request for Medical Resources Process as outlined in the IDPH ESF-8 Plan.

INCIDENT NAME:			
DATE/TIME PREPARED	**DATE/TIME RECEIVED**	**OPERATIONAL PERIOD**	**RECEIVED VIA** ☐Phone ☐Radio ☐Fax ☐Other
FROM (SENDER)	**TO (RECEIVER)**	**REPLY/ACTION REQUIRED?** ☐YES ☐NO If YES, *include detailed sending information* below **REPLY TO:** ☐**Phone** ☐**Radio** ☐**Fax** **Other (List number)**	
PRIORITY: ☐ Urgent/High ☐ Non-urgent/Medium ☐ Informational/Low			
DATE/TIME PHEOC ACTIVATED		**REASON FOR PHEOC ACTIVATION**	
DATE/TIME ANNEX ACTIVATED		**REASON FOR ANNEX ACTIVATION**	
ACTIVATION LEVEL ☐☐Local ☐Regional ☐State			
DATE/TIME PEDIATRIC CARE MEDICAL SPECIALISTS (PCMS) ACTIVATED		**REASON FOR PEDIATRIC CARE MEDICAL SPECIALISTS (PCMS) ACTIVATION**	
CURRENT INCIDENT INFORMATION			

CURRENT NUMBER OF PEDIATRIC/NEONATAL BED NEEDS

(The purpose of this section is to identify the number of pediatric/neonatal patients and what type of health care facility is needed for their care when the Annex is activated. These categories are for interfacility transfers only, not EMS scene transports. Enter the total number of patients for each triage category in the corresponding boxes below. In the *Pediatric Patient Placement Information* section on page 2 of this form, provide more specific information about the individual patients (tracking number, gender, and age). For more information, see Pediatric and Neonatal Surge Annex, Attachment 10: Pediatric Triage Guidelines.

	TRIAGE CATEGORY					
	CRITICAL CARE (PICU/NICU)	**INTERMEDIATE CARE (Pediatric/Neonatal Intermediate Care)**		**GENERAL CARE (Pediatric/neonatal general medical care)**		
	CATEGORY 1 HOSPITALS	**CATEGORY 2 HOSPITALS**	**CATEGORY 4 HOSPITALS**	**CATEGORY 2 HOSPITALS**	**CATEGORY 3 HOSPITALS**	**CATEGORY 4 HOSPITALS**
NUMBER OF PATIENTS						

Definitions:

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

*Adapted from HICS 213 Form

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ATTACHMENT 5: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

REQUIRED/REQUESTED ACTIONS AT THIS TIME

PEDIATRIC/NEONATAL PATIENT PLACEMENT INFORMATION

The transferring health care facilities should complete this section for each patient that requires transfer/placement at another health care facility when submitting a request to the PCMS. Do not include detailed information about the patient's medical condition or treatment. Once a receiving facility has been identified, the PCMS will complete the last column and send this information back to the transferring facility.

To be Completed by the Transferring Health Care Facility				To be Completed by the PCMS
Patient Tracking Number (assigned by initial health care facility)	**Triage Category**	**Gender**	**Age**	**Receiving Health Care Facility Name** **Receiving Health Care Facility Address**

SEND REPLY TO: ☐ **Phone** ☐ **Radio** ☐ **Fax**
Other (List number):

PREPARED BY

RECEIVED BY	**TIME RECEIVED**	**FORWARD TO**

COMMENTS

FACILITY NAME/LOCATION

*Adapted from HICS 213 Form

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Attachment B: RHCC Mobile Hospital Trailer Pediatric Supply List

(Under Review)

Attachment C: RHCC Access and Functional Needs Trailer Pediatric Supply List

(Under Review)

Attachment D: Patient Identification Tracking Form

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ATTACHMENT 12: PATIENT IDENTIFICATION TRACKING FORM

Purpose: Assist in identifying, tracking, and reunifying patients during a disaster.
Instructions: This form should be completed to the best of the ability given the information available on all patients, especially pediatric patients, who arrive at a health care facility regardless if accompanied by family/parent/guardian. Send the original form with the patient if transferred to another facility and keep a copy of the form on file with the patient's medical record at the transferring health care facility.
Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

Date of Arrival	Time of Arrival AM/PM	Incident name
Tracking number (assigned by transferring health care facility)		
Patient's Name (Last, First)		Patient's Phone
Patient's Full Home Address		
(For Minors) Parent/Guardians' Names		Presented with patient? ☐ Yes ☐ No
Patient's DOB ☐ Unknown	Age Years Months ☐ Estimated	Gender ☐ Male ☐ Female
Race/ethnicity, if known ☐ White non-Hispanic ☐ Black/African American, non-Hispanic ☐ Asian or Pacific Islander ☐ Hispanic ☐ Asian Indian ☐ American Indian or Alaska Native ☐ Unknown ☐ Other		Language ☐ English ☐ Spanish ☐ Nonverbal ☐ Other

☐ Accompanied ☐ Unaccompanied	Describe where patient was found. Be as specific as possible, including neighborhood/street address.	Items worn by or with patient when found (describe color, pattern, type)
How patient arrived at hospital (list name if available) ☐ EMS ☐ Private medical transport service (ambulance/flight) ☐ ☐ Law Enforcement ☐ ☐ Private Vehicle ☐ Walk-in ☐ Other		☐ Pants ☐ Shirt ☐ Dress ☐ Shoes ☐ Socks ☐ Coat/Jacket ☐ Jewelry ☐ Glasses ☐ Medical devices ☐ Other ☐ Other

DESCRIPTION OF THE PATIENT

Skin color	Attach photo here
Hair Color ☐ Blonde ☐ Brown ☐ Black ☐ Bald ☐ Red ☐ Grey ☐ White ☐ Other	
Eye Color ☐ Brown ☐ Blue ☐ Green ☐ Other	
Height ☐Estimated	
Weight ☐Estimated	
Other markings ☐ Scars ☐ Moles ☐ Birthmarks ☐ Tattoos ☐ Missing teeth ☐ Braces ☐ Other ☐ Other	

PATIENT TRACKING LOG

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

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Incident Name:

Original Form: Send with patient. Copy of Form: Maintain on file

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MEDICAL HISTORY AND TREATMENT WHILE AT THIS FACILITY

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

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

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

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

COMPLETE FOR MINORS: CHILD ACCOMPANIED BY PARENT/GUARDIAN

Name of Person Accompanying Child ☐ Adult ☐ Child/Minor

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

Attach Copy of ID

ID Checked? ☐ Yes ☐ No
Form of ID (list)

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

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

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

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

COMPLETE FOR MINORS: CHILD UNACCOMPANIED BY PARENT/GUARDIAN

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

Where and when was the parent/guardian last seen

Has the parent/guardian been contacted ☐ No ☐ Yes
Contacted by Date Time

Plans for reuniting child with parent/guardian

Agencies Used to Assist with Reunification (Date/Person Contacted)
☐ American Red Cross
☐ Illinois Department of Children and Family Services
☐ Law enforcement
☐ National Center for Missing and Exploited Children
☐ Other

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

DISPOSITION

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

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

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

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Incident Name: Original Form: Send with patient. Copy of Form: Maintain on file