

Platinum Pediatric Surge Playbook: Catastrophic Capable for Operational Impact

Transforming Strategies to Strengthen & Support CONOPs Plans across State Boundaries for Regional Health Systems & Hospitals

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Western Regional Alliance Pediatric Emergency Management (WRAP-EM) Surge Group

- Funded through the ASPR Pediatric Center of Excellence
 - Includes WA, OR, CA, NV, AZ, UT, & NY

LEVERAGED WRAP-EM SURGE GROUP — SMEs



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DELIVERABLES:

Collectively identified Pediatric Surge Planning Gaps

Optimized Access to Best Practices

State & Multi-Jurisdiction Pediatric Surge PLAYBOOK *

Maximized Response Capabilities

RAISING THE BAR: REGIONAL PEDIATRIC SURGE CATASTROPHIC CAPABLE



TRANSLATING MULTI-LEVEL HEALTH SYSTEM PLANS INTO EFFECTIVE OPERATIONAL ACTION

- **GOAL**: To strengthen & increase health care system children's medical surge response capability & capacity across state, multi-jurisdiction & health system boundaries & borders with a PLAYBOOK *
- **MISSION**: To inspire & leverage surge pediatric emergency preparedness plans & response capability with collective state & multi-jurisdiction pediatric surge PLAYBOOK implementation — that results in response that matches resources to needs for best outcomes

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GOALS

DRIVING READINESS & ACTION IN DYNAMIC TIMES

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1. Share “**Platinum Pediatric Surge PLAYBOOK**” components & resources — to reframe **inclusive & effective pediatric medical surge readiness** & enable optimal health system pediatric surge response
2. Provide **PLAYBOOK Strategies & Benchmarks** to support health system plan development & **disaster-resilient health care systems**
3. Facilitate **transformative & sustainable pediatric medical surge readiness & response recommendations & tools** to support **Concept of Operations (CONOPs)**

PLATINUM PEDIATRIC SURGE PLAYBOOK: CATASTROPHIC CAPABLE

Learning Objectives

1. Facilitate understanding of *proposed* Model State & Multi-Jurisdiction Pediatric Surge **PLAYBOOK** (Guide Toolkit) adapted for hospitals with evidence based essential elements, & “best practices”
2. Provide access to pediatric subject matter experts (SMEs), guidance, & strategic options
 - **For “real time” catastrophic event situation awareness & response capabilities**
3. Describe benefits of leveraging government response ICS systems, HICS, & coalitions collectively across states & jurisdictions
4. Identify how reframed & inclusive pediatric surge plans enable optimal health system pediatric surge response in exercises & “real events”
5. Provide multi-state transformative pediatric surge approaches, recommendations, & solutions



QUESTIONS FOR PRESENTERS & HEALTH SYSTEM PARTNERS

1. How do you define/describe **“PLATINUM PLAYBOOK: Catastrophic Capable”** Pediatric Surge & **RESPONSE** components & domains?
2. How have you addressed **catastrophic pediatric surge planning & response across regional borders** to support overwhelmed hospitals?
3. What are health system & hospital pediatric surge priority ingredients, tools, & **RECIPE FOR SUCCESS for pediatric integration in Health system & hospital plans?**
4. What are the pediatric surge gaps, **PROMISING PRACTICES** & strengths?
5. What are the **CHALLENGING** operational response **NEEDS** & solutions including checklists, tools, & products (WRAP-EM)?
6. What is the **FUTURE SOLUTION** for regional PLAYBOOK pediatric surge coordinated plans?

The Perfect Storm in Pediatric Emergency Care

EMS & Hospital Challenges

- Children NOT on hospital's RADAR screen on day-to-day & surge events
- Pediatric Center Care “hyper-regionalized”
 - staffing challenges
- Increased transfers to pediatric regional centers
- **Community Hospital Reduced inpatient pediatric capability** but expanded NICU
- **Limited Transportation Resources**
 - Competing shared 911 & Inter-Facility
 - Transport (IFT) Demands
- **Tertiary pediatric resource concentration urban hubs**



Adapted & Courtesy - Gausche-Hill M. [Emergency and Definitive Care for Children in the United States: The Perfect Storm](#). *Pediatrics*. 2020 Jan;145(1). PMID: 31882441

DISASTERS

TREAT VICTIMS OF ALL AGES

- Pediatric population a challenge — physiologically vulnerable
 - **NOT SMALL ADULTS - 25% of Population**
- Developmental differences - lack motor skills to escape
- **Lack cognitive decision-making skills**
- Vulnerable to aerosolized biological/chemical agents
- **Children may be soft targets**
- Pediatric psychological triage difficult
- **Children will be disproportionately affected**
- Benign Neglect
 - Previous National Commission on Children & Disasters Report

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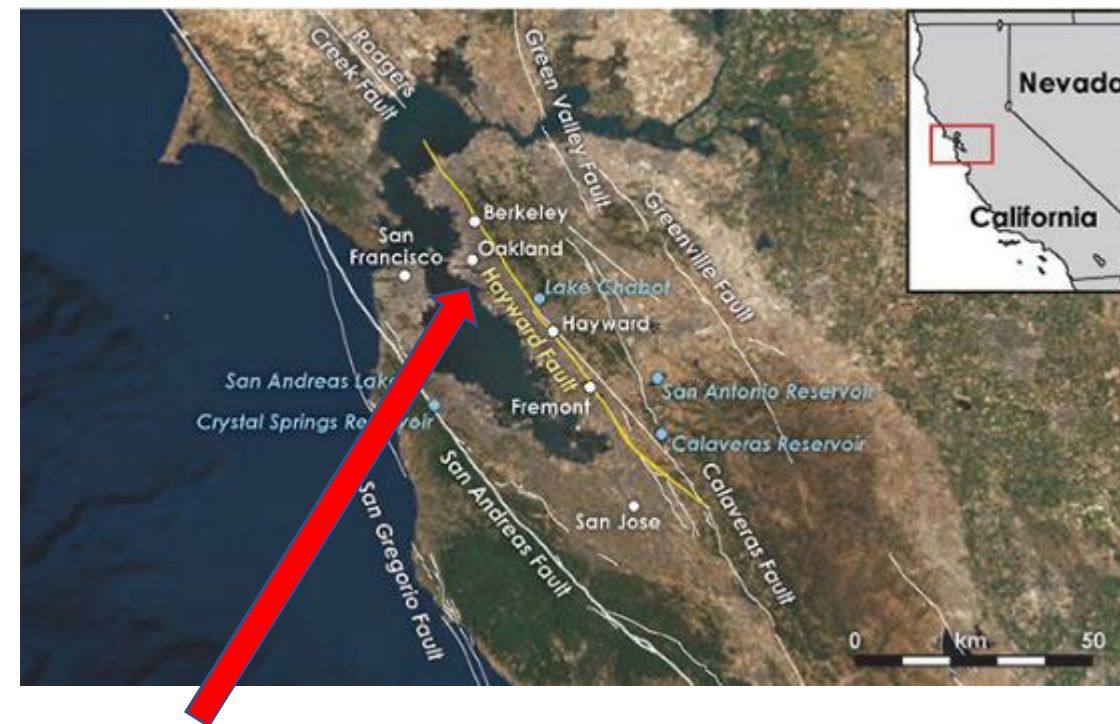
Expect children to be impacted in high-consequence disasters

“PEDIATRIC NEAR MISS”

SURGE CAPACITY & CAPABILITY CHALLENGES

LESSONS LEARNED

- **H1N1 (2009) ***
- Civil Unrest (2009-10)
- Hurricane Sandy (2012)
- Asiana accident (2013)
- Northern California firestorms (2017 - 2022)
- **COVID-19 Pandemic** – Hospital Surge
- **Ukraine Mariupol Children’s Hospital Bombing**



POTENTIAL RISK – Earthquake & Pandemic 300% increase in need for PICU beds

- Hospital surge impact — Limited PICUs - **(33 PICU BEDS CA ALAMEDA COUNTY)**

COVID-19 Adult Patient Movement Challenge

What if Pediatrics?

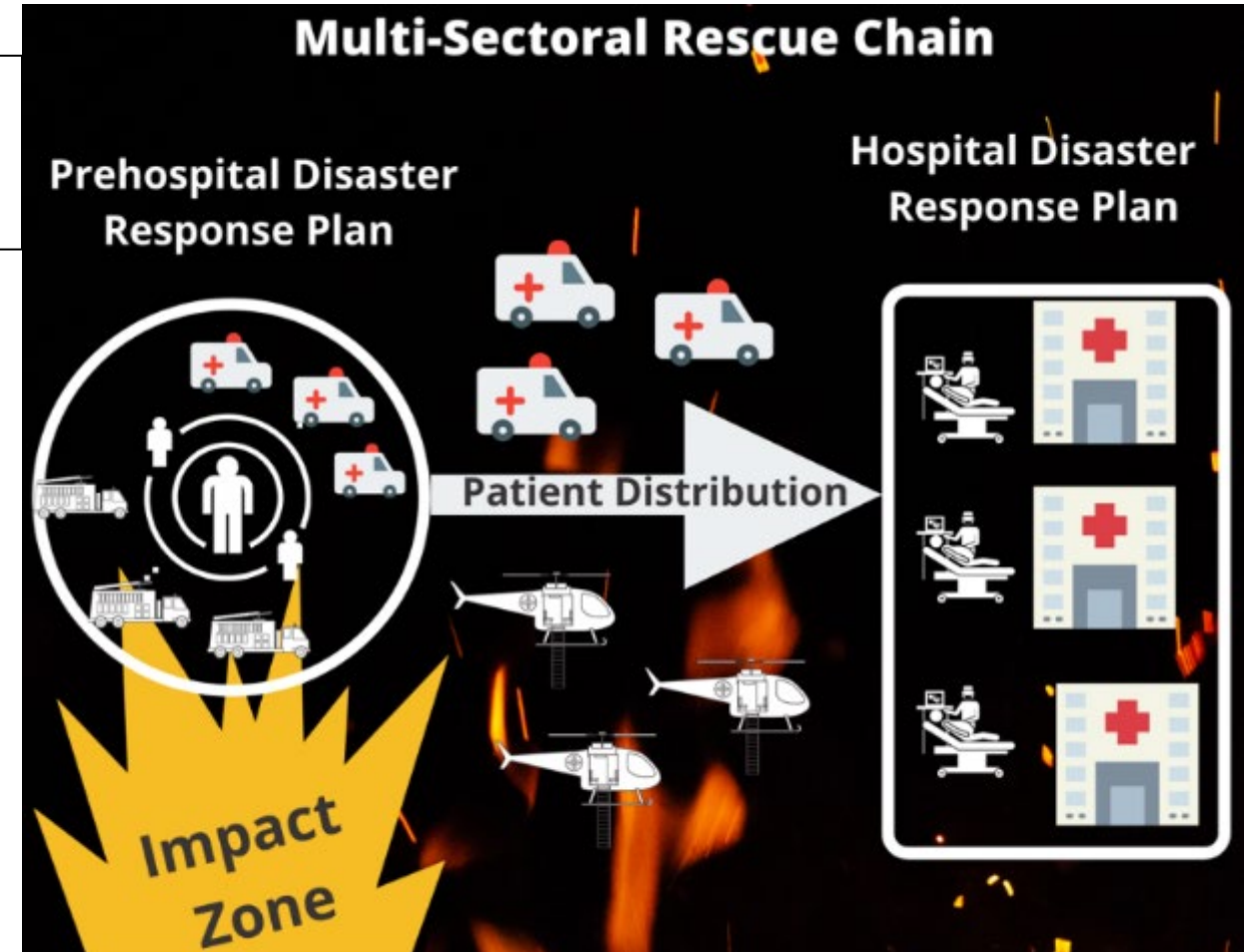
Which hospitals are available to take transfers from out of region?

PROBLEM

- **Limited non-impacted counties**
- ICU overwhelmed; not able to take secondary transfers
- Transfer Centers Report Essential Elements of Information (EEIs) & **Definitions Inconsistent.**
 - **Lack of Pediatric Standardization**
- **Pediatric Bed Data Reliability Issue**

SOLUTION

- CA requires hospitals to accept transfer patients from areas with low ICU capacity as of 8/18/2021
- Health Officer Surge Order Load Leveling**



Courtesy – Pat Frost, RN

SCENARIOS – Not Catastrophic Enough - What if Pediatrics?

- **SIMULTANEOUS COMPLEX EVENTS** result in adult & pediatric patient surge in ICU / PICU
- Pediatric MCI in schools or mass gathering event at multiple sites
- Pediatric hospital evacuation, virulent novel strain, & / or MCI impacting pediatric critical care



- 1000 pediatric hospitalizations per day



- Every regional pediatric specialty center becomes mega PICU

WELL-PREPARED HEALTH CARE SYSTEM

PEDIATRIC SURGE PLAN

- **Plans & Prepares** for healthcare consequences of pediatric disasters
- **Responds** quickly & with agility to support local needs & pediatric resource matching throughout regions & states
- **Functions** under adverse circumstances
 - **An immediate & prolonged surge of pediatric patients in need of acute critical care & transportation in all-hazard catastrophic events – causes:**
 - Disruption incident management chains of command
 - A contaminated or contagious environment
 - Loss of infrastructure — Poor situational awareness



Requires connected robust Pediatric Surge PLAYBOOK

- Prepared collectively across regions & health systems
- **Identifies OPERATIONAL RECOMMENDATIONS FOR ACTION to support State, Multi-Jurisdiction, & Hospital ICS CONOPs**

REGIONAL & LOCAL PEDIATRIC SURGE CAPABILITY

Envisioned – Across States

High reliability, highly collaborative, cross-sector – Living Plan Daily

- **Rapidly expand capacity:**

To provide guidance on how to rapidly expand capacity of health care system — multiple levels

- **Align, scale, coordinate, & integrate:**

To ensure integrated regional children's medical emergency management response system — consistent with established ICS, Hospital Incident Command System (HICS), Medical Operations Center Cells (MOCCs), EMS for Children (EMSC benchmarks, ASPR Hospital Preparedness (HPP) capabilities, & existing surge plans

- **Customize to divergent regions** & operational sections of other plans

- **High-level synthesis** & support for many existing EOCs, MOCCs, PCCCs, HICS plans & surveillance – not siloed

Starting Point – State & Multi-Jurisdiction PEDIATRIC SURGE



PLAYBOOK: CATASTROPHIC CAPABLE



1. PLAYBOOK (Master Guide) Framework – NOT A CONOPS – JUST TOOLS

2. PILLARS OF SUPPORT for OPERATIONAL RESPONSE:

- TARGET GROUP: State ICS government organizations, EOCs, & regional Pediatric Coordinating Centers with benefits to healthcare system HICS

3. DESIGNED TO INFORM “REAL TIME” DECISIONS

4. IDENTIFIES EVIDENCE-BASED CUSTOMIZED PEDIATRIC SURGE SOLUTION OPTIONS

- Event specific strategic recommendations, & “best practice” resources for time-sensitive event needs

State & Multi-Jurisdiction Pediatric Surge PLAYBOOK

ICS Pediatric SME Advisor

Objective: The Pediatric Surge SME makes data and ensure high-quality care. decision potentially other resources) from one an overwhelmed facility or system to

Mission: Advise the Incident Commander or Se pediatric transport, and surge respons

- Collecting, analyzing, and disse
- Acting as a single point of contact regions capacity
- Integrate pediatric patient transfer management as a function of the

Immediate Response (0 – 2 hours)

Receive appointment

- Obtain a briefing from the S
 - Size, location (s) and comple
 - Expectations of the Incident C
 - Incident objectives
 - Involvement of state, regional regional health systems, trans
 - The situation, incident activiti
- Assume the role of Medical-Tech
- Review this Job Action Sheet
- Put on position identification (e.g. EOC, MOCC, and or PCCC or fr
- Notify WRAP-EM, PPN, and your

Assess the operational situation

- Assess/monitor state and/or multi
 - Hospitals
 - Pediatric Specialty Ce
 - Health System Hubs
 - Transfer Centers
 - Transport Availability
 - EMS
- Review information as availab

Activities

- Meet with the Incident Commander, Operations and Planning Section Chiefs, and the Operations Section Medical Care Branch Director to plan for and project pediatric patient care needs.
- Identify the pediatric surge operational course of action as needed.
- Verify with the situation status with leadership
- Gather intel and report the following to the Incident Commander:
 - Type and location of pediatric incident (s)
 - Number and condition of expected pediatric patients at each site (hospitals, primary sites in the field).
 - Identify pediatric destinations.
 - Estimate number of patients needing transport and patient movement priority decisions.
- Resource needs for transport, hospital expansion and decompression
 - Any unusual or hazardous environmental exposure
- Provide pediatric care guidance to Operations Section Chief and Medical Care Branch Director based on incident scenario and pediatric response needs.
- Ensure pediatric patient movement, patient
 - Transport Priority
 - Identification
 - Tracking Procedures,
 - Telehealth,
 - Behavioral Health Support Are Considered And Implemented
- Communicate and coordinate with the Logistics Section Chief to determine pediatric needs:
 - Medical pediatric transport needs. Consider Transfer Centers
 - Medical care equipment and supply needs
 - Medications with pediatric dosing
 - EMS Transportation availability and needs (EMS 911; EMS IFT/CCT) and other cribs, wheel chairs, etc.)
- Additional Pediatric SME (s) and other Pediatric Teams
- Communicate with the Planning and Logistics Section Chiefs to determine overarching pediatric capability:
 - Regional Hospital Bed availability
 - Ventilators
 - Pediatric Trained medical sub-specialty SME needs (Pediatric Intensivists, MD, RN, PA, NP, PIRT, etc.)
 - Additional short- and long-range pediatric response needs
- Ensure that appropriate pediatric standards of care are being followed in all clinical areas. Evaluate need for contingency and crisis standards of care
- Collaborate with the Public Information Officer to develop media and public information messages specific to pediatric surge and care recommendations and treatment
- Participate in briefings and meetings, and contribute to the Incident Action Plan (IAP), MAC, as requested

STATE & MULTI-JURISDICTIONAL PEDIATRIC SURGE PLAYBOOK

INSIDER EXPERTS IDENTIFIED GAPS & INFUSED CONTENT FOR OPERATIONAL PLAYBOOK.

(State & Regional Medical Operations Coordination Centers (MOCCs), WRAP-EM, & regional hospital hubs)

- Outline **BROAD RECOMMENDATIONS & OPERATIONAL COURSE OF ACTION**
- Describe potential immediate & long-term **RESPONSE STRATEGIES**
- Outline **RESOURCES** to support pediatric surge response

Recommendations & strategies are provided at a high-level as needs & resources of impacted communities will vary dramatically.



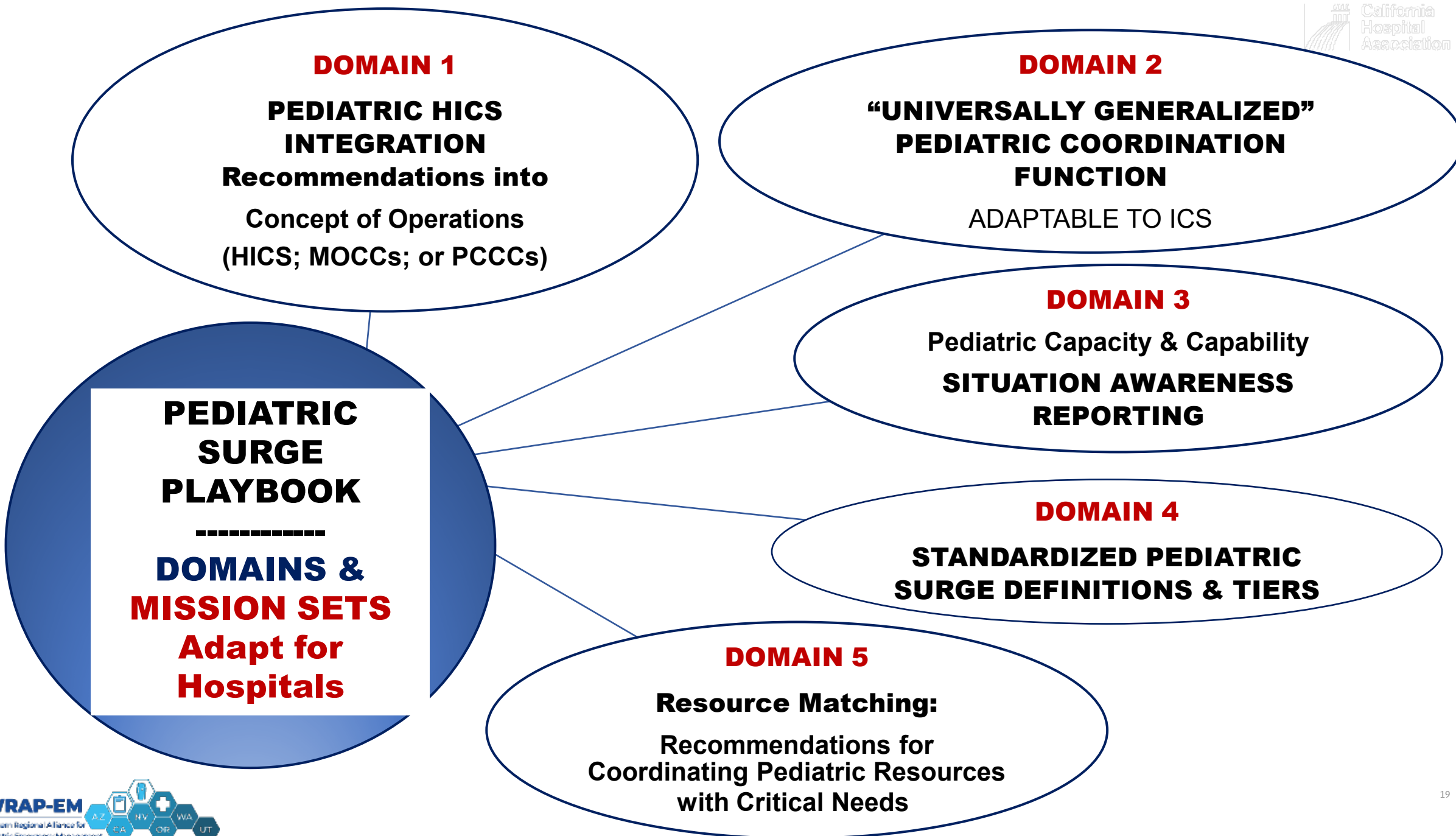
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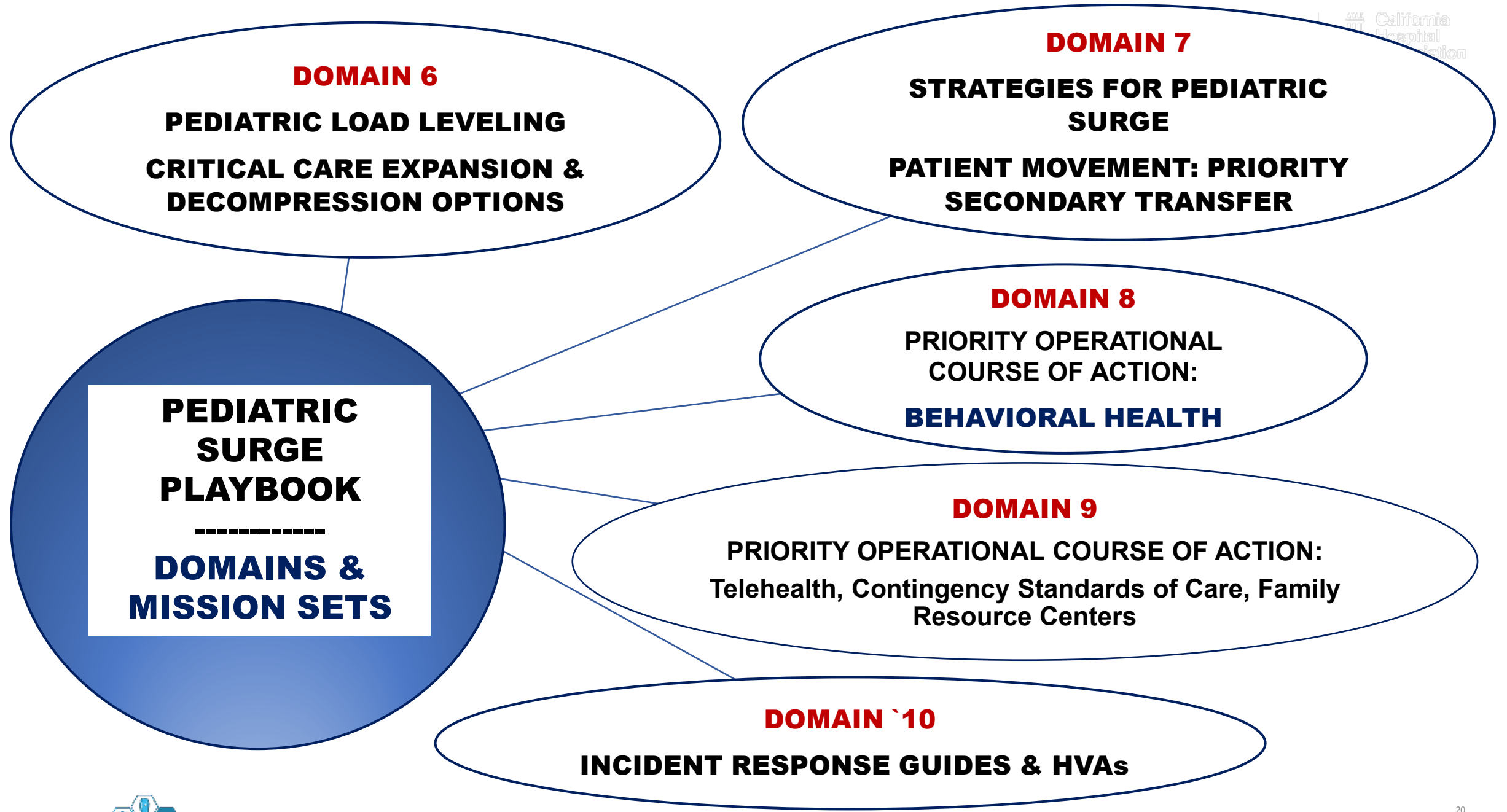
HOSPITAL PEDIATRIC SURGE PLAYBOOK

SHARED COMPONENTS - GUIDE & TOOLS

1. **UNIVERSAL OPERATIONAL TOOLS**, standard operating procedures, & guidance for state & multi-jurisdiction ICS with **Pediatric Advisor Subject Matter Experts & Resources.**
2. **PRIORITY DOMAINS - MODELS, PARADIGMS, & MISSION SETS**
 1. **Priority Patient Transfer** – Patient Tracking & Communications *
 2. **Load-balancing**
 3. **Critical Care Expansion Solutions** - - Across healthcare facilities & systems
 - To ensure **highest possible level of care** can be provided to all pediatric patients who need that care prior to transitioning to crisis measures.

Maximizes & leverages pediatric surge operational capability during catastrophic events across local, state, & regional borders





Designated Pediatric SME Advisor

What Is your Operational Course of Action?

DOMAINS	Situation Assessment / Needs	Mission Goal / Objectives / Needs	Decision Options	Description	Resources & SME Access (Including WRAP-EM)	Preferred Action	Action Taken
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Domain 1

- **ICS Pediatric Integration & Coordination:**
 - Recommendations and a concept of operations for the many **aspects of pediatric surge** as they fit within an overall regional, state, or multi-state disaster response
- **Integrate Pediatric MOCC components**
(Examples: Pediatric Integration in WA-MOCC; MI-MOCC)
- **Establish Pediatric MOCC or PCCC**
- **HICS**

CHA Hospital Activation of the Emergency Operations Plan Checklist

The initial response to an emergency begins with recognition that an incident may, or has, occurred. In cases where the incident is likely to impact or disrupt routine operations and may require coordination of efforts and response involvement among hospitals, Health Care Coalition partners, EMS, public health, and environmental health. Key management issues involving situational status, incident characteristics and resource capabilities must be quickly determined and communicated amongst response partners in order to establish a common operating picture.

1. Activation	Date/Time	Initials
A. Initiate policy and procedure for activation of the Emergency Operations Plan		
B. Activate Hospital Command Center		
C. Activate Hospital Incident Management Team <ul style="list-style-type: none"> • Incident Commander activates needed positions down to the Chief Level and holds an initial briefing • Each Chief (Operations/Planning/Logistics/Finance) activates needed Branches/Units in their Section • Provide Job Action Sheet to each activated position • Provide HICS 214 Activity Log to each activated position. Each activated position initiates the 214 to document basic incident activity and details notable details. • Provide position identification (e.g. vests, hats) 		
D. Provide associated HICS Incident Response Guides (IRG) to each Chief and above position as appropriate		

PLAYBOOK: INTEGRATES CALIFORNIA PEDIATRIC SURGE PLAN

Perinatal, Neonatal, and Pediatric
Surge Annex
to the
California Patient Movement Plan

September 2021



GOAL: California Pediatric Surge Concept of Operations (CONOPS) & Function-specific Annex to Support Response

— BUILT ON CAPACITY MODEL —

- **Establish Catchment Areas Around Regional Hospital**
- Identify Regional Health System Hubs to Authorize Patient Movement
- **Integrate Transfer Centers with Tiered Hospitals Around Levels of Care**
- Expectations Beyond National Pediatric Readiness Project (NPRP)
- **Plan = Response CONOPS with Response Partners – (i.e. Telehealth)**
- Patient Movement Decision Coordination for Transfers with Pediatric Tiers & SMEs; Integrate TRAIN
- **Promote Connectivity Across States & Coalitions – EOCs**
- Ensure “Day-to-day” & Surge Pediatric Assets – **Living Plan Daily**

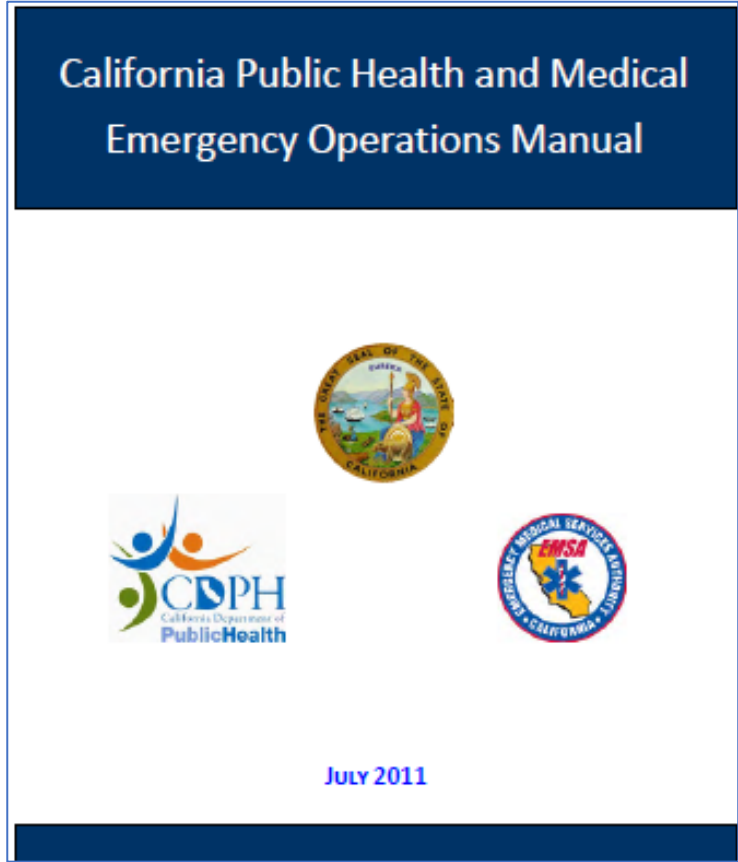
California Department of Public Health (CDPH)
California EMS Authority (EMSA)

Richard O. Johnson, M.D., MPH, FAAP, Facilitator

Tricia Blocher, Deputy Director, EPO, CDPH

Craig Johnson, Chief, Disaster Medical Services Division, EMSA

PLAYBOOK INTEGRATES CALIFORNIA PEDIATRIC SURGE PLAN & EOM



Right Patient, Right EMS Resource, Right Destination

- **Leverage & integrate CA state & regional pediatric medical surge plans** with coalitions, patient movement plans; coordinate ESF8
- **Ensure best utilization of region's pediatric resources;**
- **Maximize every asset at all levels** of capabilities for all hospitals (including Trauma & PICU, NICU)
- **Recognize coordinated & integrated response requires state ICS; Regional Disaster Medical / Health Coordinator (RDMHS); & Medical/Health Operational Area Coordinator (MHOAC)**
- **Strive to equitably maximize # of children receiving appropriate level of care** (at pediatric & adult hospitals)



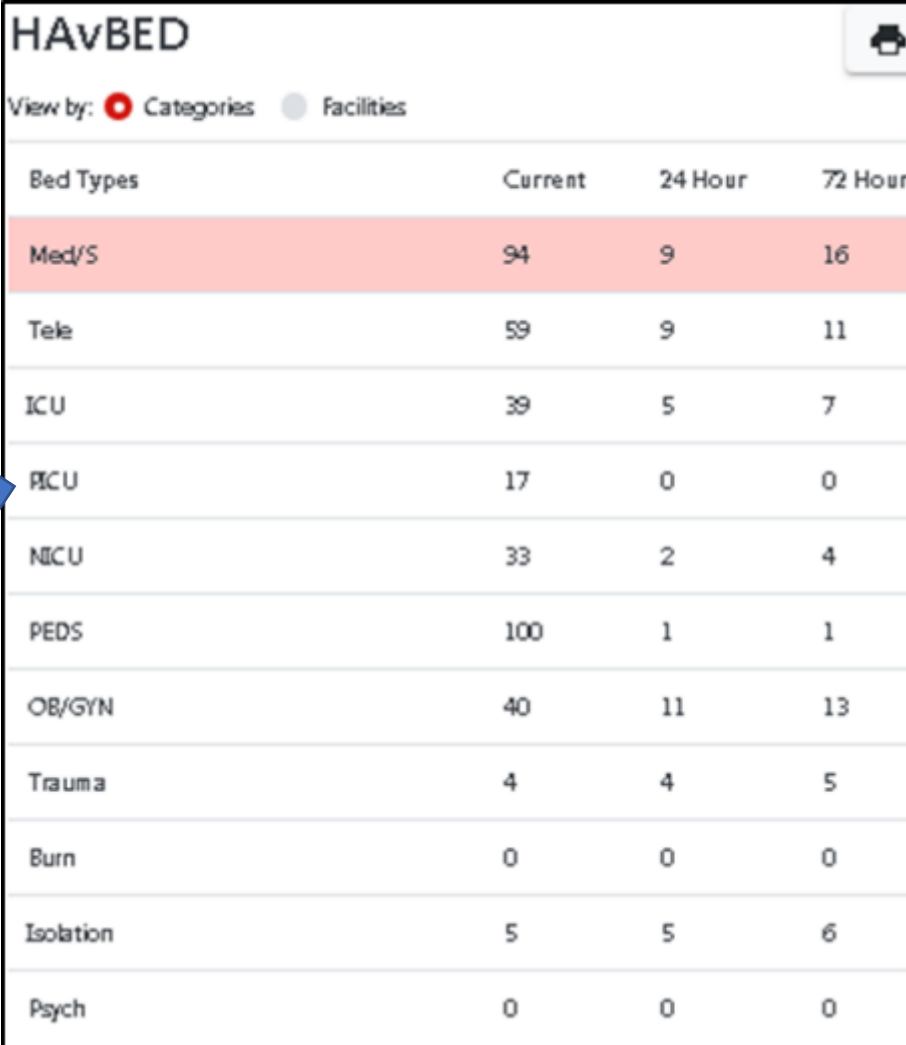
PLAYBOOK INTEGRATES COALITION PEDIATRIC SURGE ANNEX

Hospital requirements provides direction for health system hubs & hospitals

RISKS, MAPPING PEDIATRIC ASSETS, & CONOPS

Hospitals, Other HCFs, & EMS - Components

- **Hospital capacity for pediatrics (i.e. PICU, NICU) - Surveillance**
- Hospitals to facility TIER based on current capacity
- **Pediatric Readiness to tiering & expansion**
- Supply vendors for pediatric-specific equipment
- **Transport (EMS & specialized transfer capabilities)**
- **Coordination with dedicated children's hospital, trauma Centers, & hospitals with PICUs ***
- Surge inpatient/referral & transport resources; MCI -Patient Tracking
- **Prioritization method for specialty transfers**
- Process for accessing pediatric experts in prioritization
- **Prepared to care-in-place at non-pediatric centers**



Bed Types	Current	24 Hour	72 Hour
Med/S	94	9	16
Tele	59	9	11
ICU	39	5	7
PICU	17	0	0
NICU	33	2	4
PEDS	100	1	1
OB/GYN	40	11	13
Trauma	4	4	5
Burn	0	0	0
Isolation	5	5	6
Psych	0	0	0


COVID-19 CHANGES THE “PLAYBOOK” LANDSCAPE

“Children are No Longer Hidden Victims”

COVID-19 HOSPITAL REPORTING REQUIREMENTS

Hospitals, Hospital Laboratory, & Acute Care Facility Data

Situation Awareness Tools



COVID-19 TRACKING

Thank you for your participation

At the request of the Governor's office, please update your data on a daily basis by noon. To do so, click the master link below and then click on the row for your hospital. If you had access to an older version of the COVID Tracking Tool you will automatically have access through this portal. If you don't have access, you can use the [request access](#) link in the upper right corner of this dashboard and following the prompts. Instructions for how to input your data can be accessed through the [link to instructions](#) and [link to data dictionary](#) in the upper right corner of this dashboard.

Please direct any questions to COVIDTracker@calhospital.org.

[Request Access](#)
[Link to Instructions](#)
[Link to Data Dictionary](#)
[County Dashboard](#)
[Data Uploader Form](#)

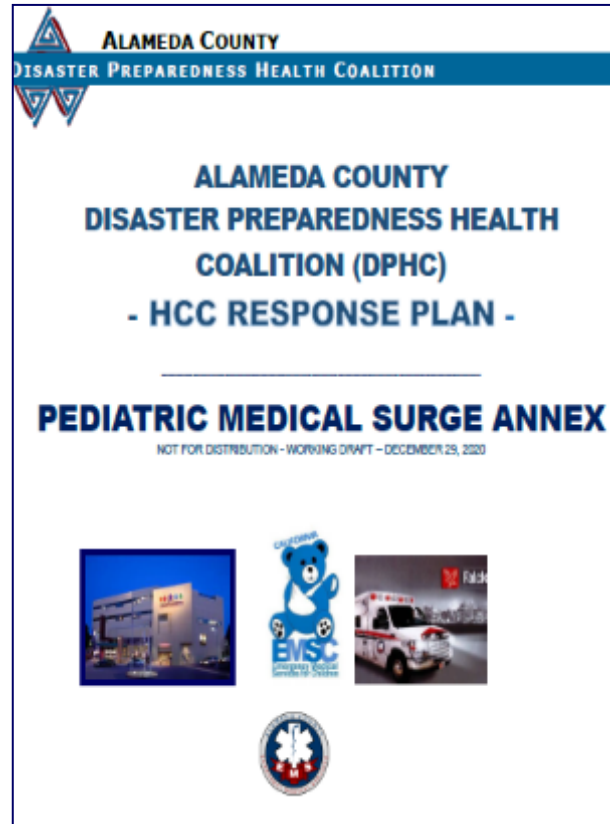
CLICK THE LINK BELOW TO ACCESS THE CHA COVID TRACKING TOOL

- CHA & California Department of Public Health developed [COVID-19 Tracking Tool](#) for collecting hospital information.
- CDPH [requires](#) hospitals to report data via tracking tool
- CDPH then shares information with U.S. Department of Health & Human Services

LOCAL & REGIONAL PEDIATRIC SURGE ANNEX

HPP HEALTHCARE COALITION & HOSPITAL RECOMMENDATION

SECTION 2 – CONCEPT OF OPERATIONS - RESPONSE
2.1 Command and Mutual Aid Organizations (include Situation Awareness; Comms, Direction)
2.2 Situation Report, Activation and Notifications
2.1.1 Activation / Levels of Activation (include WRAP-EM Based Capabilities)
- SME Integration
2.1.2 Notifications
Regional EMS Activation and Notifications Pathway- Operational Response
2.3 Roles & Responsibilities – Region Jurisdiction Coalition (Situation Awareness)
2.4 LOGISTICS
2.4.1 Surge Definitions 4Ss / 3Cs
- Space
- Staff (PECCs; SMEs; Pediatric Clinicians)
- Supplies (Caches)
2.4.2 Pediatric Critical Care Expansion Plan
Pediatric Critical Care Expansion Options – Operational Response Tool



2.5 SPECIAL CONSIDERATIONS – EVENT SPECIFIC
2.5.1 Behavioral Health
2.5.2 Decontamination
2.5.3 Evacuation
2.5.4 Specialty Pathogens / Infection Control / COVID-19
2.5.5 Security
2.5.6 Special Needs
2.5.7 Burns
2.6 OPERATIONS – MEDICAL CARE & PATIENT MOVEMENT
2.6.1 Triage
2.6.2 Treatment / Medical Care
2.7 TRANSPORTATION (includes TRAIN) - Patient Tracking
SECONDARY TRANSFER ACTIONS – USING PIRT AND EEIs
2.8 TRACKING
2.9 REUNIFICATION

EMS PEDIATRIC PRIORITY OPERATIONAL RESPONSE TOOLS

[PEDIATRIC EMS ACTIVATION CHECKLIST](#)



[PATIENT EVACUATION TRANSFER FORM](#)

PEDIATRIC SURGE EXPANSION MODELS

PANDEMIC – 3Cs OPTIONS

Contingency

- Institutional level loading: direct patient transports to like institutions with remaining capacity consistent with EMTALA requirements
- Upstaffing with licensed outside support (travelers, per diem); expansion of scope of practice
- Compare current staffing contingencies at hospitals within area to ensure consistent level of care provided as possible
- Activate telemedicine & outpatient resources to support acute care needs

			
	Conventional	Contingency	Crisis
Space	Usual patient care spaces maximized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Non-traditional areas used for critical care or facility damage does not permit usual critical care
Staff	Additional staff called in as needed	Staff extension (supervision of larger number of patients, changes in responsibilities, documentation, etc')	Insufficient ICU trained staff available/unable to care for volume of patients, care team model required & expanded scope
Supplies	Cached/on-hand supplies	Conservation, adaptation and substitution of supplies with selected re-use of supplies when safe	Critical supplies lacking, possible allocation/reallocation or lifesaving resources
Standard of care	Usual care	Minimal impact on usual patient care practices	Not consistent with usual standards of care (Mass Critical Care)
ICU expansion goal	X 1.2 usual capacity (20%)	X 2 usual capacity (100%)	X 3 usual capacity (200%)
Resources	Local	Regional/State	National
			



CALIFORNIA ALAMEDA COUNTY MEDICAL SURGE PROPOSED EMS INTERVENTIONS

CRITICAL CARE 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%–20% above licensed beds



Consider criteria for pediatrics that define children at greatest need for pediatric specialty care (i.e., complex congenital conditions, children with special needs, neonates) with Pediatric advisors

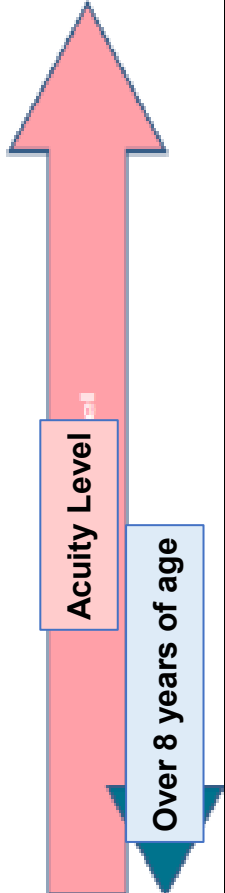
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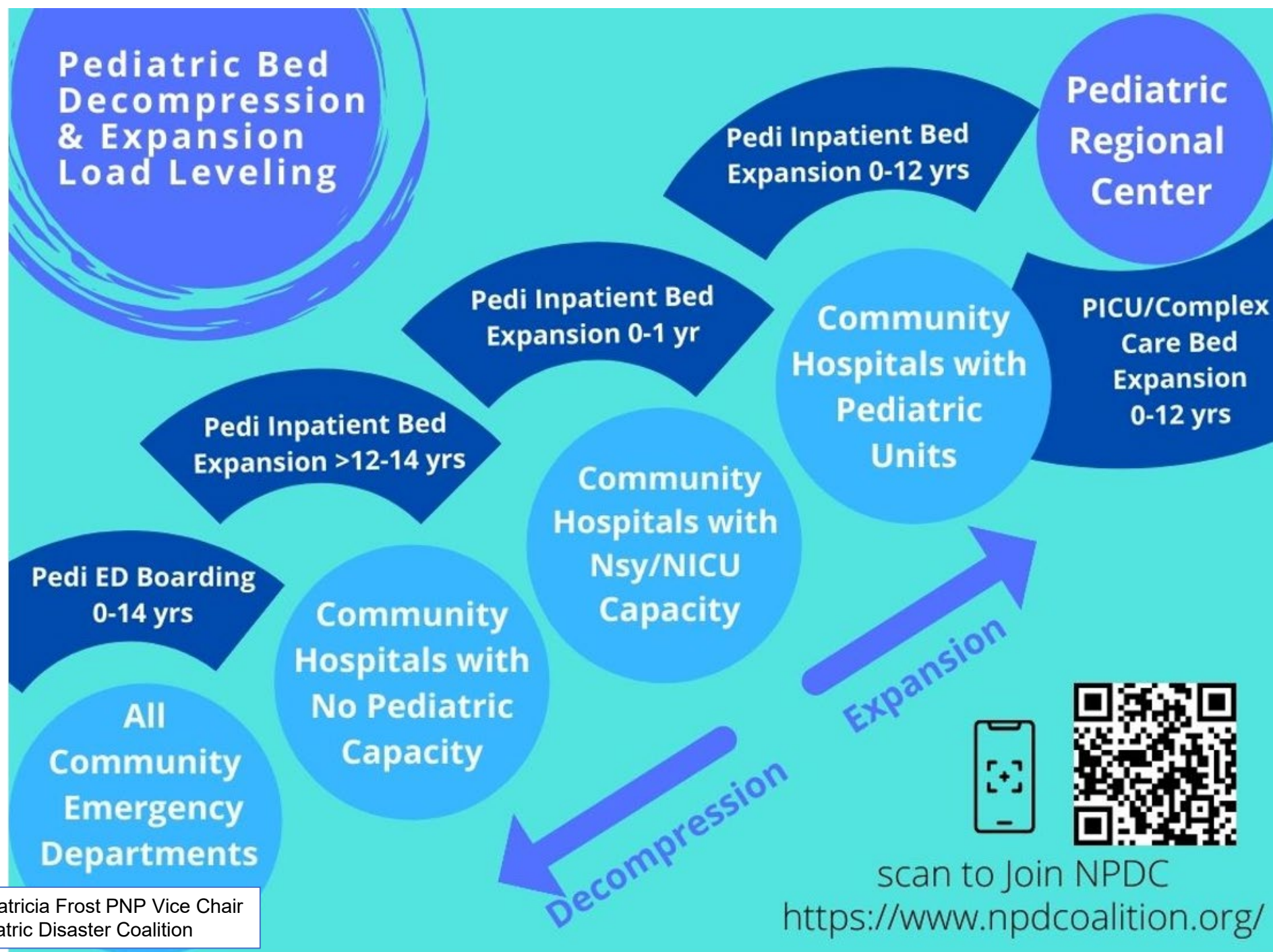
ALAMEDA COUNTY MEDICAL SURGE PLAN

CRITICAL CARE EXPANSION MODELS — OPTIONS

EMS Intervention

Pediatric Surge Bed
Preservation Model

	HOSPITAL CAPABILITY (BASED ON LICENSED BEDS)	DESCRIPTION
	CRITICAL CARE FOR PEDIATRICS	
	- PICU (UCSF Benioff Children's Hospital; Kaiser Permanente Oakland)	PEDIATRIC PICU
	- NICU	NICU
	- ICU	ICU
	- TRAUMA CENTERS	ADULT & PEDIATRIC TRAUMA CENTERS
	GENERAL MEDICAL/SURG CARE FOR PEDIATRICS	
	- GENERAL PEDIATRIC BEDS	PEDIATRIC ACUTE BEDS
	- GENERAL MED/SURGE BEDS; NO LICENSED PEDIATRIC BEDS	
	NO INPATIENT IN-PATIENT PEDIATRIC BEDS	
	- NO PEDIATRIC CRITICAL CARE; NO PEDIATRIC BEDS - - - -	
	- EMERGENCY ROOM ONLY	



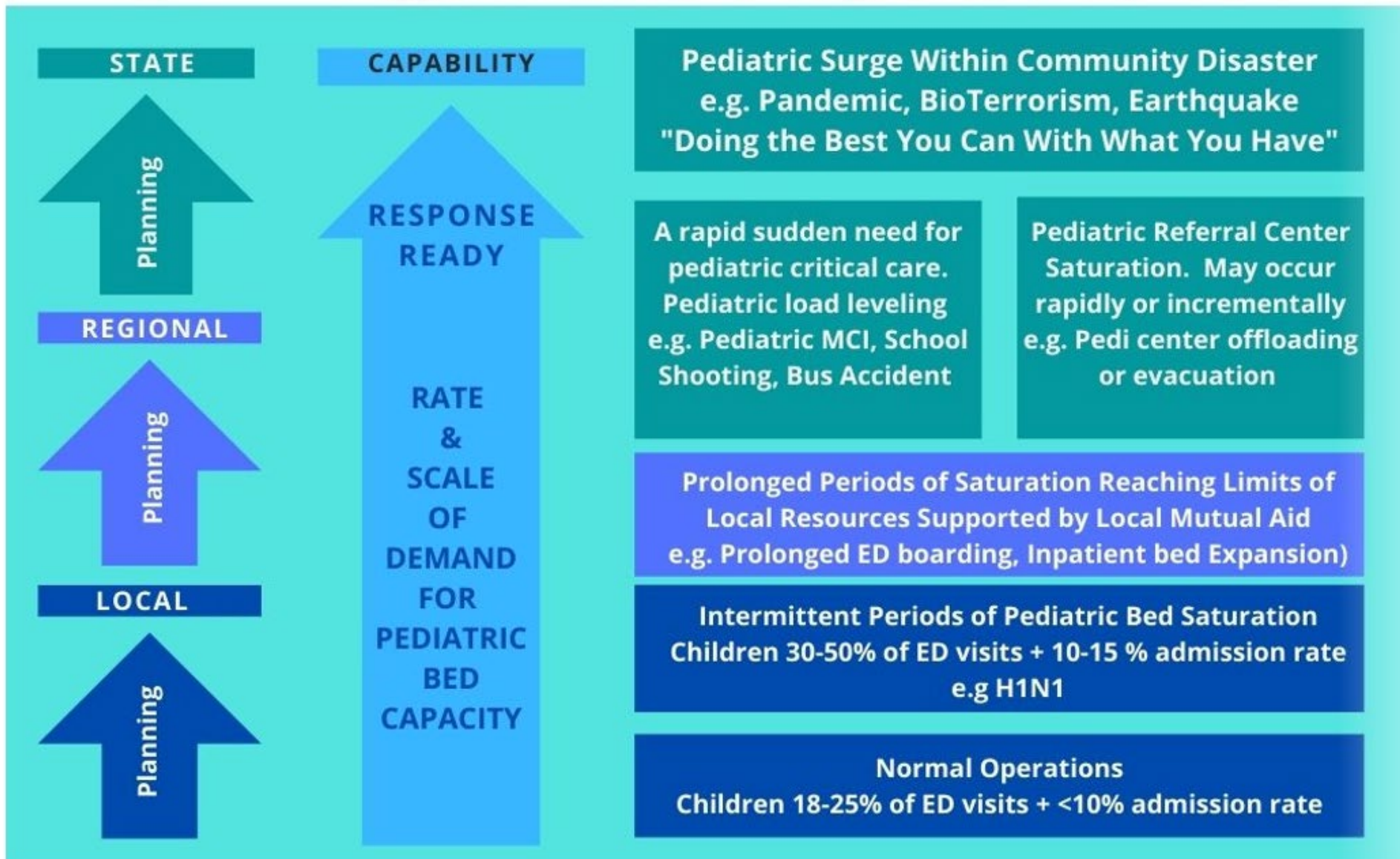
Courtesy of Patricia Frost PNP Vice Chair
National Pediatric Disaster Coalition

scan to Join NPDC
<https://www.npdcoalition.org/>



HEALTHCARE COALITION PEDIATRIC SURGE SCENARIOS

Triggers for Pediatric Regional Bed Expansion



Courtesy of
Patricia Frost PNP Vice
Chair National Pediatric
Disaster Coalition

CALIFORNIA - ALAMEDA COUNTY EMERGENCY OPERATIONS CENTER (EOC) ACTIVATION & ON-GOING RESPONSE

LINK WITH OPERATIONAL AREA (OA) MEDICAL OPERATIONAL AREA COORDINATOR (MHOAC)

OA EOC Children's SMEs
Effective Decisions

Coordinate with EMS
Procurement Center for Pediatrics

Coordinate with critical care pediatric
consultant (to **Regional Healthcare Hubs,**
Hospital HICS, Transfer Centers, &
Jurisdiction ICS) to engage
in decision-making



MEDICAL-TECHNICAL SPECIALIST: PEDIATRIC CARE

Mission: Advise the Incident Commander or Section Chief, as assigned, on issues related to pediatric care.

Position Reports to: Incident Commander		Command Location: _____	
Position Contact Information: Phone: (____) _____ - _____		Radio Channel: _____	
Hospital Command Center (HCC): Phone: (____) _____ - _____		Fax: (____) _____ - _____	
Position Assigned to: _____	Date: / /	Start: _____ hrs.	
Signature: _____	Initials: _____	End: _____ hrs.	
Position Assigned to: _____	Date: / /	Start: _____ hrs.	
Signature: _____	Initials: _____	End: _____ hrs.	
Position Assigned to: _____	Date: / /	Start: _____ hrs.	
Signature: _____	Initials: _____	End: _____ hrs.	

Immediate Response (0 – 2 hours)	Time	Initial
Receive appointment <ul style="list-style-type: none"> Obtain a briefing from the Incident Commander on: <ul style="list-style-type: none"> Size and complexity of the incident Expectations of the Incident Commander Incident objectives Involvement of outside agencies, stakeholders, and organizations The situation, incident activities, and any special concerns Assume the role of Medical-Technical Specialist: Pediatric Care Review this Job Action Sheet Put on position identification (e.g., position vest) Notify your usual supervisor of your assignment 		
Assess the operational situation <ul style="list-style-type: none"> Assess hospital pediatric staff availability and resources Provide information to the Incident Commander regarding the pediatric staff situation including capabilities and limitations 		
Activities <ul style="list-style-type: none"> Meet with the Incident Commander, Operations and Planning Section Chiefs, and the Operations Section Medical Care Branch Director to plan for and project pediatric patient care needs Verify with the emergency department leadership and report the following to the Incident Commander: <ul style="list-style-type: none"> Type and location of incident Number and condition of expected pediatric patients Estimated arrival time to hospital Any unusual or hazardous environmental exposure Provide pediatric care guidance to Operations Section Chief and Medical Care Branch Director based on incident scenario and response needs Ensure pediatric patient identification and tracking procedures are implemented Communicate and coordinate with the Logistics Section Chief to determine pediatric: 		



HICS 2014 | Page 1 of 4



MEDICAL-TECHNICAL SPECIALIST: PEDIATRIC CARE

HICS 260 – PATIENT EVACUATION / TRANSFER TRACKING FORM



HICS 260 – PATIENT EVACUATION/TRANSFER TRACKING FORM

2. From (Hospital/Address): _____		Unit _____
Name _____		4. Medical Record Number _____
Age _____	Weight _____	6. Diagnosis _____
Friend Notified (Y) <input type="checkbox"/> YES <input type="checkbox"/> NO NAME: _____ CONTACT INFORMATION: _____		
If Transport: <input type="checkbox"/> Hospital Bed <input type="checkbox"/> Wheelchair <input type="checkbox"/> Bag/Mask with Tubing Sent <input type="checkbox"/> Cardiac Monitor		
<input type="checkbox"/> Crib <input type="checkbox"/> Ambulatory <input type="checkbox"/> CPAP/BIPAP <input type="checkbox"/> Pulse Oximetry (stand-alone)	<input type="checkbox"/> Isolette/Warmer <input type="checkbox"/> Evacuation Device <input type="checkbox"/> Ventilator, Type _____	<input type="checkbox"/> Arterial Line / Swan <input type="checkbox"/> Traction
<input type="checkbox"/> Gurney <input type="checkbox"/> Other: _____	<input type="checkbox"/> # Volume Pump(s) _____	<input type="checkbox"/> Other: _____
8. Accompanying Equipment (check those that apply below):		
10. Triage Category <input type="checkbox"/> Stable/No Injury/Non-EMS Transport/Discharge <input type="checkbox"/> Minimal/Moderate acuity/ALS Transport & Care		
<input type="checkbox"/> Stable/Low acuity/BLS Transport & Care <input type="checkbox"/> Moderate/Critical acuity/ALS Transport & Care		
<input type="checkbox"/> Severe/Critical acuity/ALS Transport & Care		
11. Isolation <input type="checkbox"/> YES <input type="checkbox"/> NO TYPE: _____ REASON: _____		
12. Evacuating/Transferring Clinical Location		13. Arriving Location
Sending Physician and Contact # _____		Receiving Physician and Contact # _____
ROOM # _____	TIME _____	ROOM # _____
ID BAND CONFIRMED BY: _____	<input type="checkbox"/> YES <input type="checkbox"/> NO	ID BAND CONFIRMED BY: _____
MEDICAL RECORD SENT <input type="checkbox"/> YES, Electronically <input type="checkbox"/> NO (Not applicable)	<input type="checkbox"/> YES, Attached/Hard Copy	MEDICAL RECORD RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO
BELONGINGS <input type="checkbox"/> WITH PATIENT <input type="checkbox"/> LEFT IN ROOM <input type="checkbox"/> NONE		BELONGINGS RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO
VALUABLES <input type="checkbox"/> WITH PATIENT <input type="checkbox"/> LEFT IN SAFE <input type="checkbox"/> NONE		VALUABLES RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO
MEDICATIONS <input type="checkbox"/> WITH PATIENT <input type="checkbox"/> LEFT ON UNIT <input type="checkbox"/> PHARMACY		MEDICATIONS RECEIVED <input type="checkbox"/> YES <input type="checkbox"/> NO
Attach medication list		
Verify attached medication list		
PEDS / INFANTS		
APPROPRIATE BVM W/ TUBING & BULB SYRINGE: SENT <input type="checkbox"/> YES <input type="checkbox"/> NO		APPROPRIATE BVM W/ TUBING & BULB SYRINGE: RCVD <input type="checkbox"/> YES <input type="checkbox"/> NO
OTHER EQUIPMENT SENT: <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER EQUIPMENT RECEIVED: <input type="checkbox"/> YES <input type="checkbox"/> NO
14. Transferring to another Facility / Destination (name): _____		
Destination (address): _____		Point of Contact name/phone#: _____
TIME TO STAGING AREA: _____		TIME LOADING COMPLETED: _____
TRANSPORTATION <input type="checkbox"/> AMBULANCE, # _____	AGENCY: _____	<input type="checkbox"/> HELICOPTER <input type="checkbox"/> OTHER
ID BAND CONFIRMED <input type="checkbox"/> YES <input type="checkbox"/> NO BY _____	DEPARTURE TIME: _____	
TRANSFER CENTER & CONTACT #: _____		SENDING HOSPITAL FAX OR EMAIL CONFIRMATION SENT: <input type="checkbox"/> YES <input type="checkbox"/> NO
16. Prepared by _____ PRINT NAME: _____ SIGNATURE: _____		
DATE/TIME: _____ FACILITY: _____		



Purpose: Detail and account for patients transferred to another facility
Origination: Inpatient/Outpatient Unit Leader or Casualty Care Unit Leader

Place sending facility patient label

NATIONAL PEDIATRIC READINESS PROJECT

Promote National Quality Improvement (QI) Efforts - Hospitals



PEDIATRIC CHAMPIONS

Pediatric Emergency Care Coordinators (PECCs)

Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Policies



Disaster plan includes:

- **Pediatric surge capacity for injured & non-injured children;**
considerations (e.g., patient tracking; reunification, & peds decontamination):
 - **Availability of medications, vaccines, equipment, supplies, & trained providers for children**
 - **Access to behavioral health resources for children**
 - Minimization of parent-child separation & methods for reuniting children
 - **All disaster drills include pediatric patients**

https://media.emscimprovement.center/documents/EIICDisasterChecklist_2022.04.11.pdf

Supports California EMSC Regulations

<https://emsa.ca.gov/ems-for-children/>

ALAMEDA COUNTY EMS HOSPITAL PEDIATRIC READINESS PROJECT - SITE VISITS

GOALS

- **To conduct assessment of ED pediatric readiness ("Day-to-Day" & Surge Events)**
- To review site-visit self-assessment tool (support NPRP)
- **To gather pediatric data per the CA EMS for Children Regulations for quality improvement**
- To conduct in-situ pediatric simulations
- **To provide expert feedback, identify opportunities for improvement & pediatric hospital designation.**
- To facilitate on-going collaboration & future training

HOSPITAL TARGET GROUP

- ED Managers, Directors, PECCs, & Staff
- Pediatric Intensivist & Pediatric Champion SMEs
- Emergency Preparedness & Safety Leads
- Administration



Neonatal/Pediatric TRAIN™ Tool

<i>Transport</i>	<i>Blue/Car</i>	<i>Green/BLS</i>	<i>Yellow/ALS</i>	<i>Orange/CCT</i>	<i>Red/Specialized</i>
Life Support	Stable	Stable +	Minimal	Moderate	Maximal
Mobility	Car/Carseat	Wheelchair or Stretcher	Wheelchair or Stretcher	Stretcher	Incubator or Immobile
Nutrition	All PO	Intermittent Enteral	Continuous Enteral or Partial Parenteral	TPN Dependent	
Pharmacy	PO Meds	IV Intermit meds	IV Fluids	IV Drip x1	IV Drip ≥2
Life Support	Stable + =	Low flow oxygen			
	Minimal =	Oxygen hood, chest tube, etc.			
	Moderate =	CPAP/BiPAP/Hi-Flow, Conventional Ventilator, Peritoneal Dialysis, Externally paced, continuous nebulizer treatments, etc.			
	Maximal =	Highly specialized equipt., e.g., Neonatal Ventilator, HFOV, ECMO, iNO, CVVH, Berlin Heart, wt ≤ 1.5 kg, specialized medical personnel, etc.			
Mobility	Car/Carseat =	Able to ride in automobile with age-appropriate restraints			
	Incubator =	Transport incubator with equipment for connecting to ambulance			
	Immobile =	Unsafe to move without special equipment e.g., neurosurgical/bariatric			

TRAIN (Triage by Resource Allocation for In-patients)

EVACUATION	
EVACUATION ("TRAIN" Categories)	TOTAL COUNT
Ambulatory to Evacuate	
BLS to Evacuate	
ALS to Evacuate	
CCT	
SPECIALIZED	

REGIONAL PEDIATRIC SURGE – MOMENTUM INTO THE FUTURE

TRANSLATING EFFECTIVE PLANS INTO OPERATIONAL REGIONAL ACTION

- Implement PLAYBOOK components “day to day” with response partners
- Coordinate & integrate collective health system corporate command & coalitions
- Test pediatric CONOPS across jurisdictions
- Join WRAP-EM & other Regional Alliances; Connect across states & coalitions
- Expectations beyond NPRP for pediatric surge readiness – Use site visits & Pediatric Emergency Care Coordinators (PECCs)
- Use Operational “Just in Time” Tools (i.e., Activation, Expansion, Telehealth & Burn)
- Ensure plans realistic to address simultaneous complex catastrophic events
- COVID changing landscape & new baseline — Expand partners
- Campaign to inspire & strengthen regional surge pediatric emergency response



<https://www.canva.com>

DRIVING PEDIATRIC READINESS ACTION



CYNTHIA FRANKEL, RN, MN

- Surge Group Lead, WRAP-EM
- EMS for Children, ReddiNet, HPP LEMSA Liaison & EMS Coordinator
- Alameda County Emergency Medical Services, California
- (510) 295-9601; Cynthia.Frankel@acgov.org
- <http://ems.acgov.org/ClinicalProcedures/EMS-C.page?>

WRAP-EM <https://wrap-em.org/>

NATIONAL PEDIATRIC READINESS PROJECT (NPRP)

- <https://emscimprovement.center/projects/pediatricreadiness/>
 - [Readiness Toolkit • EIIIC \(emscimprovement.center\)](#)

NATIONAL PEDIATRIC DISASTER COALITION

- <http://www.npdcoalition.org/resources/>

NATIONAL ADVISORY COMMITTEE ON CHILDREN & DISASTERS

- <https://www.phe.gov/Preparedness/legal/boards/naccd/Pages/default.aspx>



<https://www.canva.com>

PEDIATRIC SURGE DISASTER PLANNING

Michael Frogel, MD, FAAP

Senior Advisor ASPR WRAP-EM Pediatric Center of Excellence

Chairman National Pediatric Disaster Coalition

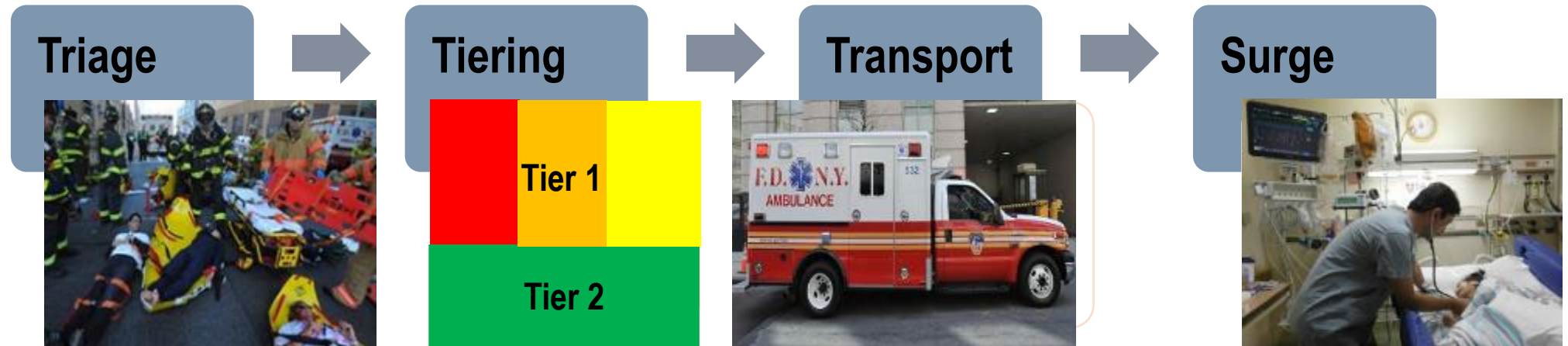
Co-Principal Investigator NYC Pediatric

Summary Pediatric Surge Planning Considerations

- Pre-event Planning is necessary for Surge, Evacuation, Shelter in Place and Supply Chain for Hospitals/ED/NICU/PICU/Ob/Newborn/General, Long Term Care Facilities and Community-Based Providers (OPD, Urgent Care etc.), Schools, Daycare
- Surge Capability includes Communications Space, Staff, Equipment and Supplies not just beds
- Plan from initial site incident through primary, secondary transport, surge and or evacuation
- For Transport: Tier Facilities and Utilize a Pediatric Care Response Team to prioritize patients
- Electronic shared situational awareness, Web based bed matching capabilities
- Utilize Pediatric EEIs from transferring (evacuating) to receiving surge facility
- Match patient transport needs to available resources (e.g. Train)

Summary (cont.)

- Consider Supply Chain including, Pharmaceuticals /Therapeutics, Equipment (Evacuation/vents)
- Provide SME experts for SME, Trauma/Burns, Poison control, patient prioritization, Pediatric Intensivist Response Team (PIRT) etc.
- ESF8 real time participation (include above SME representation)
- ESF6, ESF7, interaction, Non-medical impacts, Food, Shelter, Clothing
- Mental Health Response Hospital/Community Providers/School: Screen/Refer (e.g. PsyStart), Treatment
- Education
- Training e.g. Pediatric NICU Evacuation
- Health Care Disparities
- Exercises/ Real World Events/Lessons Learned-Restart Planning Cycle



The Pediatric Disaster Coalition and their collaborative planning team created a comprehensive Pediatric Disaster Plan from the onset of the event and first response through pediatric intensive care surge.

Pediatric Intensivist Response Team (PIRT)

- Provides prioritization triage consultation service to EMS for inter-facility transfer of patients and SME during disasters
- Volunteer Pediatric Intensivists
- Serve under Medical Reserve Corps umbrella
- All currently practice in PICUs

PIRT's Role in the Pediatric Disaster Plan

1. Upon activation of the Pediatric Disaster Plan, sending hospital will contact EMS to request a transfer
2. EMS will collect basic data and details of patient's injuries or illness
3. EMS will relay the request and information to PIRT Physician on call
4. PIRT Physician will triage/prioritize the patients based on acuity and need for specialized services, and relay this information to EMS
5. New York City Fire Department Bureau of Emergency Medical Services (FDNY EMS) will use this information as well as the list of available beds in Tiered Pediatric Disaster Admitting Destinations to determine inter-facility transfer destinations

Secondary Transport Details

6. EMS will assign Pediatric Disaster Ambulance Destination
7. Sending physician will then speak with receiving PDAD physician
8. EMS will utilize available resources to match patient needs to transport resources. - e.g. TRAIN (Triage by Resource Allocation for IN-patients)
9. EMS may also use specialized pediatric transport services if available
10. EMS will be notified upon completion of transfer

Patient Information Shared between FDNY & PIRT

- A. Patient identifier
- B. Patient age or size (infant, toddler, child, adolescent)
- C. Nature of injury/injuries
- D. Respiratory Support
- E. Medications
 - Chronic
 - Currently administered

PIRT SME Activities

- Advisory Board to the Pediatric Disaster Coalition
- PDC, PIRT and Pediatric Critical Care Society provide SME to
 - Department of Health and Mental Hygiene (DOHMH)
 - ESF8

Pediatric Essential Elements for the Transport of Pediatric Patients Model Draft

Utilization Guidance for the Collection and Reporting of the Pediatric Essential Elements of Information for Secondary Transport:

- EEs should be utilized based on your local Pediatric Disaster Plan for secondary transport of patients
- Transferring facility collects the **patient** related EEI data and transmits it to the transfer center and the receiving facility. The receiving facility provides the **facility related EEI** data to the transfer center and sending facility.
- If patient needs are potentially met. The sending physician will speak to the receiving physician, confirm the information and notify the transfer center to proceed.
- Transfer will take place if the patient care needs are matched by the facility available capabilities.
- The transfer center will decide on the type of transport need based on the transmitted EEs (e.g. TRAIN) and transfer the patient to the appropriate level of care at a facility designated in the EEs (e.g. Trauma, Burn Tiered facilities in your plan, neonatal Level 1-4 etc.).

Pediatric Essential Elements for Transport of Pediatric Patients Model Draft (cont.)

- If there are limited transport capabilities due to magnitude of the disaster the transfer center will contact the **Pediatric Intensivist Response Team (PIRT)** physician on call to prioritize the patients based on their EEIs (clinical severity, treatment, subspecialty and equipment needs).
- The transfer center will decide on the site and type of transport need based on the PIRT recommendations and EEIs.
- The collection of information should be done electronically preferably by email web-based platform or text that is accessible to both facilities and the transfer center.
- For citywide large scale events overall facility surge capacity based on the EEI current facility information would allow for best overall outcomes.
- In the event of a power or computer system failure a paper back up system should be utilized. If possible, the patient's complete medical record should accompany them to the receiving facility.

EEI Spreadsheet (Sending/Receiving Hospitals) Example

Sending hospital/contact number/requesting physician

Receiving Hospital contact number/receiving physician

- **Type of Facility and/or Unit**
- **Trauma Center, (General Level 1, Level 2, Pediatric Level 1, 2**
- **Burn Center**
- **Pediatric Ambulance Destination (Tier 1, Tier 2)**
- **Neonatal Unit Level 1-4 (Refer to Neonatal reference for description)**
- ***Newborn***
- ***PICU***
- ***PICU Vent***
- ***Peds Med/Surgery/Telemetry***
- ***Physical Rehab Peds***
- ***Psychiatry Peds***

- **Surge Beds include capability to care for patient type including space staff equipment**

Subspecialty Availability

Pediatric orthopedics ,Pediatric vascular surgery, Pediatric trauma surgery, Pediatric general surgery

Burns, Pediatric ophthalmology, Pediatric mental health psychiatry, Pediatric cardiothoracic Surgery

Pediatric neurology , Pediatric neurosurgery , Pediatric ENT, Re-Implant (Please advise if body part available, Properly maintained)

- Other (specify)

Specialized Equipment Availability

- ECMO, Neonatal Ventilator, Inhaled Nitrous Oxygen (iNO), High Frequency Oscillating Ventilator, Berlin Heart (Ventricular Assist Device)

- Continuous Veno-Venous Hemofiltration, Incubator

- Other (please specify)

EEI Spreadsheet (Patient Information e.g.)

Parental consent for treatment

Accompanying Family Member

Primary diagnosis

Co-morbidities

Chronic Conditions

Current Medications

VS, Glasgow coma scale, O2 Saturation, ETCO2,

Pupils

Burn: thermal, chemical, electrical, Depth, location If chest or extremity, circumferential? (potential for compartment syndrome/need for escharotomy)

Critical Imaging Findings

Critical Lab Findings

Treatment /Current Interventions

Type of Care by Unit Need

Subspecialty Need

Special Equipment Need (ECMO, Vent etc.)

Specialized Transport Need (TALS, TRAIN)

Supply Chain Considerations

Pharmaceuticals / Therapeutics

Immediate vs. delayed availability based on HVA

Countermeasures vs. Intravenous immunoglobulin (IVIG) for
Multisystem Inflammatory Syndrome in Children (MISC)

Equipment

Evacuation: Vertical/Horizontal, NICU, PICU, OB/Newborn

Respiratory: Oxygen, BiPAP, CPAP, Ventilators

Blood Supply

Non-Medical

Food

Clothing

Shelter

SME Considerations

- General Pediatric SME
- Trauma
- Burns
- CBRN Explosions, Utilize Poison Control,
- Develop Just in Time Training
- Transport Patient Prioritization by Pediatric Intensive Care Response Team
- Specialized Mobile Response Teams

Pediatric Disaster Mental Health Considerations

- Mental Health Response Hospital/Community Providers/School
- Immediate vs. Long Term Response
- Psychological First Aid
- Screen (Scene, shelters and transfer facilities, Primary Care Providers, Schools)
- Refer (e.g. PsyStart)
- Treatment: Short vs Long Term

Education and Training

- **Education**
 - Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS), Disaster
- **Training e.g.**
 - Expand PICU capabilities force multiplication
 - Pediatric Fundamental Critical Care Support (PFCCS) Course, Cross train staff
 - Pediatric NICU Evacuation

Health Care Disparities Considerations

- Pediatrics: 25% of Population and most vulnerable with special needs during disasters
- Poverty
- Lack of Access or Functional Capability
- Long Term Care Facilities
- Racial, Ethnic
- Language Barriers
- Lack of Healthcare Information
- Relationships
- Include in all disaster planning

Exercise Considerations

- Exercises (Integrate pediatrics into all exercises)
 - Tabletop
 - Functional (targeted)
 - Full Scale
 - Real World Events
- Include Health Care Disparities in Scenarios
- After Action Reports
- Lessons Learned
- Restart Planning Cycle

Planning is a Continuous Process

Consider Resiliency Building in Process



Exercise Description

Description: This exercise was a functional exercise (virtual) planned for a maximum of six hours for exercise play and Hot Wash activity. The exercise included 28 hospitals that care for pediatric patients in New York City and the following agencies; New York Fire Department (FDNY), New York City Emergency Management (NYCEM), the New York City Department of Health and Mental Hygiene (DOHMH), New York City Medical Reserve Corps (MRC) and the Pediatric Intensivist Response Team (PIRT). The exercise was designed to prepare New York City for a catastrophic pediatric event. The scope included hospital surge, communications, activation of the NYC Pediatric Disaster Plan and secondary transport.

Exercise Scenario

Scenario: It is a Thursday morning, approximately 8AM, with spring like weather conditions. An explosion of unknown origin occurs on a school bus at a nearby school. Patients begin to arrive to your hospital that have been self-evacuated. You learn from FDNY that several ambulances are headed your way with patients of various acuity levels. Similar incidents have taken place throughout New York City.



https://www.google.com/search?q=burning+school+bus+fdny+new+york+city&sxsrf=AOaemvKSir7firomFB1ZN17TXbpTbtHp1Q:1631829829384&tbm=isch&source=iu&ictx=1&fir=aurEC3oriGpdoM%252Cfe3wxCq8utYcQM%252C_&vet=1&usg=AI4_-kQkb8Uj6KX7NV8AoitEPiZ7a7lvkA&sa=X&ved=2ahUKEwjDp8Hqv4TzAhULh_0HHce2DRIQ9QF6BAgKEAE#imgsrc=y-HmAfSkwPoYvM

28 Hospital Exercise Video

https://youtube/1g1bGj-_Rb4

Key findings from 28 Hospital Surge Exercise

Surge Beds/Capacity/Capability

- **Added 1105 Surge Beds (baseline pediatric inpatient unit beds 1039) – double capacity**
- **Added 254 PICU Surge Beds (baseline 224 beds) – more than double capacity**
- **304 ED Critical Care Surge Beds**
- **312 ED Non-Critical Care Surge Beds**
- **203 OR Surge beds**
- **268 Adult Medical ICU Surge Beds**
- **120 Additional Adult Surgical ICU Surge Beds**
- **342 Pediatric Ventilator capable surge beds**
- **NICU total surge beds available after rapid patient discharge 247**

Key Findings from 28 Hospital Pediatric Surge Exercise

Communications:

- Over 70% of the participating hospitals utilized phone calls, emails, text messaging, and face-to-face discussions to communicate situational awareness
- Almost all hospitals were able to communicate with staff and to contact them about coming in during the surge event

Supplies:

- Over half (54%) of participating hospitals reported having gaps in their pediatric supplies during the exercise due to the influx of critical patients
- 6 hospitals reported not having a burn cart to deploy during a disaster

Key Findings from MSEL Question Responses (cont.)

Staffing:

- **Some hospitals had difficulty providing pediatric subspecialty services such as, Neurosurgery, Ear Nose and Throat (ENT), Orthopedics, Plastics, Vascular Surgery and Trauma Surgery**
- 100% of Hospitals created Mental Health Response Teams for patients and Staff

Transfer:

- All hospitals were able to identify patients requiring secondary transport and to provide information on the transport form
- Only 39% of participating hospitals identified appropriate staff to accompany patients during FDNY secondary transport
- The Fire Department was able to send the Pediatric Intensive Care Review Team a list of patient's for secondary transport and subsequently receive the PIRT's triage and prioritization patient list

Key Findings from MSEL Question Responses (cont.)

Patient Tracking:

- 93% of hospitals were able to track patients during the event
- 70% of the participating hospitals utilized paper to track and register patients, approximately 50% also used electronic methods

Surge: Mental Health/Risk Communications

- 100% of hospitals established Family Information Service Centers for Reunification
- 100% of Hospitals created Mental Health Response Teams for patients and Staff
- 100% of Hospitals established an area for press briefings and a designated Public Information Officer

Lessons Learned

- Working directly with hospitals to create and implement pediatric specific surge/evacuation plans as part of overall preparedness improved surge and secondary transport capabilities.
- Conducting multiple group and individual exercise planning meetings yielded many valuable changes in hospital plans even before the exercise took place.
- Assessing the availability of sufficient pediatric subspecialty and intensive care staff for a surge of critically ill pediatric patients is necessary for good outcomes.
- Adult staff and surge capabilities should be incorporated into the pediatric surge response, especially at Tier-2 hospitals.
- Disaster mental health issues should be addressed for children, families and hospital staff with the provision of adequate staff and appropriate space.
- A Family Reunification and Information Service Center (FISC) should be part of Surge planning.

Lessons Learned (Cont.)

- Preparing sufficient onsite pediatric surge equipment and supplies is essential especially:
 - Ventilators
 - Blood/Blood Products
 - Burn Supplies
- There is a need for “babysitters” to care for pediatric patients throughout the hospital process thereby freeing clinical staff to participate in patient care.
- Site specific areas should be pre-designated and staffed for various surge tasks.
- Begin triaging patients for secondary transport early during a surge event.
- Utilize Ambulatory Care Resources for space staff staff and integrate into hospital plans.
- It is important to have sufficient personnel to assist the controller/incident commander in data collection, communications and reporting during exercises and real time events.
- Situational awareness and communication with staff and agencies is essential.

Response: Emergency Management Considerations

ESF8 real time participation (include above SME representation as needed)

ESF6, ESF7, interaction, Non-medical impacts, Food, Shelter, Clothing

Resiliency Building

- Essential pre-event to improve outcomes from disaster physical, psychosocial, disaster mental health impacts
- Should address special needs of the pediatric population in the overall context of disasters for children, their families and the overall population
- Should address health care disparities
- Should become part of disaster mental planning, response and recovery

Regional Pediatric Surge Planning Proposed Model

- Regional Situational Awareness collected from each state, bed availability, needs/resource availability
- Web based real time situational awareness, communications, bed matching
- Coordination of External Resources, ESF8/ESF6, ESF7, Local, County, State to National (ASPR/FEMA/CDC etc. input)
- Regional Incident Command Structure, Control of Asset across State Lines
- Regional Resource Response Telemedicine, CBRNE/Poison Control, Response Teams, National Guard, DOD, mutual aid transport
- Regional PsyStart/ Mental Health match Needs/Resources, local state, regional
- Regional Transport/ Train Utilization match needs to resources
- Education, Training, Exercises within regional model that includes Health Care Disparities and pediatric patients as represented in the population



WASHINGTON WMCC and PEDIATRIC SURGE PLAN

Vicki L. Sakata, MD, FAAEM, FAAP
Senior Medical Advisor
Northwest Healthcare Response Network
Clinical Associate Professor, University of Washington
WA-DMAT CMO

Take aways

- The “joy” of being first...
- Kids ARE just small adults (!) ... and
- What the dogs hears

Serving the state's medical epicenter

- 15 counties and 25 Tribal Nations
- 5.3 million residents
- 64 hospitals and ~150 skilled nursing facilities
- Nearly 70% of the state's hospital and skilled nursing beds
- Largest concentration of critical medical specialty services in Pacific Northwest



Snohomish County man has the United States' first known case of the new coronavirus

Jan. 21, 2020 at 10:58 am | Updated March 11, 2020 at 1:08 pm



1 of 3 | At a news conference at the Washington state Department of Health's Public Health Laboratories on Tuesday, Dr. Satish Pillai of the Centers for Disease... (Greg Gilbert / The Seattle Times) More ▾

By Seattle Times staff & news services

First Patient With Wuhan Coronavirus Is Identified in the U.S.

A man in Washington State is infected with a new respiratory virus. Federal officials plan to expand screenings for the infection at major airports.

Give this article



Gov. Jay Inslee of Washington, flanked by health officials in the state, speaking in Shoreline, Wash., on Tuesday. A man in Washington State has the first confirmed case in the United States of the Wuhan coronavirus. Grant Hindsley for The New York Times



By Roni Caryn Rabin

Published Jan. 21, 2020 Updated May 7, 2020

King County patient is first in U.S. to die of COVID-19 as officials scramble to stem spread of novel coronavirus

Feb. 29, 2020 at 10:17 am | Updated March 1, 2020 at 12:37 pm



1 of 24 | King County Executive Dow Constantine addresses the media Monday in Seattle. Constantine said he had signed an emergency declaration and is in the... (Steve Ringman / The Seattle Times) More

By Sydney Brownstone, Paige Cornwell, Mike Lindblom
and Elise Takahama
Seattle Times staff reporters

First death due to novel coronavirus (COVID-19) in a resident of King County

February 29, 2020

Summary

Public Health – Seattle & King County and the Washington State Department of Health are announcing new cases of COVID-19, including one death. The individual who died was a man in his 50s with underlying health conditions who had no history of travel or contact with a known COVID-19 case. Public Health is also reporting two cases of COVID-19 virus connected to a long-term care facility in King County.

Story

Public Health
Seattle & King County

Washington State Department of
Health

CDC
ENTER • HEALTHIER • TOGETHER

Feb 27, 2020

LTCF COVID-19 Outbreak Overwhelms Single Hospital

81 residents (117)
34 staff (50)
14 visitors
23 deaths (35)

33/37 Transported to Evergreen

23 deaths (35)



WA Medical Coordination Center

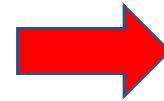
Disaster Medical Coordination Center (DMCC)



Regional COVID Coordination Center (RC3)

Harborview Medical Center/King County

Northwest Health Response Network



**Washington Medical
Coordination Center (WMCC)**



What is a MOCC?

Medical Operations Coordination Center (cell)

- Facilitate patient movement, healthcare staffing, and life-saving resource allocation
- MOCCs are cells often located within emergency operations centers (EOCs) at the sub-state regional, state-wide, and federal regional levels (FEMA/HHS regions)

A MOCC AIMS TO:

Move **patients, staff, and supplies**



to the right **provider**



at the right **time**, in the right **way**



to **improve** patient **well-being**



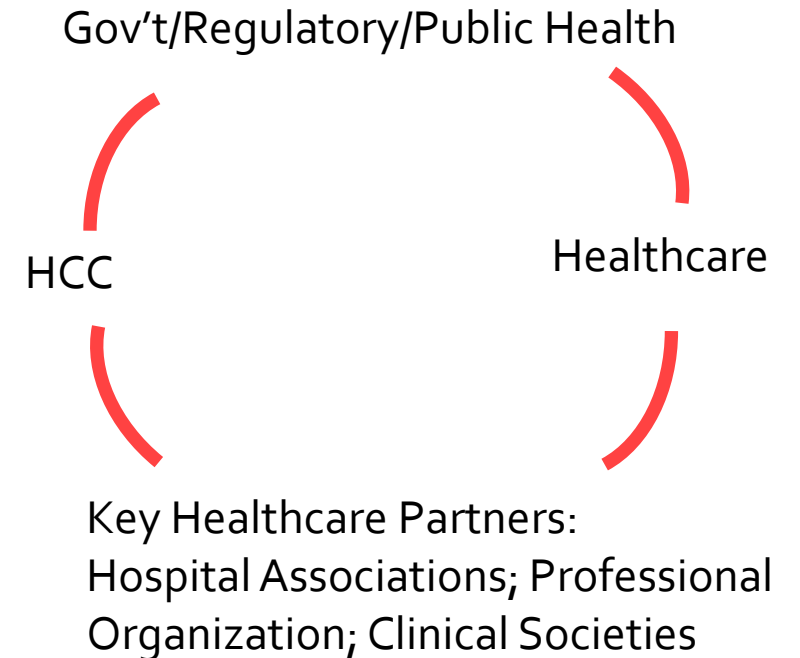
Equity

Medical Operations Coordination Cells Toolkit Second Edition

<https://files.asprtracie.hhs.gov/documents/fema-mocc-toolkit.pdf>

State Coordination Strategies

- Coordination across all aspects of Washington healthcare leadership
- **Governmental/regulatory/Public Health**
 - Governor, DOH, Sec of Health, WA State Health Officer; LHJs
- **Healthcare Facilities**
 - WA Hospital Association (WSHA), Health System Executive Leadership; LTC
- **Healthcare coalitions**
 - Northwest Healthcare Response Network, REDI Network



Plan for Success: Agree on Basic Operating Principles

- All entities must agree to submit data to support situational awareness and respond in a timely manner
- All entities must agree to provide staff who can communicate with each other and communicate back with their organizations to individuals with authority to make decisions.
- Acute care facilities agree to accept patients based on the triage decisions of the MOCC
- Facilities agree to minimize the number of “reserved” or “closed” beds and maximize additional surge capacity
- Agree that patients may need to travel long distances to align with fair and equitable processes
- Facilities seeking assistance will establish communication with the MOCC as early as possible and all patient transfers related to the incident (COVID-19) will be coordinated through the RMOC during this crisis.
- Aeromedical services and EMS ground transport agencies agree to support patient movement as directed by the MOCC
- All representatives agree to participate in regular “virtual” briefings and hold each other accountable for the principles and processes previously described

<https://www.facs.org/for-medical-professionals/covid-19/clinical-guidance/rmoc-setup/>

Guaranteed Acceptance Policy

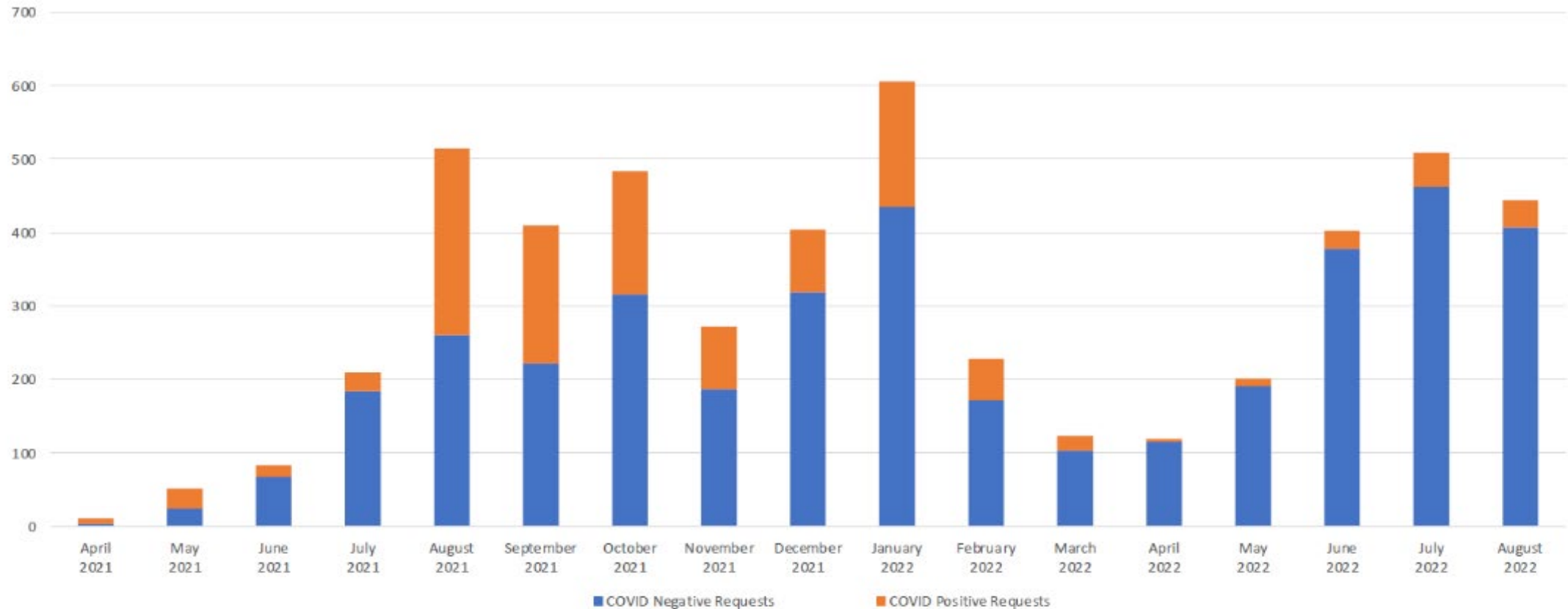
- Activated when the “highest urgency” patients cannot be placed
- WMCC Triage Categories
 - High Urgency: expected clinical decline 8-12 hours
 - *Example: : cardiogenic shock in need of CABG, GI bleeding requiring frequent transfusion, impacted and infected kidney stone with sepsis*
 - Moderate Urgency (stable, no urgent procedure/surgery necessary)
 - *GI bleeding not requiring frequent transfusion, acute coronary syndrome (ACS) requiring heparin and/or nitroglycerin with down trending troponin/stable symptoms but requiring drips*
 - Low Urgency (no expected short-term decline, would benefit by specialty consultation)
 - *resolving sepsis without need for surgical source control, biliary stone without evidence of acidosis/pancreatitis*
- *There is no such thing as “no”*

How is the WMCC Utilized?

Backstop when normal transfer patterns can't be utilized

- Hospitals utilized their normal transfer patterns
 - Typically contact 2-4 hospitals
- When normal transfer destinations not available > WMCC
- WMCC works with partner hospitals across Washington state to find appropriate destination
- Over 5,000 requests for assistance
 - 73% from rural hospitals

Total WMCC Call Volume by Month



Confidential – Do Not Distribute

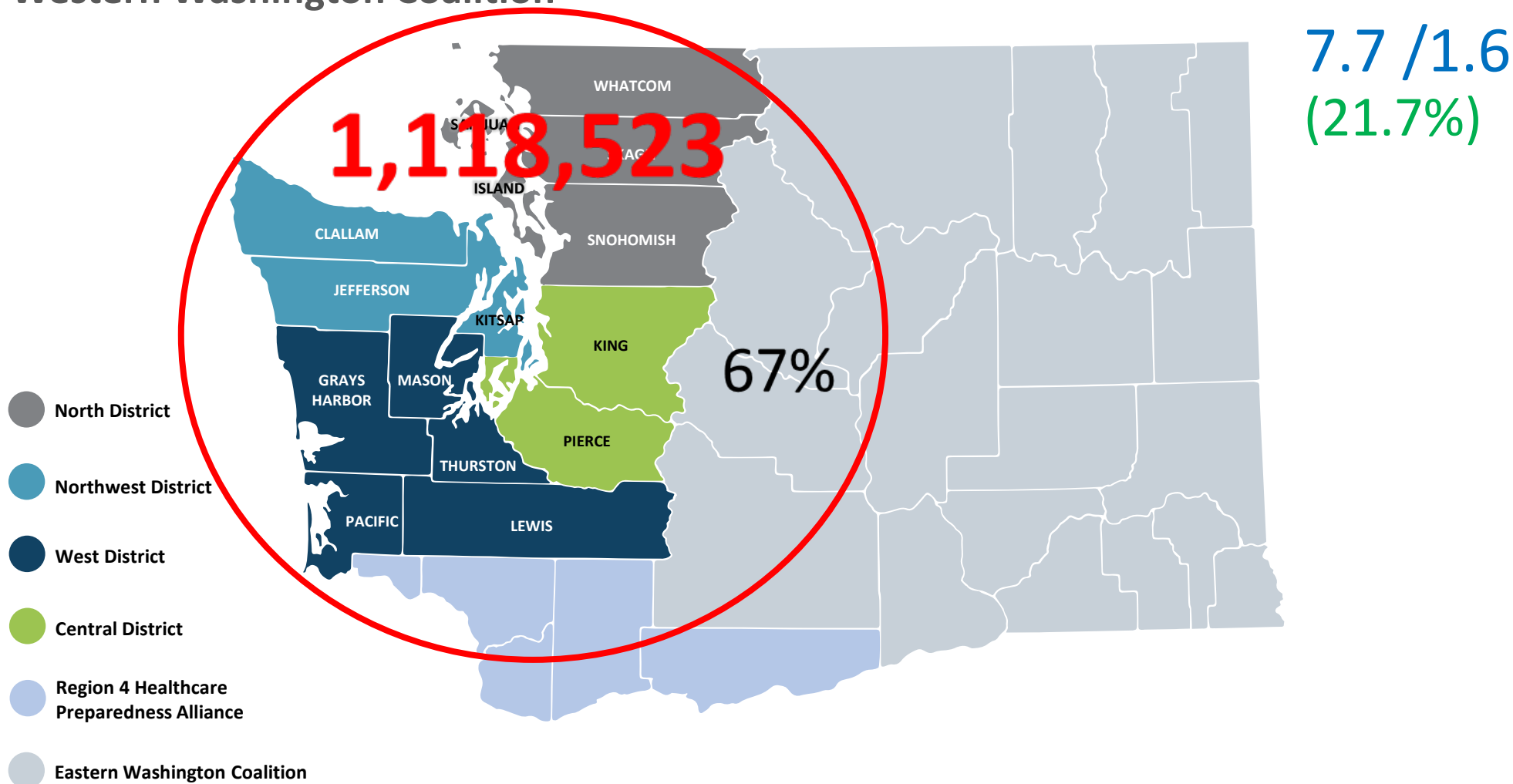


WASHINGTON
Medical Coordination Center
at Harborview Medical Center

got kids?

got kids?
US Census QuickFacts 2020 est

Western Washington Coalition



Pediatric Events and Planning - WA

- 2009: King County Pediatric Toolkit
- 2011: Pediatric Disaster Workshops - State
- 2013: Pierce County Pediatric Toolkit
- 2015: Portland Train the Trainer
- 2016: Annual UW/Tacoma Trauma Conferences
- 2020: ASPR Pediatric Annex

Pediatric Events and Planning (cont.)

2020-2021: Pediatric MIS-C/COVID-19 Surge and Pediatric BH Surge

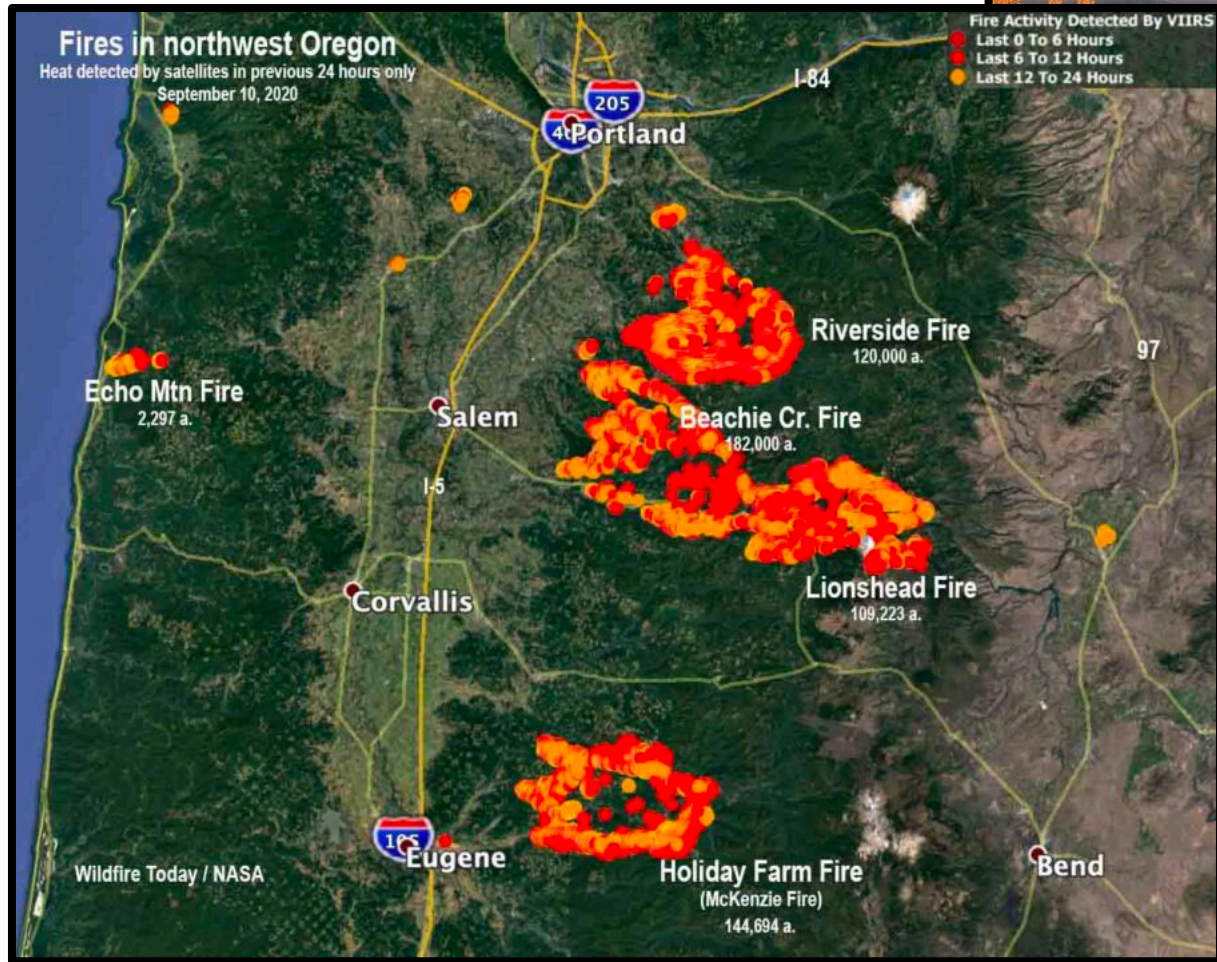
- Some peds data entered in to WATrac but not WAHEALTH
- No peds BH data
- Started Pediatric Tracker – weekly huddles

2021: WA Pediatric Clinical Leader calls and data collection (beds/COVID/BH)

- data now being entered into WATrac and WAHEALTH
- calls to verify data quality and raise issues
- data fidelity not as good for peds as it is for adults

Winter 2021-22: schools open and Delta/Omicron waves

- Pediatric Care Levels published to align NICU and PICU levels
- "PICU for the MICU" primer published for adult intensivists
- 0-5 open PICU beds

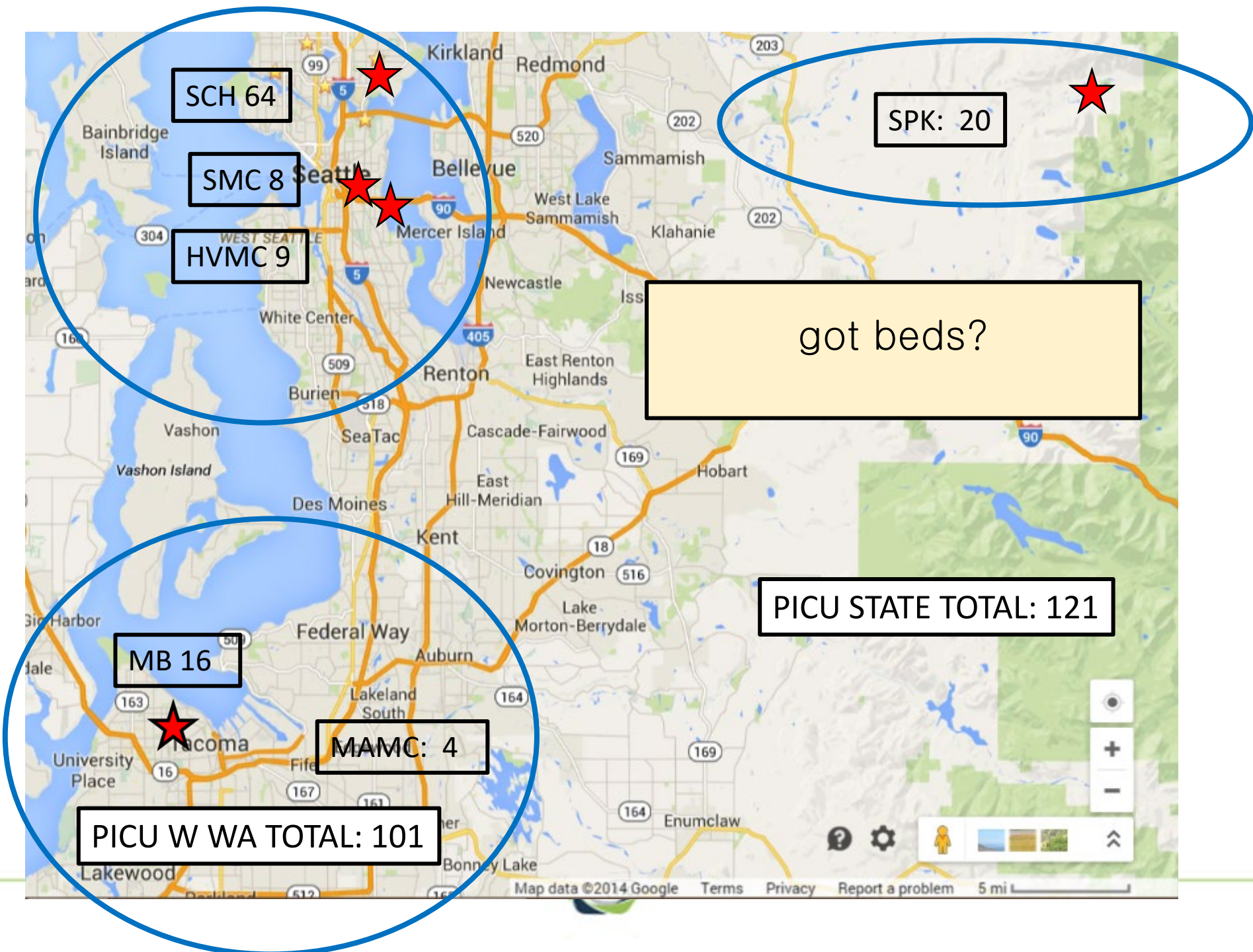


Wildfires, 2020

Pediatric Events 2020-2022

- 9/11/20: OR/WA wildfire
 - 5 hospitals on notice for evacuation – including pediatric patients
 - One hospital in Level 2 already moving 60-70 patients
 - All facilities have stopped ambulance transport
 - LTC evacuations
 - OHA notification: plan on evacuees
- 2021: DMAT Deployments
- 8/25/22: Seattle Community PICU off-line
 - W. WA PICU bed availability: 0-5
 - 8/25 notification: Community PICU off-line (4-6 beds)
 - Needed urgent surge plan

PICU Capacity
WA State



Event: Community PICU off-line

- SCH and MB notified
- Urgent discussion with WMCC in case of Pediatric Surge
 - Developed rotating Peds Intensivist SME call
 - Developed contact list - relationships
 - MAMC Option
 - Notification of all ED's and non-pediatric facilities of temporary procedure.
- Currently working to develop a WA State P-WMCC
- - Option 1: Peds SME support for WMCC RNs to create PMCC arm of WMCC
 - Option 2: Separate PMCC call center

Goal for Winter 2022-23: PMCC functioning as either option 1 or 2

Option 1: Peds SME support for WMCC RNs to create PMCC arm of WMCC

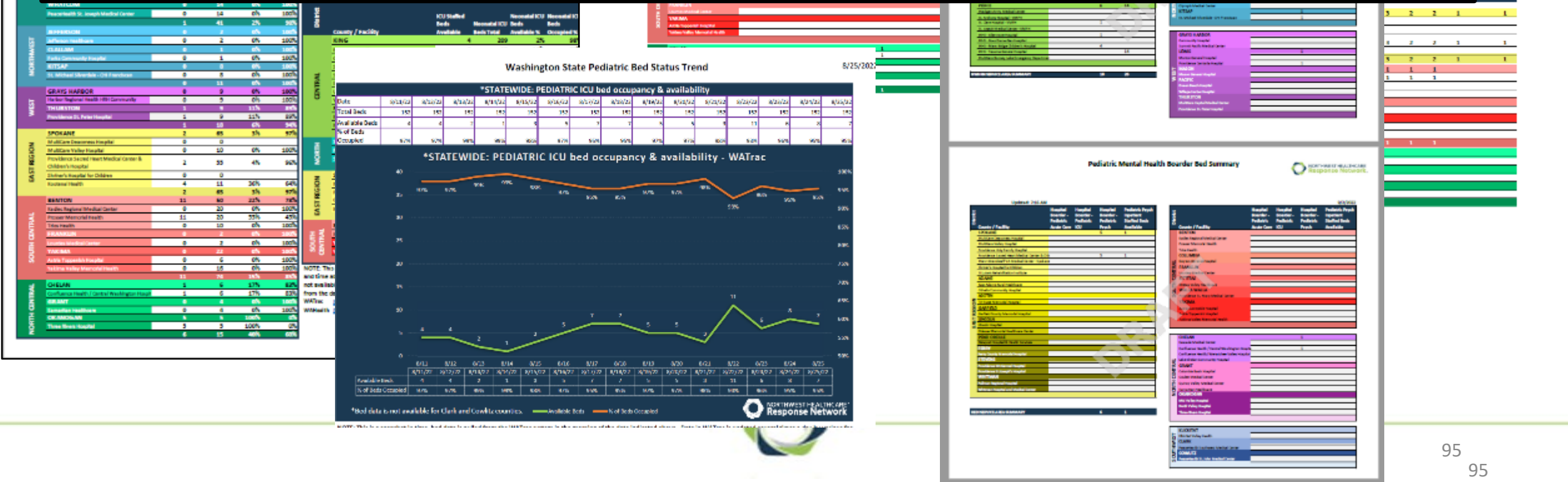
- Pediatric Annex up to date
- Peds Clinical MD and RN SMEs clearly identified to support WMCC
- Pediatric RNs folded in to WMCC RNs with standard peds protocols for all RNs
- Pediatric data entered in to WATrac and WAHEALTH with high fidelity by all peds centers

Option 2: Separate PMCC call center

- Pediatric Annex up to date
- Clarify if largest pediatric center (SCH) can manage call volume
- Clarify staffing at one hospital for a regional load-balancing program
- Clarify one hospital having access to regional WATrac and WAHEALTH data



Bad Data -> Poor Situational Awareness -> Bad Decisions



THE FAR SIDE[®]

by GARY LARSON



Pediatric Care Levels: NICU, Peds, and PICU

AAP NICU Levels

- **Level 1:** Well Newborn
- **Level 3:** Special Care Nursery
- **Level 3:** NICU
- **Level 4:** Regional NICU

AAP PICU Triage Guidelines:

- Community PICU
- Tertiary PICU
- Quaternary PICU

WRAP-EM Pediatric Care Levels

- **Level 1:** Nursery/Ward (BLS)
- **Level 2:** Intensive (ALS)
- **Level 3:** Critical (CCT)
- **Level 4:** Specialized (Specialized)

Universal Level Designations for Hospitalized Pediatric Patients in Evacuation

Anna Lin 1, Mary A King 2, David C McCarthy 3, Carl O Eriksson 4, Christopher R Newton 5, Ronald S Cohen 6
Hosp Pediatrics 2022 Mar 1;12(3):333-336. doi: 10.1542/hpeds.2021-006356.

Executive Summary: Criteria for Critical Care of Infants and Children: PICU Admission, Discharge, and Triage Practice Statement and Levels of Care Guidance

Benson S. Hsu, Vanessa Hill, Lorry R. Frankel, Timothy S. Yeh, Shari Simone, Marjorie J. Arca, Jorge A.Coss-Bu, Mary E. Fallat, Jason Foland, Samir Gadepalli, Michael O. Gayle, Lori A. Harmon, Christa A. Joseph, Aaron D. Kessel, Niranjana Kissoon, Michele Moss, Mohan R. Mysore, Michele C. Papo, Kari L. Rajzer-Wakeham, Tom B. Rice, David L. Rosenberg, Martin K. Wakeham, Edward E. Conway, Michael S.D. Agus
Pediatrics Oct 2019, 144 (4) e20192433; DOI: 10.1542/peds.2019-2433

Levels of Neonatal Care

COMMITTEE ON FETUS AND NEWBORN; Wanda Denise Barfield, MD; Lu-Ann Papile, MD; Jill E. Baley, MD; William Benitz, MD; James Cummings, MD; Waldemar A. Carlo, MD; Praveen Kumar, MD; Richard A. Polin, MD; Rosemarie C. Tan, MD; Kasper S. Wang, MD; Kristi L. Watterberg, MD
 Pediatrics (2012) 130 (3): 587–597.

<https://doi.org/10.1542/peds.2012-1999>

TABLE 1 Definitions, Capabilities, and Provider Types: Neonatal Levels of Care

Level of Care	Capabilities	Provider Types ^a
Level I Well newborn nursery	<ul style="list-style-type: none"> • Provide neonatal resuscitation at every delivery • Evaluate and provide postnatal care to stable term newborn infants • Stabilize and provide care for infants born 35–37 wk gestation who remain physiologically stable • Stabilize newborn infants who are ill and those born at <35 wk gestation until transfer to a higher level of care 	Pediatricians, family physicians, nurse practitioners, and other advanced practice registered nurses
Level II Special care nursery	Level I capabilities plus: <ul style="list-style-type: none"> • Provide care for infants born ≥32 wk gestation and weighing ≥1500 g who have physiologic immaturity or who are moderately ill with problems that are expected to resolve rapidly and are not anticipated to need subspecialty services on an urgent basis • Provide care for infants convalescing after intensive care • Provide mechanical ventilation for brief duration (<24 h) or continuous positive airway pressure or both • Stabilize infants born before 32 wk gestation and weighing less than 1500 g until transfer to a neonatal intensive care facility 	Level I health care providers plus: Pediatric hospitalists, neonatologist, and neonatal nurse practitioners
Level III NICU	Level II capabilities plus: <ul style="list-style-type: none"> • Provide sustained life support • Provide comprehensive care for infants born <32 wks gestation and weighing <1500 g and infants born at all gestational ages and birth weights with critical illness • Provide prompt and readily available access to a full range of pediatric medical subspecialists, pediatric surgical specialists, pediatric anesthesiologists, and pediatric ophthalmologists • Provide a full range of respiratory support that may include conventional and/or high-frequency ventilation and inhaled nitric oxide • Perform advanced imaging, with interpretation on an urgent basis, including computed tomography, MRI, and echocardiography 	Level II health care providers plus: Pediatric medical subspecialists ^b , pediatric anesthesiologists ^b , pediatric surgeons, and pediatric ophthalmologists ^b
Level IV Regional NICU	Level III capabilities plus: <ul style="list-style-type: none"> • Located within an institution with the capability to provide surgical repair of complex congenital or acquired conditions • Maintain a full range of pediatric medical subspecialists, pediatric surgical subspecialists, and pediatric anesthesiologists at the site • Facilitate transport and provide outreach education 	Level III health care providers plus: Pediatric surgical subspecialists

^a Includes all providers with relevant experience, training, and demonstrated competence.

^b At the site or at a closely related institution by prearranged consultative agreement.

State	Level I	Level II	Level III	Level IV
Alabama	Yes	Yes	Yes	Yes
Alaska	Yes	Yes	Yes	Yes
Arizona	Yes	Yes	Yes	Yes
Arkansas	Yes	Yes	Yes	Yes
California	Yes	Yes	Yes	Yes
Colorado	Yes	Yes	Yes	Yes
Connecticut	Yes	Yes	Yes	Yes
Delaware	Yes	Yes	Yes	Yes
Florida	Yes	Yes	Yes	Yes
Georgia	Yes	Yes	Yes	Yes
Hawaii	Yes	Yes	Yes	Yes
Idaho	Yes	Yes	Yes	Yes
Illinois	Yes	Yes	Yes	Yes
Indiana	Yes	Yes	Yes	Yes
Iowa	Yes	Yes	Yes	Yes
Kansas	Yes	Yes	Yes	Yes
Kentucky	Yes	Yes	Yes	Yes
Louisiana	Yes	Yes	Yes	Yes
Maine	Yes	Yes	Yes	Yes
Maryland	Yes	Yes	Yes	Yes
Massachusetts	Yes	Yes	Yes	Yes
Michigan	Yes	Yes	Yes	Yes
Minnesota	Yes	Yes	Yes	Yes
Mississippi	Yes	Yes	Yes	Yes
Missouri	Yes	Yes	Yes	Yes
Montana	Yes	Yes	Yes	Yes
Nebraska	Yes	Yes	Yes	Yes
Nevada	Yes	Yes	Yes	Yes
New Hampshire	Yes	Yes	Yes	Yes
New Jersey	Yes	Yes	Yes	Yes
New Mexico	Yes	Yes	Yes	Yes
New York	Yes	Yes	Yes	Yes
North Carolina	Yes	Yes	Yes	Yes
North Dakota	Yes	Yes	Yes	Yes
Ohio	Yes	Yes	Yes	Yes
Oklahoma	Yes	Yes	Yes	Yes
Oregon	Yes	Yes	Yes	Yes
Pennsylvania	Yes	Yes	Yes	Yes
Rhode Island	Yes	Yes	Yes	Yes
South Carolina	Yes	Yes	Yes	Yes
South Dakota	Yes	Yes	Yes	Yes
Tennessee	Yes	Yes	Yes	Yes
Texas	Yes	Yes	Yes	Yes
Utah	Yes	Yes	Yes	Yes
Vermont	Yes	Yes	Yes	Yes
Virginia	Yes	Yes	Yes	Yes
Washington	Yes	Yes	Yes	Yes
West Virginia	Yes	Yes	Yes	Yes
Wisconsin	Yes	Yes	Yes	Yes
Wyoming	Yes	Yes	Yes	Yes

Pediatric Care Levels: details by level

Level I, Pediatric Acute Care Ward (General Med/Surg)

- O2 by canula (simple or HFNC)
- intermittent respiratory therapies (NEB, Breathing treatment)
- IV fluids with intermittent IV medications
- simple monitoring

Level II, Community Pediatric intensive-care unit (Community PICU)

- provide pediatric resuscitation and routine mechanical ventilation (conventional or CPAP/BIPAP)
- providers can be pediatricians, family practice docs, or adult or pediatric Intensivists

Level III, Tertiary Pediatric intensive-care unit (Tertiary PICU)

- provide pediatric resuscitation and advanced mechanical ventilation (conventional, high frequency, or advanced CPAP/BIPAP)
- provide full or almost full spectrum of pediatric subspecialty access
- providers are pediatric intensivists

Level IV, Quaternary Pediatric intensive-care unit (Quaternary PICU)

- provide pediatric resuscitation and all levels of lung, heart, kidney support (including ECMO, CRRT) and typically manage complex multi system pediatric disease
- provide full spectrum of pediatric subspecialty access
- providers are pediatric intensivists
- support transport and regional education

Summary

- The “joy” of being first -> MOCC or equivalent cross-jurisdictional coordination is incredibly important, but must be done with skillful leadership.
- Kids ARE just small adults -> in a surge everyone needs the ability to care of children
- What the dogs hear -> Precise language = better communication -> improved triage and patient care.

Thank you!

vicki.sakata@nwhrn.org

Michigan Pediatric Medical Operations Coordination Cell (PMOCC)

Importance of Partnership

Damien Siwik

Project Manager University of Michigan

C. S. Mott Children's Hospital

Facilitator Lead Pediatric Coordination Center (PCCC)

Establish a pediatric incident command cell

The cell's main function is coordination of assets and capabilities to best support Michigan's pediatric population during a disaster or other incident.

Concept

A pediatric cell fulfills two main functions:

- 1) Disaster and surge response
- 2) Pre-incident planning and coordination

Founding Principle: Investing in pre-incident planning and coordination yields the best outcomes for disaster or surge events.

The cell acts as an independent agency, not aligned to any organization or healthcare system.

Concept

- ① As a stand-by, functional, incident command cell, the cell can integrate into state operations to coordinate a response for the pediatric element of a full-spectrum incident.
- ② Or the cell can lead the response to a purely pediatric incident.

The cell's main activity during response will be activating and managing the pre-existing plans and agreements.

Concept

The cell works to develop cooperative and appropriate partnerships, plans, MOUs, agreements, and policies prior to an incident.

The cell can engage and advise state leadership on pediatric specific issues.

By consolidating ongoing efforts and housing content, the cell can also serve as an education hub for Michigan pediatric readiness.

Pediatric Care Coordination Center

STATE OF MICHIGAN

CONCEPT OF OPERATIONS

Appendix to the Medical Surge Plan

January 18, 2022

it

Sample	13
Operating	26
Standard	34

Playbook

Our current ConOps is an over-arching, foundation document, but lacks specificity and detail.

The ConOps does not meet the need during an actual pediatric disaster or surge emergency.

A Pediatric Disaster Playbook for state officials could be a great tool to provide the useful, specific guidance, tasks, procedures, and policies for pediatric disaster response.

Standard Operating Procedure (SOP)

1. Guiding Principles
2. Standing Orders
3. Establish Communications
4. Questions to ask
5. Situational Awareness

Develop Contacts

Bed status

Transfer Assets

Pre-positioned Supply Stocks

Activity Log

Peds Critical Care Transfer

Air Evacuation Assets

Prepositioned Supply of Meds

6. Options for Additional Orders
7. Tasks

“How To” Areas

1. Patient Load Leveling
2. Patient Movement
3. Patient Tracking
4. Resource and Supply Allocation
5. Transition Hospitals to Disaster Operations
6. Telehealth
7. Behavioral Health
8. Reunification
9. Demobilize

Michigan Pediatric Medical Operations Coordination Cell (PMOCC)

Importance of Partnership

PLATINUM PEDIATRIC SURGE PLAYBOOK: CATASTROPHIC CAPABLE RESOURCES & TOOLS FOR OPERATIONAL IMPACT

**Transforming Strategies to Strengthen & Support CONOPs Plans
across State Boundaries for Regional Health Systems & Hospitals**



WRAP-EM GROUPS, EXPERTS, & RESOURCES

SUPPORTS STATE, REGIONS, & COALITIONS TO INFORM PLANS

- COVID-19 Focus Group - Pediatric Emerging Issues & COVID-19 Discussion
- Patient Movement & Tracking
 - Surge Group
 - Evacuations
 - NICU/OB Group
- Health Disparities
- Supply Chains



<https://www.canva.com/>

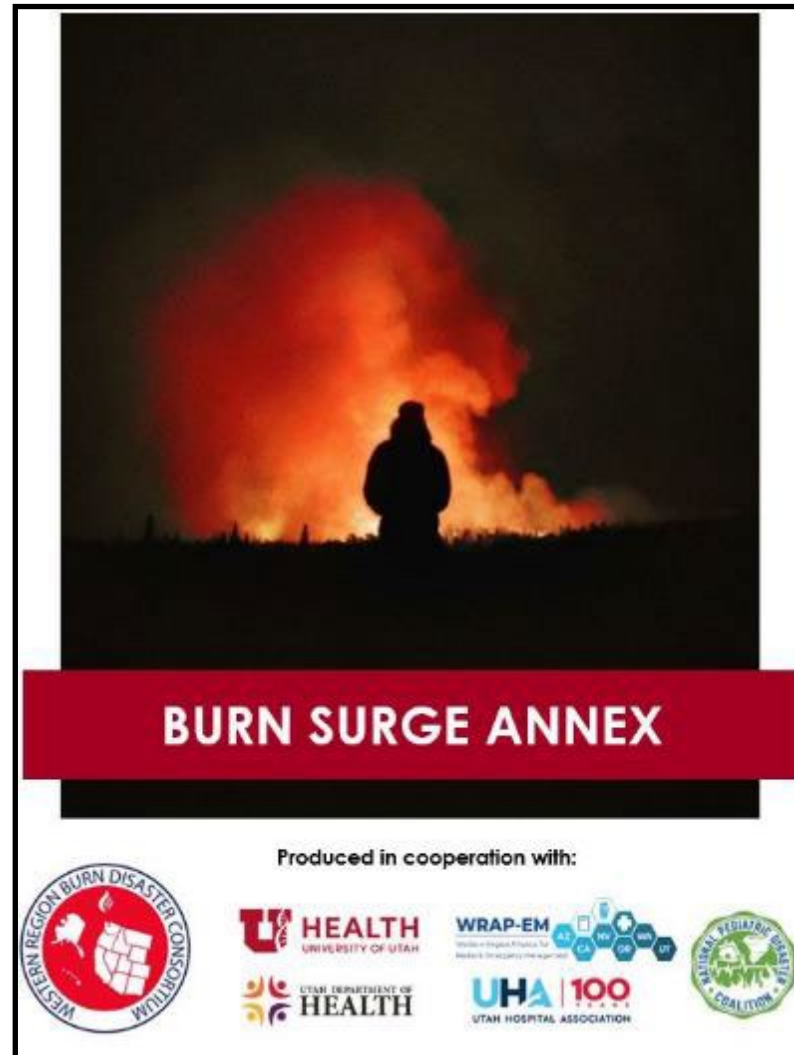
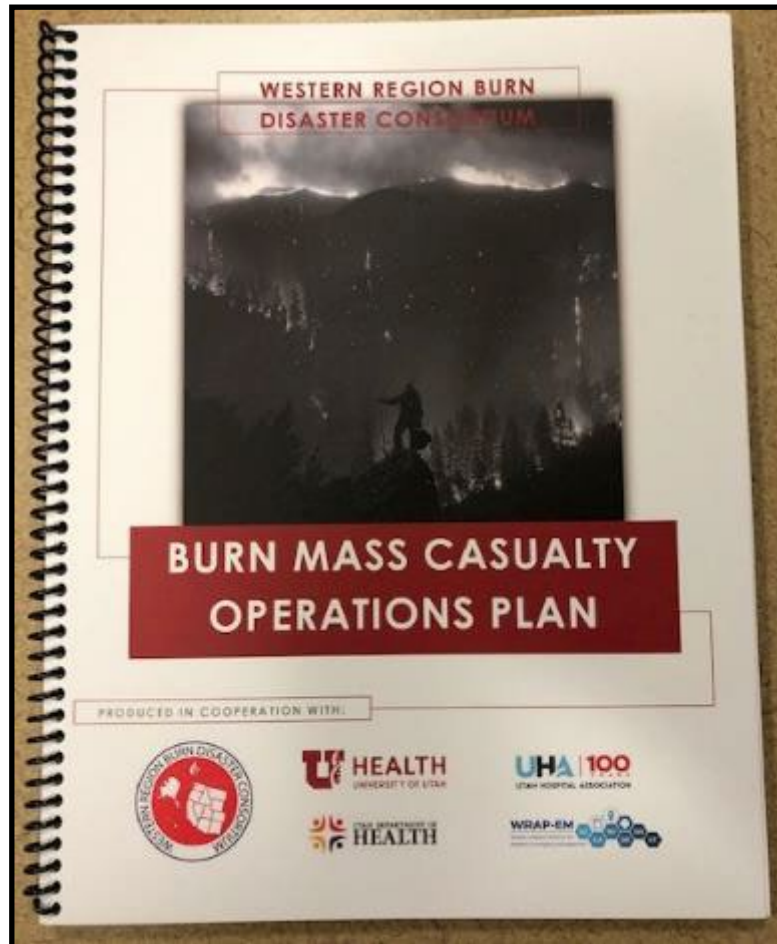
- State Agency Liaisons
- CBRNE/Infectious Disease
- Active Threats/MCI
- EMSC/Pediatric Readiness
- Deployable Assets
- Telemedicine
- Quality Improvement
- Behavioral Health
- Burns Focus Group

- [American Academy of Pediatrics COVID-19 Guidance and Resources](#)
 - [COVID Town Halls](#)
 - [Practice Management Tips](#)
- [Centers for Disease Control and Prevention](#)
- [Project Firstline](#)
- [Emergency Medical Services for Children Innovation and Improvement Center](#)
- [Region V for Kids](#)
- [EIIC Programs](#)
- [Health Resources and Services Administration](#)
- [Office of the Assistant Secretary for Preparedness & Response](#)
- [Pediatric Pandemic Network](#)
- [Western Regional Alliance for Pediatric Emergency Management](#)

WESTERN REGION BURN DISASTER CONSORTIUM

RESOURCES: BURN MASS CASUALTY INCIDENT

CONOPS & APPENDICES/CRISIS STANDARDS OF CARE (CSC) TRAINING SITE



- <http://crisisstandardsofcare.Utah.edu>
 - **Burn CSC – Apple/Android**



Courtesy of
Annette Newman (Matherly) MS, RN CCRN
Community Outreach/Burn Disaster Coordinator
Western Region Burn Disaster Consortia Coordinator

BEHAVIORAL HEALTH COMPONENTS

Job Action Sheet – Los Angeles County EMS Agency Version

Operations Section
Medical Care Branch
Mental Health Unit Leader
MENTAL HEALTH TRIAGE MANAGER
Page 1

MENTAL HEALTH TRIAGE (PsySTART) MANAGER

Mission: Coordinate Disaster Mental Health Triage activities.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

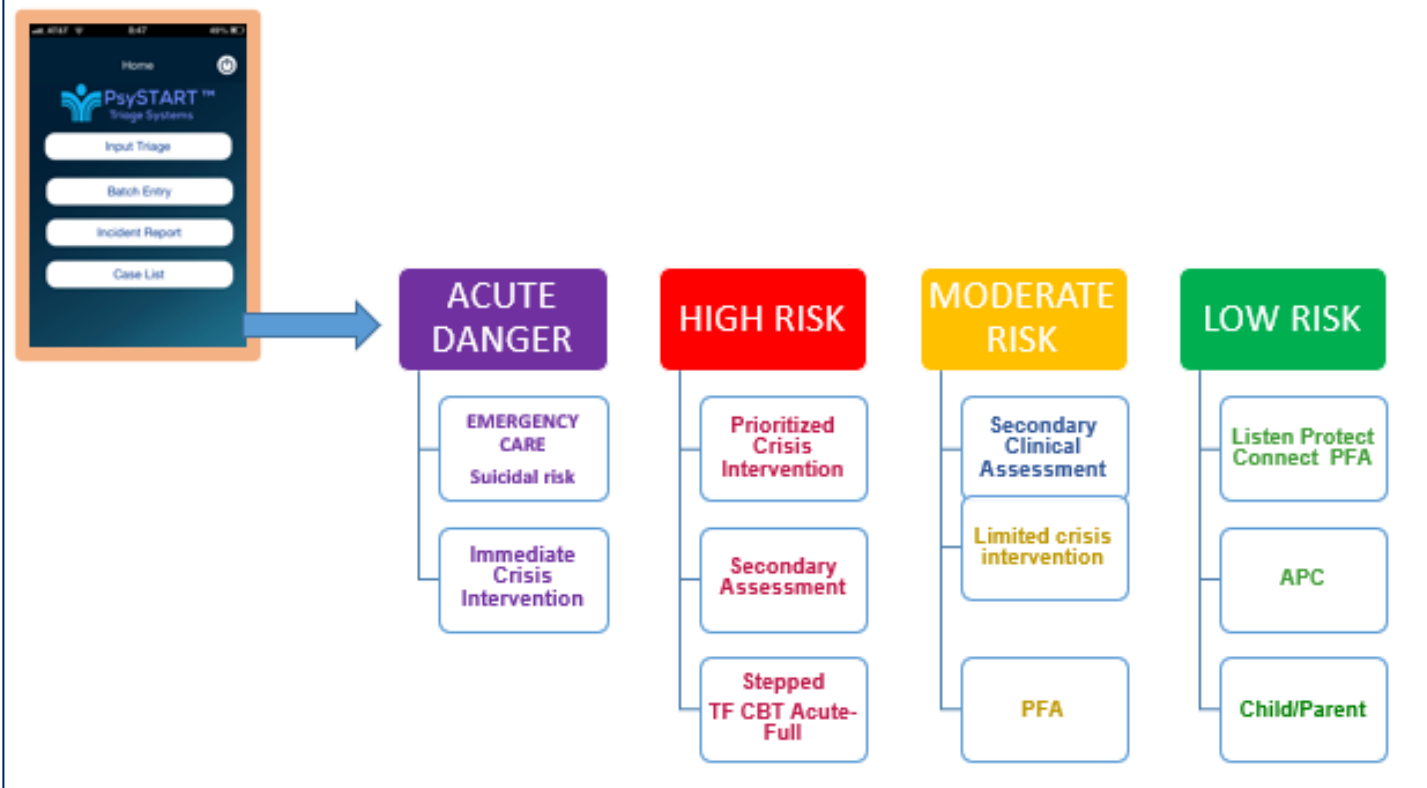
Position Reports to: Mental Health Unit Leader Signature: _____

Hospital/Clinic Command Center (HCC) Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	Time	Initial
Receive appointment, briefing, and appropriate forms and materials from the Mental Health Unit Leader.		
Ensure that you have a user name and password into the PsySTART Mobile Web Application. (Register at: insert PsySTART URL here , click on "join us" to create a new account", enter all fields plus the registration code).		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Notify your usual supervisor of your HICS assignment.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
<p>Initiate the PsySTART mental health triage activity.</p> <p>Meet with the Mental Health Unit Leader to obtain a briefing including the following information:</p> <ul style="list-style-type: none"> Type and location of incident. Number and condition of expected patients. Estimated arrival time to facility or rate of current patient surge. Unusual or hazardous environmental exposure risks. Location(s) of surge of people (who may or may not be victims of the disaster) who have arrived at the facility or who are calling to ask for assistance (e.g., facility phones, reception area, ED, decontamination area, isolation area), unaccompanied children, etc. Anticipated mental health needs. Current status regarding coordination with/availability of facility mental health and spiritual care staff, clinical staff, and volunteers who are assigned to your facility (disaster) "mental health response team". Current status/need to request additional mental health staff from your facility, partner hospitals/clinics, your facility Disaster Resource Center (DRC) group, or other mutual aid partners including the LA County Department of Mental Health (LAC DMH) and/or the LA County EMS Agency LA County Disaster Healthcare Volunteers (ESAR-VHIP/MRC) program. Any special circumstances that must be addressed due to the nature of the incident, such as special languages, cultural needs, unaccompanied children or security concerns. 		
<p>Work with the Mental Health Unit Leader to initiate, plan, project, and coordinate mental health triage of patients.</p> <ul style="list-style-type: none"> Determine the PsySTART mental health triage "work flow" for your site including of how, when and who will use the PsySTART Mobile Web 		

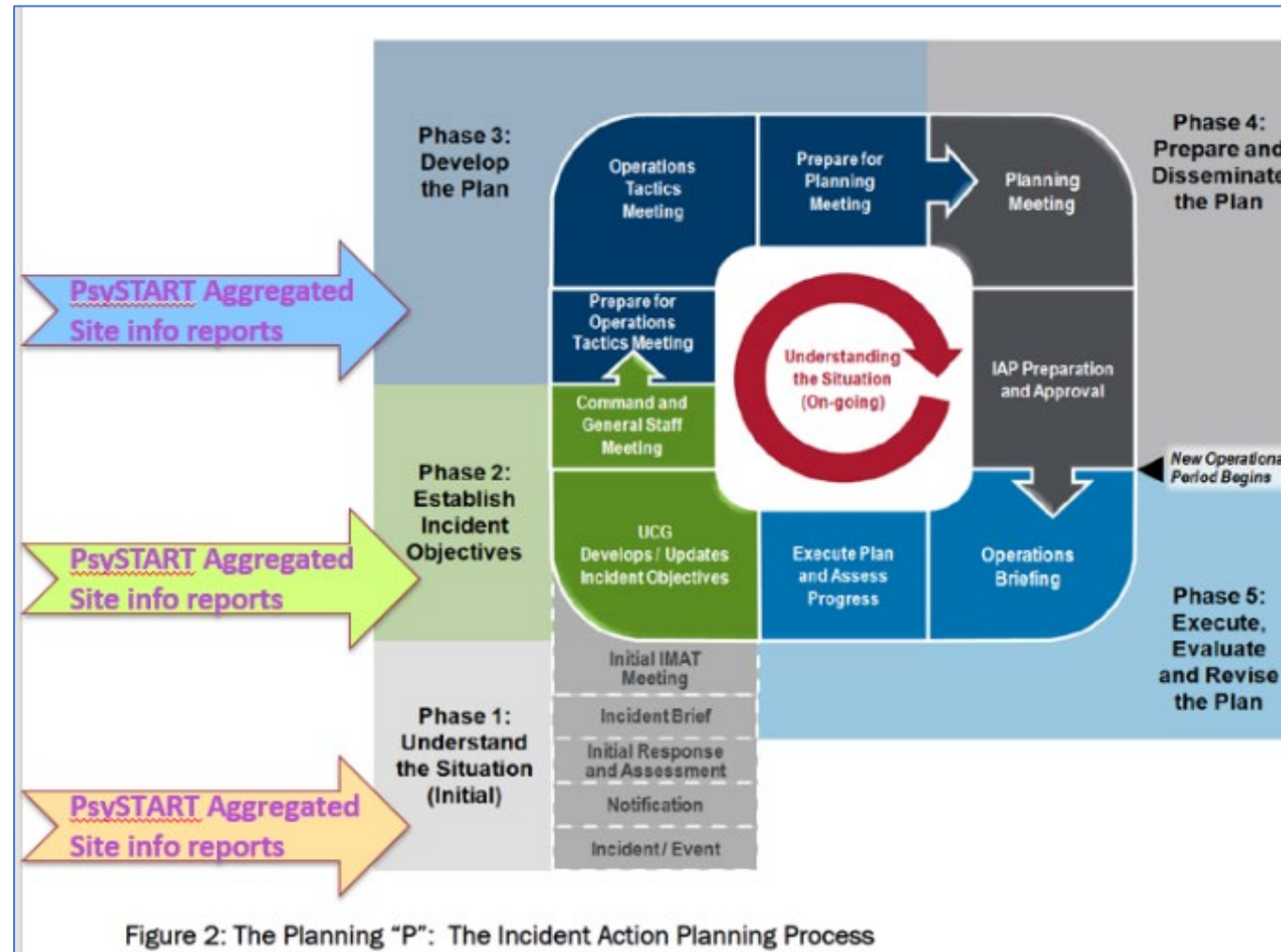
PsySTART-WRAPEM Stepped Triage to Care Model



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BEHAVIORAL HEALTH COMPONENTS



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Harbor-UCLA Medical Center, David Geffen School of Medicine at UCLA

<https://wrap-em.org/index.php/mentalhealth>

REGIONAL PEDIATRIC SURGE – MOMENTUM INTO THE FUTURE

CONCLUSION

- **PLAYBOOK OPTIONS can be adapted & modified** to strengthen pediatric surge capability with “best practice” resources, access to SMEs, & with operational **CONOPs**
- Evidence-based **essential elements & “best practices” strengthen healthcare system**
- Benefits of a regional approach in **leveraging partners collectively in development process across coalitions to ensure a “living” plan & readiness before a catastrophic event**
- Test & evolve your PLAYBOOK in “real time” & in exercises for catastrophic events

SUPPORTS FUTURE VISION

- Recommendations can be utilized by future integrated command structure across state jurisdictions to collectively leverage & incorporate pediatric situational awareness & response capabilities

<https://wrap-em.org/>



info@wrap-em.org



Learn more about WRAP-EM and our partners.

Explore a wealth of resources and tools collected here to assist healthcare centers, public agencies, providers and families!

Regional
Resources



COVID-19 and
MIS-C

Mental Health
Resources



Provider
Resources



Questions?

Contact

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