Disaster Planning for California Hospitals

CALIFORNIA HOSPITAL ASSOCIATION

Disaster Planning for California Hospitals

California's Neonatal, Pediatric and Perinatal Disaster Preparedness in Action

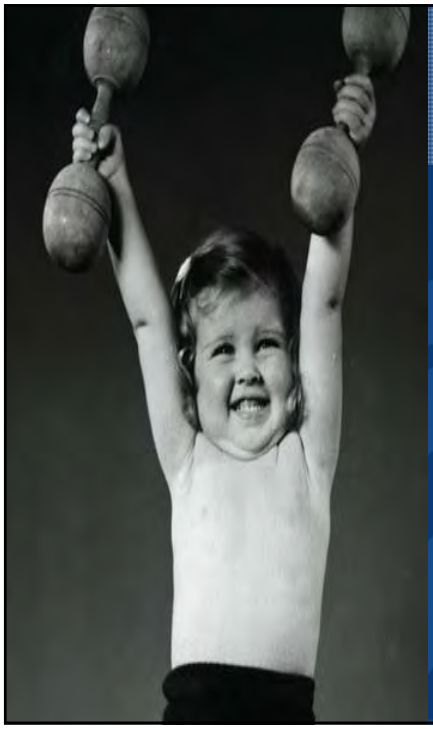
Patricia Frost, RN, MS, PNP (moderator)
Emergency Medical Services Director, Contra Costa Health Services

Kay Daniels, MD
Clinical Professor, Obstetrics & Gynecology, Stanford University School of Medicine

Cynthia Frankel, RN, MN
Prehospital, Emergency Medical Services for Children & HPP Coordinator, Alameda County Emergency Medical Services

Jason Silvas, RN
Pediatric Program Coordinator San Joaquin Community Hospital

Bridget Berg, MPH, FACHE
Manager, Pediatric Disaster Resource & Training Center, Children's Hospital Los Angeles



Raising the Bar

California's Neonatal, Pediatric and Perinatal Disaster Preparedness In Action!

Moderator: Patricia Frost RN, MS, PNP

EMS Director Contra Costa Health Services

Founder & Co-Chair California Neonatal, Pediatric & Perinatal Disaster Coalition

Vice Chair National Pediatric Disaster Coalition

Objectives

- Identify current local, regional, state and national resources and efforts supporting disaster preparedness for infants and children
- Describe why a statewide CONOPs for infants and children is essential to California's Med/Health Preparedness
- List three resources you can use to improve your local capabilities for infants, children and pregnant women

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National Survey
The Public Expects Children First

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PAHPRA Reauthorization Act 2013
Legal requirement to include children in all disaster planning

Pediatric Preparedness for Healthcare Coalitions
Capability #1 and # 10

Requires Children Have A Seat at the Table

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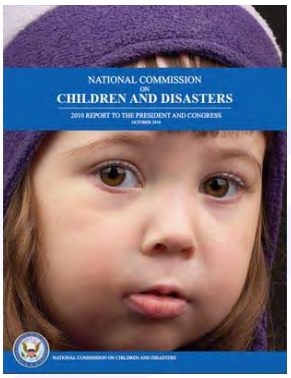
2010 National Commission for Children and Disaster



2014 National Advisory Committee for Children and Disasters (NACCD)

http://cybercemetery.unt.edu/archive/nccd/20110426214402/http://www.acf.hhs.gov/ohsepr/nccdreport/nccdreport.pdf

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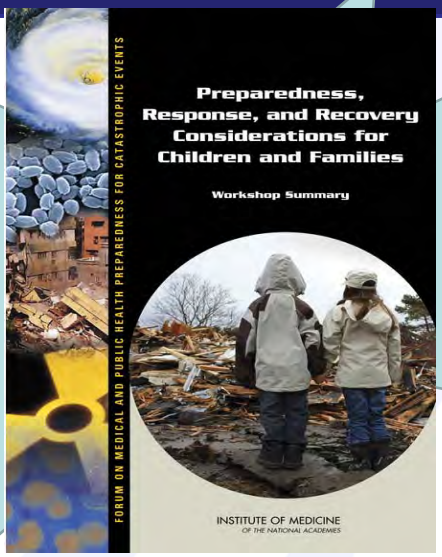
Institute of Medicine: June 2013



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Never Been a Better Time

Develop Pediatric Capabilities

It Does NOT Have to Be Scary!

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It Starts with Learning about the Children in Your Community

Pediatric Disaster Preparedness

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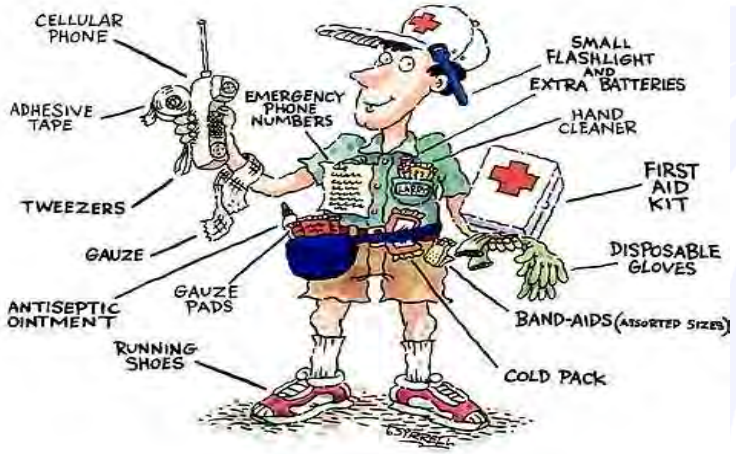
Improves
Personal and Family Readiness



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How Well a Community Recovers Measured by What Happens to the Children

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ASPR: 30% Surge Within 4 Hours
New Model Came Out of Pediatrics

System Decompression

CATEGORY 1
Pediatric Tertiary Care Centers in and around region (PICU and/or NICU) (includes PCCC hospitals)

CATEGORY 2
Community hospitals with some pediatric services (includes EDAP hospitals)
Accepts 0–12 year olds

CATEGORY 3
Community hospitals with no pediatric or neonatal (i.e. SEDP hospitals)
Accepts > 12 year old

CATEGORY 4
Community hospitals with Level I, II or II-E nurseries
Accepts 0–1 year old

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The Focus on Children has Strengthened Disaster Mental Health for All

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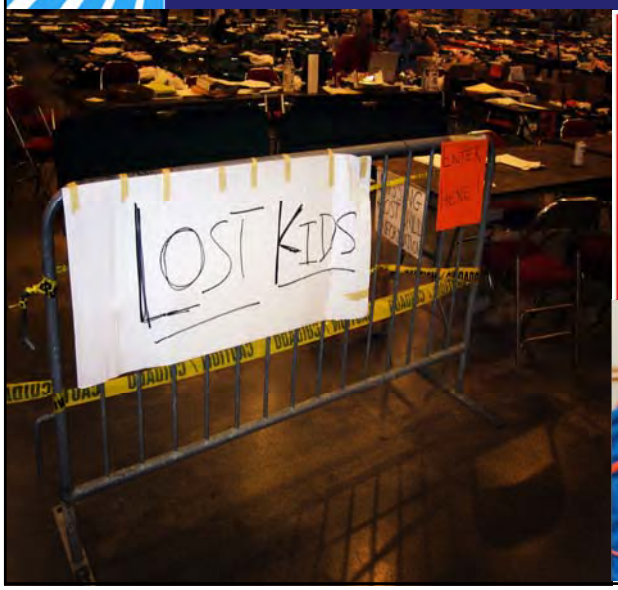
Reunification and Patient Tracking



Schools: Practice with Them

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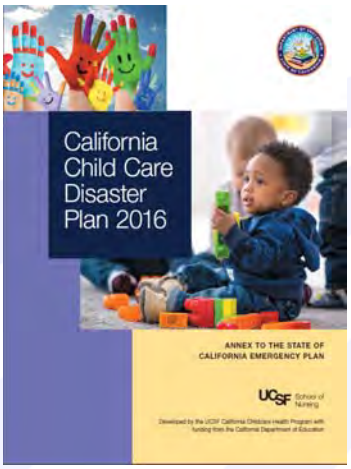
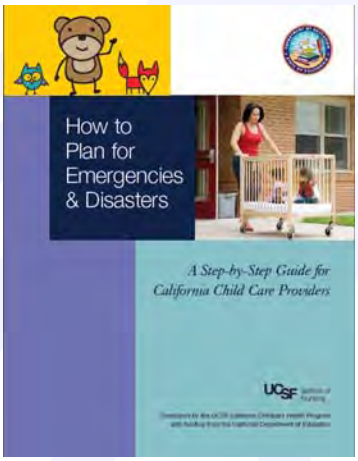
California Child Care Disaster Plan

An Annex to the State Emergency Plan

http://cchp.ucsf.edu/content/disaster-preparedness





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The Good News

Pediatrics Creates REAL Engagement

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2015 – Our Annual Disaster Report Card

This year, we find 32 states now require minimum emergency planning standards at schools and child care. But a decade after Hurricane Katrina, 18 states and D.C. still fall short.

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California
Leadership in Perinatal, Neonatal and Pediatric Disaster Preparedness

Our Outstanding Panelists

Kay Daniels, MD
Clinical Professor, Obstetrics & Gynecology, Stanford University School of Medicine, and Co-Director of Disaster Planning, Johnson Center

Cynthia Frankel, RN, MN
Prehospital, Emergency Medical Services for Children & HPP Coordinator, Alameda County Emergency Medical Services

Jason Silvas, RN
Pediatric Program Coordinator
San Joaquin Community Hospital

Bridget Berg, MPH, FACHE
Manager, Pediatric Disaster Resource & Training Center, Children's Hospital Los Angeles

Earthquakes and fires and floods … OH MY !!

Disaster Preparedness for OB Units

Kay Daniels, MD
Clinical Professor
Obstetrics & Gynecology
Stanford University
School of Medicine

If there is an OB Unit in your hospital

The American College of Obstetricians and Gynecologists note:

"Providers of obstetric care and facilities that provide maternity services, offer services to a population that has many unique features warranting additional consideration"

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Why Moms and their Babies are at Risk in Disasters?

- >97% of all births in the U.S. occur in a hospital or clinical setting … which may not be accessible or may be severely damaged during a disaster event
- Mom and babies are physically more vulnerable to disaster-related toxins

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Why Moms and their Babies are at Risk in Disasters? (cont.)

- Pregnant women are subject to the usual risks of injury at a disaster, but with more complicated care

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Keeping mom and baby together …

- In the days after Hurricane Katrina struck Louisiana, 125 critically ill newborn babies and 154 pregnant women were evacuated to Woman's Hospital in Baton Rouge
- *It was at least 10 days before some of the infants and mothers were reunited*

Washington Post 2006

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Hospital disaster planning : OB is Unique

One size ≠ all in a disaster setting for OB

Within the same footprint of any OB unit there exists a large variety of patient acuity and needs

- Healthy postpartum patients with their newborns
- Laboring women
- Intra-op and post-operative patients

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Why is OB unique?

We always have 2 patients

- Ante partum (AP) = mom and fetus
- Postpartum = mom and newborn

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Disaster Planning for OB: A Triage Algorithm

OB TRAIN* =

***Triage** by **R**esource **A**llocation for **IN** patient*

*Based on the triage system created by Dr. Ron Cohen for the NICU at Lucile Packard Children's Hospital

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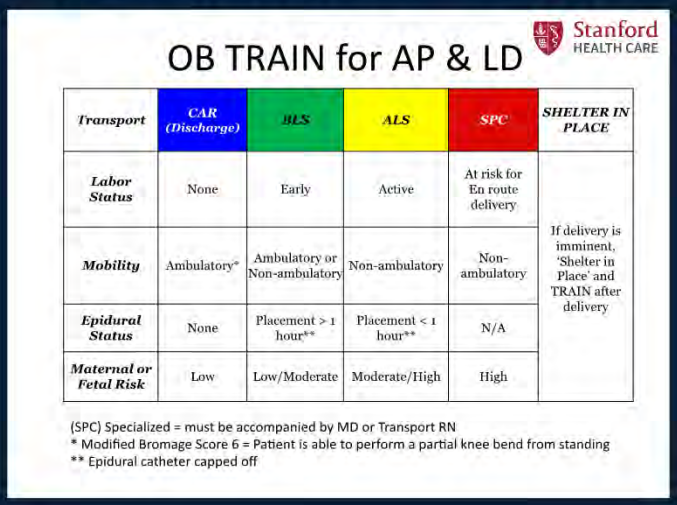
OB TRAIN for AP + L&D



(S) Specialized = must be accompanied by MD or Transport RN
* MBS 6 = Patient is able to perform a partial knee bend from standing
** Epidural catheter capped off

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Basis of Triage System for OB TRAIN

- Labor status
- Mobility
- Anesthesia status
- Maternal risk factors/fetal risk factors

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OB TRAIN Triage Example

26yrs @ 40 weeks

- Early labor: 4cm
- Can ambulate
- No epidural
- Cat 1 FHR
- No significant maternal or fetal risk factors

Transport	CAR (Discharge)	BLS	ALS	SPC	
Labor Status	None	Early	Active	At risk for En route delivery	If delivery imminent: Shelter in place and TRAIN after delivery
Mobility	Ambulatory*	Ambulatory or Non-ambulatory	Non-ambulatory	Non-ambulatory	
Epidural Status	None	Placement > 1 hour**	Placement < 1 hour**	N/A	
Maternal or Fetal Risk	Low	Low/ Moderate	Moderate/High	High	

OB TRAIN Triage Example #2

32 yrs @ 31 weeks with severe preeclampsia undergoing induction of labor

- Early labor: 2 cm
- Nonambulatory
- Epidural in place < 1 hr
- Cat 1 FHR
- Intermittent IV labetalol for BP control
- On 2 g IV magnesium sulfate

Transport	CAR (Discharge)	BLS	ALS	SPC	
Labor Status	None	Early	Active	At risk for En route delivery	If delivery imminent: Shelter in place and TRAIN after delivery
Mobility	Ambulatory*	Ambulatory or Non-ambulatory	Non-ambulatory	Non-ambulatory	
Epidural Status	None	Placement > hour**	Placement < 1 hour**	N/A	
Maternal or Fetal Risk	Low	Low/ Moderate	Moderate/High	High	

Specialized

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Levels of Maternity Care
ACOG Consensus Feb. 2015

SENDING THE RIGHT PATIENT TO THE RIGHT HOSPTIAL

1. Levels
   - Birthing Centers
   - Basic Care (Level I)
   - Specialty Care (Level II)
   - Subspecialty Care (Level III)
   - Regional Perinatal Health Care Centers (Level IV)

2. Capabilities

3. Types of providers

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Being prepared to evacuate L&D

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WE'VE GOT TO GO!!

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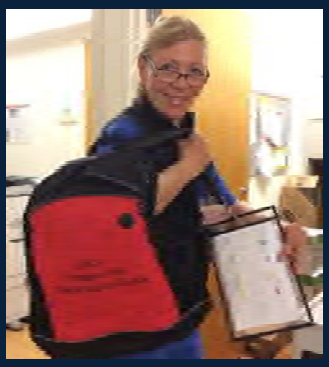
L&D Disaster Plan: Evacuation



Grab and GO "Off Site Delivery Kit"

Item:	Location:		Quantities/Details:
Sterile single gloves	Delivery Cart Drawer #:	2	5-10 gloves
Exam gel		2	5-10 packets
Bulb Syringe		3	x1
Umbilical cord clamp		3	x3
Sutures		3	Monocryl 2-0 x1 Monocryl 3-0 x1 Vicryl 3-0 x1
Sterile gloves		4	Size 6.5 x1, Size 8 x1
L&D Instrument Set		5	Mayo Scissors Mayo Clamp Needle Driver
Delivery Pack		5	Underbuttocks drape Sterile gown Sterile towel Needle count box Table cover Sponges Cord clamp x1
Red bag		5	x2
Peripad		6	x2
Large non-sterile gloves	Wall above sink		One box (50 gloves)
Hand Sanitizer	LDR room		
Chux	LDR Closet		One chux
Ambu-bag self-inflating (neonatal)	PANDA		
Neonatal stethoscope	PANDA		
Baby blanket	Warmer		
Baby hat	Warmer		
Fetal Doppler	Disaster Box or lock drawer by clerk		
Space Blanket	Disaster Box		
Sharps Box	Disaster Box		
Paper & Pen	Front Desk		
Oxytocin 20U IM + needle/syringe	Pyxis		
Methergine 0.2mg IM + needle/syringe	Pyxis		
Misoprostol 1000mcg buccal/rectal	Pyxis		
Lidocaine 1% 30ml + needle/syringe	Pyxis		

Labor Module | Delivery Module
Medication Module | Neonatal/Postpartum Module

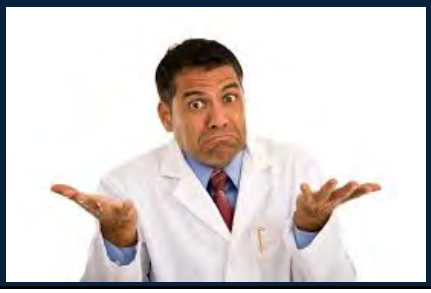
COMMUNICATION: Peds ⬅ ➡ OB

How will peds know where OB is evacuating to?

- Is there a system in place for notification?

Who from peds has been designated to go with OB ?

- To care for '*shelter in place'* in deliveries



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Coordination of OB and Pediatrics

Ideas to insure that mom and baby are not separated

- On baby's transfer forms – mom's information
- On mom's transfer form – baby's info
  - Newborn screening # or other unique identifier
- Record where both baby and mom are being transferred to in multiple sites
- Arm bands with matching information

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Next steps: Collaborative network on a regional, statewide and national level

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In summary: to accomplish a comprehensive obstetric disaster plan there needs to be:

1. Adoption of an obstetric-specific triage system like OB TRAIN to allow a universal language for evacuation and surge processes
2. A system in place to transfer OB patients to the appropriate hospital (the right patient to the right hospital)

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In summary (cont.)

3. An comprehensive *shelter in place* plan for laboring patients that includes:
   - Grab and go bags/equipment
   - Communication with peds
4. Postpartum plan that takes into consideration transport of mom and baby
   - Avoid maternal-neonatal separation when possible
   - Accurately track location if separated
5. Create a regional and ultimately national collaborative network of maternity hospitals

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Online access to disaster tools

Stanford Disaster OB Planning “Tool kit”

http://obgyn.stanford.edu/community/disaster-planning.html

Kay Daniels

k.daniels@stanford.edu

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THANK YOU FOR YOUR ATTENTION

Stanford University

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LEVERAGING SUSTAINABLE PEDIATRIC/NEONATAL CAPABILITY & READINESS UNDER ALL CONDITIONS

CALIFORNIA CHILDREN'S MEDICAL SURGE CONCEPT OF OPERATIONS

ALAMEDA COUNTY DISASTER PREPAREDNESS IN ACTION

CYNTHIA FRANKEL, RN, MN
CO-CHAIR, CALIFORNIA NEONATAL/PEDIATRIC DISASTER COALITION
ALAMEDA COUNTY EMERGENCY MEDICAL SERVICES

CALIFORNIA NEONATAL/PEDIATRIC DISASTER COALITION

TRANSLATING EFFECTIVE GUIDANCE INTO ACTION

- **GOAL: To strengthen** statewide & local children's **medical surge capability & readiness**
- **MISSION: Campaign to inspire & build** statewide & local emergency preparedness, **RESPONSE** capability & plan implementation throughout California

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GOALS

DRIVING READINESS & ACTION IN DYNAMIC TIMES

- Provide **strategies & benchmarks** to support **disaster-resilient health care systems**
- Share projects — **to reframe inclusive & effective pediatric medical surge readiness** & enable health care system surge response
- Facilitating **transformative & sustainable medical surge readiness**

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"PEDIATRIC NEAR MISS"

SURGE CAPACITY & CAPABILITY CHALLENGES

LESSONS LEARNED

- **H1N1 (2009) ***
- Mehserle Verdict (2009–10)
- San Bruno pipeline explosion (2010)
- **Occupy Oakland/civil unrest (2012)**
- Hurricane Sandy (2012)
- **Asiana Accident (2013)**
- **Napa Earthquake (2014)**
- Valley Fire & Calistoga Shelter (2015)
- **Train Derailment (2016) ***

POTENTIAL RISK – ALAMEDA COUNTY

- Hospital medical surge impact
- Limited PICUs, EDs & beds **(ONLY 33 PICU BEDS)**
- Earthquakes & pandemic flu

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ANTICIPATE EARTHQUAKE OF M6.8 OR GREATER ON HAYWARD FAULT

- **13 hospitals within 1 mile of Hayward Fault**
- Last major earthquake on Hayward Fault — 1868 (over 140 years ago)
- Research by U.S. Geological Survey (USGS)

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DISASTER — SURGE PEDIATRIC PREPAREDNESS VISION

WELL-PREPARED PEDIATRIC DISASTER HEALTH CARE SYSTEM:

- **Plans** for healthcare consequences of pediatric disasters
- **Responds** quickly & with agility to harness all vital resources
- **Functions** under adverse circumstances
  - An immediate & prolonged surge of pediatric patients in need of acute critical care
  - Disruption of incident management chains of command
  - A contaminated or contagious environment
  - Loss of infrastructure
  - Poor situational awareness

REQUIRES CONOPS

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CALIFORNIA CHILDREN'S MEDICAL SURGE
CONCEPT OF OPERATIONS (CONOPS)

CURRENT INITIATIVE:

- Strategic Plan Priority CA EMSC Technical Advisory Committee, Annex to CA EOP - ESF 8

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CONOPS Envisioned

High reliability, highly collaborative, cross-sector

- **Strengthen:** To strengthen California's ability to care for children during medical surge event & leverage medical system partners
- **Seamless:** To provide incident response strategy for "seamless" medical **response** operations
- **Resiliency:** To promote pediatric health care system emergency readiness solutions, response resiliency strategies, & evidence-based tools

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CONOPS Envisioned (cont.)

High reliability, highly collaborative, cross-sector

- **Rapidly expand capacity:** To provide guidance on how to rapidly expand capacity of existing heath care system at multiple levels
- **Align, scalable, coordinated, & Integrated:** To ensure integrated children's medical emergency management response system — consistent with California Medical/Health **EOM**, state EMSC benchmarks & existing surge plans

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CALIFORNIA CHILDREN'S MEDICAL SURGE CONOPS PROJECT REQUIREMENTS

- **High-level overarching framework** with state coordinated pediatric medical surge procedures
- **Customized to divergent regions** & operational
- Sections of other plans integrated in CONOPS
- **High-level synthesis of many existing plans**
- Institutionalize our vision

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CALIFORNIA CHILDREN'S MEDICAL SURGE

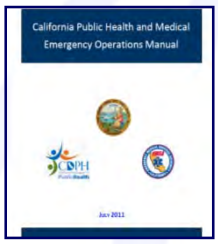
CONOPS PROJECT MISSION

FRAMEWORK

- **Bed expansion/decompression: Flex Models ****
- Pediatric expert focal points: Effective decisions
- **Resources:** Links resources & map assets
- **Management responsibilities: Role clarity**
- Coordination: Pediatric surge & patient transfers

PRIORITY

- Leverage **EXISTING** regional/OA Pediatric Surge Plans
- Supplement CA Med/Health EOM



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EMSA/CDPH PEDIATRIC SURGE

NEW FOCUS — PLANNING MEETING 4/28/16

GOAL: Develop State CONOPs & function-specific chapter California Public Health/Medical EOM

—— **Built on capacity model** ——

- Establish **catchment areas** around **regional hospital**
- Create **tiered hospital structure** around **levels of care**
- Expectations for **pediatric readiness**
- Connectivity via MHOAC / RDMHS program
- "Day-to-day**"** pediatric assets (i.e., neonatal transport network)

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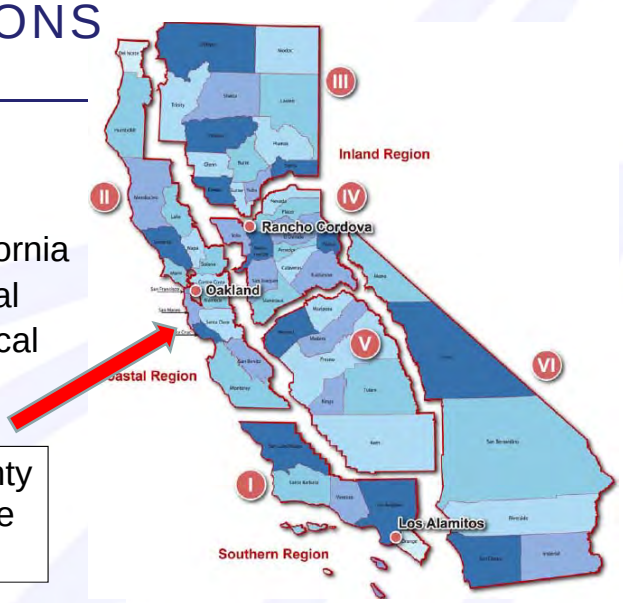
REGIONS

GOAL:

Leverage & integrate California state & regional pediatric medical surge plans

Alameda County Medical Surge Planning



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ALAMEDA COUNTY MEDICAL SURGE
PANDEMIC EXPANSION MODELS — OPTIONS

1. Hospitals increase pediatric beds by **5%** above total licensed beds
2. Hospitals with ICU & PICU **double** numbers of staffed beds
3. Hospitals take **5 additional patients** in their ICU & PICU
4. Hospitals increase bed capacity by **10% above licensed beds**

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ALAMEDA COUNTY PEDIATRIC READINESS "DAY TO DAY" & SURGE

What's sustainable? Leveraging & Energizing Partners

- Priority Pediatrics Benchmarks
  2014 to 11/17/16 Exercises
- HPP 2014-17 Pediatric medical surge deliverables – CONOPS
- Pediatric Readiness Project & Champion Recognition

UCSF Benioff Children's Hospital
Oakland

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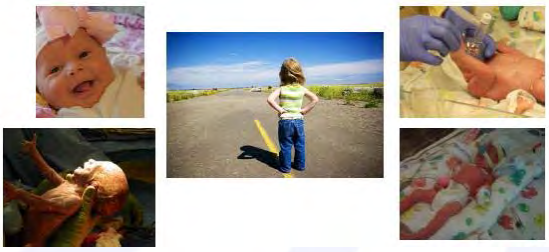
ALAMEDA COUNTY CHILDREN'S DISASTER CONOPS

ANNEX TO COUNTY EMERGENCY OPERATIONS PLAN

Current initiative:

- Strategic Plan Priority Annex to OA EOP - ESF 6 & 8
- Includes **High Level EOC Coordination** for Children
- Focus Medical & Care & Shelter (Multi-Agency Approach)
- Currently at Emergency Operations Council for Board Approval
- Potential for adapting model to other OAs & New State CONOPs



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ALAMEDA COUNTY CHILDREN'S MEDICAL SURGE

PROJECT REQUIREMENTS

- Define Strategic Approach
- Define Support Structure
- Delineate Key Roles and Responsibilities

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ALAMEDA COUNTY EMERGENCY OPERATIONS CENTER (EOC)

ACTIVATION

Children's Technical Expert / SMES – Coordination Group – Effective Decisions

COLLABORATION ACTION OPPORTUNITY

"FUTURE ROAD MAP—BREAKING NEW GROUND"

Fuel Statewide Partnerships & Mobilize Champions

- **Short & long term project ***
  CA Children's Medical Surge CONOPS Project
- **"Robust" collaboration team -** Reinvigorate partner support
- Align & promote Pediatric Readiness Project
- Plan & conduct medical surge pediatric **exercises**
- Annual state EMSA/CDPH & CHA conferences – pediatric tracks

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DRIVING PEDIATRIC READINESS

MOMENTUM & ACTION

CYNTHIA FRANKEL, RN, MN

Co-Chair, California Neonatal/Pediatric Disaster Coalition
(510) 618-2031 (office) | (925) 285-2403 (cell)
Cynthia.Frankel@acgov.org

Neonatal/Pediatric Disaster Preparedness Information:

http://www.acphd.org/emsc.aspx

https://sites.google.com/site/pedineonetwork/

Pediatric Disaster Preparedness

Jason J. Silvas
San Joaquin Community Hospital

Pediatrics and Emergency Rooms

Are You Pediatric Ready, Today?

- Just the stats
  - 20% of all ER visits are children
  - 90% of those visits occur in a local, general hospital setting
- Emergency Room defined
  - Hospital room or area staffed & equipped for treatment of persons needing immediate medical care

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Preparing for Pediatric Disasters

Collaboration is Key

- Recent local accomplishments
  - 2014 – Central Valley Regional Pediatric Disaster Surge Framework adopted (by 10 counties)
  - 2015 – Kern County Pediatric Receiving Center Designation Policy adopted
  - 2016 – Kern County Pediatric Advisory Committee established
    - Local services now include PICU, Trauma Center and Burn Center

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Preparing for Pediatric Disasters

Preparing for pediatric disasters means …

- Being prepared for pediatric patients
  - Policies, procedures and protocols
  - Quality improvement process in place
  - Equipment, supplies and medications
  - Staffing
  - Education (this is a must!)

Preparing for pediatric disasters does NOT mean …

- Large expenditures

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Preparing for Pediatric Disasters

Reinvent the wheel? Why?

- National Pediatric Readiness Project
  - Peds Ready Assessment

2015-16 Quality Improvement Emergency Department Assessment

National PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children

Hospital Name: San Joaquin Community Hospital
Hospital Volume: High: >=10,000 pediatric patients (average of 27 or more a day)
Respondent Name: Jason Silvas, Pediatric Program Coordinator, RN
Respondent Contact Info: (661) 319-2823, silvasjj@ah.org
Report Date: 11/2/2015 10:36:18 AM

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Preparing for Pediatric Disasters

San Joaquin Community Hospital

- 2 year progress report

YOUR SCORE AND COMPARATIVE SCORES:

92	53	84 n=561	69 n=4146
YOUR 2015-16 HOSPITAL SCORE OUT OF 100	2013-14 SCORE FOR YOUR HOSPITAL	2013-14 AVERAGE SCORE OF SIMILAR PEDIATRIC ED VOLUME HOSPITALS	2013-14 AVERAGE SCORE OF ALL PARTICIPATING HOSPITALS

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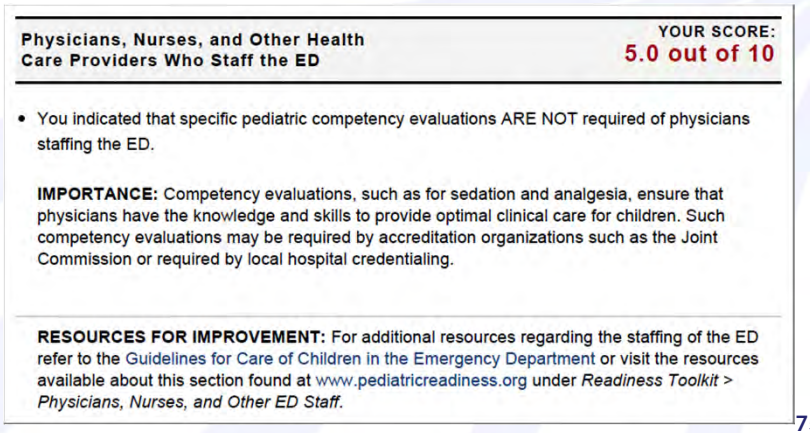
Preparing for Pediatric Disasters

Peds Ready Project: The Assessment

- Provided immediate gap analysis report



Physicians, Nurses, and Other Health Care Providers Who Staff the ED

YOUR SCORE: 5.0 out of 10

- You indicated that specific pediatric competency evaluations ARE NOT required of physicians staffing the ED.

IMPORTANCE: Competency evaluations, such as for sedation and analgesia, ensure that physicians have the knowledge and skills to provide optimal clinical care for children. Such competency evaluations may be required by accreditation organizations such as the Joint Commission or required by local hospital credentialing.

RESOURCES FOR IMPROVEMENT: For additional resources regarding the staffing of the ED refer to the Guidelines for Care of Children in the Emergency Department or visit the resources available about this section found at www.pediatricreadiness.org under *Readiness Toolkit > Physicians, Nurses, and Other ED Staff.*

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Preparing for Pediatric Disasters

Current Kern County initiatives and goals

- Pediatric-specific bioorganic response
  - Hospital- and field-based drill
  - Pediatric-specific decontamination considerations
  - Reunification planning
- Active shooter preparedness
- Open a pediatric-specific ER
  - Planned opening by end of 2016

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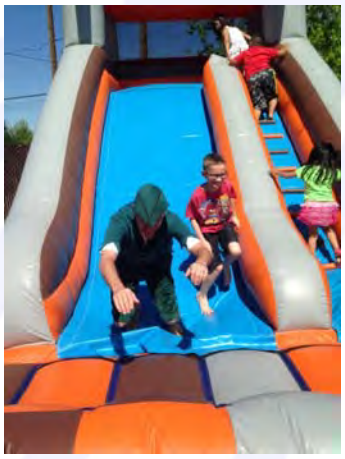
Preparing for Pediatric Disasters

So … Are You Pediatric Ready, **Today?**

Because just another normal day …



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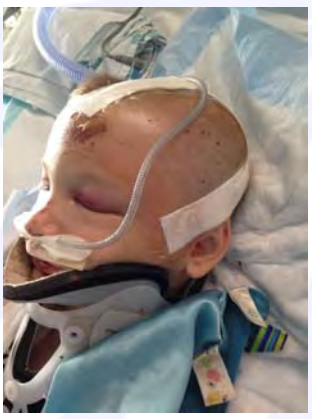
Preparing for Pediatric Disasters

Could change in an instant AND…



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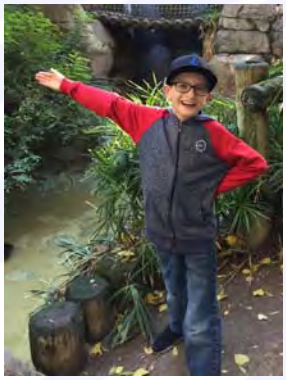
Preparing for Pediatric Disasters

If You **ARE** Pediatric Ready, **Today**

- Outcomes WILL improve!



Coleman Silvas

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Preparing for Pediatric Disasters

Thank you,

Jason J. Silvas

Pediatric Program Coordinator

San Joaquin Community Hospital

Office: (661) 637-8830

Email: silvasjj@ah.org

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Preparing hospitals for pediatric surge
Los Angeles County

Bridget Berg, MPH, FACHE
Manager, Disaster Resource Center
Children's Hospital Los Angeles

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Topics

- Los Angeles County Hospital Preparedness Program (HPP) — Pediatrics
- Pediatric Surge Plan
- Tools of the trade
  - Training resources
  - Support for Children with Access and Functional Needs
  - Guidance

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LAC HPP – Efforts to Date

- Los Angeles County Pediatric Surge Plan 2011–2015
- SurgeWorld – web-based training tool — JumpSTART and START triage — 2015
- Improving Preparedness for Children with Special Needs (Access and Functional Needs) — 2015
- Incident Command — app-based tool to support leadership engagement in emergency management and areas of concern related to children — 2015–2016

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

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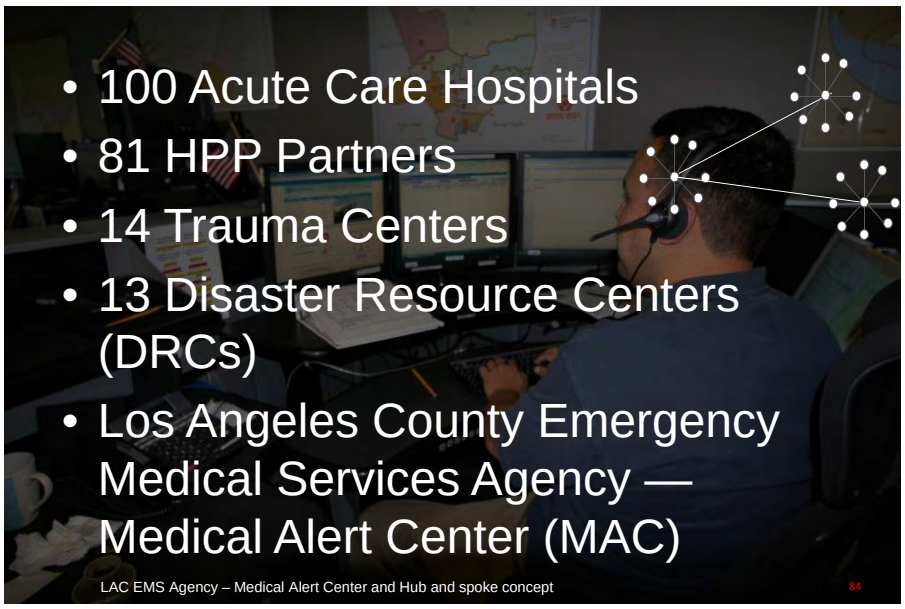
LA County Existing Systems and Resources



- 100 Acute Care Hospitals
- 81 HPP Partners
- 14 Trauma Centers
- 13 Disaster Resource Centers (DRCs)
- Los Angeles County Emergency Medical Services Agency — Medical Alert Center (MAC)

LAC EMS Agency – Medical Alert Center and Hub and spoke concept

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LOS ANGELES COUNTY PEDIATRIC SURGE PLAN

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Phase 3 — Plan Evaluation — Exercises April 20, 2015 and June 11, 2015

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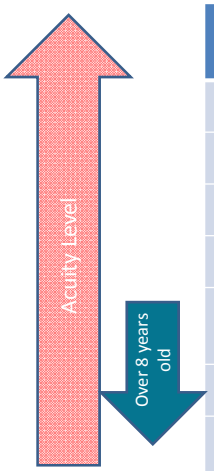
Children's Hospital Los Angeles –Susan Goldman

Pediatric Surge Plan — 2016



HOSPITAL TIER	TIER DESCRIPTION
Tier 1	Pediatric Centers (PTC/PMC)
Tier 2*	Pediatric Medical Centers (PMC)
Tier 3	Adult Trauma Centers
Tier 4	Pediatric Acute Beds
Tier 5	Emergency Departments Approved for Pediatrics (EDAP)
Tier 6	No Pediatric Services
Tier 7	No Emergency Services/ Specialty Centers

* Note: In a pediatric trauma surge event, patients would go to Tier 3 before Tier 2

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TOOLS OF THE TRADE

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Surge World

Disaster Triage
- START
- JumpSTART

Player
- Selects who to triage
- Learns algorithm

Surge Logistics
- Staff
- Space
- Stuff

Player
- Manages patient surge by allocating resources

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Incident Command

- Leadership
- Communication
- Decisionmaking
- Teamwork

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Pediatric Surge Quad Fold

Includes:

- Pediatric risks during disasters
- Pediatric Assessment Triangle
- Pediatric signs of respiratory distress and respiratory failure
- JumpSTART triage
- Daily maintenance fluid and electrolyte requirements
- Nutrition
- Dehydration
- Normal development
- Equipment sizes
- Shock
- Fluid resuscitation
- Burn treatment – fluid resuscitation

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Elements of Pediatric Preparedness for Health Care Facilities

- Awareness and acknowledgement
- Leadership
  - Identify a pediatric champion (MD and non-MD)
- Plan
  - Understand your risks
  - Family Reunification
- Decontamination Nuances
  - Keep parents/babies together, baby baths, warmers
- Pharmaceuticals
  - A method for dosing

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Elements of Pediatric Preparedness for Health Care Facilities (cont.)

- Safety & Security
- Staff
  - Pre-identified
- Supplies
  - Basic supplies (diapers, nutrition, activities & distraction)
  - Medical supplies (e.g., smaller items – ETT, IVs)
- Transportation
- Triage
  - JumpSTART reference tools
- Training
  - Advanced training
  - Just-in-time training

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IMPROVING PREPAREDNESS FOR CHILDREN WITH ACCESS AND FUNCTIONAL NEEDS

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Defining At-Risk Individuals

- Before, during, and after an incident, members of at-risk populations may have additional needs in one or more of the following functional areas:
  - Maintaining independence
  - Communication
  - Transportation
  - Supervision
  - Medical care
- Examples: children, senior citizens, pregnant women … individuals who have disabilities; live in institutionalized settings; are from diverse cultures; have limited English proficiency or are non-English speaking; are transportation disadvantaged; have chronic medical disorders; and have pharmacological dependency.

Source: Pandemic and All-Hazards Preparedness Act (PAHPA), Progress report Aug. 2008

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Themes

- Parents typically did not feel prepared, but wanted to be prepared
- Managing child's everyday needs was a factor in delaying preparedness efforts
- Concerns: transportation, evacuation, medication, food and technological dependency
- Clinicians didn't have specific plans but were interested

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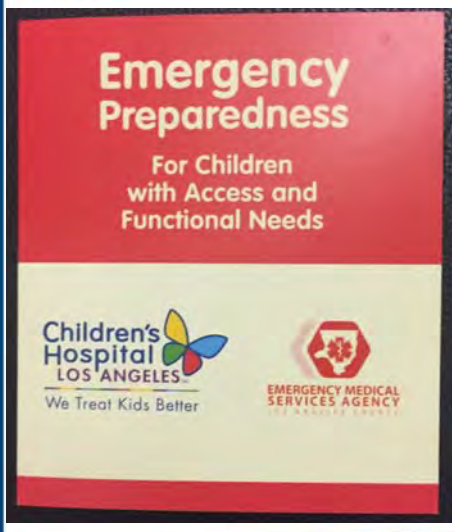
Resources Developed/Translated



1. Trifold for parents/caregivers
2. AAP Emergency Information Form
   - Translated to Armenian (Spanish existing)
2. Univ. of Washington – Disaster checklist for children with special nutritional needs
3. Division of Industry and Consumer Education – FDA Preparing for Power Outage for Medical Devices

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www.CHLA.org/DisasterCenter

Jeffrey S. Upperman, MD FACS FAAP
Director, Trauma and PDRTC

Nancy Blake, PhD, RN, CCRN, NEA-BC, FAAN
VP, Critical Care Services

Bridget M. Berg, MPH, FACHE
Manager

Rita V. Burke, PhD, MPH
Assistant Professor of Research

Brenna Carlson, MPH
Emergency Management and Trauma Surge Coordinator

Katie Meyer, RN, BSN
House Supervisor

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QUESTIONS?

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Most Children Get Care in Their Own Communities

Nationally 80% of all children are seen in "non-pediatric" Emergency Departments

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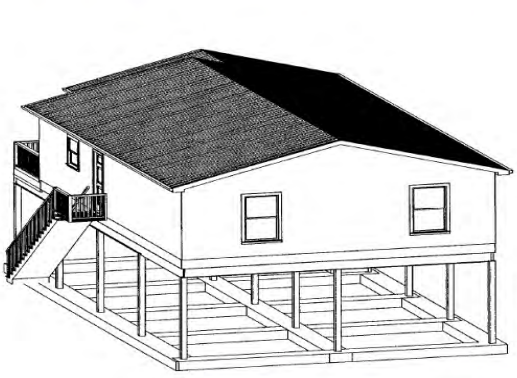
Relies on a Foundation of Day-to-Day Pediatric Readiness

A 'Blueprint' for Disaster Readiness



All-hazard mass casualty event readiness

Day-to-day emergency readiness

"The Elevated Hurricane Zone Housing Solution"

Slide from Steven Krug chair AAP disaster preparedness advisory council presentation...March 2010

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Getting Started…

"All emergency planning is local"

Dr. Jeffrey Upperman
Children's Hospital Los Angeles
National Disaster Center
National Advisory Committee for Children and Disasters

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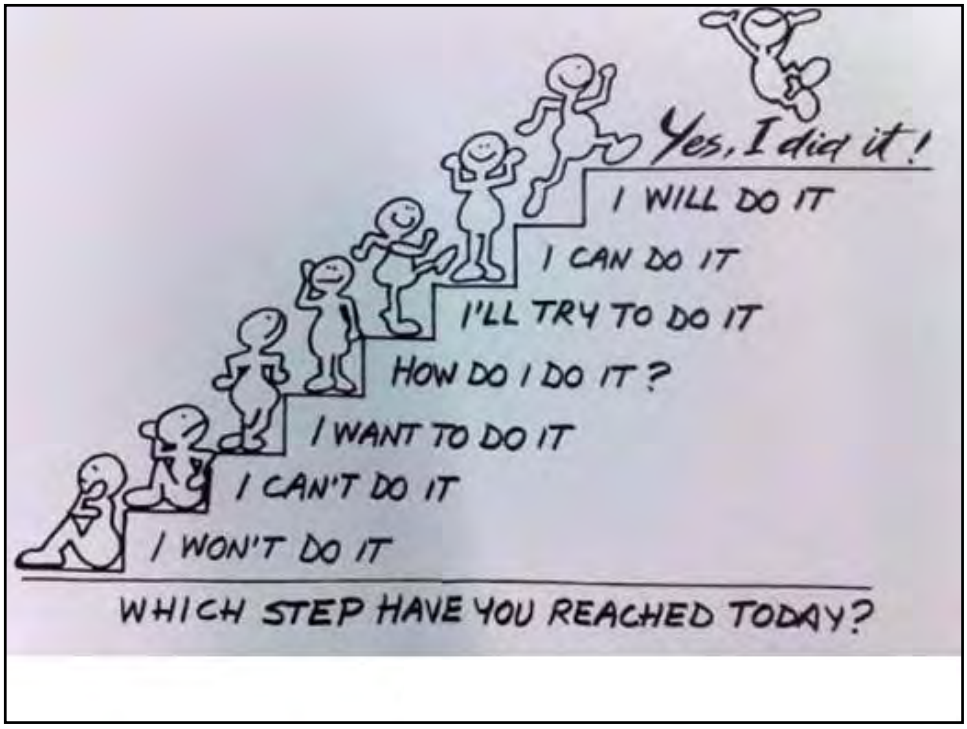

American Academy of Pediatrics

"WINGING IT"
IS NOT AN EMERGENCY PLAN

Make a disaster plan with your kids.

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Guidance is Overflowing!

The National Curriculum is Here!

Texas A&M Engineering Extension Service | TEEX | National Emergency Response and Rescue Training Center

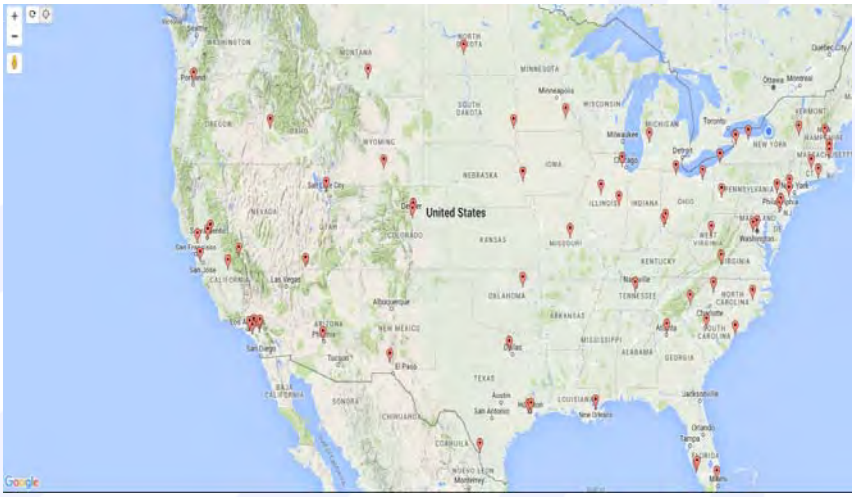
PEDIATRIC DISASTER RESPONSE AND EMERGENCY PREPAREDNESS

MGT-439

DHS/FEMA-funded course

FEMA

First Year: Over 50 Deliveries



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Functional and Access Needs

Universal Design: Accessibility for All

Behavioral Health Tools

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National Pediatric Disaster Coalition http://www.npdcoalition.org/

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NPDC: Highly Networked State and Federal Engagement

CAL OES
EMSA
CDPH
CDHS
UASI
CHA
CAN
CCHA

FEMA
ASPR
DHHS
AHA
NACHRI
EMSC

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New Partners Coming on Board Everyday

Community Health Resilience Initiative National Toolset

http://communityhealthresilience.anl.gov/pls/apex/f?p=101:1

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NEW !

TRACIE
HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

TECHNICAL RESOURCES — https://asprtracie.hhs.gov/technical-resources

ASSISTANCE CENTER — 1-844-5-TRACIE or askasprtracie@hhs.gov.

INFORMATION EXCHANGE — https://asprtracie.hhs.gov/information-exchange

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American Academy of Pediatrics

Children & Disasters

http://www.aap.org/disasters/peds.cfm

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Help Find the Free Stuff
It's not about cost it's about focus

http://hsc.unm.edu/emermed/
PED/education/onlineEd.shtml

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EMSC | IIC

Emergency Medical Services for Children | Innovation & Improvement Center

HOME ABOUT NEWS RESOURCES PROJECTS

Welcome To

The EIIC

EMERGENCY MEDICAL SERVICES FOR CHILDREN
INNOVATION AND IMPROVEMENT CENTER

July 2016 - The Web resources of the EMSC National Resource Center (NRC) are moving to the new Center Website. During our transition, contact EIIC Coordinator Krisanne Graves, Ph.D., R.N. (kxgraves@texaschildrens.org; 832-824-1301) if you are in urgent need of information.

The future of Emergency Medical Services for Children

American College of Emergency Physicians | ENA | NASEMSO | Baylor College of Medicine

EIIC | American Academy of Pediatrics | Texas Children's Hospital

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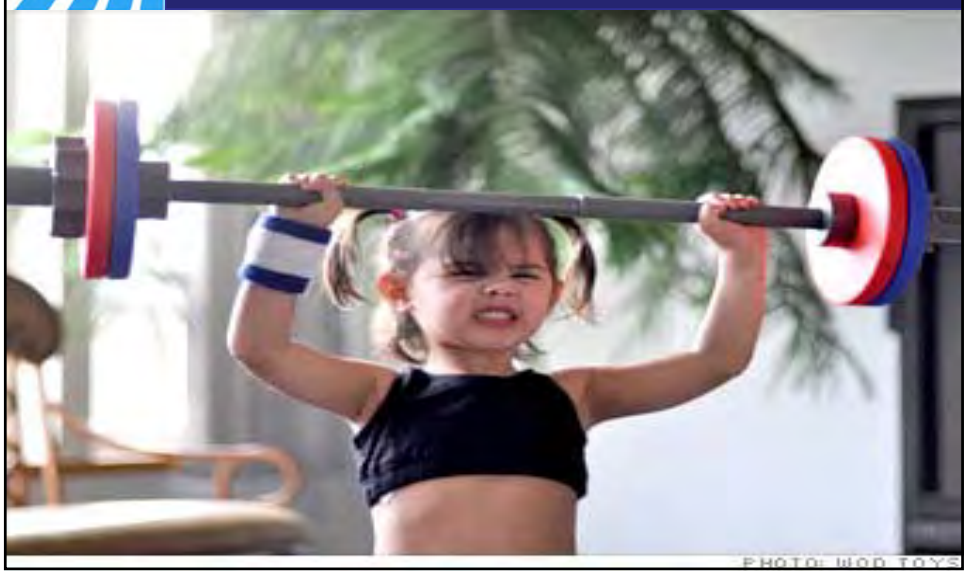
Looking Ahead

Every Drill Integrate Children Children should represent 25%

Flexing Regional Pediatric Capacity within Local Resources



Small But Mighty Successes Matter

Make it Routine and Normal

Include Family and Community

Building Relationships: Listening and Learning

The Tools and Talent Exist

Information is at Your Fingertips So Get Connected

Heavy Lifting is NOT Required

You Too Can Raise the Bar for Children in Your Community!

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For More Information

Patricia Frost RN, MS, PNP
Contra Costa County EMS Director
Patricia.Frost@hsd.cccounty.us

National Pediatric Disaster Coalition Site
www.npdcoalition.org/

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Panel Q&A

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Thank You!

Patricia Frost, RN, MS, PNP
Patricia.Frost@hsd.cccounty.us

Jason Silvas, RN
silvasJJ@ah.org

Kay Daniels, MD
kdaniels@stanford.edu

Bridget Berg, MPH, FACHE
bberg@chla.usc.edu

Cynthia Frankel, RN, MN
Cynthia.Frankel@acgov.org

CALIFORNIA HOSPITAL ASSOCIATION