Creating and Building a PECC Program in Rural America

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Disclosures

In relation to this specific presentation, I declare that there are no conflicts of interest related to this specific presentation, and no off-label use of medications will be discussed

A conflict of interest is any situation in which a speaker or immediate family members have interests, and those may cause a conflict with the current presentation. Conflicts of interest do not preclude the delivery of the talk but should be explicitly declared. These may include financial interests (eg. owning stocks of a related company, having received honoraria, consultancy fees), research interests (research support by grants or otherwise), organisational interests and gifts.

Upon Completion, Participants should be able to:

- Describe and discuss strategies/tactics for developing a PECC program.

- Understand the PECC role and its importance for all EMS agencies.

- Apply lessons learned to confront and navigate barriers.

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Roles in the PECC Project

- Gail P Gibson, RN BSN, MN, CPM, FABC **(Co-PI)**
  - RN Nurse Consultant | Bureau of Family Health, Louisiana Department of Health
- Cindy Duplessis-Childers, NRP **(Program Manager)**
  - EMSC Manager| Bureau of Family Health, Louisiana Department of Health – Office of Public Health
- Toni Gross, MD, MPH **(Co-PI)**
  - (Formerly) Children's Hospital New Orleans, Chief of Emergency Medicine
- Randy Kearns, DHA, MSA, NRP(ret.) **(Program Director)**
  - University of New Orleans, Dean of the College of Business Administration
- Meg Marino, MD **(EMSC Medical Director)**
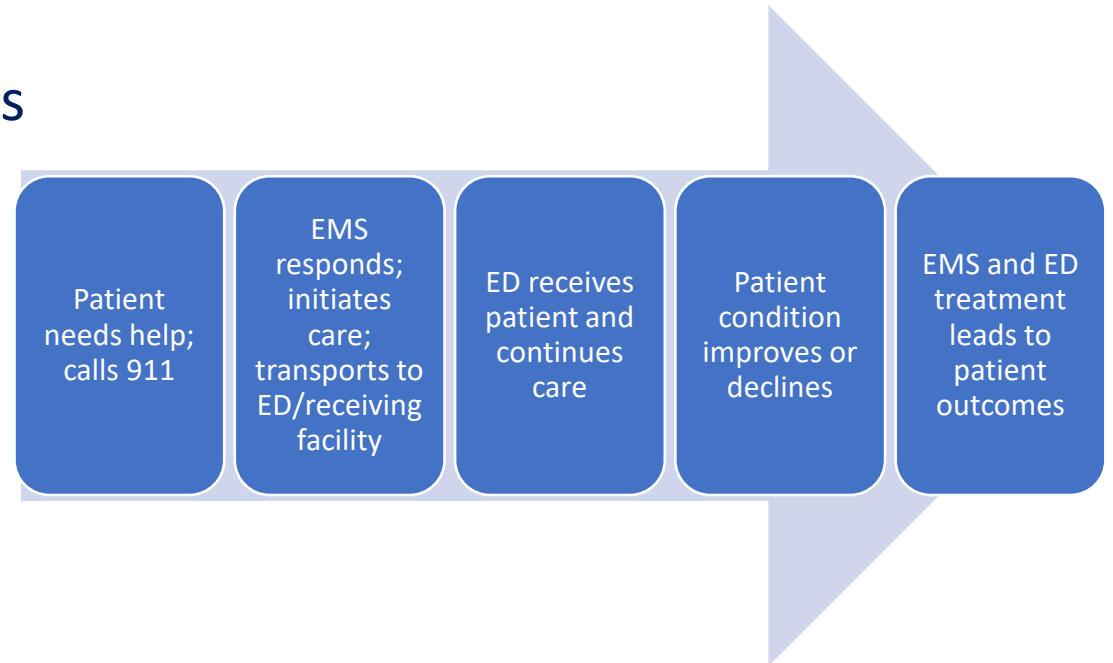 - New Orleans Emergency Medical Services, Chief and Medical Director

EMSC is…

- Federally funded
  - LA is one program of 56 across the nation and U.S. territories
  - Located in the Louisiana Department of Health (LDH)
- Federal Performance Measures
  - Hospital recognition (trauma & medical)
  - **Pediatric Emergency Care Coordinators (PECCs)**
  - **Policy and guideline development**
  - NEMSIS data submission (LERN)
  - EMSC Permanence
- A **resource** to you (EMS Agencies & Emergency Departments)
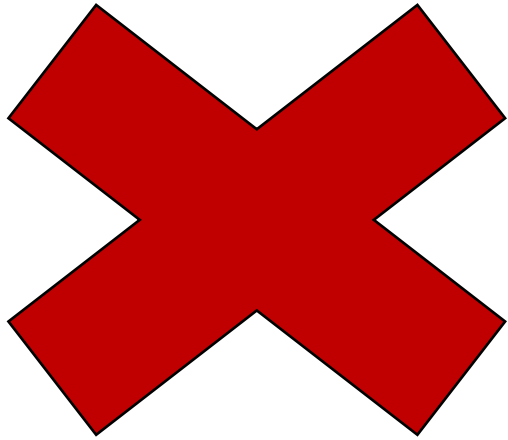
EMSC Overview

- **<u>Mission:</u>** Reduce child and youth mortality and morbidity rates in Louisiana by improving pediatric emergency **healthcare systems**
- How:
  - Data driven, evidence -based practices
    - Requires data
    - Requires practice
  - Implementing policies and guidelines
    - Requires policies
    - Requires guidelines

| Patient needs help; calls 911 | EMS responds; initiates care; transports to ED/receiving facility | ED receives patient and continues care | Patient condition improves or declines | EMS and ED treatment leads to patient outcomes |

EMSC is not…

…State funded
…A regulatory body

PM 02: PECC

- **Pediatric Emergency Care Coordinator (PECC)**

  The percentage of EMS agencies in the state or territory that have a designated individual who coordinates pediatric emergency care.

- **Target Percentage of EMS agencies in the state or territory <u>have a designated individual</u> who coordinates pediatric emergency care.**
  - By 2020, 30 percent of EMS agencies
  - By 2023, 60 percent of EMS agencies
  - By 2026, 90 percent of EMS agencies

Why a PECC Program?

Louisiana - Highest child mortality rate (ages 1-14) in the U.S. (2014–16) *(most complete dataset available at the time of the grant application, 2018).*

System readiness in pediatric emergency care was a critical priority.

Pediatric Care Coordinator (PECC)

The PECC is dedicated to staying abreast of the most current evidence based and best practices in pre-hospital pediatric emergency care.

The PECC understands the importance of and advocates for the EMS agency to collect and submit EMS data by collaboration with the Louisiana Emergency Response Network (LERN) which is complaint with the most current version of the National EMS Information System (NEMSIS).

The PECC has direct access to EMS leadership, including inclusion, involvement, and collaboration to advocate specifically for improving pediatric care.

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The Need

National literature explains the need to improve pediatric emergency care across the nation and internationally.

Louisiana data .

EMS Agencies

Individual providers

The Need

National literature explains the need to improve pediatric emergency care across the nation and internationally.

Louisiana data is sobering, our *pediatric morbidity and mortality rates are the highest in the nation.*

EMS Agencies

Individual providers

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EMS Agencies struggle to incorporate new and emerging approaches to managing pediatric patients.

Individual providers

The Need

National literature explains the need to improve pediatric emergency care across the nation and internationally.

Louisiana data is sobering, our pediatric morbidity and mortality rates are the highest in the nation.

EMS Agencies struggle to incorporate new and emerging approaches to managing pediatric patients.

Individual providers all to often make mistakes or delay treatment for pediatric patients because they lack confidence in caring for them.

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The Vision

1. Reduce childhood death and disability

2. Improve prehospital emergency care for children

3. Increase everyday readiness to care for children in EMS systems
   - Consistent coordination of pediatric care

The Vision – cont.

4. Rely on individuals designated to coordinate pediatric care to assure high standards of care

5. Create an EMS Pediatric Emergency Care Coordinator Consortium
   - Facilitate data sharing, centralize education resources, and regional networking

6. Establish an EMS agency pediatric care recognition program

7. Strengthen prehospital clinician resilience

Project Aim & Stakeholder Engagement

❖ Uniting rural and urban providers.

❖ Metro areas as clinical leaders and high volume pediatric care providers

Building the PECC Network

- Started in urban services, expanded to rural areas

- Supported by EMSC leadership and HRSA grant.

Encouraging Participation

❖ Awareness campaigns (2018 launch).

❖ Semi-annual in-person and monthly virtual meetings.

❖ Annual state conferences (attendance doubled).

❖ State EMS Bureau: required reporting field for PECCs.

Challenges Faced

Louisiana is now the only state in U.S. history to be hit by two hurricanes of over 150 mph. This remarkable occurrence highlights the state's vulnerability to severe weather, as it has experienced significant hurricanes in the past. 99.9 KTDY

COVID-19 pandemic.

18 federal disaster declarations (wildfires, hurricanes, etc.).

Competing priorities for agencies.

Serving All Agencies

118 unique EMS agencies: non-transporting, low to no pediatric volume, rural.

Shared PECC services and expertise for smaller agencies.

CONSORTIUM

Formally established in 2024 through a partnership with the EMSC Program.

Created and approved a La. PECC Consortium Charter

Chair: Mendy White

Co-Chair: Vincent Trabona

The Goal of the Louisiana EMS PECC Consortium is to:

- Provide a forum for collaboration, sharing of resources, and sharing data for quality improvement, as well as supporting clinicians and agencies in their pediatric readiness efforts

Consortium Charter

- Improving the Network.
- Shared Governance.

PECC
PEDIATRIC
EMERGENCY CARE
COORDINATOR

Louisiana EMS

Pediatric Emergency Care Coordinator (PECC)

CONSORTIUM CHARTER 2024

PECC CONSORTIUM CHARTER 2024

PECC MISSION

The mission of the Louisiana (LA) Emergency Medical Services (EMS) PECC Consortium is to:

Ensure an organized and deliberate prehospital system of care is available for every injured and sick child across the State of Louisiana.

PECC VISION

The Vision of the Louisiana EMS PECC Program is to:

Ensure optimal emergency medical care for all children in Louisiana.

PECC GOAL

The Goal of the Louisiana EMS PECC Consortium is to:

Provide a forum for collaboration, sharing of resources, and sharing data for quality improvement, as well as supporting clinicians and agencies in their pediatric readiness efforts.

External Objectives

Review and promote evidence-based practices

Aggregate data for quality assurance and improvement

Coordinate resources to build community and provider capacity

Recruit PECCs from EMS agencies

Advise the Louisiana Department of Health, including an EMS Agency Pediatric Readiness Recognition program

Provide an annual Pediatric Symposium continuing education conference

Internal Objectives

Collaborate within PECC consortium

Adapt internal procedures to maximize efficiency, promote equity, and drive innovation

Share knowledge and experience

Receive train-the-trainer education

Standardize triage, treatment, and transport protocols

Frequency and Activities

Monthly: PECC Pulse Check

Virtual

Agenda sent ahead of the meeting

Establish rapport

Introduce new members

Open forum for questions, concerns

Brief educational topic

Frequency and Activities

Quarterly: Regional CE opportunities
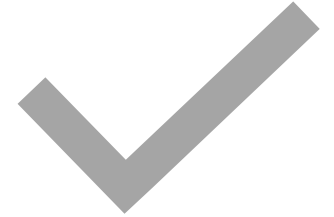
Frequency and Activities

Annually: In-person

Train-the-trainer

Case reviews

Leadership elections

Set annual goals

Louisiana PECC Pediatric Symposium 2024

📅 Sat, Dec 7, 2024, 8:00 AM

Draft ⌄   Preview ↗
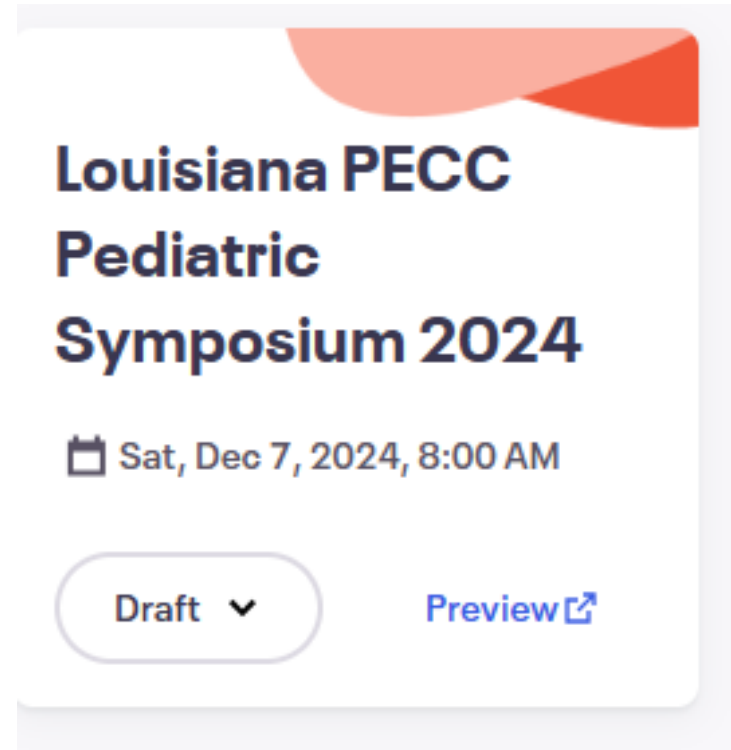
Louisiana PECC Pediatric Symposium New Orleans, 2024

Maintaining Momentum

❖ Initial HRSA grant support.

❖ Transition to local leadership and EMSC program backing.

❖ Launch of PECC webpage

❖ Ongoing activities: monthly meetings, annual conference, provider recognition, hospital expansion.

Tracking Progress

❖ Longitudinal Analysis (2017-2023)

❖ Agencies self-reporting PECC selection

❖ Annual statewide surveys

Program Growth

PECCs Reported by Year

```
| Year | Number of PECCs
|-------- |--------------|
| 2018 |    13
| 2020 |    29
| 2021 |    29
| 2022 |    39
| 2023 |    48
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PECC Growth 2018-2023
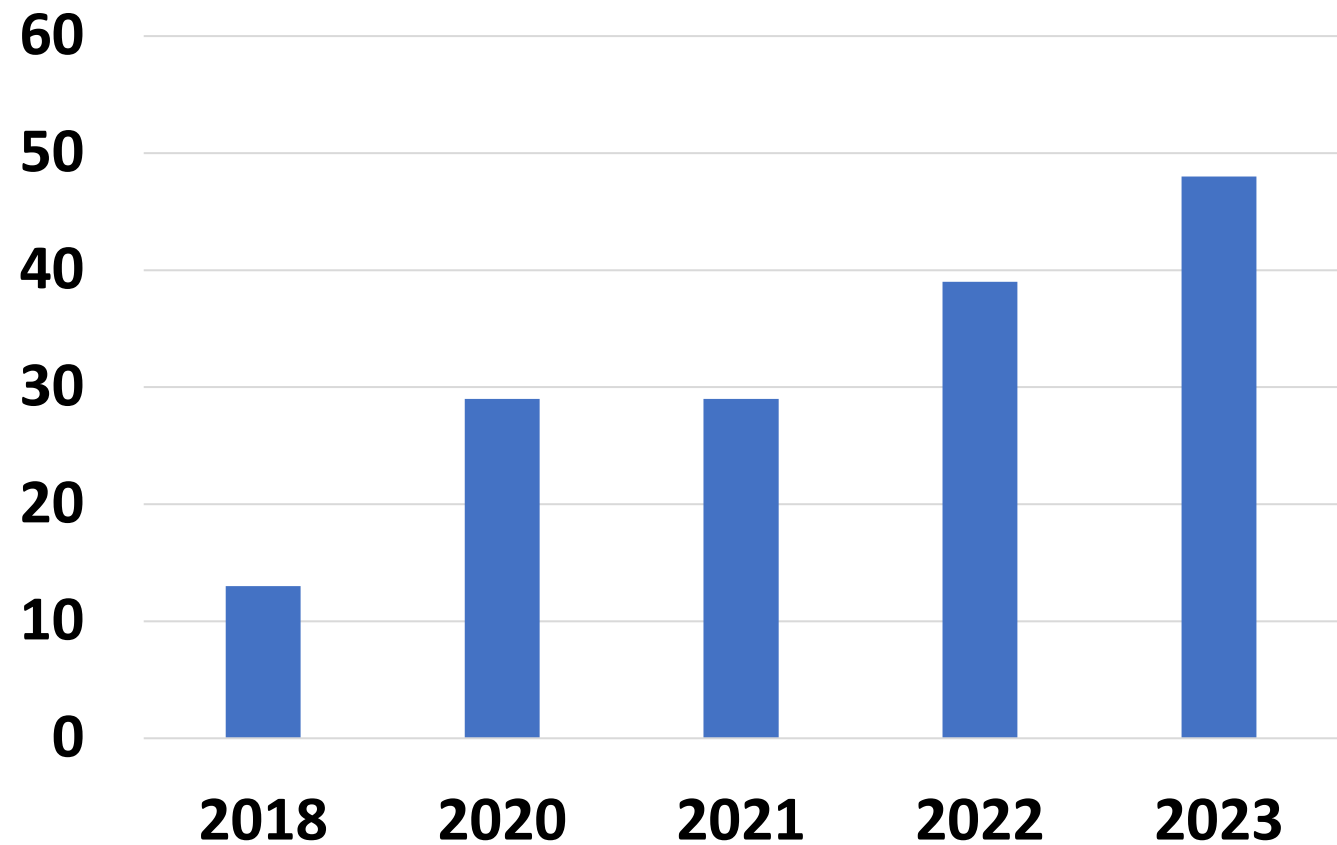
Louisiana EMS for Children Program 2023 EMS Agency Survey Results

Number of respondents: 118

Number Surveyed: 118

Response Rate; 100%

Pediatric Emergency Care Coordinators 41.0% (48/117)

(one air-only agency excluded)

EMSC wants 100% of EMS agencies to have a PECC be part of the statewide consortium.

Program Impact

- 369% growth in agencies with a PECC.

- Ongoing consortium-led efforts.

- Expanding to hospitals and broader healthcare system.

What does this mean?

Opportunities abound
- for OUR pediatric patients
- for Louisiana to be a leader (new PM)
- for each agency to improve pediatric care

Agency considerations
- Use current human resources (new hire is not necessary)
- Determine % of time dedication (not full time)
- 1 person may be identified for multiple agencies

Key Takeaways

❖ Multiple methods needed for awareness and engagement.

❖ Flexibility and adaptation critical in rural settings.

❖ Sustained growth possible with local leadership and ongoing support

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Clarification

- While there were other aspects and successes from this five-year effort, the purpose of this report is to focus on the PECC component of the effort.
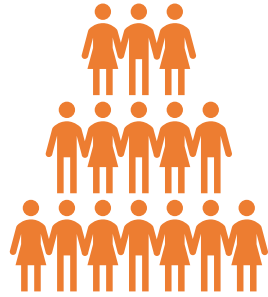
EMSC will bring these individuals together

Collaboration, not isolation

For more information:

Cindy Duplessis, EMSC Manager
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Mendy Jinks –Chair
medic8_cpadii.com

Vincent Trabona- Co-Chair.
vtrabona@mandevillefire.com

Thank You!

Questions?

Acknowledgments & Disclaimer

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Objectives

Upon completion, participants will be able to…

1. Identify disaster planning approaches to strengthen pediatric disaster management within institutions and in partnership with other hospitals, healthcare coalitions, and external partners.

2. Highlight effective communication strategies for pediatric professionals to enhance connection, engagement, and relationship building with healthcare coalitions.

3. List strategies to improve evacuation, reunification, surge, and triage/infections/decontamination planning based on actions from exercises, drills, and lessons learned from disaster response events.

Overview

Pediatric Pandemic Network

Legacy of Improving Everyday and Disaster Readiness

1991
EMSC Targeted Issues Grants & National Resource Center Created

1997
EMSC State Partnership Program replaces individual state grants

2012
National Pediatric Readiness Project launches

2019
Prehospital Pediatric Readiness Project launches

2022
ASPR adds third PDCOE

2021-22
Pediatric Pandemic Network created

1980s

1990s

2000s

2010s

2020s

1986
First EMSC grants awarded to 4 states

1995
EMSC Data Center created

2002
Pediatric Emergency Care Applied Research Network (PECARN) created

2016
EMSC Innovation & Improvement Center (EIIC) replaces the National Resource Center

2019
ASPR launches 2 Pediatric Disaster Centers of Excellence (PDCOEs)

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Pediatric Readiness

- Children represent 22% of the U.S. population
    - 30% of children/youth have special health care needs, medical complexity
    - *Systems of care* must be optimized for children:
        - Concentration of resources across urban hubs
        - Gaps in geographic representation
    - Gaps in interstate coordination & systems of care
    - Decreasing capacity: >1,000 pediatric unit closures
- Optimizing care for children in public health crises requires systems and communities to be "pediatric ready"

Population density, 2010

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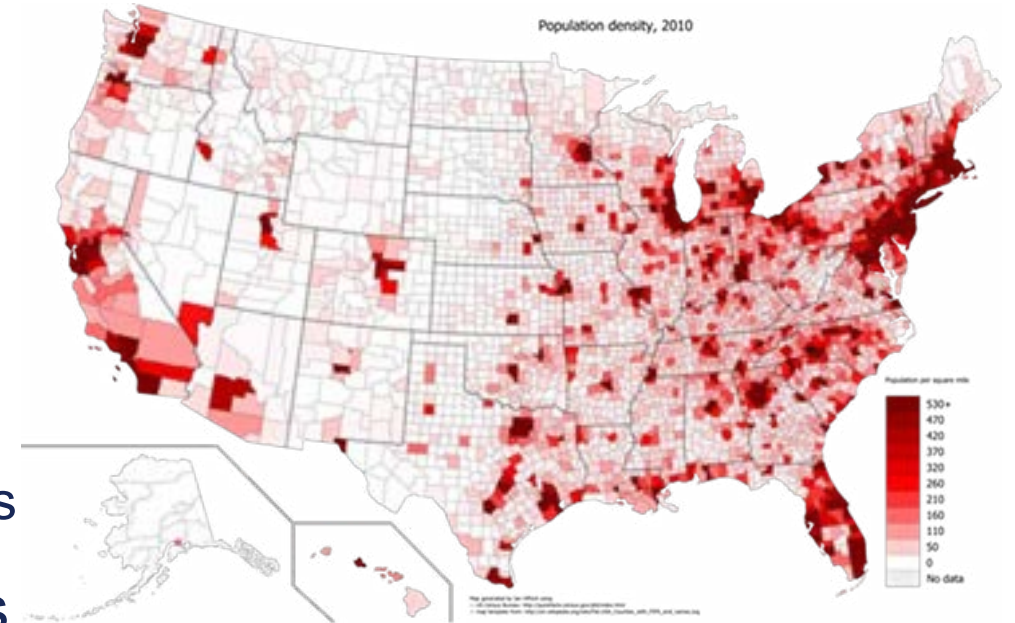
Closing the Gaps: Examples from COVID-19 that Remain

- Behavioral health
  - Increased volumes
  - >160,000 children experienced the loss of a primary caregiver
  - Rising pediatric suicidality
- Disparate access to resources exacerbating differences and outcomes of care
  - Cancelled surgical procedures
  - Exacerbations of chronic illnesses
- Staffing & workforce: 18.5% attrition
- Gap: a coordinated national pediatric and disaster readiness strategy

PPN Goals

➢ **Expand** children's hospitals partnership with local, state, and national emergency preparedness systems

➢ **Collaborate** with community and other pediatric partners

➢ **Improve** the pediatric emergency readiness of health care systems, including hospital and prehospital systems

➢ **Increase** the capability of telehealth system utilization in disasters

➢ **Accelerate** the development and dissemination of research-informed pediatric care

➢ **Coordinate** research-informed responses to disaster and health threats impacting children

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Hub Sites, Affiliate Hubs, and Key Partners

PPN Organization

HRSA MCHB

Advisory Committees

Executive Principals

Network Operations

Service Cores

- **Analytics**
- **Community Engagement**
- **Education**
- **Communications/Dissemination**
- **Evaluation**
- **Quality Improvement**
- **Research & Innovation**

Support

Everyday Domains

- Infectious Diseases
- Medical Home
- Mental & Behavioral Health
- Pediatric Readiness
- Prehospital
- Telehealth
- Trauma/Burns

Disaster Domains

- Capacity & Capability (Surge)
- CBRN *
- Deployable Assets
- Drills & Exercises
- Health Information Portability
- Reunification
- Supply Chain

Operations Leadership Hub Sites

Rainbow Babies & Children's (Lead Site)
Children's National Hospital (Lead Site)
UCSF Benioff Children's Hospitals
SSM Cardinal Glennon Children's Hospital
Children's of Alabama
Children's Mercy Kansas City
Lurie Children's Hospital
Northwell Cohen Children's Medical Center
Norton Children's Hospital
Intermountain Primary Children's Hospital
Seattle Children's Hospital
Yale New Haven Children's Hospital
Dell Children's Medical Center
Oklahoma Children's Hospital

* Chemical, Biological, Radiological, and Nuclear

Task Forces: Weather
CYSHCN/Children with Medical Complexity (CMC)

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PPN Core Activities

1
Provide training, support, and tools

2
Sharing best practices

3
Encouraging collaboration instead of competition

4
Using a systems-based approach to align priorities and strategies

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Ultimate Goal - Ongoing/Integrated Network

The Pediatric Pandemic Network aims to empower health care systems and communities to provide high-quality, equitable care to children every day and in crises.

- DNC: strengthen pediatric disaster preparedness in US children's hospitals.

- DRC: improve pediatric disaster response capability and capacity among children's hospitals.

AIM: Ensure that at least 90% of children's hospitals have working partnerships with local, state, regional and/or national emergency preparedness systems and networks to address the needs of children and families during disasters.

Based on evidence-based material and domains/topics in…

Checklist of Essential Pediatric Domains and Considerations for Every Hospital's Disaster Policies
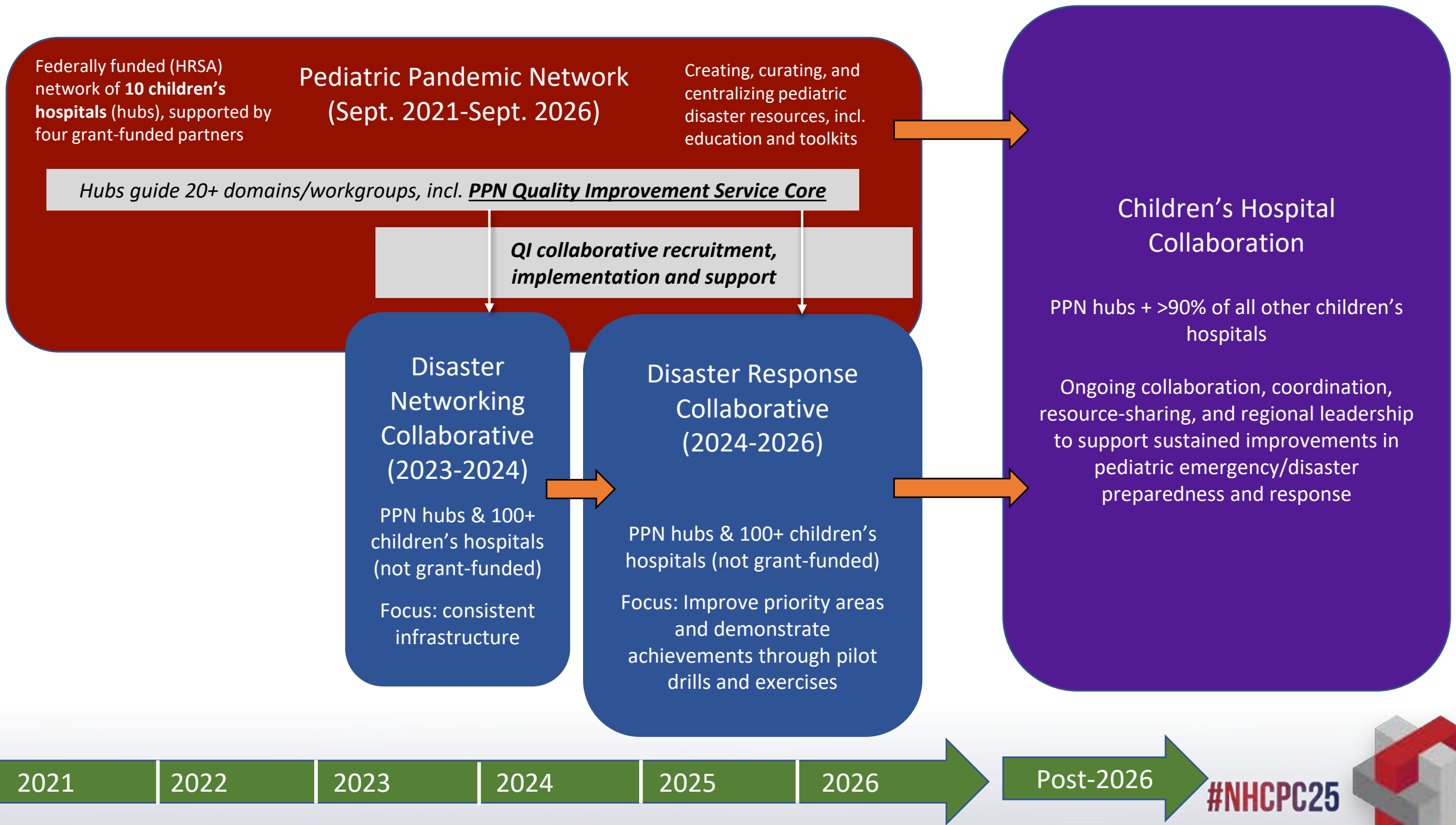
Quality Improvement Collaboratives
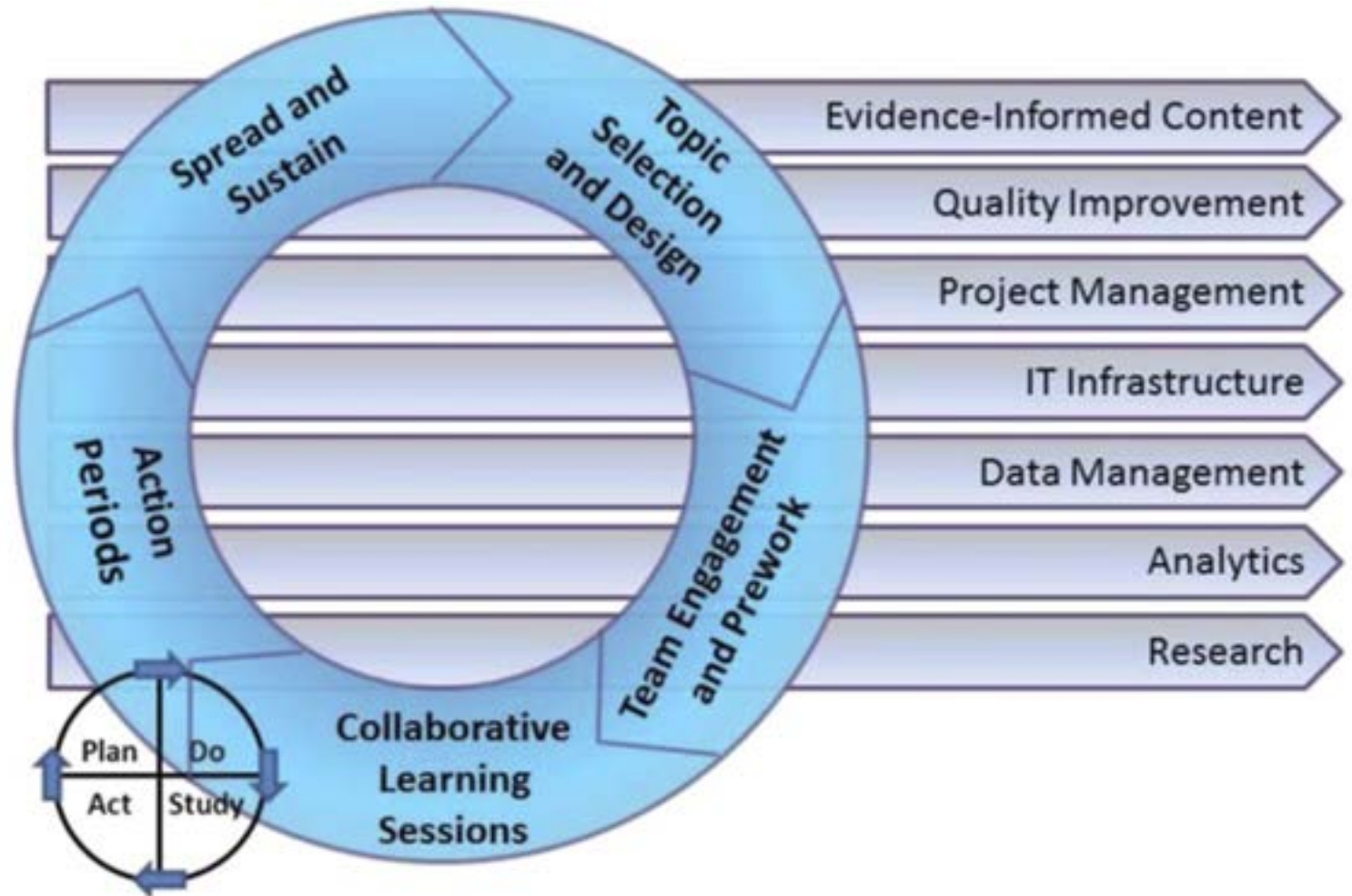
Spread and Sustain

Topic Selection and Design

Action Periods

Team Engagement and Prework

Collaborative Learning Sessions

Plan | Do
Act | Study

Evidence-Informed Content
Quality Improvement
Project Management
IT Infrastructure
Data Management
Analytics
Research

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The Disaster Networking Collaborative (DNC)

- Goal: strengthen pediatric disaster preparedness in US children's hospitals
  - Internally within the hospital; externally in collaboration with others
- "All Teach - All Learn": participants share with/learn from each other, supported by experts
- 10 monthly 90 minute sessions; September 2023 through June 2024
- Foundational areas or key topics upon which teams focused:
  - C-suite or hospital leadership support and buy-in (letter of commitment)
  - Infrastructure: roles/responsibilities, emergency committee
  - Engagement with the emergency management landscape

Growing Your Influence in the Emergency Management Landscape

The illustration below can be used to guide your hospital's disaster management team or experts to engage with the EM landscape and promote leadership roles in pediatric preparedness.

DNC Participants

DNC Hospital Types

- Free standing children's hospital
- Children's Hospital within a larger healthcare system

50% / 50%

Annual Pediatric Patient Volume

- Low: < 1,800 pediatric patients
- Medium: 1,800 - 4,999 pediatric patients
- Medium to High: 5,000 - 9,999 pediatric patients
- High: >10,000 pediatric patients

Licensed Pediatric Beds

Number of Hospitals

0-49, 50-99, 100-199, 200-499, 500+
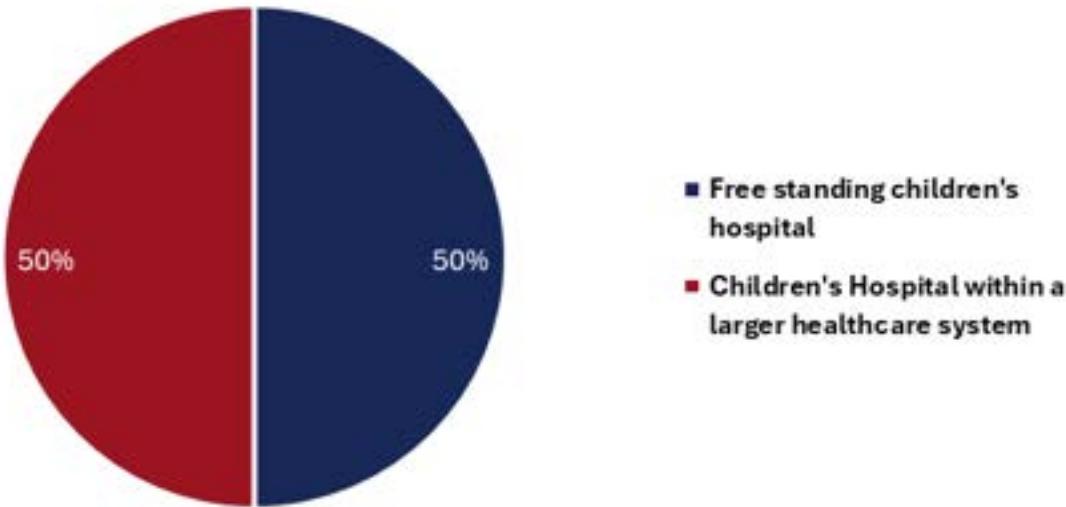
Licensed Beds

102 children's hospitals
530+ team participants

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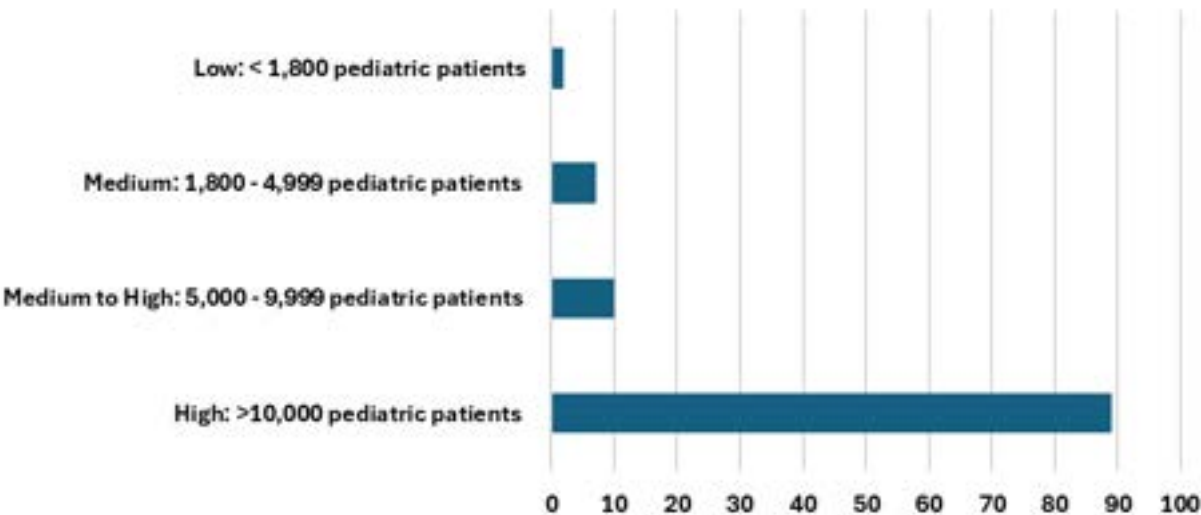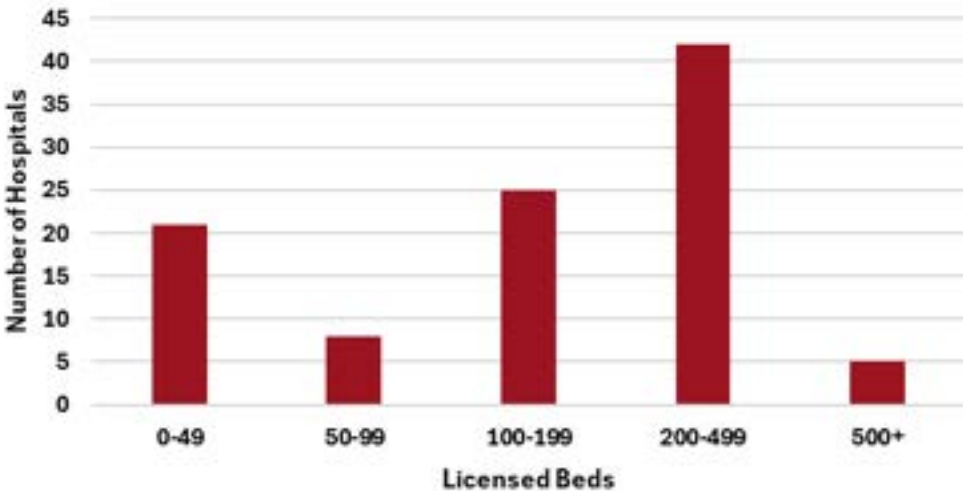
DNC Team Member Roles

DNC Hospitals
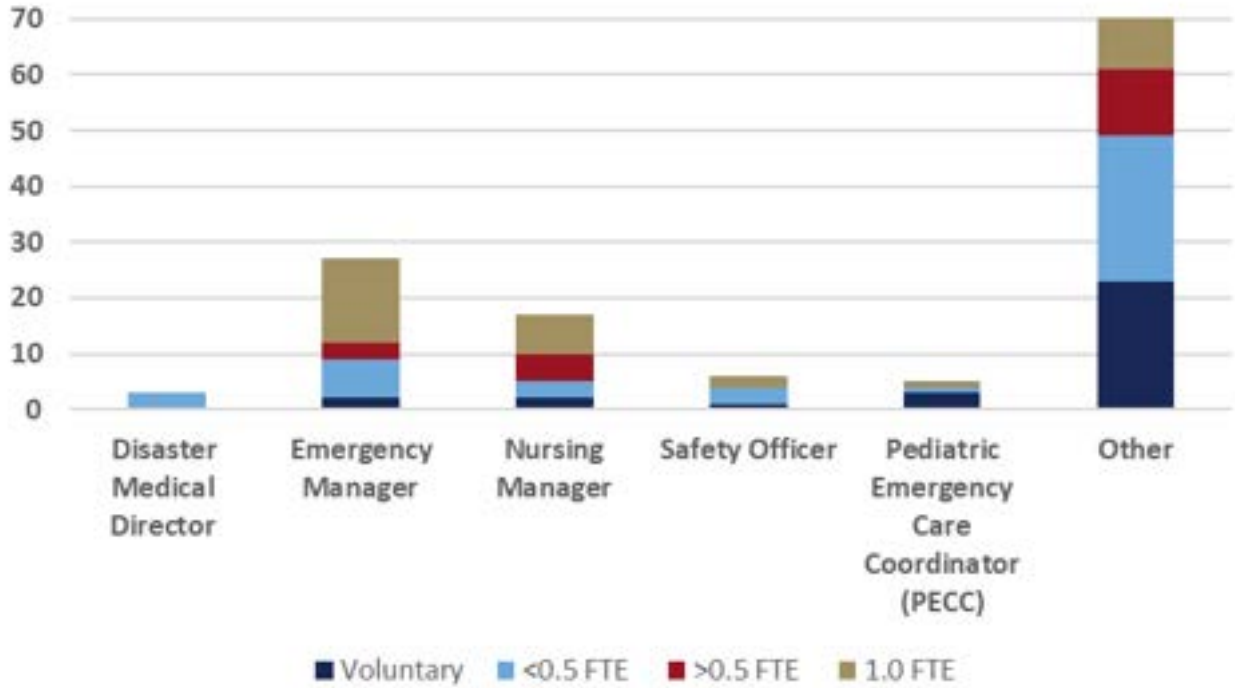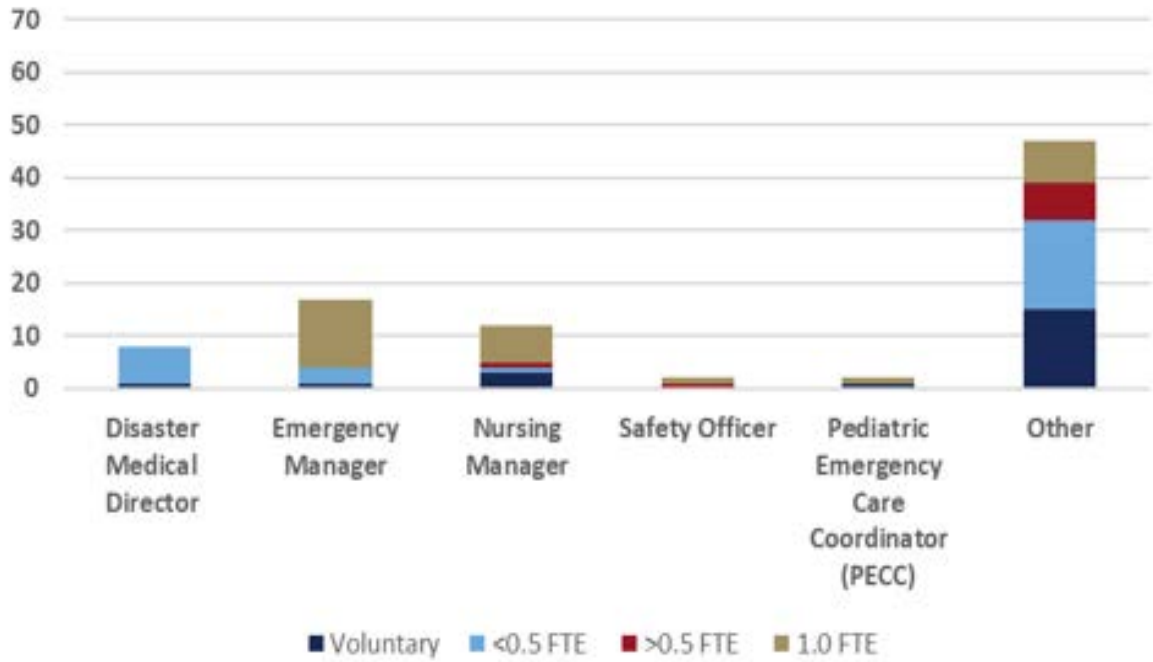
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DNC Hospital Funding

PDMD Funding Sources

- No Funding, 21%
- University, 8%
- Grant, 4%
- Academic/Department Division, 13%
- Hospital, 71%
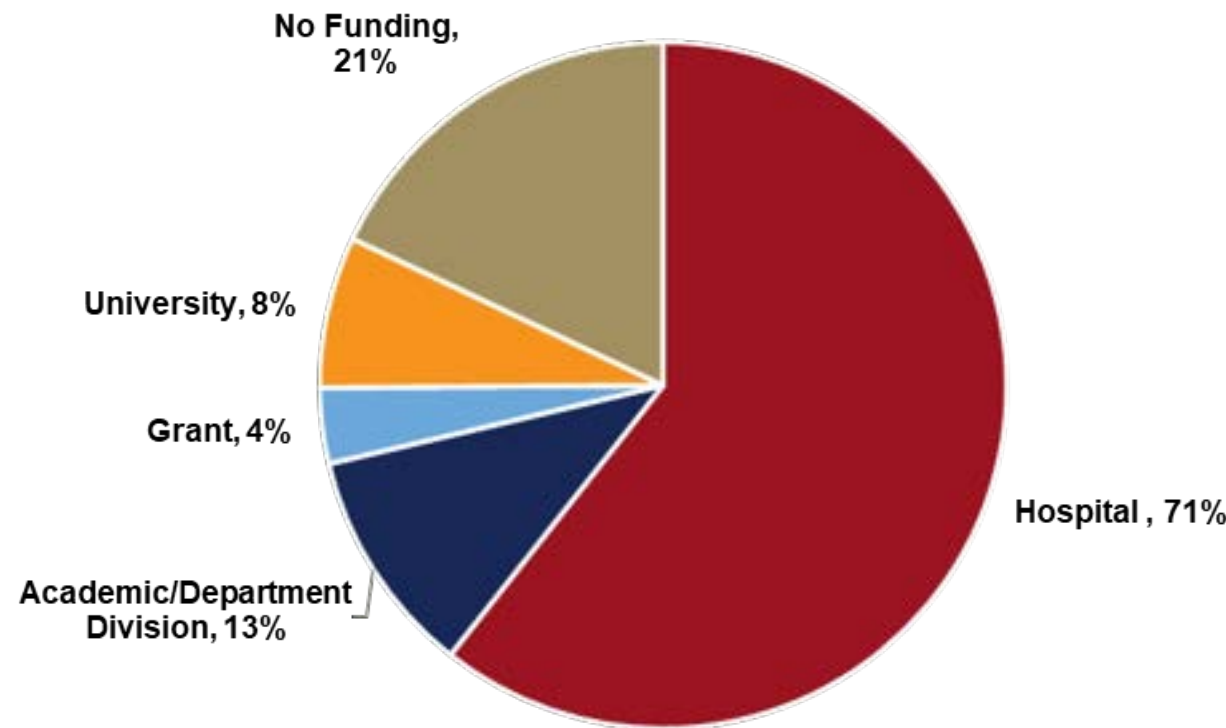
HOUSING FOR DM/EM PERSONNEL

- FACILITIES 21%
- SECURITY 24%
- QUALITY AND SAFETY 9%
- RISK MANAGEMENT 6%
- CLINICAL DIVISION 23%
- OTHER 44%

OTHER HOUSING

- EMERGENCY DEPARTMENT 4%
- EMERGENCY MANAGEMENT 30%
- ENVIRONMENTAL OPERATIONS... 4%
- EXECUTIVE LEADERSHIP (C... 11%
- HOSPITAL ADMINISTRATION 11%
- INFORMATION SERVICES (IS) 4%
- PREPAREDNESS AND RESPONSE 4%
- SAFETY OPERATIONS 19%
- SUPPORT SERVICES 11%
- SWORN POLICE DEPARTMENT ... 4%
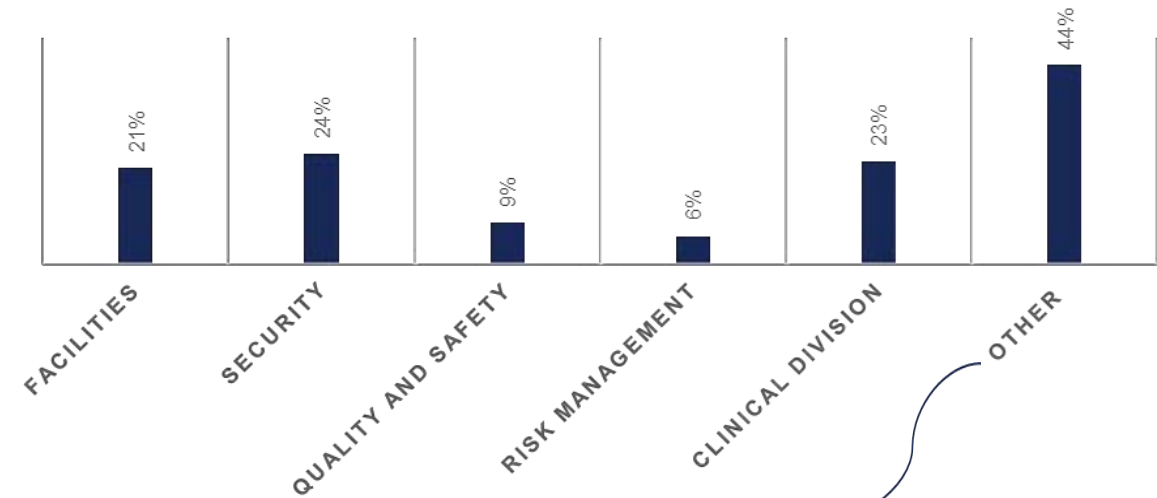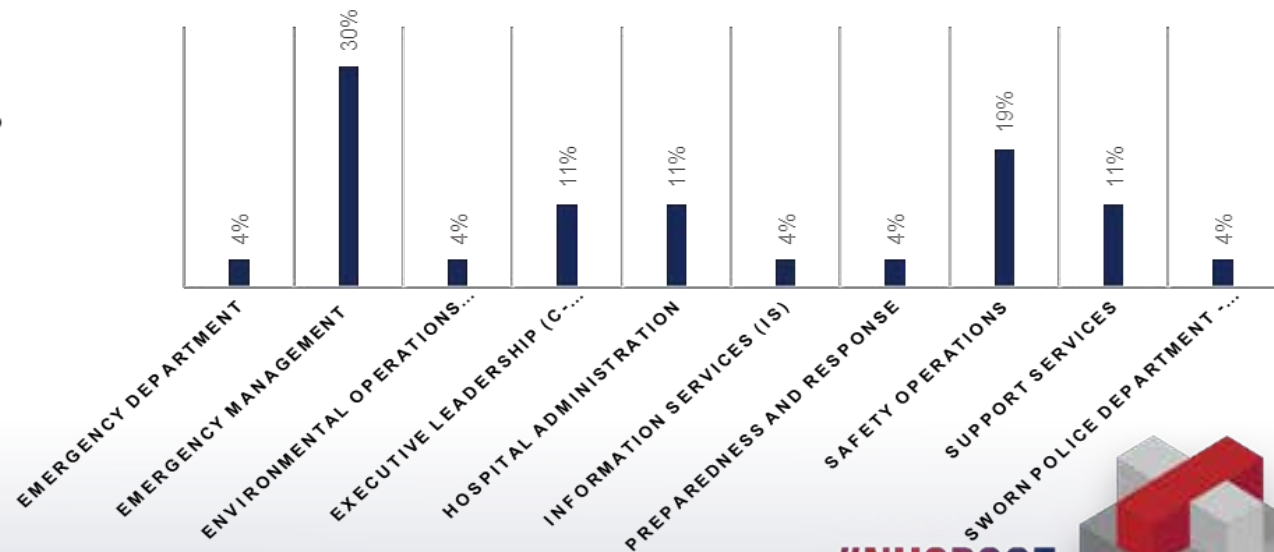
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Emergency Preparedness Relationships

Expertise on the Disaster/Emergency Management Committee
- Infectious Disease or… 84%
- Cybersecurity 72%
- Mental Health 42%
- Operations 99%
- Security 96%
- Surgery/Trauma 88%
- Emergency Medicine 97%
- Community Partner(s) 40%
- Other 25%

Hospital representation
- Yes: 94% / 67%
- No: 3% / 25%
- Unsure: 3% / 7%

- ■ Regularly attends/engages in regional and/or state healthcare coalition meetings
- ■ Holds a leadership role in a regional and/or state healthcare coalition

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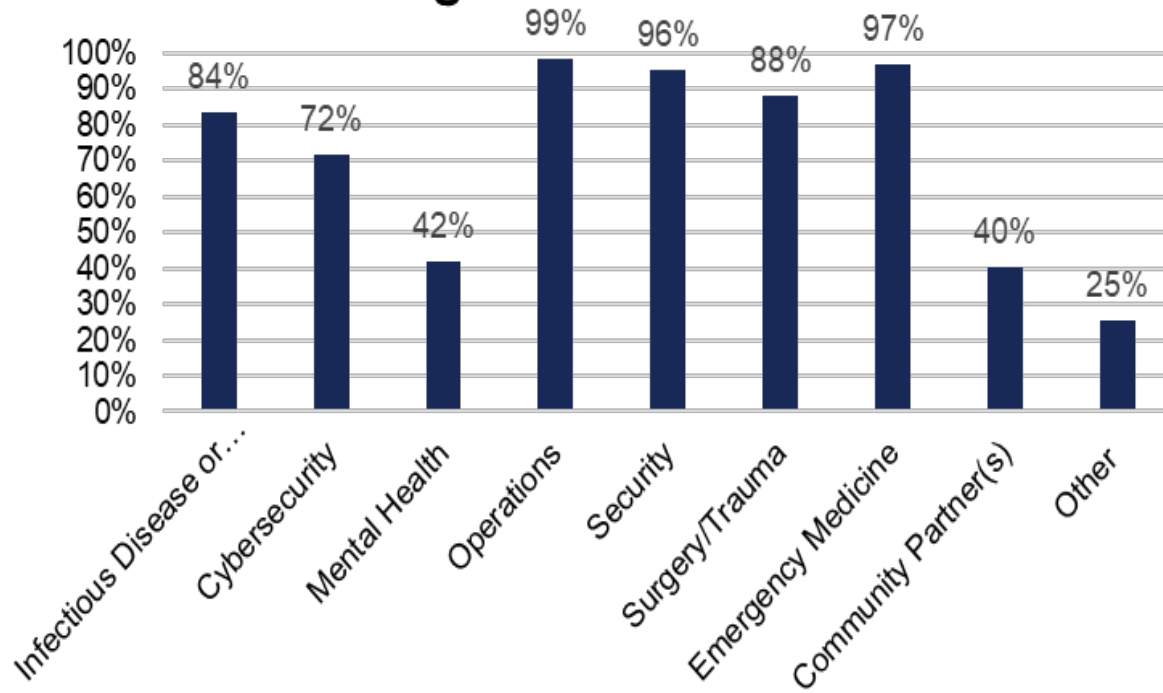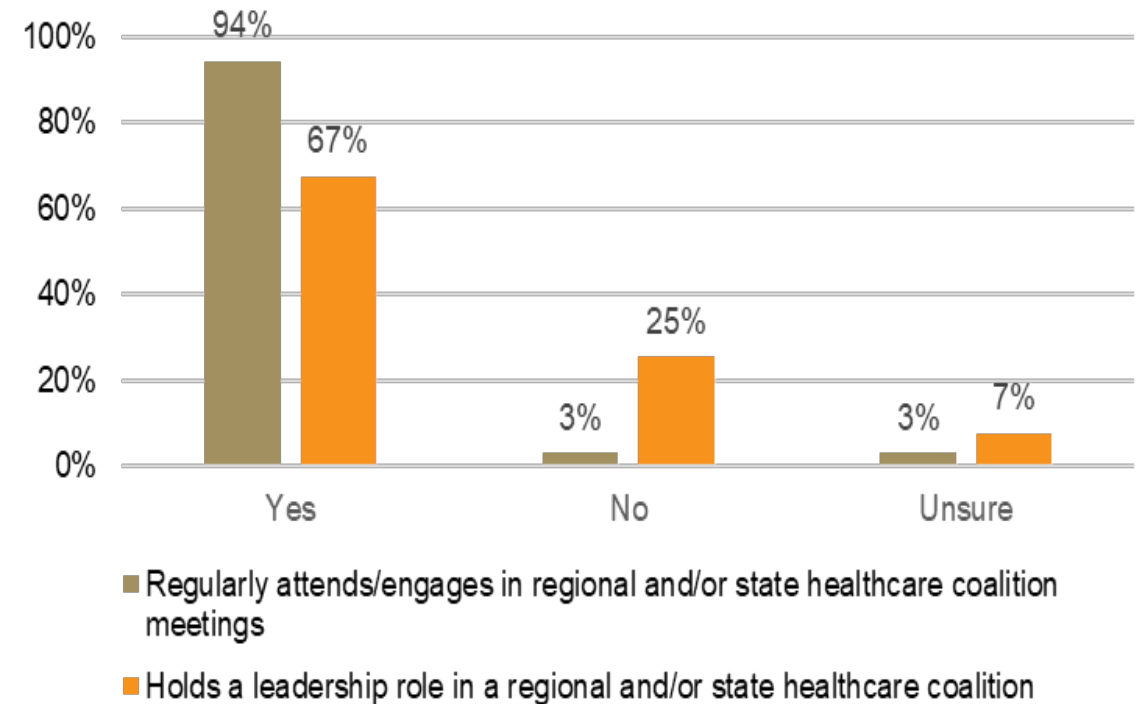
Improvements Made in DNC

- Developed and/or strengthened our hospital's **networking and partnership** with other children's hospitals across the U.S. (39%)
- **Increased engagement** with the Emergency Management (EM) landscape (34%)
- Increased **pediatric leadership** roles within the EM landscape (14%)
- Increased **support from the C-suite and leadership** for pediatric disaster preparedness work (24%)
- Added **pediatric representation** to the hospital's disaster or emergency management committee (24%)
- Added new pediatric disaster preparedness **role(s) or responsibilities** to an existing position (13%)
- Increased **FTE or financial compensation** for disaster preparedness roles and responsibilities (4%)
- Developed or enhanced pediatric preparedness **job description(s)** [13%]

Disaster Response Collaborative

Improve pediatric disaster response capability and capacity among children's hospitals

1

Establish a collaborative of children's hospital leaders who are actively participating in pediatric disaster planning and response efforts

2

Assess pediatric disaster planning and response among participating children's hospitals

3

Support children's hospitals to drive evidence-based or consensus-driven **regional pediatric disaster planning and response** activities

4

Augment pediatric disaster response capabilities of **children's hospitals**

5

Create a **sustainable network** to drive a coordinated response among children's hospitals in times of a national disaster/surge event

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DRC Children's Hospital Teams

- **111 children's hospitals**
- **550+ team participants**

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DRC Team Member Roles
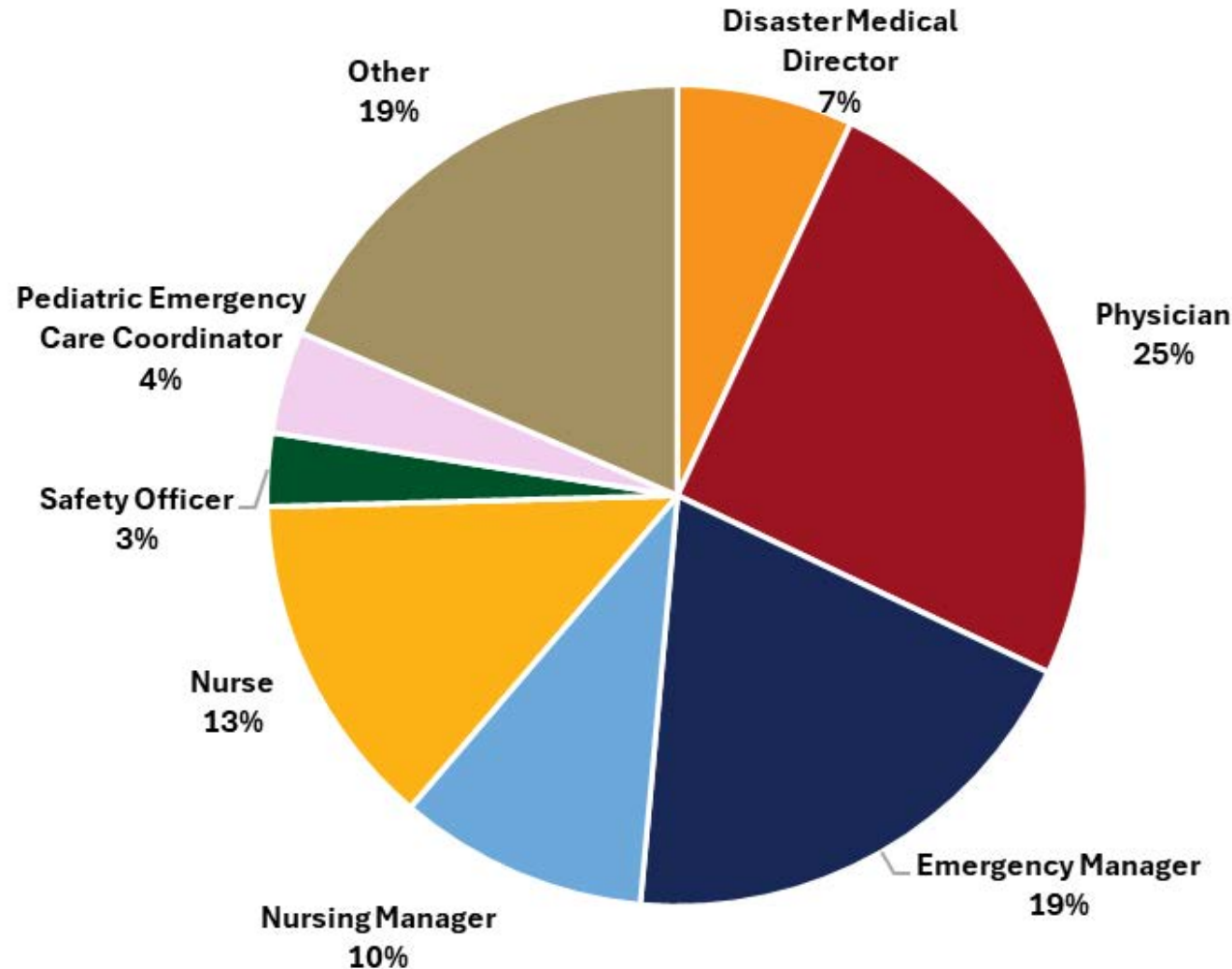
Other:
Administration
Medical Director
C Suite
Burn center liaison
Business Personnel
Child Life Specialist
Nurse specialist
HCC
Director (Facilities, operations, LTC
Pediatrics,
Disaster Committee
Pharmacist
Emergency Management Personnel
EMSC Program Manager
ER Personnel
Facilities Personnel
Infection Prevention
Quality and Safety
Transport Team
Pediatric Emergency Personnel
Physician Assistant
Nurse Practitioner
PPN Manager
Research Coordinator
Trauma Program Personnel

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DRC Hospital Numbers by Selected Focus Area
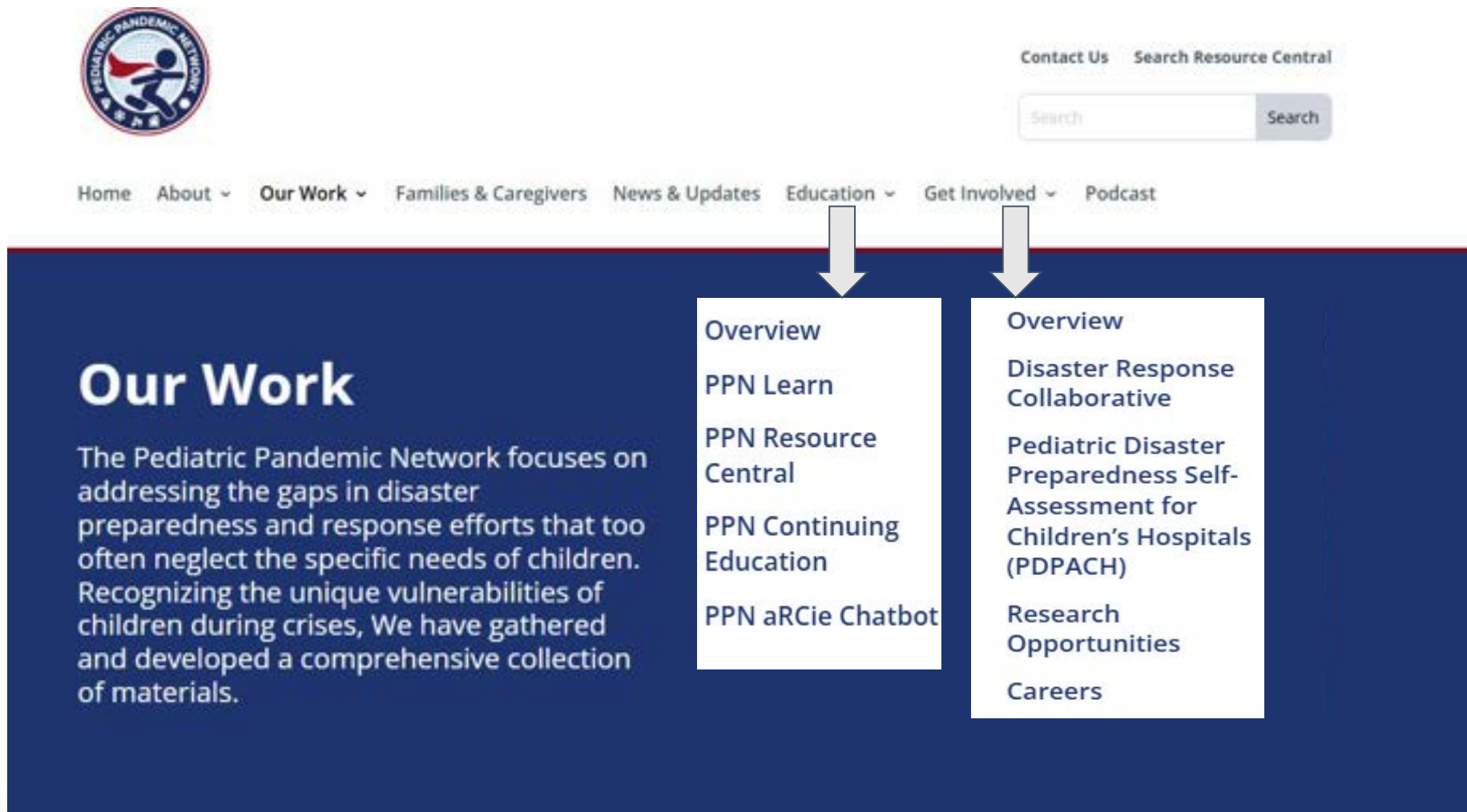
Focus Area	Primary Focus	2nd Focus Area	Total
Evacuation	17	2	19
Reunification	21	7	28
Surge Capacity	24	7	31
Triage, Infection Control, and Decontamination	10	3	13

Strengths and Gaps Identified in TTXs

Strengths ■ Gaps

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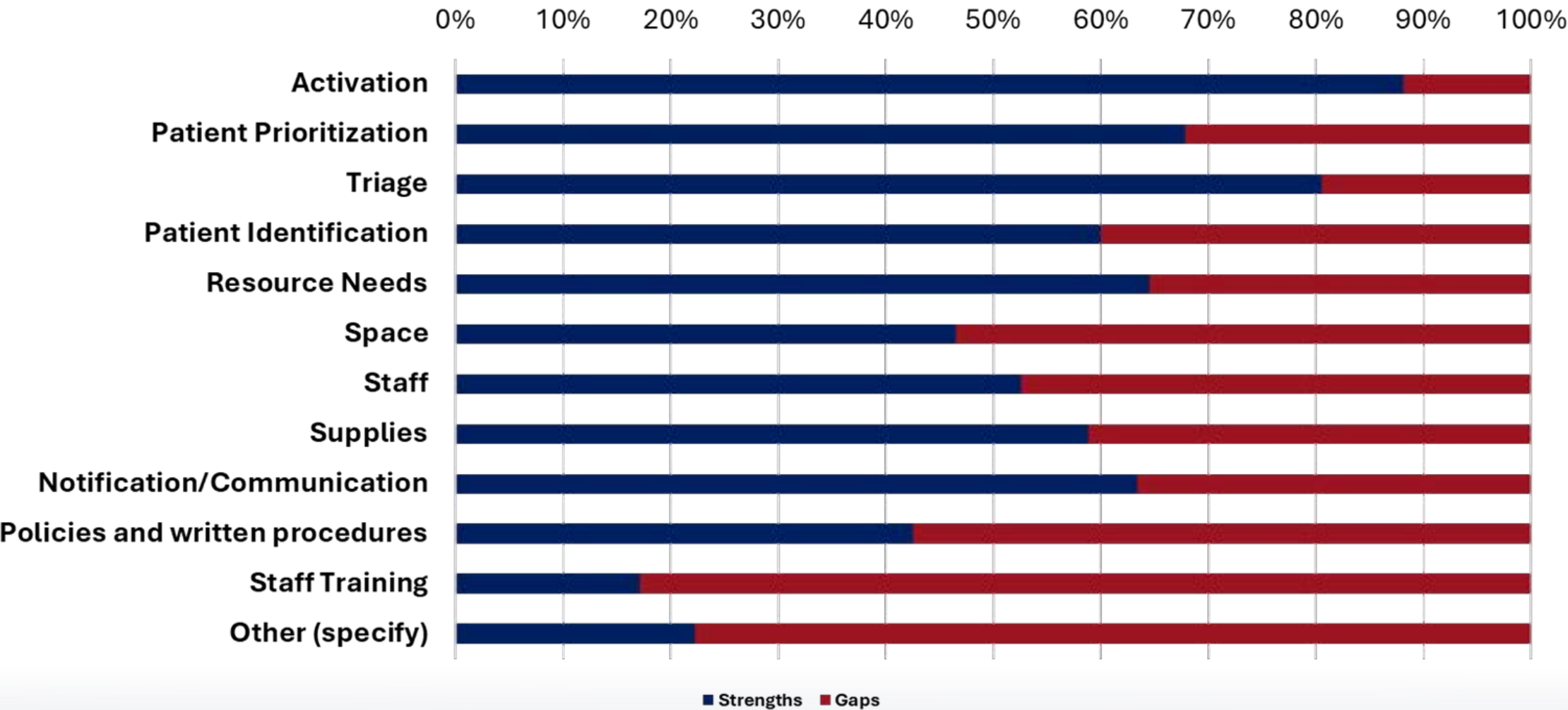
Resources Available through PPN

Our Work

The Pediatric Pandemic Network focuses on addressing the gaps in disaster preparedness and response efforts that too often neglect the specific needs of children. Recognizing the unique vulnerabilities of children during crises, We have gathered and developed a comprehensive collection of materials.

Overview

PPN Learn

PPN Resource Central

PPN Continuing Education

PPN aRCie Chatbot

Overview

Disaster Response Collaborative

Pediatric Disaster Preparedness Self-Assessment for Children's Hospitals (PDPACH)

Research Opportunities

Careers

https://pedspandemicnetwork.org/

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Overview
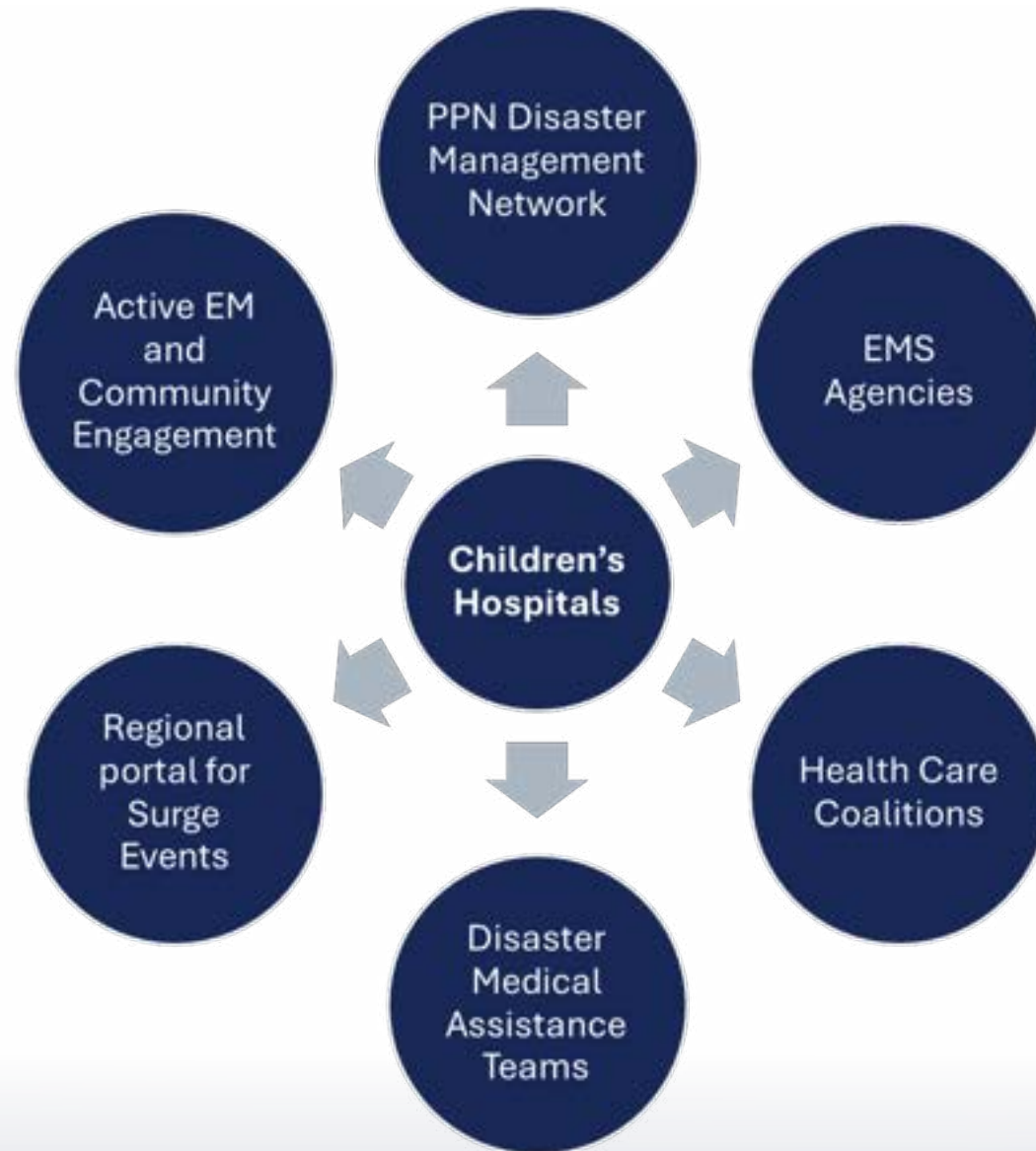
Discussions at Tables

Table Discussions

Questions:

1. Build the perfect emergency management team for the hospital - who is at the table?

2. What have been effective means of information delivery from SME to hospital system/provider level?

3. What have been system barriers for engagement with Children's centers? What have been effective strategies to mitigate those barriers?

4. How can we use prior work to expand the hub and spoke model to include new partners in an ongoing network to support pediatric disaster management?

Discussion Report Out

Questions:

1. Build the perfect emergency management team for the hospital - who is at the table?

2. What have been effective means of information delivery from SME to hospital system/provider level?

3. What have been system barriers for engagement with Children's centers? What have been effective strategies to mitigate those barriers?

4. How can we use prior work to expand the hub and spoke model to include new partners in an ongoing network to support pediatric disaster management?

Thank You

Questions?

Email: dncppn@austin.utexas.edu

Website: https://pedspandemicnetwork.org/disaster-response-collaborative/

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111 Michigan Avenue NW, Washington, DC 20010

DISASTER NETWORKING COLLABORATIVE

DISASTER RESPONSE COLLABORATIVE

Disaster Networking Collaborative

Recommended Disaster Roles and
Responsibilities for a Children's Hospital

Purpose: This document highlights recommendations for two critical disaster leadership roles and their related responsibilities for every children's hospital.

Children's hospitals play a vital regional role in the healthcare of children every day. In a disaster, both natural and manmade, this role is even more critical. The value of a disaster leadership team cannot be overstated and is the first step to ensuring uptake of evidence-based guidelines and a coordinated regional disaster response that meets the needs of children. Below are recommendations to help ensure the disaster leadership team is appropriately staffed, supported, and effective. While the recommendations are not prescriptive, having consistency among leadership positions and an emergency/disaster committee with pediatric representation is optimal.

For the purposes of this document, a children's hospital may be defined as a freestanding hospital or exist within a general hospital.

Team Role 1: Pediatric Disaster Medical Director

Purpose: The pediatric disaster medical director (ie. a physician with pediatric preparedness expertise) oversees disaster preparedness activities for the hospital and facilitates integration into regional emergency management groups/coalitions.

Minimum Recommended FTE: 0.1-0.3

Reporting Structure: This role might report to a representative on the emergency management committee, C-suite, or Chief Medical Officer.

Qualifications:
- Physician with clinical experience (preferably in a landscape where hospital operations and flow are understood)
- An understanding of the role and interplay of pediatric emergency care, pediatric disaster preparedness, pediatric prehospital care, pediatric hospital-based care, pediatric critical care, pediatric infectious disease, pediatric community/public health, surgical care, and mental and behavioral health
- Understanding of the regulatory environment (e.g. Emergency Medical Treatment and Labor Act [EMTALA])
- Comprehensive knowledge and experience working with emergency, Emergency Medical Services (EMS), and disaster management groups
- Understanding of disaster operations at the hospital (e.g., Personal and Protective Equipment (PPE), staging, trained staff, incident command setup)
- Knowledge of regional hospitals/health system networks and their pediatric capabilities, including pediatric readiness, disaster preparedness and response, epidemiology, and disease reporting surveillance tools
- Participation in regional emergency management committees and coalitions
- Strong working relationship with local public health and law enforcement, including an understanding of their response capabilities and capacity

- Knowledge of local EMS agencies and scope of practice, staffing, and response capabilities
- Familiarity with the Emergency Medical Services for Children (EMSC) Program and other national resources available in pediatric emergency and disaster preparedness and response

Training/Experience: Federal Emergency Management Agency National Incident Management System (NIMS) and Incident Command System (ICS) courses (minimum)

Recommended:
- Federal Emergency Management Agency (FEMA)
- Texas A&M Engineering Extension Service (TEEX)
- Radiation Emergency Assistance Center and Training Site (REACTS)
- Hospital Emergency Response Training (HERT)
- International Committee of the Red Cross (ICRC) Health Emergencies in Large Populations (HELP)
- Deployable Teams, Disaster Medical Assistance Teams (DMAT), Community Emergency Response Teams (CERT), Medical Reserve Corps (MRC)
- Center for Domestic Preparedness (CDP)
- Fellowship training in Emergency Management/Disaster/ Disaster Medicine

Continuing Education: Participate in the American Academy of Pediatrics Council on Children and Disasters (COCD), National Healthcare Coalition Preparedness Conference (NHCPC), Preparedness Summit, and/or The National Emerging Special Pathogens Training and Education Center (NETEC)

Regional Partnerships: Collaborate with a regional Pediatric Disaster Care Center of Excellence (COE), Pediatric Pandemic Network (PPN), EMSC State Partnership Program Managers/Advisory Board, AAP state chapter/ disaster champion, Public Health Emergency Preparedness Program, Hospital Preparedness Program (HPP), other regional pediatric disaster coalitions, adult hospital disaster experts/centers, and/or regional medical center disaster teams.

Duties—In conjunction with emergency management/disaster management committee:
- Support the development and annual review of a Hazards Vulnerability Analysis (HVA) with consideration of pediatric vulnerabilities
- Form Subject Matter Expert groups around specialized topics (i.e., cybersecurity, Infectious Diseases [ID], radiological, mental health) and be a liaison for these consultants to the disaster leaders
- Review and amend pediatric disaster plans for your local institution
- Adopt best practices, policies, and research-informed pediatric care
- Represent pediatrics within the ICS of the hospital or healthcare system
- Maintain input from ID, Pediatric Intensive Care Unit, Emergency Department (ED), hospitalist and other subspecialist counterparts
- Implement pediatric disaster simulation and drills (i.e., be the content leader for drills but partner with others in the hospital to accomplish)

- Coordinate regional disaster drills with nearby community hospitals and partners
- Uphold personal and personnel training within the institution surrounding pediatric disaster response (e.g. decontamination, triage, surge, PPE)
- Engage in PPN disaster content regarding pediatric disaster response
- Participate in scholarly activities related to pediatric disaster preparedness and response including Quality Improvement (QI) activities, manuscript development, regional/state presentations, educational products, disaster research
- Represent the children's hospital during local/regional disaster events
- Work with Emergency Department leadership to ensure day-to-day pediatric readiness
- Work with the disaster committee to create regular and just-in-time messaging regarding disaster preparedness and response plans
- Integrate disaster response training into staff credentialing
- Engage GME trainees in training and education
- Act as co-representative for The Joint Commission (with Emergency Manager)
- Coordinate activities with the Hospital Emergency Manager or Trauma Coordinator and nursing leadership
- This role could serve as Incident Commander in the setting of a disaster

Liaison work:
- Work with Public Information Officer to form relationships and have important contacts ready
- Participate in regional emergency management committees and state disaster response forums
- Partner with other disaster leads at other hospitals within the region
- Ensure integration of disease and patient tracking methodology for surge planning
- Work with coalitions to assess capabilities of all hospitals in the area to develop a regional triage plan for accurately placing patients during a mass casualty incident

- Provide guidance to regional hospitals regarding pediatric disaster planning, pediatric transport and transfer plans, and reunification planning
- Provide education to, and seek input from, community pediatricians on pediatric disaster planning
- Advocate for pediatric disaster training and awareness
- Facilitate community partnerships to strengthen regional networks and drive educational content dissemination

Team Role 2: Pediatric Emergency Preparedness Coordinator

Purpose: Oversee operational aspects of disaster planning and response for the hospital in collaboration with the Disaster Medical Director, Disaster Preparedness Committee, and other emergency management personnel

Administrative: This position can be housed under different departments (e.g., security, operations, facility). Determine which serves as the best conduit for multi-department collaboration

Duties:
- Collaborate with the management team in the creation, development, education, training, and implementation of disaster plans that are in alignment with state and other regulatory agencies
- Conduct an annual hazard vulnerability assessment (HVA)/risk analysis to determine the facility's risk for natural (e.g., hurricanes, floods, earthquakes), technological (e.g., nuclear power plant emergencies or hazardous materials spills), human-caused (e.g., active shooter or hostage situations), and other disasters
- Develop and maintain emergency and mitigation plans and procedures for disasters identified in the HVA/ risk analysis
- Manage disaster response or crisis management activities for the facility. Facilitate planning for availability of staff 24/7 to respond to disaster or potential disaster situations
- Participate in the organization's committee for general administration in planning, coordinating, maintaining, and updating disaster plans, including internal and external event response. Provide necessary project management and support for all related emergency preparedness sub-committee work
- Oversee the development and management of the emergency preparedness budget
- Develop and prepare reports that fulfill grant contract requirements as outlined by the specific funding stream
- Perform an education and training needs assessment and work collaboratively with staff development representatives to create, implement, and review safety/regulatory education and training requirements/programs to meet the needs of staff (e.g., hospital ICS)
- Establish mechanisms to collect, review, and track data required by local, state, and federal entities which are consistent with the facility's policies and procedures.
- Represent the organization on various preparedness committees, such as the regional healthcare coalition

pedspandemicnetwork.org/disaster-networking-collaborative

Disaster Networking Collaborative

Talking Points—Why Engage in Pediatric Disaster Preparedness?

Hospital leadership support is crucial when any improvement planning occurs. These talking points will help children's hospital professionals communicate with and engage C-suite or hospital leaders in pediatric disaster preparedness.

WHAT IS THE DNC?

The Disaster Networking Collaborative (DNC) is a first step in supporting children's hospitals to improve pediatric disaster preparedness efforts in their region. During this quality improvement (QI) collaborative, we will 1) work to garner C-suite support and drive home the value pediatric disaster preparedness brings to the institution, 2) help to promote more standardization of a disaster care team infrastructure, and 3) identify mechanisms to build community engagement. The DNC will serve as an entry point into future and/or ongoing pediatric disaster activities supported by the Pediatric Pandemic Network (PPN).

WHY JOIN THE DNC?

Joining the DNC will support children's hospitals to improve pediatric disaster planning through support, collaboration, and sharing of best practices. The DNC will enable hospitals to strengthen the infrastructure hospitals need to achieve pediatric disaster preparedness. Children's hospital teams that register for the DNC will also recognize the benefits of engaging in this collaborative and joining a PPN network of children's hospitals that are collectively prepared for emergencies, disasters, and pandemics that impact children. Participants in the DNC can expect to gain the following:

1. **Hospital/Clinical Operations and Workforce Resiliency**
   Disaster preparedness is compatible with the organization's mission and leadership is supportive of the medical center's capability to fulfill that mission. As children's hospitals (CHs) have been substantially impacted by the COVID-19 pandemic, other emergencies or disasters, and recent respiratory illness surges, we have collectively learned how disruptive disasters are on hospital operations and finance. Going forward, CHs are likely to fare better and plan effectively through active engagement in preparedness activities. The COVID-19 pandemic prompted many untested solutions, some costly and with variable effectiveness. The DNC supports collective efforts to identify and share best practices and cost-effective solutions in creating a hospital structure to address disaster preparedness. Healthcare personnel resignations across the sector increased during the pandemic. However, disaster preparedness also enhanced retention and job satisfaction of the dedicated personnel upon which the hospital relies to provide services.

2. **Community and Medical Home Engagement, Education, and Partnership**
   The communities that CHs serve are also substantially impacted by emergencies, disasters, and pandemics. The DNC fosters CH engagement with community groups and medical homes. CHs are often viewed as a key resource for pediatric subject matter expertise, and DNC participation will establish local CHs as the leading resource for pediatric emergency preparedness for their communities. Community engagement builds on this foundation and demonstrates ongoing commitments to communities during challenging or difficult times. DNC participation also provides opportunities to develop, distribute, and exchange educational materials with community stakeholders.

3. Data, Research, and Improvement Science Infrastructure

The DNC will identify a core data set for use within the collaborative. This data set provides opportunities to benchmark performance across DNC centers. Additionally, this data infrastructure supports local investigators interested in emergency preparedness and/or improvement science. Thoughtful planning and conducting drills and exercises with a Plan-Do-Study-Act (PDSA) approach promotes the health and resiliency of the organization in the face of crisis. Ongoing collaboration will identify new research questions in disaster preparedness and foster multicenter research, the funding for which can be pursued by leveraging DNC and/or external funding opportunities.

4. Professional Education and Development

As part of the overarching Pediatric Pandemic Network (PPN), the DNC offers career development opportunities for hospital staff and providers, trainees, and faculty, through networking and participation in educational forums. The PPN:

- Provides access to more than 200 pediatric topic-specific experts across the nation.
- Offers connection to domains that bolster strategies for infectious disease/outbreaks, mental and behavioral health emergencies, connections to and communication with each child's medical home, reunification planning, as well as provides opportunities to strengthen health equity, and community and regional engagement.
- Improves awareness of disaster and pandemic preparedness approaches.
- Enhances satisfaction of participants and stakeholders by helping them to feel that they are doing all they can to achieve quality emergency care through pediatric readiness and a disaster management framework.

5. Clinical Care Regionalization and Telehealth

The DNC offers a platform for resource data sharing and the ability to meet the needs of all children, especially high acuity and/or critically ill/injured children from a regional perspective, fostering alignment of key resources such as ICU beds and subspecialty care. Sharing best practices for telehealth and using lessons learned from regulatory changes achieved during the pandemic, the DNC permits real-time sharing of pediatric expertise between CH centers and their regional healthcare partners, as well as provision of essential care to patients by CH providers.

6. Healthcare Access and Equity

Health equity is core to the DNC mission and DNC efforts focus on the importance of following health equity trends affecting the nation's diverse, vulnerable, and socially disadvantaged populations. Despite the ongoing and determined efforts of CHs and other pediatric and community organizations, the healthcare system landscape varies greatly in terms of available and accessible services for children, particularly those in marginalized populations, resource poor communities, and with special health care needs. These inequities were further exposed and worsened during the pandemic. Including representatives from historically marginalized populations in improvement planning efforts is critical. The DNC offers opportunities to adopt best practices and work with peers towards equitable access to quality healthcare and other essential resources, particularly during emergencies, disasters, and pandemics.

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Disclosure

In This Session You Will

Understand challenges faced by the Blackfeet community with everyday and cumulative trauma, tied to high youth suicide rates, coupled with limited mental health resources, and impact on the community.

Be able to describe the Stepped Triage to Care model in providing early trauma care for high-risk youth in communities like the Blackfeet Nation, to reduce downstream mental health problems including suicide.

Recognize the value of sustained collaborative partnerships for creating long-term, culturally relevant mental health interventions, as demonstrated by the Blackfeet Nation's request for continuation.

Who we are

- WRAP-EM Pediatric Disaster Center of Excellence Mental Health Team

- Director, Southern Piegan Health Center, Blackfeet Nation Tribal Health Department

Federally Funded Networks for Children in Disasters
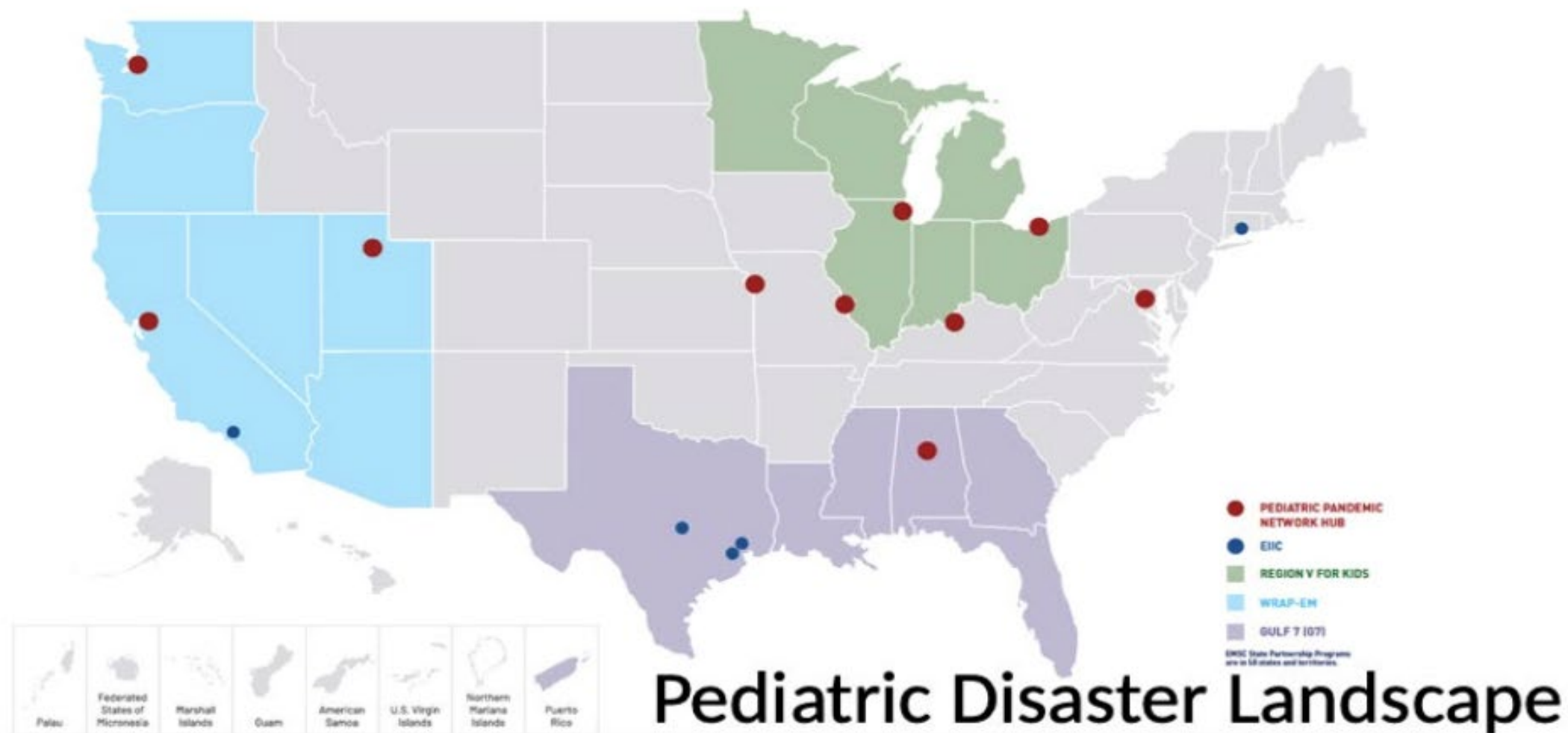
Pediatric Disaster Landscape

Legend:
- ● PEDIATRIC PANDEMIC NETWORK HUB
- ● EIIC
- REGION V FOR KIDS
- WRAP-EM
- GULF 7 (G7)

EMSC State Partnership Programs are in 50 states and territories.

Territories shown: Palau, Federated States of Micronesia, Marshall Islands, Guam, American Samoa, U.S. Virgin Islands, Northern Mariana Islands, Puerto Rico

Suicide Ideation

28. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?

County	Yes	No	Totals	Felt sad or hopeless for two or more weeks in a row
Big Horn	101	106	207	48.8
Blaine	80	121	201	39.8
Cascade	51	120	171	29.8
Chouteau	35	51	86	40.7
Dawson	37	70	107	34.6
Fergus	29	40	69	42.0
Flathead	166	182	348	47.7
Gallatin	184	300	484	38.0
Glacier	116	102	218	53.2
Golden Valley	7	21	28	25.0
Hill	83	99	182	45.6
Jefferson	65	105	170	38.2
Lake	69	85	154	44.8
Lewis & Clark	96	163	259	37.1
Mineral	78	104	182	42.9
Missoula	129	215	344	37.5
Musselshell	47	64	111	42.3
Park	55	100	155	35.5
Phillips	51	87	138	37.0
Pondera	68	121	189	36.0
Ravalli	110	206	316	34.8
Richland	103	139	242	42.6
Roosevelt	128	153	281	45.6
Rosebud	129	153	282	45.7
Sanders	99	140	239	41.4
Stillwater	118	162	280	42.1
Teton	87	175	262	33.2
Toole	45	74	119	37.8
Valley	52	84	136	38.2
Yellowstone	272	354	626	43.5

2023 Montana Youth Risk Behavior Survey

County-Level Results

32. If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?

County	I did not attempt suicide during the past 12 months	Yes	No	Total	Suicide attempt required medical treatment
Big Horn	160	10	38	208	4.8
Blaine	171	16	24	211	7.6
Cascade	155	2	16	173	1.2
Chouteau	72	4	10	86	4.7
Dawson	95	1	11	107	0.9
Fergus	58	2	9	69	2.9
Flathead	293	28	31	352	8.0
Gallatin	429	18	39	486	3.7
Glacier	165	20	37	222	9.0
Golden Valley	25	1	2	28	3.6
Hill	158	7	20	185	3.8
Jefferson	155	3	16	174	1.7
Lake	131	7	16	154	4.6
Lewis & Clark	230	11	20	261	4.2
Mineral	150	16	19	185	8.7
Missoula	302	16	30	348	4.6
Musselshell	88	8	15	111	7.2
Park	145	3	9	157	1.9
Phillips	119	7	11	137	5.1
Pondera	171	3	17	191	1.6
Ravalli	276	8	35	319	2.5
Richland	204	12	26	242	5.0
Roosevelt	233	18	30	281	6.4
Rosebud	228	20	35	283	7.1
Sanders	197	8	37	242	3.3
Stillwater	236	13	30	279	4.7
Teton	240	7	16	263	2.7
Toole	100	5	14	119	4.2
Valley	123	2	12	137	1.5
Yellowstone	546	30	53	629	4.8

YRBS US all groups average: 3% (vs. 9.0)

Indicators of Anxiety or Depression Based on Reported Frequency of Symptoms

Select Time Period

Mar 5 - Apr 1, 2024

Select Indicator

Symptoms of Anxiety Disorder or Depressive Disorder

Symptoms of Anxiety Disorder or Depressive Disorder

Legend:
- 14.9-19.5
- 19.6-21.2
- 21.3-22.8
- 22.9-25.4

State Ranking

State ranking bar chart (Percent):
- South Carolina
- Kentucky
- Mississippi
- New Mexico
- Indiana
- Montana
- Texas
- Alaska
- Oklahoma
- Alabama
- Arkansas
- Utah
- Tennessee
- West Virginia
- Oregon
- Washington
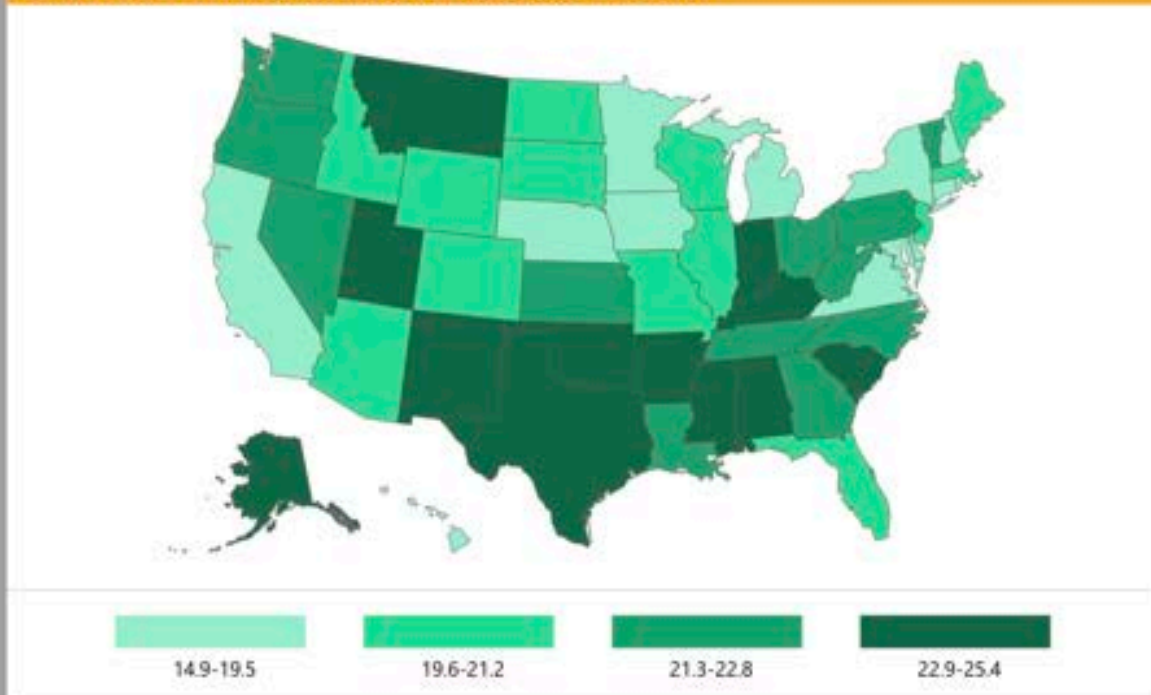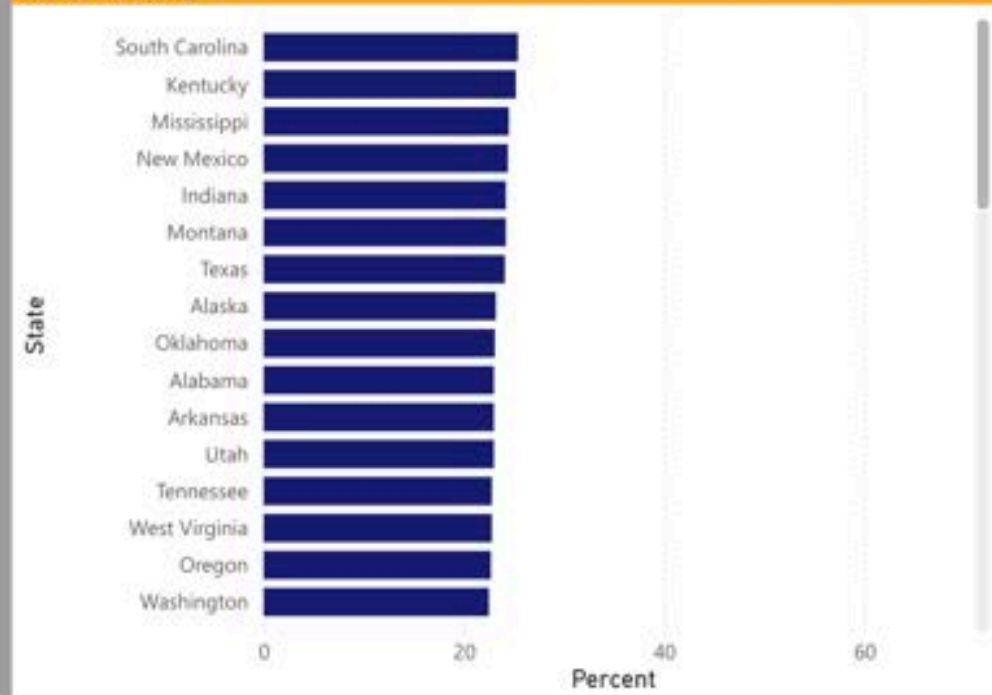
NOTE: All estimates shown meet the NCHS standards of reliability. See Technical Notes below for more information about the content and design of the survey. From Phase 1 through Phase 3.1 of data collection and reporting, the question reference period was 'during the last 7 days'. Beginning in Phase 3.2, the question reference period changed to 'during the last two weeks'.

SOURCE: U.S. Census Bureau, Household Pulse Survey, 2020-2024

Data Table | National Estimates | State Estimates

#NHCPC25

Percentage of High School Students Who Attempted Suicide during the Past Year, by Demographic Characteristics, United States, YRBS, 2021

- Total: 10%

Sex
- Female: 13%
- Male: 7%

Race & Ethnicity
- American Indian or Alaska Native: 16%
- Asian: 6%
- Black: 14%
- Hispanic: 11%
- Native Hawaiian or Pacific Islander: 10%
- White: 9%
- Multiracial: 12%

Sexual Identity
- Heterosexual: 6%
- LGBQ+: 22%

Sex of Sexual Contacts
- Opposite Sex Only: 12%
- Any Same Sex: 33%
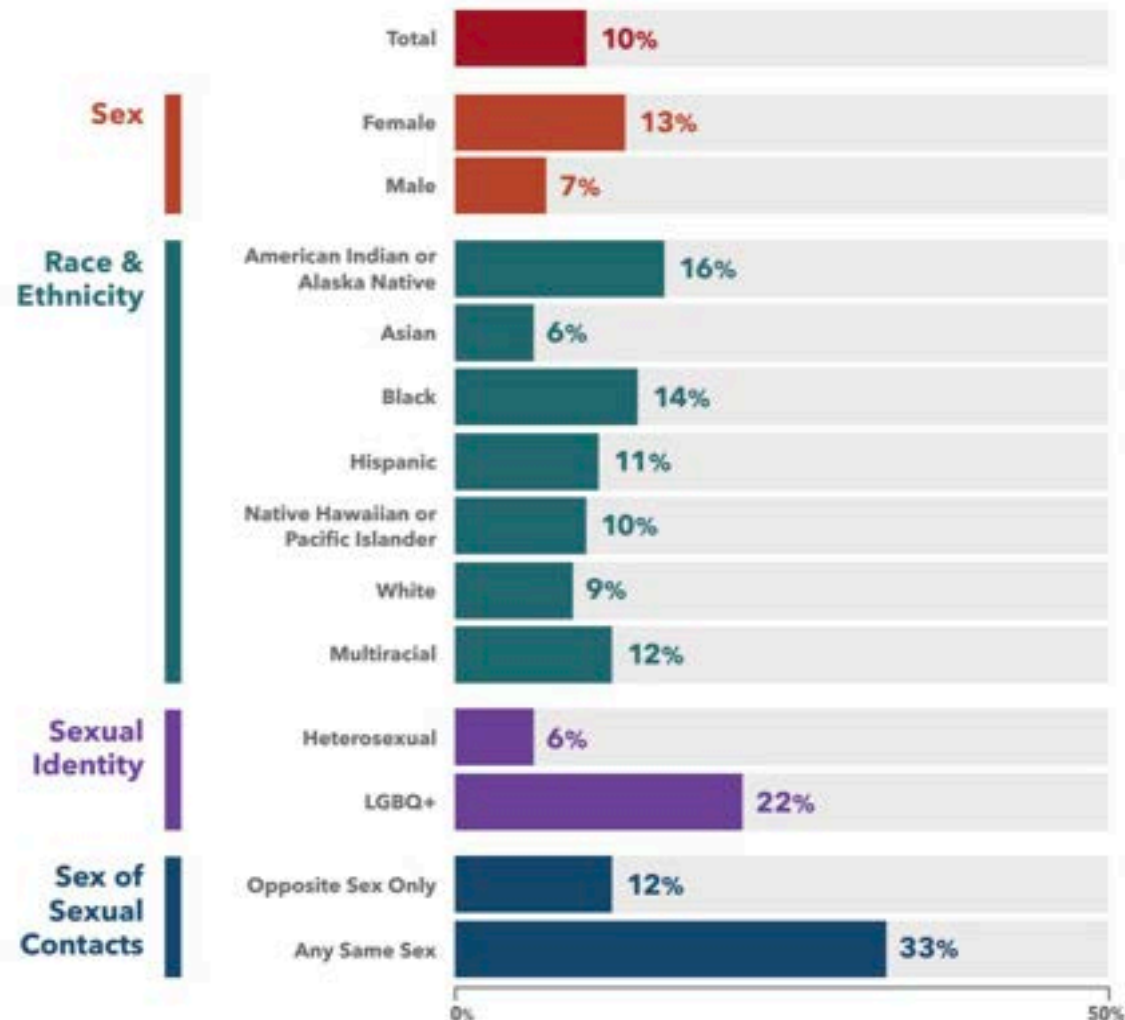
Ever told you that you have a form of depression?

Montana

Year	○ All Available Years ● 2023 ˅
View by	Age Group ˅
Response	All responses
Data type	Crude Prevalence

Montana - 2023

Ever told you that you have a form of depression? (Crude Prevalence)

View by: Age Group

Response: (All)

	18-24	25-34	35-44	45-54	55-64	65+
Yes						
Percent (%)	31.1	30.7	25.3	27.9	24.2	16.2
95% CI	25.8 - 36.3	26.3 - 35.1	21.8 - 28.9	24.2 - 31.6	21.1 - 27.3	14.6 - 17.8
n	119	178	212	227	285	515
No						
Percent (%)	68.9	69.3	74.7	72.1	75.8	83.8
95% CI	63.7 - 74.2	64.9 - 73.7	71.1 - 78.3	68.4 - 75.8	72.7 - 78.9	82.2 - 85.4
n	300	483	603	635	967	2591

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)
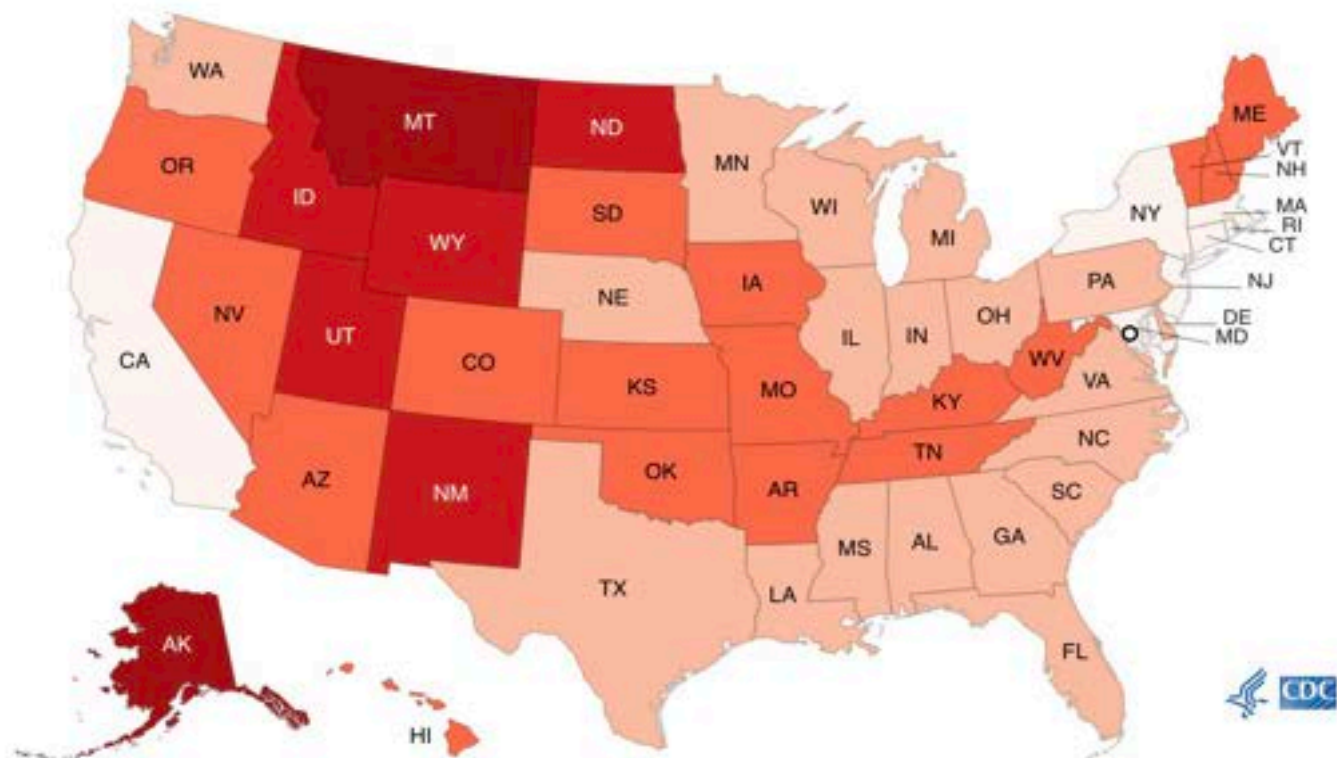
#NHCPC25

County-Level Results

29. During the past 12 months, did you ever seriously consider attempting suicide?

County	Yes	No	Totals	Seriously considered attempting suicide
Big Horn	54	156	210	25.7
Blaine	49	161	210	23.3
Cascade	33	140	173	19.1
Chouteau	24	62	86	27.9
Dawson	19	88	107	17.8
Fergus	17	52	69	24.6
Flathead	105	245	350	30.0
Gallatin	103	386	489	21.1
Glacier	70	152	222	31.5
Golden Valley	4	24	28	14.3
Hill	49	136	185	26.5
Jefferson	41	133	174	23.6
Lake	38	116	154	24.7
Lewis & Clark	66	195	261	25.3
Mineral	46	138	184	25.0
Missoula	77	271	348	22.1
Musselshell	35	76	111	31.5
Park	30	127	157	19.1
Phillips	38	99	137	27.7
Pondera	37	154	191	19.4
Ravalli	70	249	319	21.9
Richland	56	186	242	23.1
Roosevelt	75	206	281	26.7
Rosebud	84	200	284	29.6
Sanders	61	182	243	25.1
Stillwater	82	199	281	29.2
Teton	44	219	263	16.7
Toole	30	89	119	25.2
Valley	31	106	137	22.6
Yellowstone	191	437	628	30.4
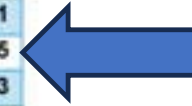
Consultation and Collaboration with the Blackfeet Nation

#NHCPC25

Glacier County, Montana

2022 Statewide Overall SVI Score:

1

Possible scores range from 0 (lowest vulnerability) to 1 (highest vulnerability).

A score of 1 indicates a high level of vulnerability.

View County Map Series

View in Table
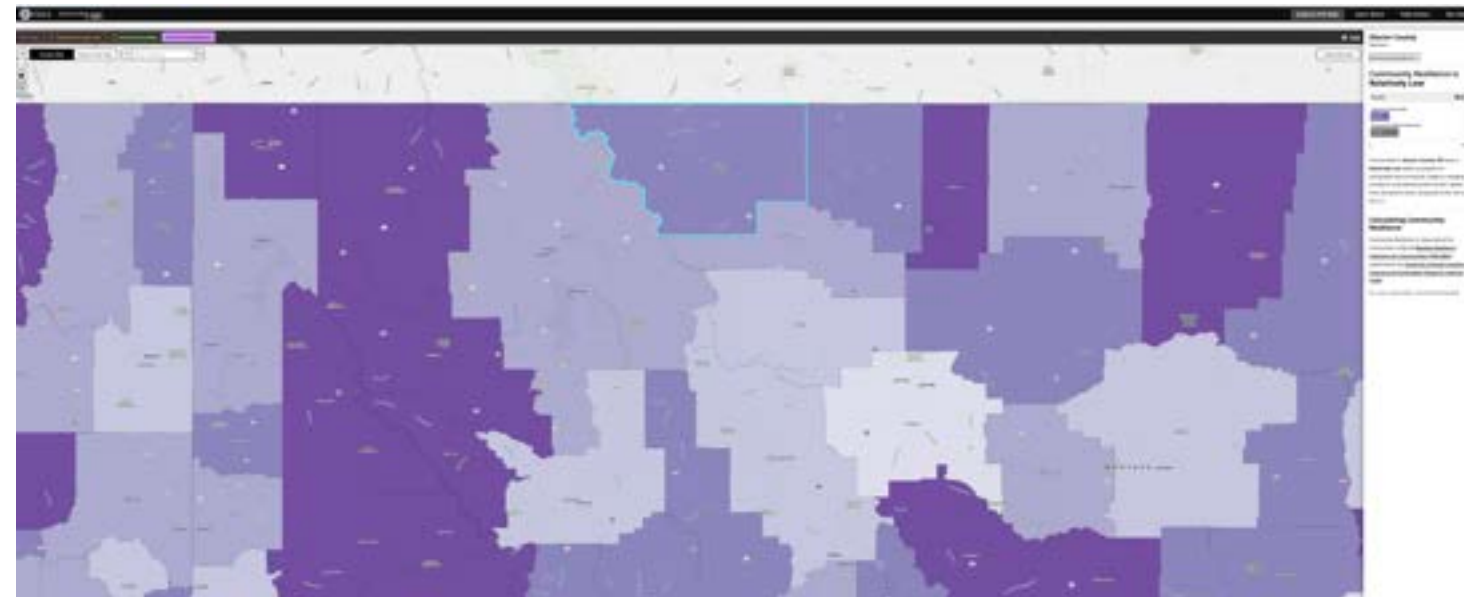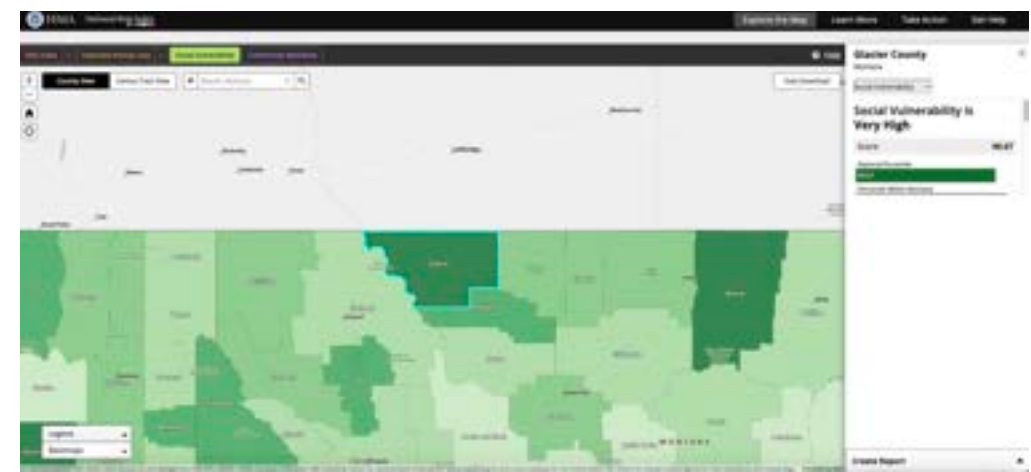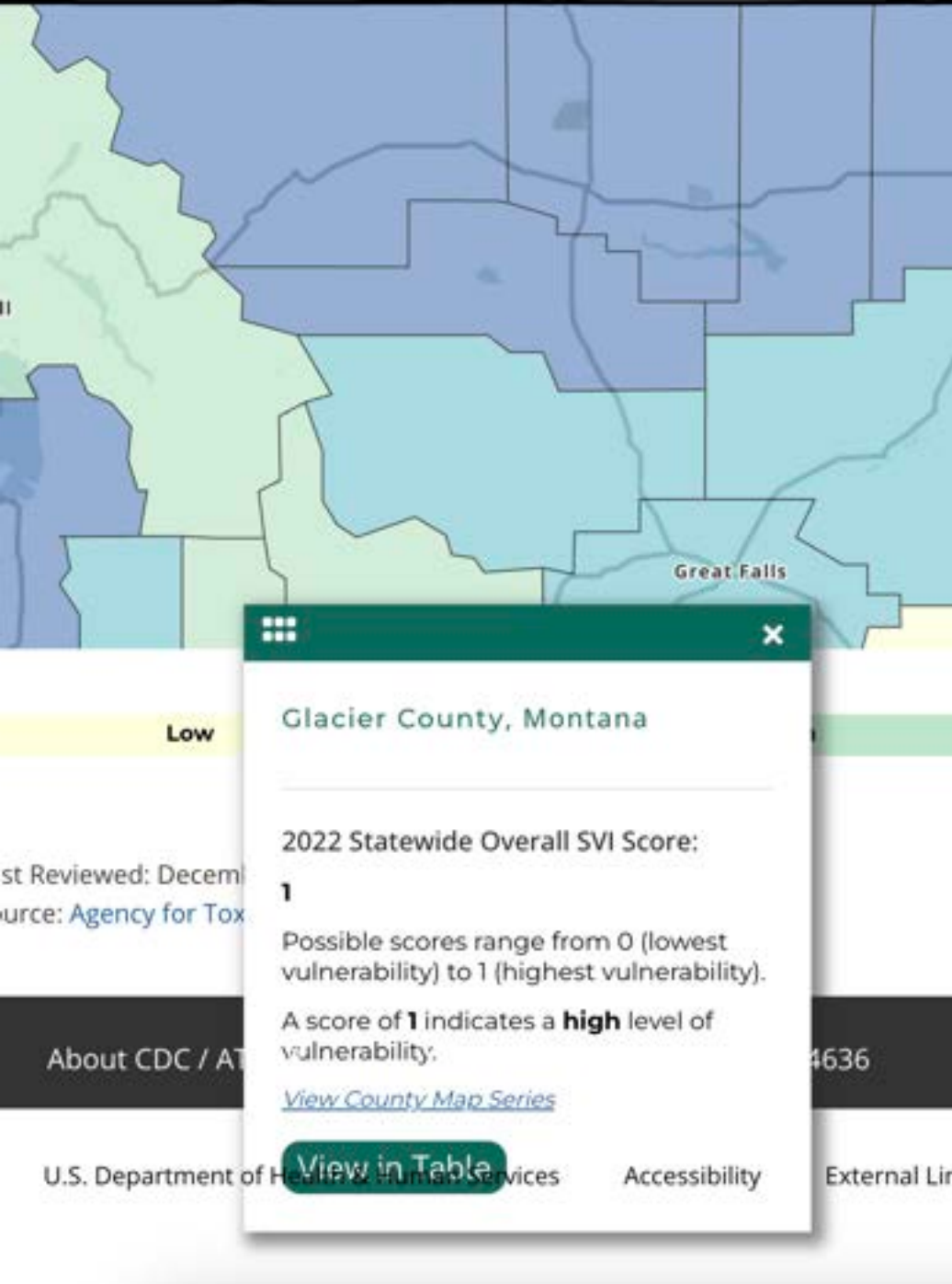
#NHCPC25

Connecting with Systems of Care for Tribal Youth

IHS Blackfeet Hospital clinical staff

IHS Area Office Crisis Program Director

Tribal council

Tribal health and mental health staff

School District(s) staff
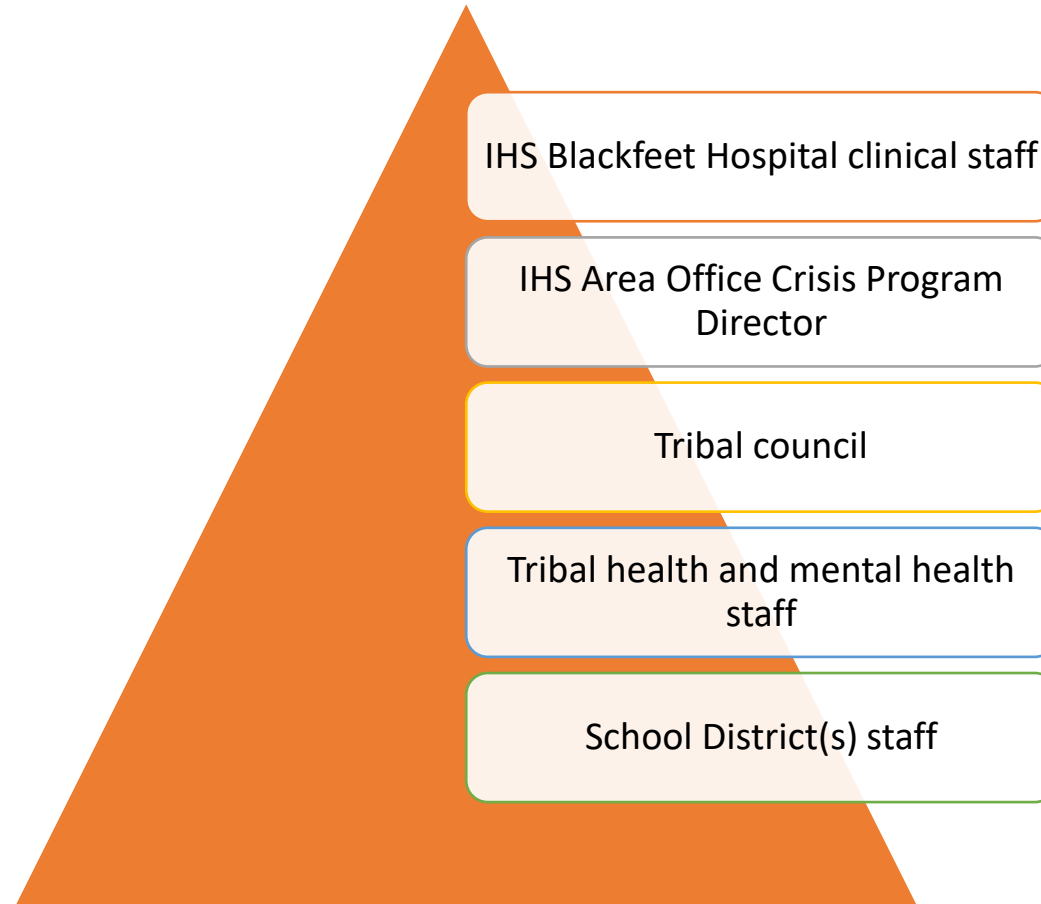
Step 1: Listening sessions with school districts, IHS Hospital mental health and medical staff, Blackfeet Nation Tribal Health(FQHC, Mental Health), IHS Area Office crisis director

Step 2: Local stakeholders selected from a menu of offerings based on menu provided

Step 3: Provided on-site trainings

| CONSULTATION SERVICES	RESOURCES	TRAININGS
Consultation toward immediate training tools from the PPN PsySTART Triage to Care Learning Collaborative to support the Tribal Council and Tribal Behavioral Health, IHS Billings Area Office Crisis Unit and the IHS Blackfeet Service Unit.	The WRAP-EM Mental Health Readiness Team offered the following resources and tools with technical assistance to support adaptation and implementation that are components of the stepped triage to care package.	Learning Collaborative overview
Offer to provide on-going consultative assistance in the development of a locally adapted mental health trauma efforts for everyday and disaster trauma, using the PPN Triage to Care Learning Collaborative with Tele-Health TF-CBT delivery, and based on the National Children's Disaster Mental Health Concept of Operations	PsySTART Rapid Triage MH System, system modifications as needed to support response models, and additional resources for use with schools, EMS, hospital, primary care and other child serving entities.	Summary of Learning Collaborative option for Stepped Triage to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) with option of tele-health delivery.
Offer to build local "Stepped Tele-Health TF-CBT" including conceptualization, adaptation, training, and consultation calls	Overview of Triage to TF-CBT Model, including potential local modifications implementation for the children of the Blackfeet Nation	Community resource coordination/linkage mapping idea with specific training elements including as selected by IHS and Tribal Health members in the pre-planning calls. Provided preliminary version for discussion purposes
Consultation with HST Trainers about implementation challenges for additional community trainings as needed	Health Support Team Trainer and Basic Volunteer Manuals, and PowerPoint slides for training.	Health Support Team: Disaster Behavioral Health Curriculum to Assist Communities in Planning and Response.

Blackfeet Tribe: Resource Mapping

Conducted a number of "listening" and and planning meetings, leading to a three-day in person training

Shared a the National Children's Emergency MH Concept of Operations for the youth mental health response, including the concept of community mapping of resources and vulnerable populations as a first step "gap" analysis
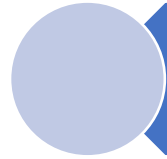
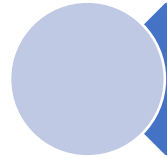 Outlined the PsySTART Triage to Care System for everyday trauma and disasters that the team could provide to support the community's efforts.

Mapping Community Resources

©Schreiber, 2025
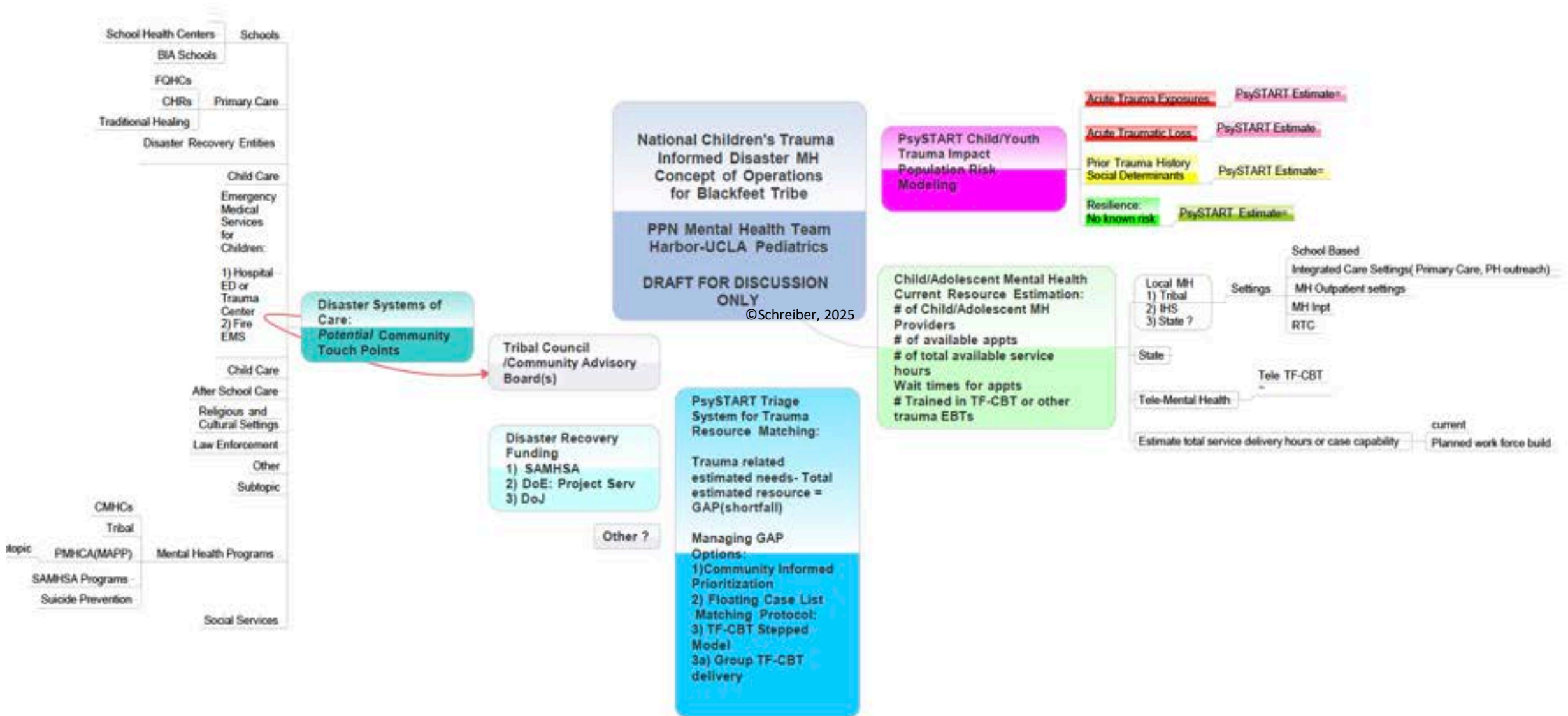
Recommendations

- Create and enhance training for Tribal and IHS-based mental health providers on stepped trauma triage to care with case management approach

- Establish a routine meeting tempo to include all responding agencies and tribal members
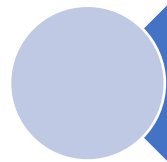
- Establish a "community advisory board" of those agency reps and survivors (i.e. those directly impacted, which will monitor and provide input on the enhancement of mental health initiatives on a continuous improvement model
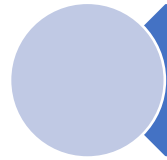
- Engage Native American/Tribal healing organizations and cultural experts to ensure treatments and approaches include appropriate cultural and healing integrated into "western" medicine approaches
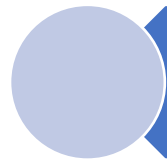
- Combine acute suicide crisis-focused/immediate response efforts with pre-crisis trauma informed care for upstream efforts to reduce acute crisis.

- Offered Youth Suicide Prevention Linkages-Link to UCLA-Duke ASAP center/National Child Traumatic Stress, Network, SAMHSA Tribal MH Lead,, UW/Seattle Children's Pediatric Suicide SMEs

Blackfeet Tribe: "Filling the Triangle"

Photo by: Amanda MorningStar

- Glacier County, in which the Blackfeet Tribe is located, has the highest rate in the state of youth suicide attempts resulting in injury or poisoning requiring medical treatment, according to the Montana Youth Risk Behavior Survey, 2024. Suicide rates on the Blackfeet Tribe specifically are x5 the already high Montana state average.

- Glacier County also reports the highest rate of reported youth suicidal ideation, reported plan for suicide, and youth suicide attempts.(Montana YBRS Data Report ,2024)

- Social Vulnerability Score for Glacier County is rated "very high" and at the 90th %ile, indicating challenges with housing, socio-economic factors such as acute and on-going trauma and social determinants of health impacts: high poverty rates, lack of transportation and low access to resources.(CDC SVI System).

Training across the Triange:
Provided training broadly to community members on LPC psychological first aid

Provided training on Health Support Team to community members, MH providers, and school staff organizations

Provided training on use of PsySTART triage for everyday trauma and disasters

Trained Anticipate.Plan.Deter. Provider Resilience to MH and school staff

Described Stepped TF-CBT and invited MH providers to become trained

WRAP-EM
Western Regional Alliance for
Pediatric Emergency Management

AZ CA NV OR WA UT

Intervention   Intensity

Risk---------Resilience

Emergency Care - Safety A

TF-CBT

TF- CBT Acute

Disaster Crisis Intervention"

Digital/Internet (IBI) Secondary Screening

HST (Health Support Team)

"Listen, Protect and Connect" Neighbor to Neighbor (Psychological First Aid)
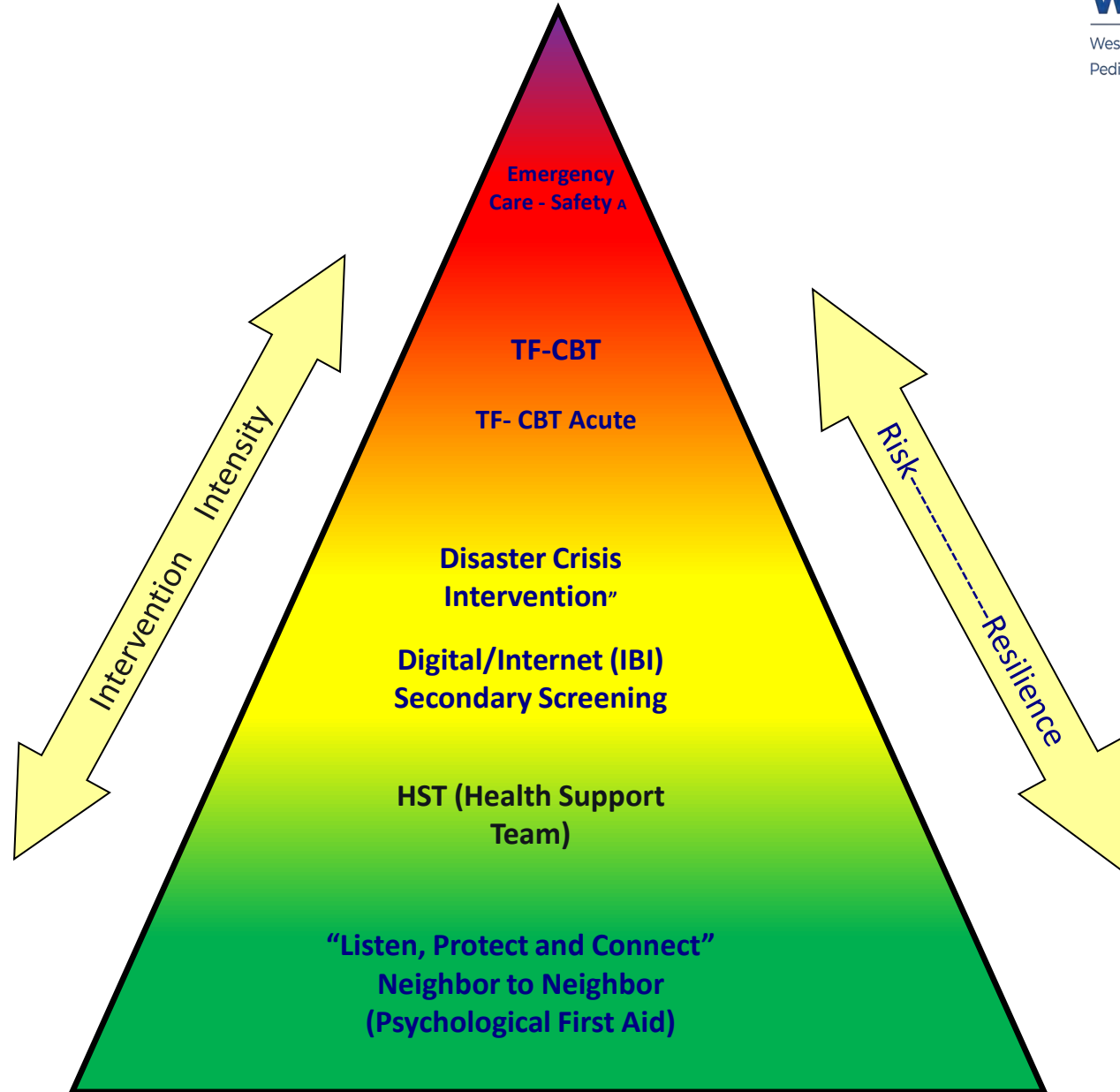
Multiple "Train the Trainer" Trainings Over Three Days

Goals:

Provide knowledge about psychological trauma and coping skills to community member to address mental health impacts across a variety of levels of risk via psychological first aid.

Train community members and professional staff in basic disaster behavioral health knowledge and Cognitive Behavioral Therapy skills to provide peer support to their neighbors, family members and colleagues, via Health Support Team.

Train personal resilience and risk monitoring for those community members who are healthcare providers or first responders.

Provide information and offer training on psychological triage via PsySTART and Stepped TF-CBT

Listen, Protect and Connect®

Psychological First Aid for Community Resilience

Merritt Schreiber, Ph.D.
Kira Mauseth, Ph.D.
Tona McGuire, Ph.D.

WRAP-EM — Western Regional Alliance for Pediatric Emergency Management

HARBOR-UCLA PEDIATRICS   UCLA David Geffen School of Medicine

©2006-2025mschreiber rl

Health Support Team

Disaster Behavioral Health Training and Response

HST CHILDREN YOUTH & TEEN TRAINER GUIDE

A Disaster Behavioral Health Curriculum to Assist Communities and Organizations in Planning and Response

Kira Mauseth, Ph.D. Tona McGuire, Ph.D

HST
TRAIN-the-TRAINER:
for adults supporting Children, Youth, Teens, and Families

Anticipate. Plan. Deter / PsySTART R Responder Resilience System

- "**Anticipate** impacts you and your family will face as a responder in any disaster
  - Tailored, mission/incident specific configurations
    - Manage predictable risk *"precursors"*
- **Plan** how you will handle expectable stress for you and family
- **Deter** expectable stress during a disaster
  - Automated feedback from PsySTART R via SMS text link
  - "Coping *Solution Focused Self Monitoring*" to digital health next steps
  - Enables linkage to stepped care for higher risk providers

- **With Population Level Incident Management**
- Allow agencies to see provider/responder *population* level impacts immediately via PsySTART Impact Temperature Mapping^{tm}
  - Real-Time, Dynamic Population Situational Awareness :
    - Creates mitigation strategies based on actual event impacts
    - Targeted risk factor reduction and engagement for mission continuity

Building Your Responder Personal Resilience Plan™

Anticipate
Plan
Deter

Maximizing Resilience For Healthcare Workers

Supported by a grant FEMA's Grant Programs Directorate, U.S. Department of Homeland Security. The document does not necessarily reflect the views of FEMA or the US Department of Homeland Security.
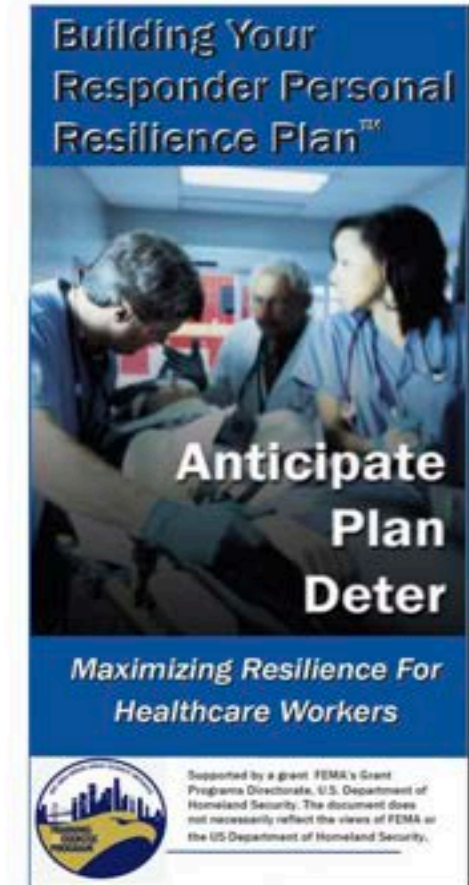
Anticipate. Plan. Deter.

- A focus on resilience
- *Anticipate*
  - What your role is and challenges you may experience, sometimes called "stress inoculation"
- *Plan*
  - Develop your personal resilience plan to help you cope
  - Build on your personal strengths and social connections
  - Consider what else you may need in your coping plan
- *Deter:*
  - Activate individual coping and resilience plan
  - Self-monitoring: Monitor your exposure risk by monitoring what has happened to the children you help
  - Manage "next steps"

Example: APD/PsySTART Responder Training: Over 500 trained from 2020-2022 via WA State Dept of Health's

Behavioral Health Strike Team

- Front line healthcare workers in hospitals
- Fire and EMS
- Staff in skilled nursing facilities
- Staff in correctional facilities and juvenile justice centers
- Behavioral health providers
- Staff in Isolation and Quarantine setting

Stepped Triage to Care for Pediatric Disaster Victims Model

(c)copyright M Schreiber, 2023
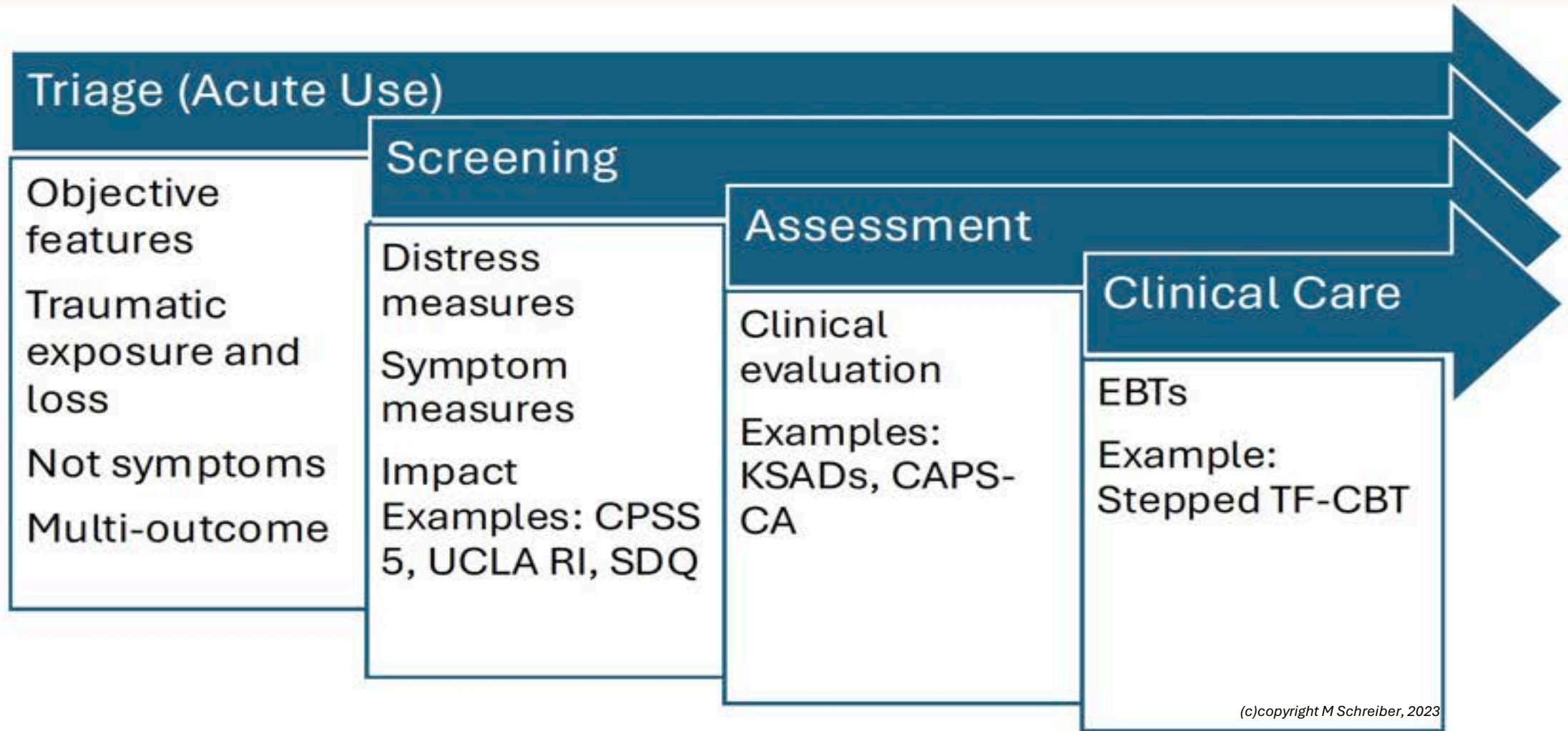
PsySTART Triage to Care

Goal:

Identification of at risk children and early intervention for PTSD
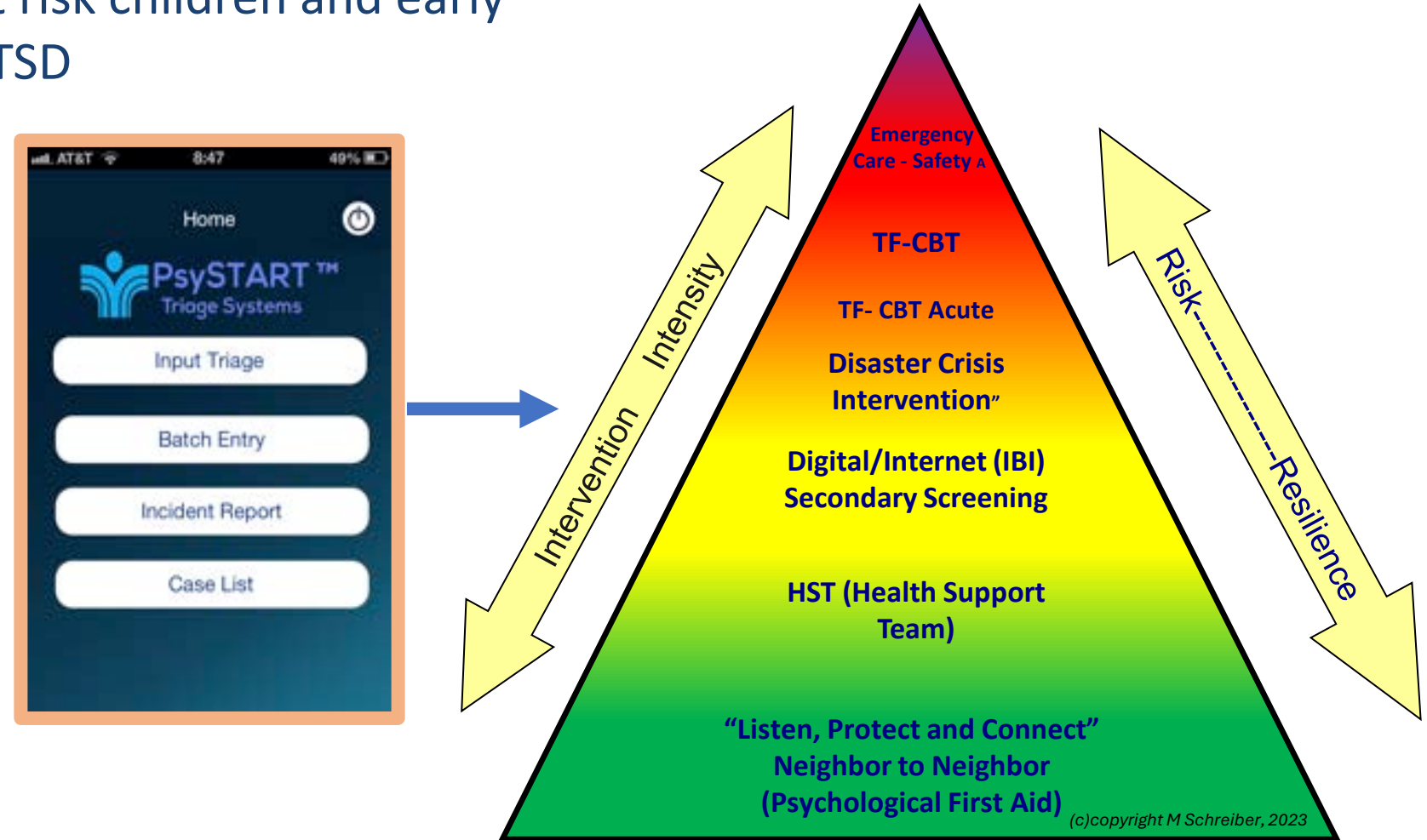
Intervention Intensity

Risk--------------------Resilience

Emergency Care - Safety ᴀ

TF-CBT

TF- CBT Acute

Disaster Crisis Intervention"

Digital/Internet (IBI) Secondary Screening

HST (Health Support Team)

"Listen, Protect and Connect" Neighbor to Neighbor (Psychological First Aid)

(c)copyright M Schreiber, 2023

WRAP-EM
Western Regional Alliance for
Pediatric Emergency Management
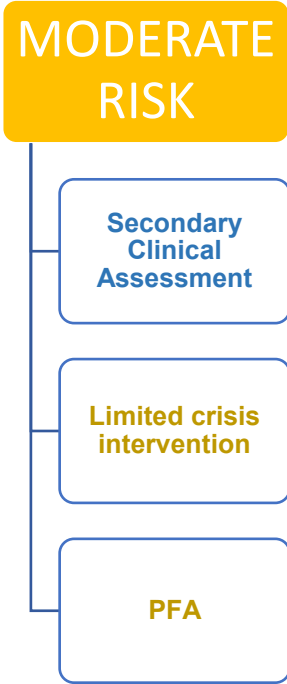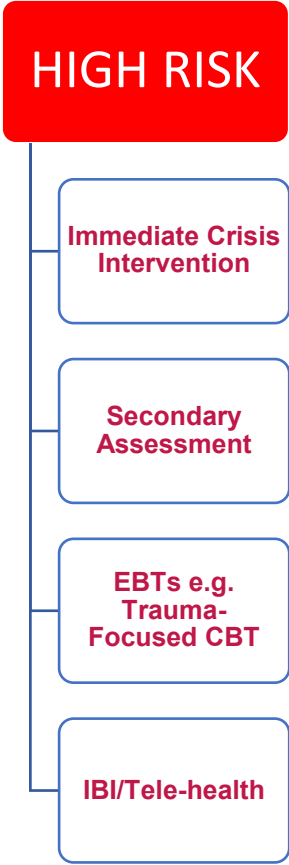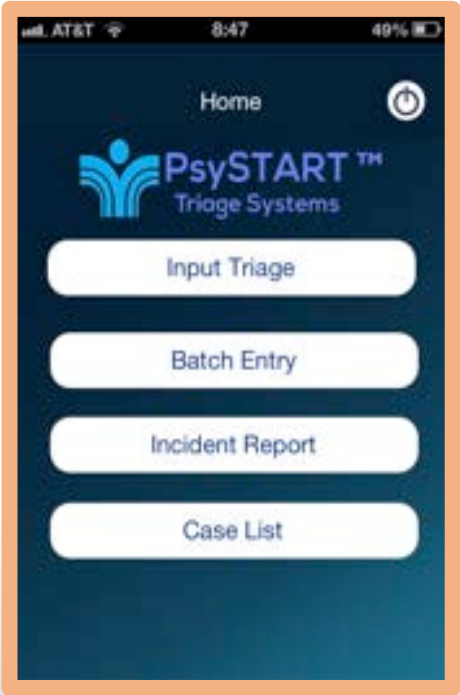
Stepped Triage to Care = Three Steps

Step 1:
PsySTART TRIAGE

- Provided by non-clinical personnel
- Based on experiences and exposures, not symptoms
- Doesn't require in-depth questioning or story telling
- High-risk referred to Step 2

Step 2:
TF-CBT (**acute**)
4 modules

- Symptom screening via CPSS-5
- Psycho-education on trauma for child and parent
- Relaxation skills
- Affective modulation
- Cognitive coping processing skills
- Reassess with CPSS for Step 3 *(50-70% stop at 2)*

Step 3:
TF-CBT(**full**)
4 modules

- 6-8 additional sessions to complete the full TF-CBT model
- Trauma Narrative, conjoint parent and child sessions and safety planning

©Schreiber, 2025

WRAP-EM
Western Regional Alliance for
Pediatric Emergency Management

PsySTART Pediatric Community MH Risk/ "Community Trauma Temperature" Mapping
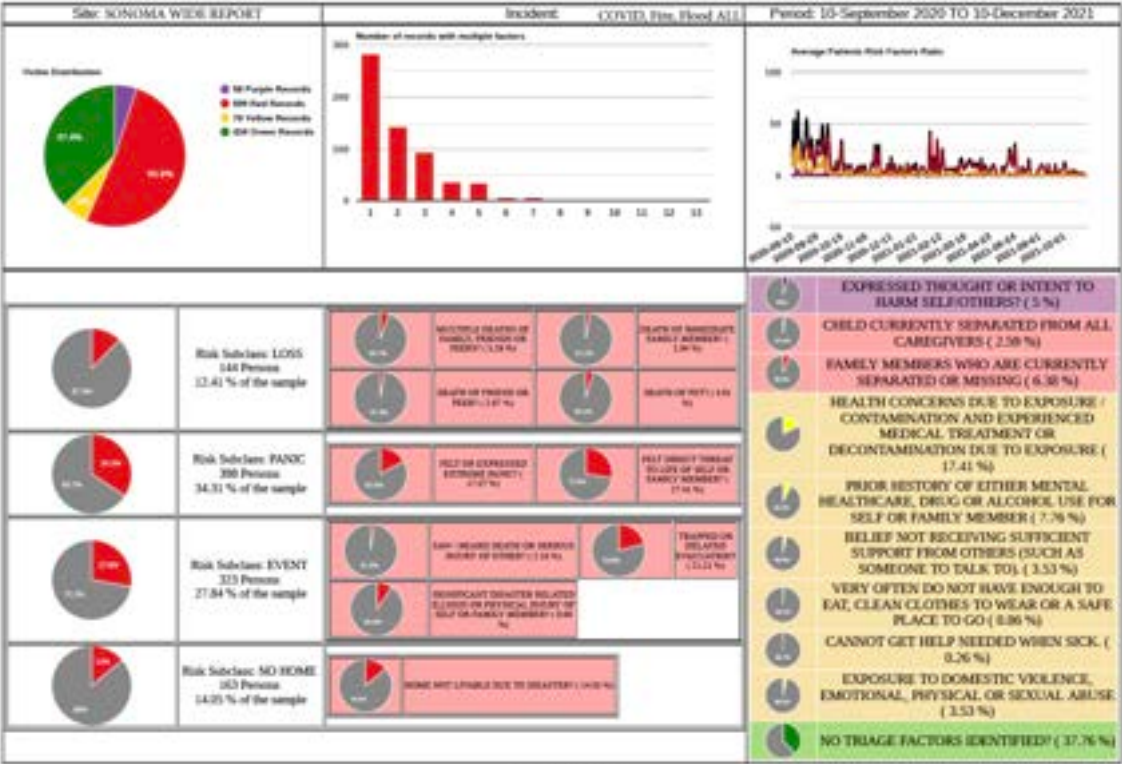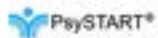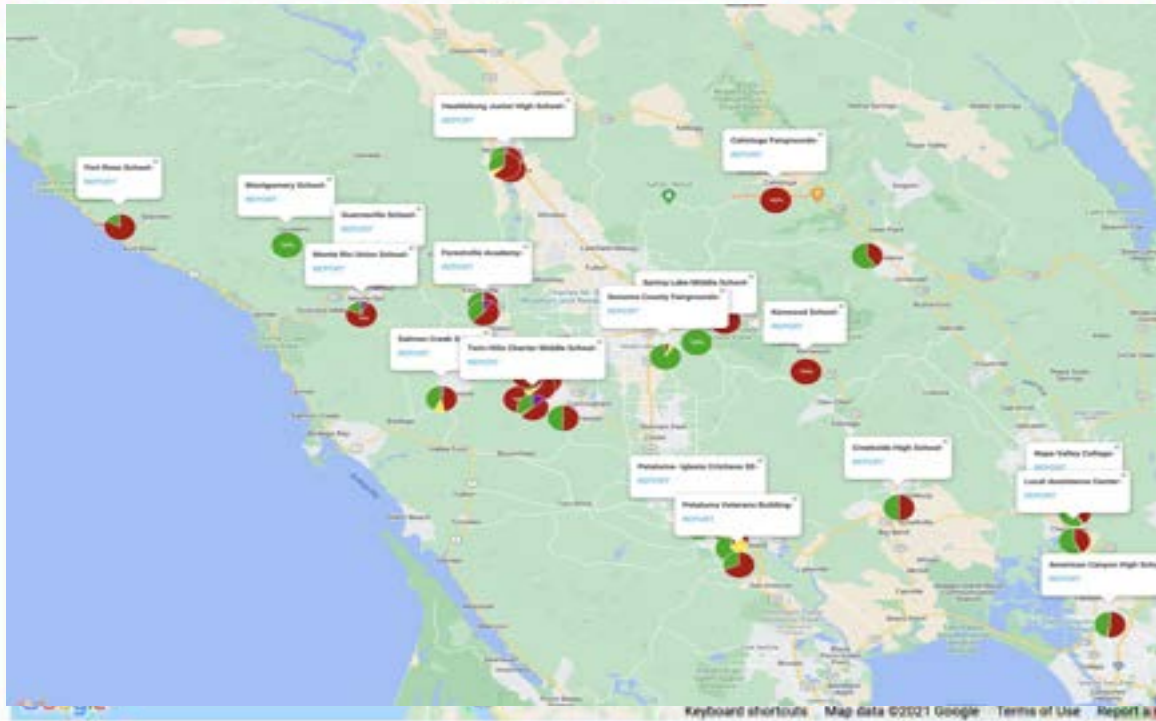
Goal: Early Intervention with Evidence-Based Treatments

The goal of this approach is to offset a wide range of downstream trauma impacts, such as serious mental health disorders and suicide crises, by intervening in the trauma cycle early.

-Emphasis on early intervention with trauma-informed pediatric care, via training and on- going consultative assistance to the Blackfeet Nation.

-With this we hope to enhance locally operational "upstream" care options.

Source: Public Health Sudbury & Districts www.phsd.ca

Irving Zola's "Upstream-downstream parable";

Increasing Access to Limited Mental Health Resources via Stepped Triage to TF- CBT

- Positive PsySTART Triage cases assigned to Stepped TF-CBT
- Tele-Behavioral Health, in person, or hybrid
- In natural disaster projects, over half "graduated" from care after receiving first four modules of the intervention
- Increases individual provider efficiency by 60+%, allowing more children to be served (i.e., KPI=.67

PsySTART Stepped Triage to Care : Washington State Project: Using RCI 2022-2023 end of project year

Child Outcome Measures 2022-2023

Legend:
- Improvement Improved
- Improvement No change
- Improvement Worsened

Measure	Improved	No change	Worsened
cpss	80%	8%	12%
mfq	82%	6%	12%
scared	76%	6%	18%
sfssA	88%	8%	4%
sfssB	82%	9%	9%

WRAP-EM
Western Regional Alliance for
Pediatric Emergency Management
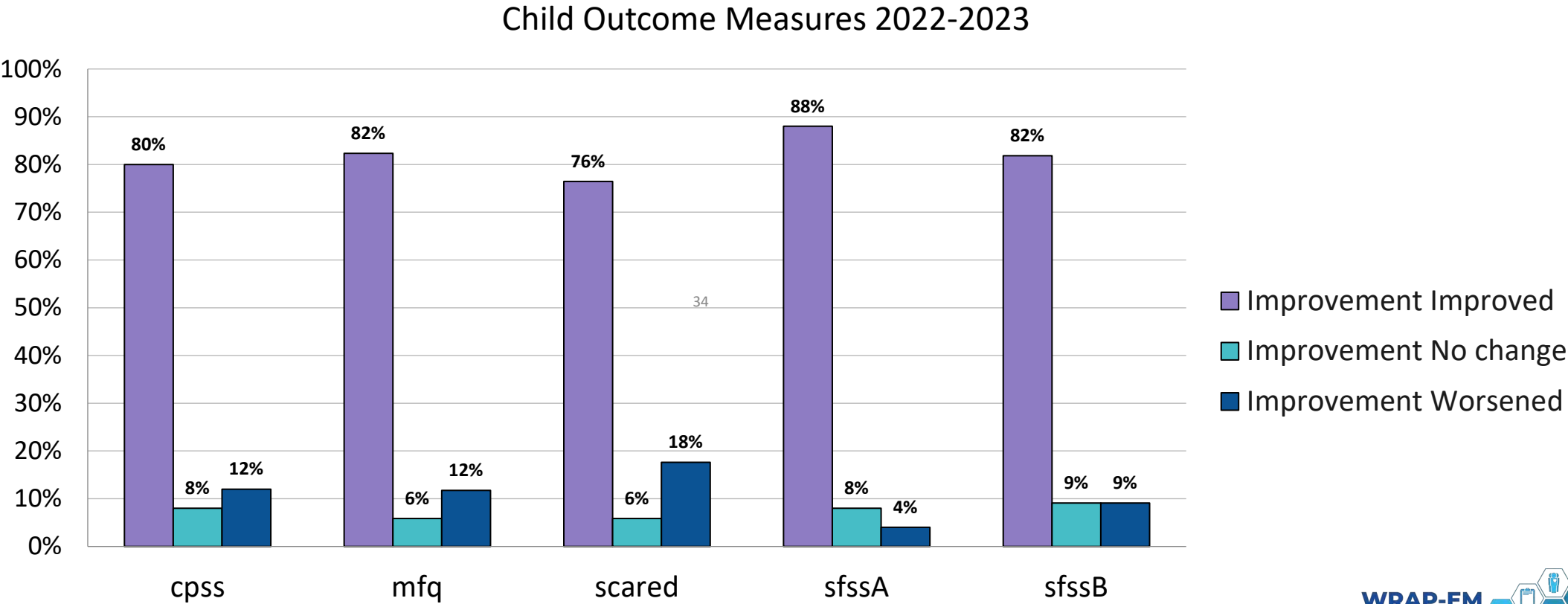
Partnership Between the Blackfeet Nation and WRAPEM

5th
Introducing the Stepped Triage to Care model in providing early trauma care for high-risk youth in communities like the Blackfeet Nation, to reduce downstream mental health problems including suicide.

!st and last
Planning for ongoing consultation and support. Not a "one and done" approach.

2nd
Providing training across the spectrum of impact and risk from Psychological First Aid, through a more intensive community-based behavioral health curriculum (Health Support Team)

3rd
Fostering resilience and training on monitoring risk for those who support youth such as healthcare providers, school staff, and first responders

4th
Establishing a system to identify PTSD risk in Blackfeet youth via PsySTART

#NHCPC25

Thank You! Questions?

Tona McGuire

tonam2@uw.edu

Merritt Schreiber

m.schreiber@ucla.edu

Jennifer St.Goddard

j.stgoddard@blackfeetnation.com

HICS 255 - MASTER PATIENT EVACUATION TRACKING FORM – NICU

1. INCIDENT NAME	2. DATE/TIME PREPARED	3. PATIENT TRACKING MANAGER

4. PATIENT EVACUATION INFORMATION

Patient Name or Sticker	Disposition ☐ Home ☐ Discharge ☐ Transfer ☐ Morgue	Evacuation Triage Category ☐ Immediate ☐ Delayed ☐ Minor	Mode of Transport		Family Present ☐ Yes ☐ No
			☐ CCT	☐ ALS	
			☐ BLS	☐ Bus	Family Notified ☐ Yes ☐ No
			☐ Car	☐ Van	Medication/Supplies Sent ☐ Yes ☐ No
			☐ Aircraft		Heat Source ☐ Yes ☐ No Type: ☐ Radiant Warmer ☐ Isolette ☐ Gel Pad

Accepting Hospital or Location	Time Accepting Hospital Contacted & Report Given _____	Transport Initiated Company: _____ Time: _____	Admit Location ☐ NICU Rm/Bed #_____ ☐ ER Rm/Bed #_____ ☐ Floor Rm/Bed #_____	Arrival Confirmed ☐ Yes ☐ No Time: _____

Patient Name or Sticker	Disposition ☐ Home ☐ Discharge ☐ Transfer ☐ Morgue	Evacuation Triage Category ☐ Immediate ☐ Delayed ☐ Minor	Mode of Transport		Family Present ☐ Yes ☐ No
			☐ CCT	☐ ALS	Family Notified ☐ Yes ☐ No
			☐ BLS	☐ Bus	Medication/Supplies Sent ☐ Yes ☐ No
			☐ Car	☐ Van	Heat Source ☐ Yes ☐ No
			☐ Aircraft		Type: ☐ Radiant Warmer ☐ Isolette ☐ Gel Pad

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			☐ CCT	☐ ALS	Family Notified ☐ Yes ☐ No
			☐ BLS	☐ Bus	Medication/Supplies Sent ☐ Yes ☐ No
			☐ Car	☐ Van	Heat Source ☐ Yes ☐ No
			☐ Aircraft		Type: ☐ Radiant Warmer ☐ Isolette ☐ Gel Pad

Accepting Hospital or Location	Time Accepting Hospital Contacted & Report Given _____	Transport Initiated Company: _____ Time: _____	Admit Location ☐ NICU Rm/Bed #_____ ☐ ER Rm/Bed #_____ ☐ Floor Rm/Bed #_____	Arrival Confirmed ☐ Yes ☐ No Time: _____

5. SUBMITTED BY	6. DATE/TIME SUBMITTED	7. FACILITY NAME **St. Louis Children's Hospital**

HICS 260 – PATIENT EVACUATION TRACKING FORM – NICU

FACILITY NAME	St. Louis Children's Hospital	1. DATE

PLACE PATIENT STICKER IN THIS SPACE

3. DIAGNOSIS (-ES)	4. ADMITTING PHYSICIAN

5. FAMILY NOTIFIED ☐ YES ☐ NO	FAMILY PRESENT ☐ YES ☐ NO

CONTACT INFORMATION:

6. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY)

☐ Crib	☐ IV Pumps	☐ Chest Tube(s)	☐ Foley Catheter
☐ Isolette	☐ Oxygen	☐ Monitor	☐ IO Device
☐ Open Table	☐ Ventilator	☐ A-Line/Swan	☐ Heat Source Type:
☐ Other	☐ Other	☐ Other	☐ Other

ISOLATION ☐ YES ☐ NO	TYPE

REASON

7. DEPARTING LOCATION/DEPARTMENT	8. EVACUATION STAGING/HOLDING LOCATION
MODE OF TRANSPORT ☐ CARRY ☐ CRIB / ISOLETTE / TABLE ☐ EVACUATION BASKET	MODE OF TRANSPORT ☐ CARRY ☐ CRIB / ISOLETTE / TABLE ☐ EVACUATION BASKET
ROOM# | TIME	ROOM # | TIME
ID Band Confirmed ☐ YES ☐ NO | By:	ID Band Confirmed ☐ YES ☐ NO | By:
Belongings ☐ with Patient ☐ Left in Room ☐ None	Belongings Received ☐ YES ☐ NO
Valuables ☐ with Patient ☐ Left in Safe ☐ None	Valuables ☐ YES ☐ NO
Medications ☐ with Patient ☐ Left on Unit ☐ to Pharmacy	Medications Received ☐ YES ☐ NO

PEDS/INFANTS

Bag/Mask with Tubing Sent ☐ YES ☐ NO	Bag/Mask with Tubing Received ☐ YES ☐ NO
Bulb Syringe Sent ☐ YES ☐ NO	Bulb Syringe Received ☐ YES ☐ NO

9. TRANSFERRING TO ANOTHER FACILITY

TIME TO LOADING AREA:	DESTINATION:
TRANSPORTATION ☐ Ambulance Unit ☐ Helicopter ☐ Other:	
ID BAND CONFIRMED ☐ YES ☐ NO BY: (please print)	
STAFF ACCOMPANYING PATIENT: ☐ YES ☐ NO NAME: (please print)	
	DEPARTURE TIME:

Purpose: Detail and account for patients transferred to another facility
Origination: Inpatient/Outpatient Unit Leader or Casualty Care Unit Leader
Copies to: Patient Tracking Manager or Documentation Unit, Medical Care Branch Director, evacuating clinical location

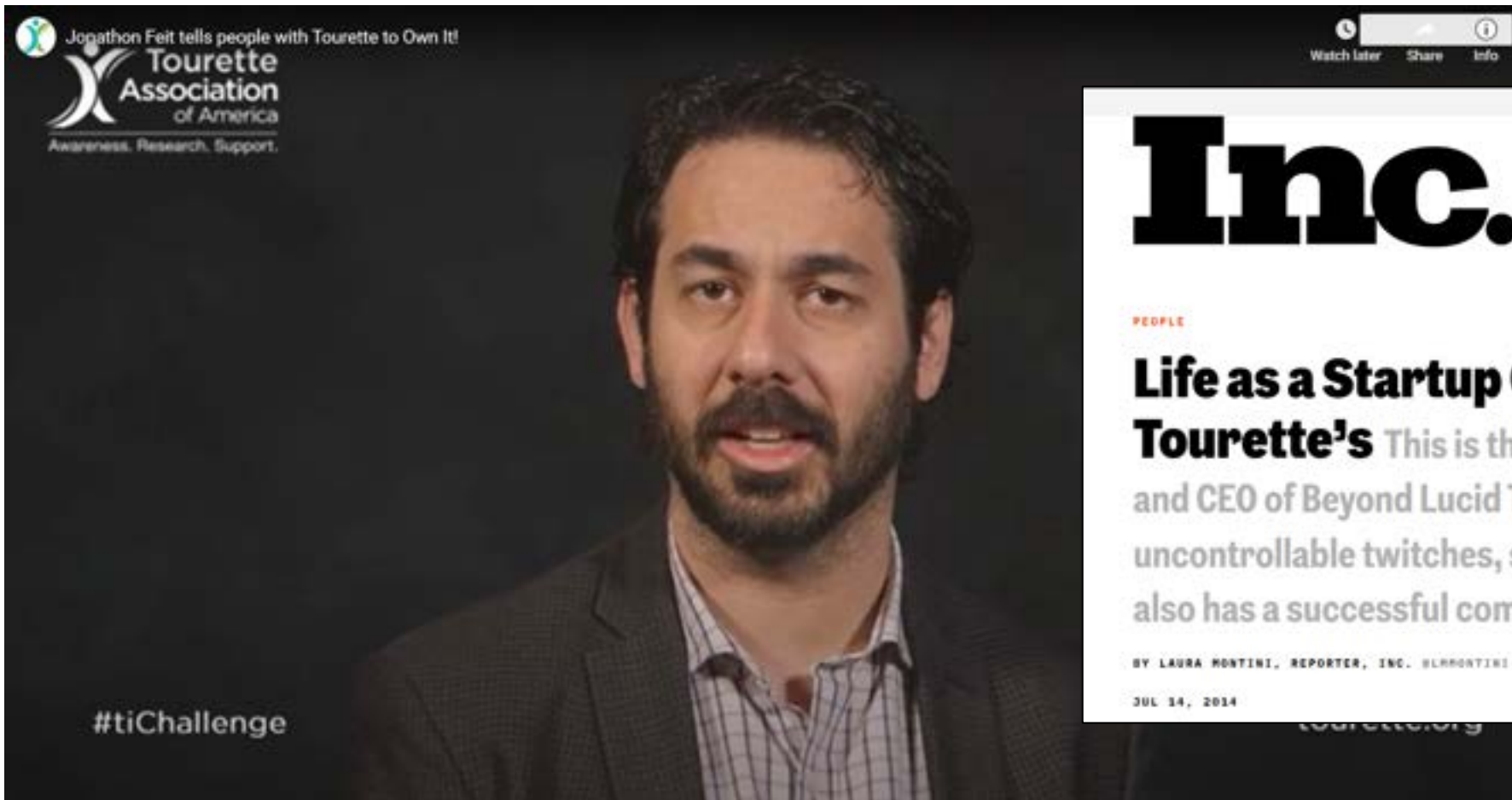**Page 1 of 1**
Rev. 6/2024

Disabilities and Disasters

Perhaps the single-most personal presentation I have ever given.

Jonathon S. Feit, MBA, MA
Co-Founder & Chief Executive
BeyondLucid.com
(650) 648-3727
Jonathon.Feit@beyondlucid.com

BEYOND LUCID

Look, Ma – I'm a twitchy guy!

There's nothing theoretical about this talk.
This talk is as serious as it gets.
I hope what we discuss makes you livid.

Head home and question every healthcare IT investment if any of what we discuss today holds true in your community.

Because people DIED.

Altadena man shares unimaginable loss of disabled father, brother in Eaton Fire

by: Josh DuBose
Posted: Jan 14, 2025 / 05:29 PM PST
Updated: Jan 14, 2025 / 05:38 PM PST

KTLA 5

1:16 / 4:10

HEADLINES   sh ktla.com   FBI looking for pilot of drone that grounded plane battling Pal   55°   10:17P

KTLA 5

Disabled Eaton Fire victim escaped deadly flames in wheelchair

by: Josh DuBose
Posted: Jan 14, 2025 / 08:00 PM PST
Updated: Jan 14, 2025 / 08:00 PM PST

0:54 / 3:18

Los Angeles Daily News

News | Disabled father and son died awaiting rescue...

nbcnews.com/news/us-news/former-child-star-rory-sykes-dies-california-wildfires-rcna187252

Former child star Rory Sykes dies in California wildfires as mom tried to save him

SHARE & SAVE —

Former child star Rory Sykes dies in California wildfires as mom tried to save him

Sykes, 32, was born blind and had cerebral palsy and difficulty walking, his mother said.

California has known that disabled people need help in fires. After LA, can it better prepare for the next one?
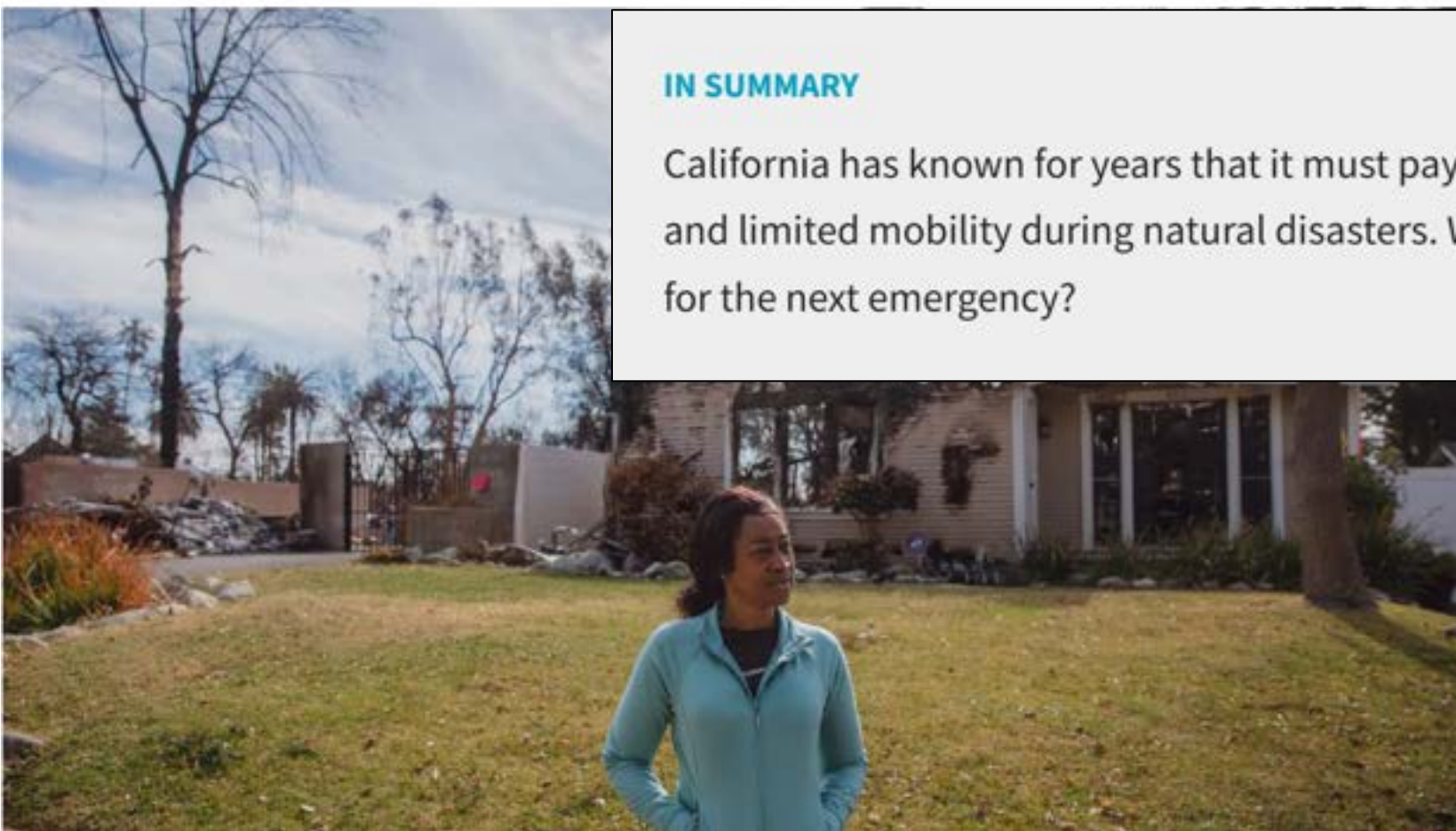
BY ANA B. IBARRA
FEBRUARY 19, 2025

Republish

IN SUMMARY

California has known for years that it must pay extra attention to people with disabilities and limited mobility during natural disasters. Will it put the lessons of the L.A. fires to use for the next emergency?

Accessible Evacuations: How All Californians Can Prepare for Emergencies

Published: Apr 12, 2023

Vulnerable populations are typically disproportionately affected by disasters. That's why it's so important to have specific plans in place and a go-bag ready in case of an emergency or evacuation. The California Governor's Office of Emergency Services (Cal OES) wants to ensure the Access and Functional Needs (AFN) community can respond quickly to emergency orders.

Different Needs Create Different Plans

AFN refers to individuals who are/have:

- Physical, developmental, or intellectual disabilities
- Chronic conditions or injuries
- Limited English proficiency
- Older adults
- Children
- Low income, homeless and/or transportation disadvantaged (i.e., dependent on public transit)
- In late stages of pregnancy

IN SUMMARY

California has known for years that it must pay extra attention to people with disabilities and limited mobility during natural disasters. Will it put the lessons of the L.A. fires to use for the next emergency?

Jan 16, 2025

Preparing for a Natural Disaster

Learn about where to start, items to prepare, and view a video with tips for the disability community

Natural disasters can impact California at all times of year. For residents with disabilities, events like wildfires, earthquakes, and floods pose additional risks.

Read More >

Jan 15, 2025 | #1099R

Wildfire Resource Guide & How Disability Rights California Can Help You

If you have an emergency or are in trouble, call 911. Disability Rights California cannot help you evacuate or stay safe.

Read More >

Many residents with disabilities can't flee fires on their own. Could a database help?

Anthony Mitchell Sr. poses with two of his great-grandchildren. The Altadena patriarch died in the fast-moving Eaton fire Wednesday while waiting to be evacuated with his disabled son. (Courtesy of Mitchell family)

≡ Q

FIREHOUSE

2025 CALIFORNIA FIRE STORM

CA Wildfires Show Need for Database of Disabled Residents

Some of the elderly residents who perished in the Eaton Fire had mobility or health issues, Los Angeles County Fire Chief Anthony Marrone said.

By Rebecca Ellis

Jan. 22, 2025 • 4 min read

Source Los Angeles Times (TNS)

Here's what feels **offensive**…

<u>Disclosure</u>
My family lives in L.A. and my father has a serious disability (transplant, diabetes, more)

The Qualified Health Information Organization (QHIO) operating in Los Angeles County is **LANES (Los Angeles Network for Enhanced Services)**. Other QHIOs that may have a presence or serve the area include Cozeva, Health Gorilla, and Manifest MedEx, but LANES is the primary organization focused specifically on Los Angeles County. 🔗

- **LANES (Los Angeles Network for Enhanced Services):** A nonprofit organization designated as a QHIO, it facilitates the exchange of health and behavioral health information for providers in Los Angeles County. Its mission is to improve patient care and outcomes by connecting physical and mental health providers.

- **Other QHIOs:** Other statewide QHIOs that may serve Los Angeles County providers include Cozeva, Health Gorilla, and Manifest MedEx. Providers can work with any QHIO to meet their data sharing obligations under the California Data Exchange Framework. 🔗

We need to ask:
Why aren't Response agencies using the tools they already have?

A big, pervasive, national question.

An imperative as budgets shrink.
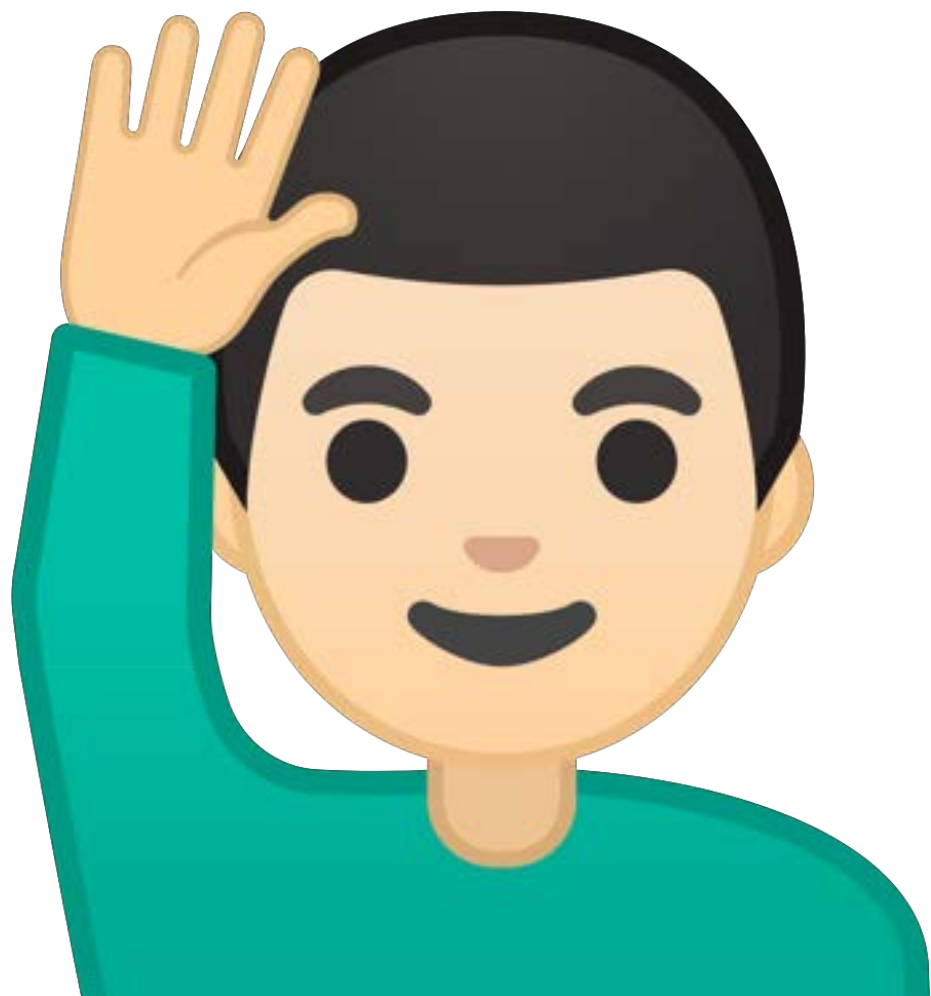
https://www.youtube.com/watch?v=DFJDX_AyzG8

for EMS data to be shared with,
the broader health care ecosystem.

https://www.youtube.com/watch?v=DFJDX_AyzG8

https://www.youtube.com/watch?v=DFJDX_AyzG8

https://www.youtube.com/watch?v=DFJDX_AyzG8

Health System Transformation Through EMS Data Integration

October 2025

Emergency Medical Services (EMS) data represents a critical, yet underutilized, resource with significant potential to transform public health surveillance, support the delivery of health and social services, and improve health outcomes. Investing in the integration of this near real-time data source will provide visibility into patient needs that remain hidden in traditional clinical settings, driving better care coordination, efficiency, and resource allocation.

The Data Gap: Unlocking Hidden Health Needs

EMS systems operate as a crucial entry point to care. As a mobile safety net service for individuals without insurance or those in communities with limited health care resources, EMS encounters provide a unique view of patients' living environments and health-related social needs (e.g. housing instability or lack of access to primary care).

In a way that's usable and also useful to the end user.

Health System Transformation Through EMS Data Integration

October 2025

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In a way that's usable and also useful to the end user.

https://www.youtube.com/watch?v=DFJDX_AyzG8

Okay, but…

The State of Michigan already did this (more than a year earlier).

Michigan Health Information Network Demonstrates Enhanced Care Coordination Among EMS & Hospitals

by MiHIN | Aug 6, 2024 | Announcements, News, Press Releases

MiHIN
MICHIGAN HEALTH INFORMATION NETWORK
SHARED SERVICES

For im   August 6, 2024

For additional information, contact: Ery Mata | 517.745.8835

emily.mata@mihin.org

healthleaders TOPICS EVENTS RESOURCES SUBSCRIBE f

MICHIGAN HIE TARGETS DATA EXCHANGE SILOS IN EMERGENCY CARE

ANALYSIS | BY ERIC WICKLUND | AUGUST 22, 2024

f 𝕏 in ✉ 🖨

TOPICS

Care Continuum

Care Coordination

A pilot project coordinated by the Michigan Health Information Network aims to help hospitals share critical patient data with EMS providers and ambulances.

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healthcareitnews.com/news/hie-pilot-tackles-emergency-response-data-silos

HIE pilot tackles emergency response data silos

A prehospital health information exchange in Michigan that provides bidirectional interoperability will bridge ambulatory data gaps and enhance care coordination en route to the hospital and during post-discharge care transitions.

Global   Interoperability

By Andrea Fox, Senior Editor | August 8, 2024 | 9:27 AM   f 𝕏 in

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FEATURE

How real-time health data exchange emergency care

Michigan Health Information Network has launched a pilot project that enables real-time health data exchange between emergency medical services and hospitals.

By Hannah Nelson, Xtelligent/TechTarget   Published: 13 Dec 2024

Be he

Why rebuild it all again?

Why didn't experts know?

Is there *that much* *noise*?

This isn't limited to Michigan.

It is urgently relevant to NHCPC participants.

Emergency Preparedness
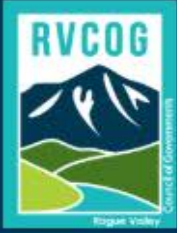
Disaster Registry

Jackson and Josephine Counties, Oregon

Would you need special help in an emergency?

You might want to apply to be in the Disaster Registry if—in the case of a flood, forest fire or other disaster—you or someone you care for would:

- Need outside help to safely leave your home during a disaster
- Be in jeopardy if you stayed in your home, without assistance, for three days;
- Need special notification about the need for evacuation, due to impairment.

The Disaster Registry provides the names and locations of people who need special assistance to fire, police, health, and rescue workers. Being on the Disaster Registry does not guarantee that you'll get help first in a disaster. There are so many needs during a disaster that our fire fighters and police can't help everyone at once. But if your name is in the Disaster Registry, they will know of your need for special assistance.
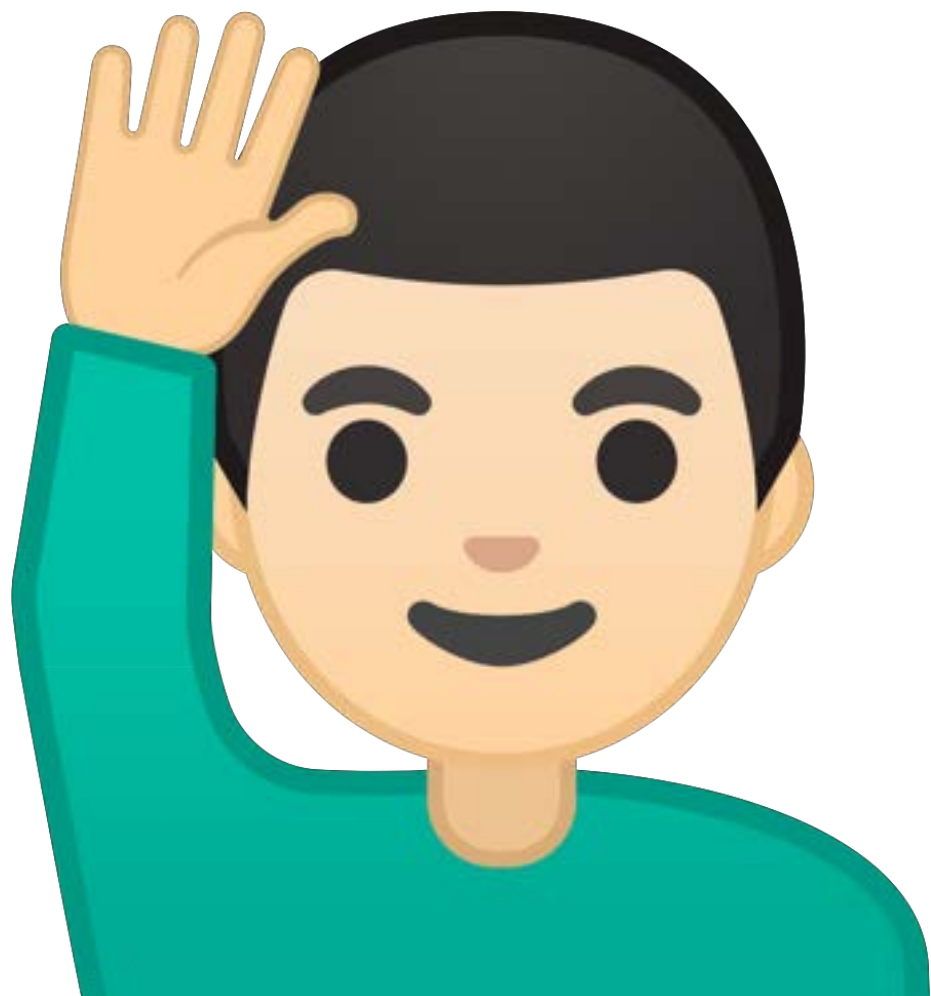
RVCOG

Emergency Preparedness

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Oregon **also** has…

Why don't they **all** connect?

OPR
portable orders for life-sustaining treatment
Oregon POLST® Registry

Reliance
eHEALTH COLLABORATIVE

HIT COMMONS
Accelerating
Health Information
Technology

HERO
Kids

Here's a terrible task as a Responder during a disaster:

Here's a terrible task as a Responder during a disaster:

FIND THE KID WITH CANCER, **WHO CANNOT RUN/ESCAPE** BECAUSE OF CHEMO MEDS.

Was the first topic raised in 2024 by a family of a SHNs child in Wash., DC

My inspiration.

My inspiration.

Kendall Marissa Bresocnik

October 30, 2012 – May 16, 2020

Mr. Bresocnik

The 2024-2025 school year will be my 23rd at CHS.

At 6'7", I have always been the tallest teacher at CHS.

I am the father of two beautiful girls.

"I run. I strum. I won."

- I run the Marine Corps. Marathon in Washington DC every year. I play guitar. I am part of the back-to-back Brain Bowl Championship winning team.

I absolutely *love* American History and I love to entertain people.

I collect military pictures of former students who have proudly served our country.

*I often wear a tie that corresponds to what we are learning in class or a historical event of that day, so keep an eye out!

Phone: (732) 541-8960 x4037

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Degrees and Certifications:

B.S. Boston University, 2001
Governor's Educator of the Year, 2020-2021

My inspiration.

VALLEY

A Gilbert mom asked her son's school to honor his 'do not resuscitate order.' The school refuses to do so.

—

Susie Jackson's 17-year-old son, Rigo, was born with several medical conditions. His parents say they ultimately feel a 'DNR' is appropriate. The school disagrees.

https://www.12news.com/article/news/local/valley/a-gilbert-mom-asked-her-sons-school-to-honor-his-do-not-resuscitate-order-senior-gilbert-public-school-district/75-4f59b673-a9d4-4a5a-954a-4bef6223f67f

"...**District personnel shall not comply with DNR Orders or other directives or requests that emergency life-sustaining care be withheld from a student in need of such care while the student is under the control and supervision of the District.** Any such request should be made by the parent or guardian to the emergency response team at the 911 dispatch office or to the treating physician(s) and medical staff..."

-Gilbert Public Schools

DNR orders that emergency life sustaining care

"...The Arizona School Boards Association does not have a statewide policy specific to Do Not Resuscitate (DNR) orders in schools. Each district adopts its own policies, and **while there are state statutes that outline parents' rights to make health care decisions for their minor children, including in education settings, there is no single statewide rule requiring school districts to follow or not follow DNR orders**..."

-AZ School Boards Assoc.

care decisions for their minor children,

What is the risk to the patient, the family, <u>and the Responders</u> when a patient's needs/wishes are unknown during a "normal" health emergency.

What is the risk to the patient, the family, <u>and the Responders</u> when a patient's needs/wishes are known but ignored during a "normal" health emergency.

Now imagine what could happen if you don't obey a patient's wishes or needs **during a disaster…** **when nothing is "normal."**

(It's not just an inconvenience.)

QUESTION:

QUESTION:

Where do patients with disabilities and special health needs go during a disaster?

ANSWER:

ANSWER:

Anywhere they can.

The New Orleans 'diaspora'

Katrina's Diaspora

The victims of Hurricane Katrina have filed for assistance from FEMA from every state. The map shows the distribution and number of the 1.36 million individual assistance applications as of Sept. 23.

The New York Times, used by permission

Number of applications from selected metropolitan areas

Counties from which families filed applications

Circles are sized according to the number of applications from a ZIP code

10,000
5,000
1,000
100
10

Dallas
Ft. Worth
30,117

San Antonio
6,025

Houston
84,769

Corpus Christi
1,169

New Orleans 160,617

Ft. Walton
Beach
3,342

Tampa
7,907

Atlanta
29,252

Jacksonville
2,797

Orlando
7,690

Miami
Ft. Lauderdale
4,188

Fla.

PUERTO RICO

Miles

0   100   200   300   400

What if their data don't go with them?

The New Orleans 'diaspora'

Katrina's Diaspora

The victims of Hurricane Katrina have filed for assistance from FEMA from every state. The map shows the distribution and number of the 1.36 million individual assistance applications as of Sept. 23.

In the hours before, during, and after the storm, New Orleanians evacuated to cities and towns all over the country. Sometimes they chose a destination in order to be with family or friends. Other times, FEMA sent them off to places unknown. "We have residents who were loaded onto buses bound for Memphis or Salt Lake City and only found out once they got there," says Michelle Whetten, vice president of the affordable housing and community

The New York Times, used by permission

Katrina birthed America's **first real, sustainable** EHR/health data standards:

"MEANINGFUL USE"
(2009 via the HITECH Act)

New Orleans native and former city health commissioner Dr. Karen DeSalvo has been hired as Google Health's first chief health officer.

DeSalvo was New Orleans' health commissioner from 2011 to 2014 before serving as the national coordinator for health information technology and assistant secretary for health at the U.S. Department of Health and Human Services in the Obama administration. Prior to working for the city, she was a vice dean at Tulane University Medical School.

▶ RECENT APPEARANCES

SEPTEMBER 20, 2017
Hurricane Preparation and the Elderly
The Senate Special Aging Committee held a hearing focusing on disaster planning and response to ensure the health and safety ...

SEPTEMBER 30, 2016
Cancer Prevention
Cancer researchers and public health experts talked about cancer prevention efforts, including campaigns to promote screening...

MAY 5, 2015
Improving Disease Treatment
Dr. Francis Collins was among the three witnesses who updated the Senate Health, Education, Labor and Pensions Committee on P...

MARCH 13, 2007
Post-Katrina Health Care
Witnesses testified about continuing concerns and immediate needs for health care in New Orleans since Hurricane Katrina.

Electronic Health Records and Preparedness: Lessons from Hurricanes Katrina and Harvey

The levees of New Orleans broke on August 29, 2005. The bayous of Houston crested on August 29, 2017. The resulting floods were catastrophic and deadly for each community. It's been a busy twelve years in America: three presidents have resided in the White House, Osama bin Laden was killed, gay marriage supported in the Supreme Court, and we've cured Hepatitis C, to name a few. While the lesson about climate change continues to fall on ears deafened by the whirs of the oil rigs, there was one significant mass casualty that was spared 2017 when compared to 2005: medical records. As far as casualties go, this one certainly lacks a certain heroism. Let us not forget however, that one million people were displaced in the aftermath of Hurricane Katrina, each of those a patient with a history. A patient, for example, on a fluctuating diuretic regimen dictated by a tenuous volume status, or one with drug resistant HIV now setting up shop in a new community, or a cancer patient who just completed cycle 2 of 5 of chemotherapy, arriving in your practice asking for help.

In the twelve years that separated Hurricane Katrina from Hurricane Harvey, the advances to the electronic health record (EHR) has been powerful, allowing for safe continuity of care in the face of catastrophe. A Houston clinic may now be underwater, but with patient interactive portals that allow patients to access their labs and medications remotely, a patient of that clinic has a better chance of seeing a new physician in a neighboring town and providing an accurate picture of his or her medical history.

Considerations for emergency planning that **includes people with disabilities.**

Risks of Not Considering People with Disabilities in Emergency Planning

1. Individuals with mobility impairments may be unable to evacuate safely or at all.

2. People who are Deaf or hard of hearing may miss critical warnings or evacuation orders.

3. Individuals who are blind or have low vision may become disoriented without accessible guidance systems.

4. Communication breakdowns can lead to confusion, panic, or noncompliance with safety instructions.

5. Emergency shelters may be physically inaccessible, preventing safe refuge for people with disabilities.

6. Lack of accessible transportation can leave individuals stranded during evacuation.

7. Service animals may be denied entry, separating individuals from essential support.

8. Absence of power for medical devices may result in injury, health deterioration, or death.

9. Interrupted access to medications or medical treatments can cause preventable medical crises.

Risks of Not Considering People with Disabilities in Emergency Planning

10. Lack of trained responders can lead to unsafe transfers, injuries, or mishandling of mobility aids.

11. People with cognitive or intellectual disabilities may not understand complex emergency directions.

12. People with autism/sensory sensitivities may experience extreme distress in chaotic environments.

13. Emergency comms that are only verbal or visual exclude portions of the population entirely.

14. People dependent on caregivers may lose critical assistance if care continuity is not planned.

15. Unprepared shelters may violate ADA standards and expose agencies to legal and financial liability.

16. Isolation and lack of accessible information can cause psychological trauma and long-term fear of emergencies.

17. Excluding people with disabilities from planning leads to policies that don't reflect real-world needs.

18. Lack of assistive equipment replacements after disasters prolongs recovery and independence loss.

Risks of Not Considering People with Disabilities in Emergency Planning

19. Emergency responders may waste time improvising accessibility solutions during a crisis.

20. Public trust and confidence in emergency services may decline among disability communities.

21. Discriminatory practices or unintentional neglect can lead to civil rights violations and lawsuits.

22. People relying on ventilators, oxygen, or powered wheelchairs face life-threatening risks during outages.

23. Inaccessible recovery centers can prevent people with disabilities from applying for aid or benefits.

24. Families and caregivers may experience increased stress, burnout, or separation trauma.

25. Inadequate mental health support can lead to PTSI or worsening disability-related conditions.

26. Critical community networks may break down if organizations serving people with disabilities are not included.

27. People with temporary injuries (e.g., after the disaster) may face barriers they didn't anticipate.

Risks of Not Considering People with Disabilities in Emergency Planning

28. Inaccessible environments can delay response times for everyone, not just those with disabilities.

29. Uncoordinated responses increase mortality and morbidity among vulnerable populations.

30. Failure to document and track affected individuals can lead to people being lost or unaccounted for.

31. Reputational damage for agencies or jurisdictions seen as excluding or endangering disabled residents.

32. Recovery efforts may become inequitable, leaving people w/disabilities behind after others recover.

33. Financial costs rise when retroactive accommodations are needed instead of proactive planning.

34. Legal noncompliance can result in federal investigations, fines, or loss of emergency funding.

35. Missed opportunities for inclusive planning weaken community resilience overall.

36. The community's overall emergency readiness and response effectiveness are reduced.

Opportunities to Include People with Disabilities in Emergency Planning

1. Involve people with disabilities directly in emergency planning and exercises.

2. Partner with disability advocacy groups, caregivers, and service providers.

3. Ensure all plans comply with the Americans with Disabilities Act and relevant accessibility laws.

4. Provide emergency communications in multiple formats, including visual, auditory, tactile and plain language.

5. Ensure alerts, warnings, and instructions are accessible to people with hearing or vision disabilities.

6. Offer captioned videos and sign language interpretation for all emergency briefings or broadcasts.

7. Make emergency materials available in large print, Braille, and screen-reader–compatible formats.

8. Provide text alerts and other non-audio options for people who are Deaf or hard of hearing.

9. Include plain-language versions of emergency procedures and instructions.

Opportunities to Include People with Disabilities in Emergency Planning

10. Offer real-time communication support such as text-to-911, TTY, and video relay services.

11. Identify and maintain accessible evacuation routes, ramps, and exits.

12. Provide evacuation assistance devices such as evacuation chairs and lifts.

13. Ensure emergency transportation can accommodate wheelchairs, service animals, and mobility aids.

14. Train responders in proper transfer and handling techniques for people with mobility limitations.

15. Maintain a voluntary registry or list of individuals who may need evacuation or medical assistance.

16. Designate shelters that are physically accessible and compliant with ADA standards.

17. Ensure shelters have power sources for medical equipment and refrigeration for medications.

18. Provide quiet or low-sensory spaces in shelters for people w/ autism, PTSD or sensory sensitivities.

Opportunities to Include People with Disabilities in Emergency Planning
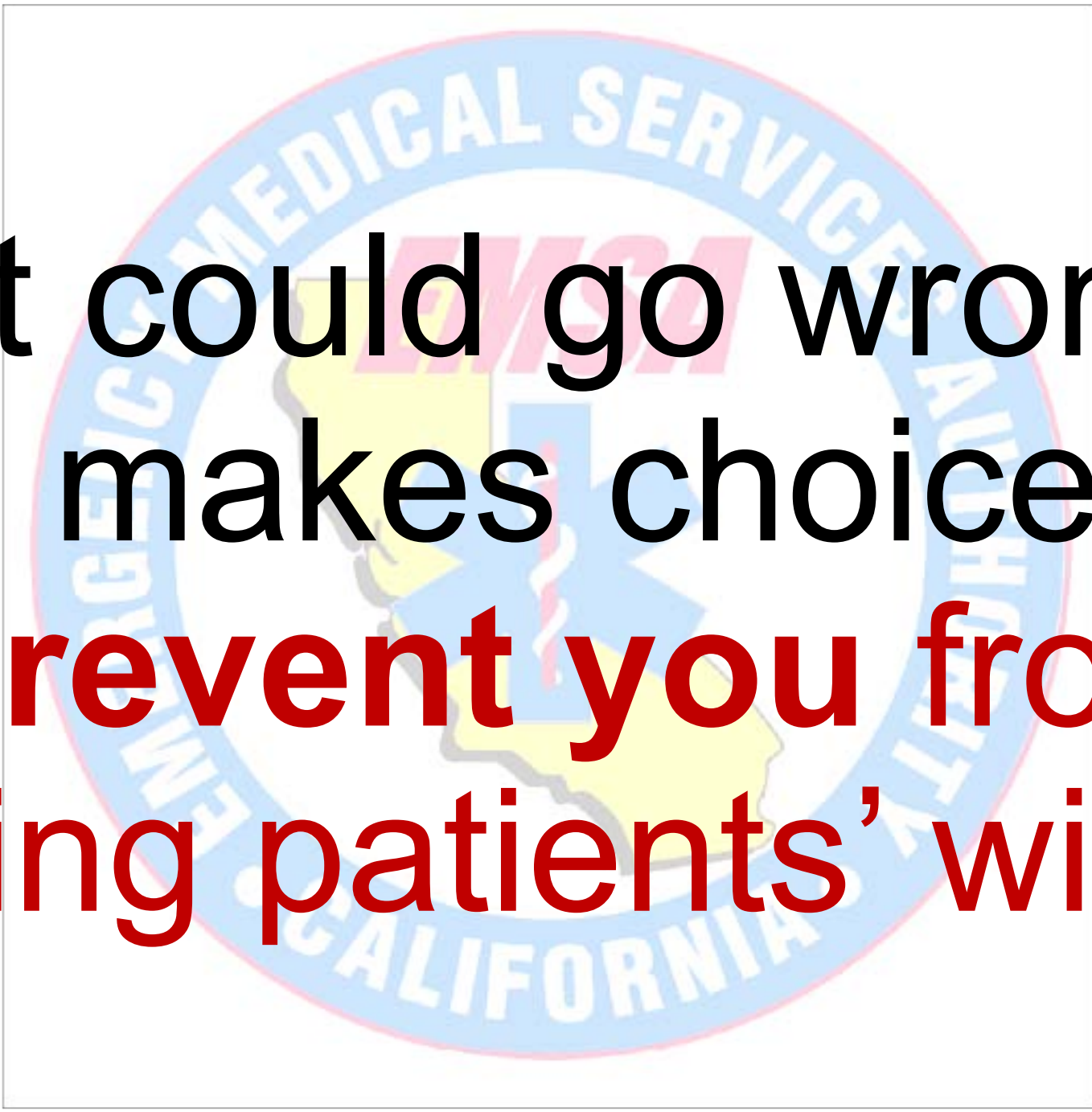
19. Allow service animals and personal care attendants to accompany individuals into shelters.

20. Ensure adaptive bedding, cots, and restrooms are available in shelter environments.

21. Plan for continuity of medical care, including dialysis, oxygen, and other life-sustaining treatments.

22. Provide backup power options for assistive or medical devices.

23. Provisions for maintaining access to medications, durable medical equipment, and mobility aids.

24. Coordinate with home health agencies and hospitals for ongoing care and patient tracking.

25. Train responders and volunteers on disability awareness, communication, and respectful interaction.

26. Conduct inclusive emergency drills that specifically test accessibility features and plans.

27. Encourage individuals with disabilities to create personal emergency plans and support networks.

Opportunities to Include People with Disabilities in Emergency Planning
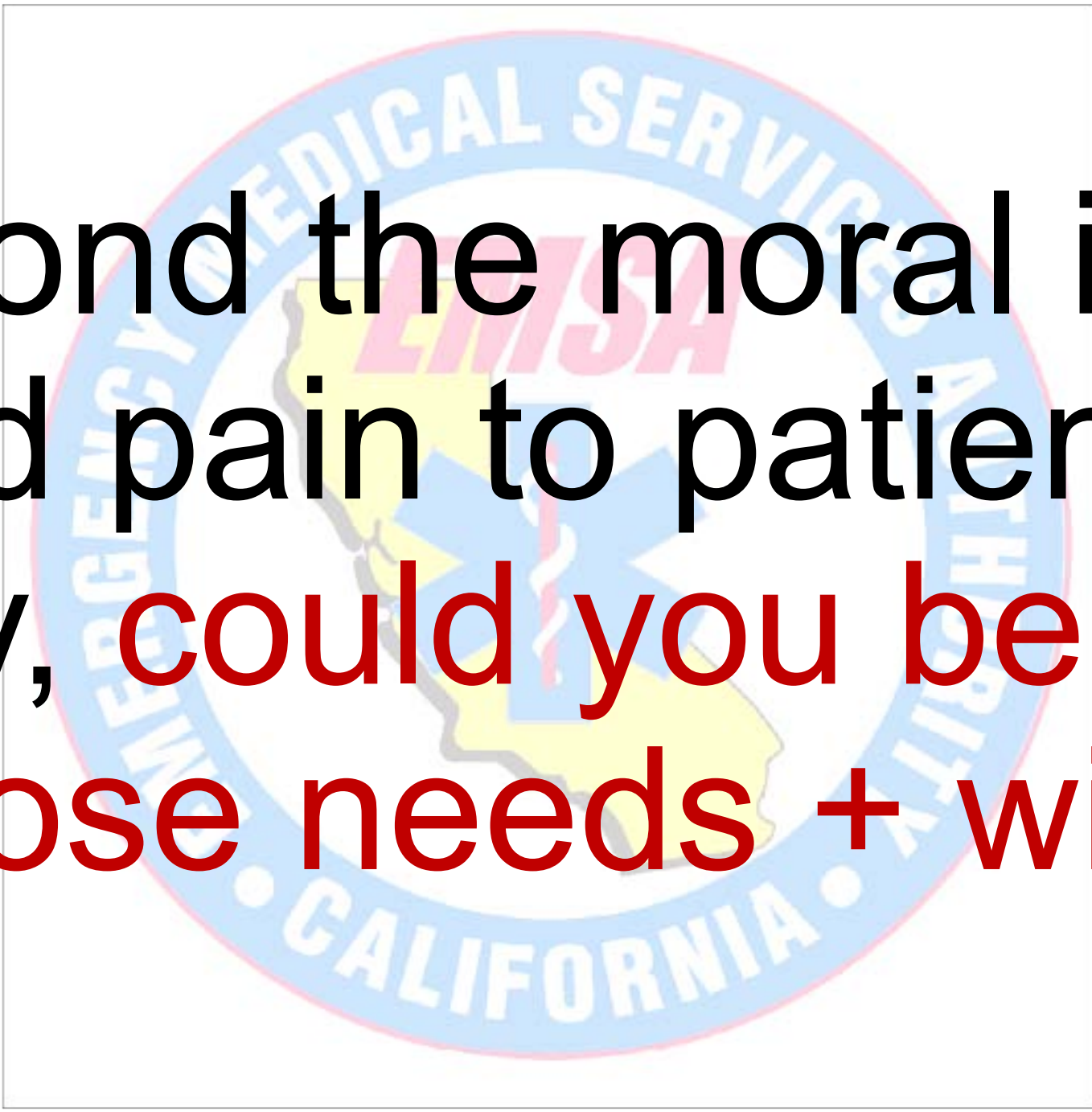
28. Promote buddy systems among neighbors, coworkers, or caregivers to assist during emergencies.

29. Ensure redundant communication systems that support both text and video communications.

30. Provide backup power, chargers, and generators at evacuation points and shelters.

31. Establish accessible disaster recovery centers for post-emergency assistance.

32. Replace lost or damaged assistive devices quickly after an emergency.

33. Provide mental health and trauma support specifically tailored for people with disabilities.

34. Include disability-focused case management in recovery and long-term support programs.

35. Ensure all emergency response actions uphold the dignity, autonomy, and privacy of individuals with disabilities.

36. Regularly review and update plans to reflect lessons learned and changing accessibility needs.

Considerations for emergency planning that **includes people with disabilities.**

What could go wrong if a state makes choices that **prevent you** from obeying patients' wishes?

Beyond the moral injury and pain to patient or family, could you be **liable** for those needs + wishes?

Thank you! Let's chat the world (**a bit more**) together.

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BEYOND
LUCID

Disaster Networking Collaborative

Introduction to the Emergency Management Landscape

INTRODUCTION TO THE EMERGENCY MANAGEMENT LANDSCAPE

Purpose: The following information can be used by children's hospitals to increase awareness of the Emergency Management (EM) landscape and the external partners involved, thereby creating a space to integrate into the EM landscape by a "lead from behind" model where children's hospitals can aid local and regional efforts to develop training and resources for a pediatric focused disaster response.

Background: An Emergency Operations Plan can point the planning coordinator/emergency manager to applicable authorities, perceptions of risk in the community, members of the jurisdiction's emergency response organization, and mutual aid agreements with other jurisdictions.

**A cohesive Emergency Operations Plan involves
several crucial concepts: (FEMA 1996)**
- Assigns responsibility to organizations and individuals for carrying out specific actions at projected times and places in an emergency that exceeds the capability or routine responsibility of any one agency, e.g., the fire department
- Sets forth lines of authority and organizational relationships and shows how all actions will be coordinated
- Identifies personnel, equipment, facilities, supplies, and other resources available — within the jurisdiction or by agreement with other jurisdictions — for use during response and recovery operations

Within the Robert T. Stafford Disaster Relief and Emergency Assistance Act, the elected leadership in each jurisdiction is legally responsible for ensuring that necessary and appropriate actions are taken to protect people and property from the consequences of emergencies and disasters.

There should be an existing Threat and Hazard Identification and Risk Assessment (THIRA) that focuses on infrastructure, high level threats, and most likely scenarios. Generally, a THIRA is conducted and maintained in the office of public health. The point of contact is the state Hospital Preparedness Program (HPP)'s director and/or state emergency management coordinator.

REGIONAL ORGANIZATIONS IN THE EM LANDSCAPE WITH WHOM TO PARTNER AND ENGAGE

Please note this list is not comprehensive. Each region and area could have additional organizations to consider.

Emergency Medical Services for Children (EMSC) State Partnership Programs: The purpose of this program is to support demonstration projects for the expansion and improvement of emergency medical care for children. This program achieves these goals by 1) expanding the uptake of Pediatric Readiness Guidelines in emergency departments and emergency medical services (EMS) systems; 2) increasing pediatric disaster readiness by supporting the integration of pediatrics in hospital and prehospital disaster plans; 3) and prioritizing family partnership and leadership to improve EMSC systems of care. The details on this foundational initiative can be found at **https://emscimprovement.center/ programs/partnerships/** and **https://www.hrsa.gov/grants/find-funding/ HRSA-23-063**. The EMSC state programs are located in the state offices of EMS or accredited schools of medicine across the majority of states, territories, and freely associated states. While there are overarching priorities, each State Partnership Program has individualized areas of focus, staff support, and an advisory committee that includes a pediatrician.

Hospital Preparedness Program (HPP): Provides leadership and funding through cooperative agreements to states, territories, and eligible major metropolitan areas to increase the ability of HPP funding recipients to plan for and respond to large-scale emergencies and disasters. HPP is the primary source of federal funding (through the Administration for Strategic Preparedness and Response or ASPR) for health care system preparedness and response and, in collaboration with state and local health departments, prepares health care delivery systems to save lives through the development of health care coalitions (HCCs). The HCCs offer the following:
- Sharing strategies for contingencies
- Just in time training modules
- Crisis Standards of Care
- Surge capacity
- Deployment of staff and supplies
    - Disaster Medical Assistance Teams (DMAT)
    - Supply depots/trailers around the state
    - Chemical, Biological, Radiological and Nuclear (CBRN) training and materials

Healthcare Coalition: Healthcare coalitions play a critical role in providing and linking healthcare and public health preparedness and response capabilities. HCCs are groups of individual healthcare and response organizations in a defined geographic location that serve as multi-agency coordinating groups to support and integrate with public health and medical services activities. HCCs include four core members: hospitals, EMS, EM organizations, and public health agencies. The Indian Health Service and local tribal councils should be involved in planning and outreach. HCCs serve as communication hubs for participating

entities and coordinate the sharing of resources, policy, and practices both prior to and during an event. HCCs can be led by local health departments or share responsibility with healthcare and emergency management agencies.

ASPR Pediatric Disaster Care Centers of Excellence: Through cooperative agreements, three centers were established to improve disaster response capabilities for children in the U.S. For additional information, see Region V for Kids, Western Regional Alliance for Pediatric Emergency Management, and Gulf-7 Pediatric Disaster Network at **https://emscimprovement.center/domains/preparedness/asprcoe/**.

Public Health Emergency Preparedness (PHEP): Through a cooperative agreement with the Centers for Disease Control and Prevention, provides critical funding for state, local, and territorial public health departments. Since 2002, PHEP has aided public health departments across the nation to build and strengthen their abilities to effectively respond to a range of public health threats, including infectious diseases, natural disasters, and biological, chemical, nuclear, and radiological events. Preparedness activities funded by the PHEP cooperative agreement specifically target the development of emergency-ready public health departments that are flexible and adaptable.

Intersystem Coordination-Hospital Systems: Large hospital organizations are nimbler and often have greater local understanding than federal government response. They can coordinate transfer centers, chief nursing and medical officer meetings, load leveling to share higher and lower acuity patients among different hospitals within the same network, and perform large scale drills and exercises.

State Emergency Manager Programs: It is necessary for pediatric providers to have a seat at state meetings to advocate for pediatric specific needs and response measures.

Local Emergency Planning Committee: Local Emergency Planning Committees (LEPCs) must develop an emergency response plan, review the plan at least annually, and provide information about chemicals in the community to citizens. Plans are developed by LEPCs with stakeholder participation. There is one LEPC for each of the more than 3,000 designated local emergency planning districts. The LEPC membership must include (at a minimum):
- Elected state and local officials
- Police, fire, civil defense, and public health professionals
- Environment, transportation, and hospital officials
- Facility representatives
- Representatives from community groups and the media

Community-based Organizations
Examples include, but are not limited to:
- Medical Reserve Corps
- Red Cross
- Salvation Army
- Faith-based groups
- Educational leaders/school districts and related personnel

GROWING YOUR INFLUENCE IN THE EMERGENCY MANAGEMENT LANDSCAPE

The illustration below can be used to guide your hospital's disaster management team or experts to engage with the EM landscape and promote leadership roles in pediatric preparedness.

Assume a role in disaster leadership

Become a Pediatric Disaster Preparedness Champion

Identify the top priorities within the coalition

Engage with State and Regional Disaster Groups and Coalitions

Seek Disaster Preparedness Education Opportunities and Resources

Learn About Key Stakeholders and Priorities

pedspandemicnetwork.org/disaster-networking-collaborative

DISASTER NETWORKING COLLABORATIVE LETTER OF COMMITMENT

Children's Hospital Site Name:

We are pleased to join the Disaster Networking Collaborative (DNC), an initiative of the Pediatric Pandemic Network (PPN). The DNC is the first step in supporting children's hospitals to improve pediatric disaster preparedness in their region. Through the DNC our hospital recognizes the value pediatric disaster preparedness brings to the institution, helps to promote more standardization of a disaster care team infrastructure, and identifies efforts to enhance community and regional engagement.

We understand that:
- The DNC was designed to help children's hospitals improve pediatric disaster preparedness primarily through project work on one or more focus areas including:
  - C-suite engagement and support for pediatric preparedness planning and infrastructure
  - Consistency across recommended pediatric disaster roles and responsibilities
  - Community engagement planning and outreach, primarily within emergency management
- This collaboration will offer opportunities to adopt best practices to enhance/build our organization's pediatric disaster preparedness and optimize collaboration with regional entities.
- Once enrolled, our team will have access to materials and activities including learning sessions, testimonials from leaders, and access to national disaster preparedness experts.
- Should the designated team leader for the collaborative be unable to complete the commitment to the initiative, another leader will be identified within one month to continue project activities.
- **There is no cost to participate in this collaborative.**

Roles and responsibilities of the DNC Team Leader:
- The team leader for our site will help complete an environmental scan, engage in monthly learning sessions and networking activities via Zoom (or ensure additional team participants join in these efforts). Maintain a comprehensive team roster, share updates, and meet with team members.
- Add Name has agreed to serve as the DNC Team Leader for the site listed above.
- Participation in the DNC is scheduled to occur from September 2023 through June 2024.

Hospital Executive Leader Name: Hospital Executive Leader Title:	Signature:	Date:
Designated Team Leader Name: Designated Team Leader Title:	Signature:	Date

Evacuation Manager/Charge Nurse
Job Action Card

Date	Time	Initials	Task
			Retrieve the Charge Nurse NICU Evacuation Box
			Distribute the following to the appropriate individuals: • All Job Action Cards • All HICS Forms (214, 255, and 260)
			Use HICS Form 214 – Operational Log for documenting your actions (i.e. – communications, moving patients, etc.)
			Direct Unit Secretary to notify NICU Manager on duty of emergency
			Give HICS Form 255 – Master Patient Evacuation Tracking Form to Unit Secretary. Instruct to follow the steps listed on Unit Secretary Job Action Card.
			Obtain 2-way radio from Unit Secretary. Use for communication with the NICU Incident Command Center if other modes (phones) are not available
			Fill out the Departmental Disaster Report and relay information to the NICU Incident Command Center
			Assign an area/pod leader to each area. Provide Job Action Cards (Pod Team Leader & RN), HICS Form 260 – Patient Evacuation Tracking Forms, and 2-way radio
			Consult with the Neonatologist(s) to review patients and determine order of potential evacuation based on TRAIN level of acuity and nature of event. ***DO NOT EVACUATE WITHOUT ORDER AND GUIDANCE TO DO SO FROM HOSPITAL OR NICU INCIDENT COMMAND***
			Direct Labor Pool/Ancillary helps to assist Area/Pod Leaders in gathering and carrying supplies
			Supervise evacuation of areas/pods
			If ordered to evacuate, bring Master Evacuation Tracking Form and all documentation to NICU Incident Command and/or evacuation areas

Area/Pod Team Leader (RN)
Job Action Card

Date	Time	Initials	Task
			Handoff assigned patients to other pod RN(s)
			Assist bedside nurses in completing their job cards: • Affix ID bands to patient limb • Place patient label on infant's back (skin), secure with transparent dressing, and place additional patient labels on the inside waistband of diaper and inside of hat for identification in case ID band comes off • Ensure all infants are wearing hats and wrapped in blankets • Disconnect tubes/wires (if necessary) • Saline lock peripheral IVs and heparin locking central lines • Disconnect chest tubes from suction if ordered to evacuate
			Designate each patient with triage level • Obtain NICU charge nurse report sheet – triage levels are updated every shift • Obtain triage level colored adhesive dots from unit secretary • Affix dot to patient specific tracking HICS Form 260
			Ensure HICS Form 260 – Patient Evacuation Tracking Form is filled out for each patient. A copy stays with the patient and a copy for each patient is given to the Unit Secretary
			Provide updates regarding the area's progress/status to the Charge Nurse and/or NICU Incident Command
			Keep bedside nurses in the area updated with information from charge nurse and/or NICU Incident Command
			Direct Labor Pool/Ancillary helpers assigned to your area to gather supplies for evacuation
			Supervise evacuation of area/pod in coordination with Evacuation Manager/Charge Nurse
			Provide a detailed briefing to Evacuation Manager

Bedside Nurse (RN)
Job Action Card

Date	Time	Initials	Task
			Prepare infants by ensuring an ID band is attached to limb
			Place a patient label directly on each infant's back (skin) and secure with transparent dressing
			Place an identifying patient label on inside waistband of diaper
			Secure a patient label to infant hat with tape and place on infant
			Wrap patients in blankets
			Gather only necessary supplies: • Evacuation boxes • Patient folder/chart with patient labels • Patient medications • Bedside stethoscope • Bulb syringe • Prepared formula or breastmilk Supplies should be packed in patient belonging bags with a patient label attached and can be carried or packed in bottom compartment of Med-evac basket.
			Fill out HICS Form 260 – Patient Evacuation Tracking Form for each patient. A copy must stay with the patient at all times.
			If ordered to evacuate by Incident Command: • Disconnect as many tubes and wires as possible • Saline lock all peripheral IVs • Heparin lock all central lines • Disconnect chest tubes from suction

Rev. 2025

Physician/APN Leaders
(Attending, Fellow, APN Resource)

Date	Time	Initials	Task
			On-Call Attending, Medical Control Fellow, & APN Resource collaborate with Evacuation Manager/Charge Nurse to allocate provider resources for evacuation of most critical patients.
			Assist in preparing patients for potential evacuation. ***DO NOT EVACUATE WITHOUT ORDER AND GUIDANCE FROM HOSPITAL OR NICU INCIDENT COMMAND***
			Collaborate with Evacuation Manager/Charge Nurse in assigning a practitioner to evacuation areas/sites with the first infants and act as coordinator
			Assist with stabilization and transport of the sickest infants
			Delegate providers to call sign out for patients transferred to other facilities.

Providers
(APNs, Residents)
Job Action Card

Date	Time	Initials	Task
			Assist in preparing patients for potential evacuation. ***DO NOT EVACUATE WITHOUT ORDER AND GUIDANCE TO DO SO FROM HOSPITAL OR NICU INCIDENT COMMAND***
			Collaborate with physician/APN leaders in assigning a practitioner to evacuation areas/sites with the first infants
			Assist with stabilization and transport of the sickest infants
			Call sign out for patients transferred to other facilities as directed by physician/APN leaders

Unit Secretary
Job Action Card

Date	Time	Initials	Task
			Remain stationed at the desk as long as possible to facilitate communications
			Obtain HICS Form 255 – Master Patient Evacuation Tracking Form from the Evacuation Manager/Charge Nurse. • Complete by placing patient labels on each line or fill out by hand with patient names. • Send copies to the NICU Incident Command Center electronically or via runner once completed
			Receive HICS Form 260 – Patient Evacuation Tracking form from Area/Pod Leaders. Send copies to the NICU Incident Command
			Prepare for evacuation by gather the following: • Telephone list • Updated census sheet • Patient labels • All evacuation related documentation • Patient Movement Clipboard
			Act as scribe for forms as directed by Evacuation Manager/Charge Nurse or Area/Pod Leaders

Respiratory Therapist
Job Action Card

Date	Time	Initials	Task
			Assist with infants on respiratory support
			Gather/organize E-cylinders and H-cylinders along with regulators to be used during and after evacuation
			Gather intubation boxes, available ventilators and CPAP machines to be used at the evacuation areas/alternate care site locations after evacuation
			If ordered by hospital or NICU Incident Command or Fire Department Chief, shut off gas valves to the NICU (if not already completed)
			Assist in transport of infants on respiratory support
			Provide respiratory support at evacuation areas

Family/Caregiver
Job Action Card

Date	Time	Initials	Task
			Please stay in your baby's room and put your visitor badge on.
			Gather any personal, essential belongings.
			Assist the nurse with preparing baby for evacuation.
			Place the patient sticker given by the RN on your visitor badge.
			Wait for next steps from the bedside staff – please do not leave without instruction.

Labor Pool/Ancillary Staff
Job Action Card

Date	Time	Initials	Task
			Report to the Evacuation Manager/Charge Nurse to receive instructions
			Assist Charge Nurse, Area/Pod Leaders, bedside nurses and/or unit secretaries in gathering and carrying supplies, as needed
			Give special attention to maintaining clear hallways and mobilization of equipment and supplies needed for the evacuation
			Carry disaster equipment, patient charts, and other supplies to evacuation areas/sites
			Assist with use of evacuation devices (just in time training materials are provided with equipment)

Milk Room
Job Action Card

Date	Time	Initials	Task
			Report to the Evacuation Manager/Charge Nurse to receive instructions
If instructed by Evacuation Manger/Charge Nurse to Assist with Milk Evacuation, follow these steps:			
			Ensure that all bins are labeled with updated patient identifier
			Load breast milk, donor milk and Prolacta onto carts in labeled individual patient bins. • If coolers are available, place refrigerated milk in cooler. • Do not mix refrigerated and frozen milk in a cooler.
			Transport breast milk, donor milk and Prolacta in individual labeled bins to evacuation areas/sites
			Assist with use of evacuation devices (just in time training materials are provided with equipment)

NICU Triage Levels for Evacuation Planning
Daily Patient Census

✓ Triage each shift
✓ Include special medications/equipment
✓ Label Equipment

Wednesday, October 9, 2024

Yellow 17 Barb Cohan 314-393-1057 Marina Metzler 314-393-6442 Rph: B. Zeller 314-738-427116	Blue 18 Carly Schuetz 314-393-0094 No Fellow RPH: B. Zeller 314-738-4271	Green 19 Lila Nolan 314-393-0654 Amy Hammen 314-393-6313 Rph: C. Livinskie 314-732-4231	Red 20 Hayley Friedman 314-393-6200 No Fellow RPh: C. Livinskie 314-732-4231	Orange 19 Luke Viehl 314-393-3873 Jess Kris 314-393-6557 RPh: C. Livinskie	Purple 19 Gillian Pet 314-296-0742 Kelly Meyer 314-203-3370 RphB. Zeller 314-738-4271	Pink 21 Elisabeth Cole 314-686-2203 Allyson Schreiber 314-393-6366 Rph: C. Livinskie 314-732-4231

S400E Aggravation, Mylo BCPAP 6 PICC NPO Rep- LIS Q12 XR 🚑(orange)	**S400 FP** Alchemy, GirlWanda OG/1h PIV Abx Intubated 🚑(orange)	**NRP** Azkend, GirlWanda**MRSA RA PO/NG 🚑(green)
NRP Babel, Sam 6L Opti NG/1h 🚑(yellow) moved x3	**S400E** Bejeweled, Alex 1L PO (30m IQ3)NG/1h Gaba L Reservior/VP Shunt 10/2-laser 🚑(green)	**NRP** Atari, Mylo 1L NG/1h 🚑(yellow)
S400 FP Bicycle, Charlie RA NG ECHO-Cardiomegaly 🚑(green) moved x4		

Negative Pressure Rooms:
513, 524, 5103, 5108, 5113
5403, 5421, 5430, 5432

Legend:

Triage Levels for Evacuation Planning:
🚑(green) RA/NC, PIV, open crib
🚑(yellow) Resp. support >NC, Central line, Isolette/Open
🚑(orange) Vent, Chest Tube, Drips, Cont. PD
🚑(red) Osc, iNO, Cooling, ECMO/AKRT

Legend:

🚑(green) RA/NC, PIV, open crib

🚑(yellow) Resp. support > NC, central line, isolette/table

🚑(orange) Vent, chest tube, drips, continuous PD

🚑(red) Oscillator, iNO, cooling, ECMO/AKRT

10/21/2025 MO Pediatric View Snapshot

St. Louis Hospital ED	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
BARNES - JEWISH HOSPITAL --L-1	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No		
Barnes - Jewish St. Peters Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Barnes - Jewish West County Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Christian Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	N/A	No		
Homer G. Phillips Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Mercy Hospital Jefferson	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Mercy Hospital Lincoln	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Mercy Hospital South---L-II	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No	12	Level 2 Trauma Center
Mercy Hospital St. Louis---L-1	Trauma Center / Burn	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	Yes	121	
Mercy Hospital Washington---L-III	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No		Level 3 Trauma Center
Missouri Baptist Medical Center	Emergency Care Capable	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	No	25	
Northwest Health Care	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
ParkLand Health Center - Bonne Terre	Emergency Care Capable	N/A	N/A	N/A	Pediatric Capable	No		
Parkland Health Center - Farmington	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Pike County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Progress West Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No	9	
SSM Cardinal Glennon Children's Hosp L-1	Pediatric Trauma Center	Emergency Care Only	Emergency Care Only	Level 4 NICU	Designated Peds Beds	Yes	65	
SSM DePaul Hospital-St. Louis	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Emergency Care Only	No		
SSM Health Saint Louis Univ. Hosp. L-1	Trauma Center	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
SSM St. Clare Hospital- St. Louis	Emergency Care Capable	Level 2 Specialty Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
SSM St. Joseph Hospital- St. Charles	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No	0	
SSM St. Joseph Hospital- Wentzville	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Emergency Care Only	No		
SSM St. Mary's Hospital-St. Louis	Emergency Care Capable	Emergency Care Only	Emergency Care Only	Level 3 NICU	Pediatric Capable	No	42	
SSM St.Joseph Hospital-LakeSt.Louis-L-III	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No		Level 3 Trauma Center
St. Louis Children's Hospital L-1	Pediatric Trauma Center	Emergency Care Only	Level 1 Well Nursery	Level 4 NICU	Designated Peds Beds	Yes	150	
St. Luke's Hospital	Emergency Care Capable	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No	12	
VA St. Louis Health Care System	Emergency Care Capable	N/A	N/A	N/A	N/A	No		
Washington County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		

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6/17/2025 MO Pediatric View Snapshot

KC Hospital ED	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
AdventHealth College Boulevard (KS)	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
AdventHealth Lenexa (Prairie Star) (KS)	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
AdventHealth Shawnee Mission (KS)	Emergency Care Capable	Level 4 Perinatal Care	Level 1 Well Nursery	Level 3 NICU	Pediatric Capable	No		
AdventHealth South Overland Park (KS)	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Belton Regional Medical Center - TC	Trauma Center	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		Level 3 Trauma Center
Cass Regional Medical Center - TC	Trauma Center	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		Level 3 Trauma Center
Centerpoint Medical Center - TC	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No	12	Level 2 Trauma Center
Children's Mercy Hospital - TC	Pediatric Trauma Center	Level 4 Perinatal Care	Emergency Care Only	Level 4 NICU	Designated Peds Beds	Yes	87	Level 1 Pediatric Trauma Center/ACS Certified Pediatric Surgery Center | Fetal Surgery Center | Level 4 NICU/ CMH does not do normal deliveries only delivery of high risk infants | ECMO | ECMO/ACS Certified in Pediatric Surgery/Transplant and Dialysis
Children's Mercy Kansas	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Designated Peds Beds	No		Pediatric Emergency Dept
Excelsior Springs Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Kansas City VA Medical Center	Emergency Care Capable	N/A	N/A	N/A	N/A	No		n/a
Leavenworth VA Medical Center								
Lee's Summit Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Liberty Hospital - TC	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No	4	Level 2 Trauma Center
Menorah Medical Center	Emergency Care Capable	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No		
North Kansas City Hospital - TC	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No	18	Level 2 Trauma Center
Olathe Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
OPR - ER of Olathe								
OPR - ER of Shawnee								
OPR - Pediatric ER of Overland Park								
Overland Park Regional Med Ctr - TC	Trauma Center	Level 4 Perinatal Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	Yes		Level 2 Trauma Center
Providence Medical Center	Emergency Care Capable	Emergency Care Only	N/A	N/A	Emergency Care Only	No		
Research Medical Center - TC	Trauma Center	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Pediatric Capable	Yes	19	
RMC-Brookside Campus	Emergency Care Capable	N/A	N/A	N/A	Emergency Care Only	No		
Saint John Hospital (KS)	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Saint Joseph Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Saint Luke's Community Hospital Leawood	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Saint Luke's Community Hospital Legends	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Saint Luke's Community Hospital Roeland	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Saint Luke's East Hospital	Emergency Care Capable	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No	18	
Saint Luke's Hospital - TC	Trauma Center	Level 4 Perinatal Care	Level 1 Well Nursery	Level 4 NICU	Pediatric Capable	No		
Saint Luke's North Hospital Barry Rd.	Emergency Care Capable	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No		
Saint Luke's South Hospital (Ks)	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No	49	
St. Mary's Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
The University of Kansas Health System 39th & Rainbow Campus - TC	Trauma Center	Level 4 Perinatal Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	Yes		Level 1 Trauma Center
University Health Lakewood Medical Ctr	Emergency Care Capable	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No	5	
University Health TMC -TC	Trauma Center	Level 4 Perinatal Care	Level 1 Well Nursery	Level 3 NICU	Emergency Care Only	No	29	

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KC Northern District	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Carroll County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Fitzgibbon Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		Med Surg only; no PCU or ICU
Lafayette Regional Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Ray County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		

6/17/2025 MO Pediatric View Snapshot

KC Southern District	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Bates County Memorial	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Bothwell Regional Health Center	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No	4	
Golden Valley Memorial Healthcare	N/A	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Western Missouri Medical Center	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No		Level 3 Trauma Center
4							4	

6/17/2025 MO Pediatric View Snapshot

Region B Hospitals	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Hannibal Regional Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Moberly Regional Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		Level III Stroke Center | No specialty care for neonates is provided at MRMC.
Northeast Regional Medical Center---LIII	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		Level 3 Trauma Center
Pershing Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Putnam County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Samaritan Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Scotland County Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Sullivan County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		

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Region D Hospitals	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Cedar County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Citizens Memorial Hospital---LIII	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Cox Barton County Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Cox Medical Center Branson	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No		
Cox Monett	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Cox North	N/A	N/A	N/A	N/A	N/A	No		
Cox South---LI	Trauma Center	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	Yes	34	
Ellett Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Freeman Neosho Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Freeman West	Trauma Center	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	No	24	Level 2 Trauma Center
Mercy Hospital Aurora	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Mercy Hospital Carthage	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Mercy Hospital Cassville	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Mercy Hospital Joplin	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	Yes	16	Level 2 Trauma Center
Mercy Hospital Springfield---LI	Trauma Center	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	Yes	63	
Nevada Regional Medical Center	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No		
							137	

6/17/2025 MO Pediatric View Snapshot

Region E Hospitals	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Iron County Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
John J. Pershing VA Medical Center	N/A	N/A	N/A	N/A	N/A	No		
Madison Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Mercy Hospital Perry	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Emergency Care Only	No		
Mercy Hospital Southeast	Emergency Care Capable	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No	15	
Mercy Hospital Stoddard	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		NO Neonatal Specialty Care Available
Missouri Delta Medical Center	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No		
Pemiscot Memorial Health Systems	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Poplar Bluff Regional Medical Center	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No		
Saint Francis Medical Center---LIII	Trauma Center	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Emergency Care Only	No	36	Level 3 Trauma Center
Ste. Genevieve County Memorial Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Emergency Care Only	No		
							51	

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Region F Hospitals	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Boone Hospital Center	Emergency Care Capable	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	No	21	
Capital Region Medical Center (MUHC)	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Emergency Care Only	No		
Harry S Truman Memorial Veterans Hospita	Emergency Care Capable	N/A	N/A	N/A	N/A	No		
Hermann Area District Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Lake Regional Health System---LIII	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		Level 3 Trauma Center
SSM Health St. Mary's - Jefferson City	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
University Hospital (MUHC)--LI	Trauma Center	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Pediatric Capable	Yes		WH Birthing Center relocated to UH campus | WH Birthing Center relocated to UH campus | WH Birthing Center relocated to UH campus
							21	

6/17/2025 MO Pediatric View Snapshot

Region G Hospitals	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Mercy St. Francis Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Ozarks Healthcare	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Texas County Memorial Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		

6/17/2025 MO Pediatric View Snapshot

Region H Hospitals	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
Cameron Regional Medical Center, Inc.	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Community Hospital - Fairfax	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No		
HARRISON COUNTY COMMUNITY HOSPITAL	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Hedrick Medical Center	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		NA
Mosaic Life Care Medical Center---LII	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No		Level 2 Trauma Center
Mosaic Medical Center - Albany	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Mosaic Medical Center - Maryville	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Wright Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		

6/17/2025 MO Pediatric View Snapshot

Region I Hospitals	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
General Leonard Wood Army and Comm Hosp								
Mercy Hospital Lebanon	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Designated Peds Beds	No		
Missouri Baptist Sullivan Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Phelps Health	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No		
Salem Memorial District Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		

6/2025 Neonatology Resources

ARKANSAS	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
Arkansas Children's Hospital	Level 4 NICU	104	Children's Hospital
Baptist Health Medical Center	Level 3 NICU	65	Community Hospital - Non-Children's
Mercy Hospital Fort Smith	Level 3 NICU	29	Community Hospital - Non-Children's
Mercy Hospital Northwest Arkansas	Level 3 NICU	10	Community Hospital - Non-Children's
St. Bernard's Medical Center	Level 3 NICU	12	Community Hospital - Non-Children's
University of Arkansas Medical Services	Level 3 NICU	64	Academic - Non-Children's
Washington Regional Medical Center	Level 3 NICU	34	Community Hospital - Non-Children's
Willow Creek Women's Hospital	Level 3 NICU	24	Community Hospital - Non-Children's
Baptist Health Fort Smith	Level 2 NICU	0	Partners with Arkansas Children's
Baxter Regional Medical Center	Level 2 NICU	10	Community Hospital - Non-Children's
CHI St. Vincent	Level 2 NICU	0	Partners with Arkansas Children's
Conway Regional Medical Center	Level 2 NICU	6	Community Hospital - Non-Children's
Jefferson Regional Medical Center	Level 2 NICU	0	Partners with Arkansas Children's
Medical Center of South Arkansas	Level 2 NICU	4	Community Hospital - Non-Children's
National Park Medical Center	Level 2 NICU	0	Partners with Arkansas Children's
Northwest Medical Center - Bentonville	Level 2 NICU	6	Community Hospital - Non-Children's
Saint Mary's Regional Medical Center	Level 2 NICU	0	Partners with Arkansas Children's
Siloam Springs Regional Hospital	Level 2 NICU	0	Partners with Willow Creek Women's
White River Medical Center	Level 2 NICU	4	Community Hospital - Non-Children's
		372	

10/2025 Neonatology Resources

ILLINOIS	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
Adventist Hinsdale Hospital	Level 3 NICU	12	Community Hospital - Non-Children's
Advocate BroMenn Medical Center	Level 2 NICU	8	Community Hospital - Non-Children's
Advocate Christ Medical Center	Level 3 NICU	61	Community Hospital - Children's Hospital w/i Hospital
Advocate Condell Medical Center	Level 2 NICU	14	Community Hospital - Non-Children's
Advocate Good Samaritan Hospital	Level 3 NICU	24	Community Hospital - Non-Children's
Advocate Good Sheperd Hospital	Level 2 NICU	8	Community Hospital - Non-Children's
Advocate Illinois Masonic Medical Center	Level 3 NICU	34	Community Hospital - Non-Children's
Advocate Lutheran General Hospital	Level 3 NICU	54	Community Hospital - Children's Hospital w/i Hospital
Advocate Sherman Hospital	Level 2 NICU	16	Community Hospital - Non-Children's
Advocate South Suburban Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Advocate Trinity Hospital	Level 2 NICU	8	Community Hospital - Non-Children's
Alexian Brothers Medical Center	Level 2 NICU	10	Community Hospital - Non-Children's
Alton Memorial Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Amita Adventist Health Medical Center Bolingbrook	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Amita Adventist Health Medical Center LaGrange	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Amita Health Glen Oaks	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Amita Health Mercy Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Amita Health Resurrection Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Amita Health St. Joseph Hospital	Level 3 NICU	20	Community Hospital - Non-Children's
Amita Health Saints Mary and Elizabeth Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Amita Health St. Joseph Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Anderson Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Blessing Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Carle Foundation Hospital	Level 3 NICU	48	Community Hospital - Non-Children's
Centegra McHenry Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Decatur Memorial Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Edward Hospital	Level 3 NICU	35	Community Hospital - Non-Children's
Elmhurst Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Evanston Hospital	Level 3 NICU	44	Academic Medical Center - Non-Children's
Franciscan Health Olympia Fields	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Genesis Medical Center - Silvis	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Graham Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
HSHS St. Anthony's Memorial Hospital	Level 3 NICU	Unknown	Community Hospital - Non-Children's
HSHS St. John's Hospital	Level 3 NICU	40	Community Hospital - Children's Hospital w/i Hospital
HSHS St. Joseph's Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
HSHS St. Mary's Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Ingalls Memorial Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Little Company of Mary Hospital	Level 2 NICU	12	Community Hospital - Non-Children's
Loyola University Medical Center	Level 3 NICU	50	Academic Medical Center - Children's Hospital w/i Hospital
Lurie Children's Hospital of Chicago	Level 4 NICU	60	Academic Medical Center - Freestanding Children's Hospital
McNeal Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Memorial Hospital Belleville	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Memorial Hospital East	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Memorial Hospital of Carbondale	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Memorial Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Mercy Hospital & Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
MercyHealth - Javon Bea Hospital	Level 3 NICU	52	Regional Medical Center - Non-Children's
Mount Sinai Hospital	Level 3 NICU	44	Community Hospital - Children's Hospital w/i Hospital
Northwest Community Hospital	Level 3 NICU	22	Community Hospital - Non-Children's
Northwestern Medicine Central DuPage Hospital	Level 3 NICU	29	Community Hospital - Non-Children's
Northwestern Medicine Delnor Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Northwestern Medicine Huntley Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Northwestern Medicine Lake Forest Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Northwestern Memorial Hospital	Level 3 NICU	44	Academic Medical Center - Non-Children's
OSF Children's Hospital of Illinois	Level 3 NICU	64	Community Hospital - Children's Hospital w/i Hospital
OSF Heart of Mary Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
OSF St. Joseph Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Palos Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Passavant Area Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Roseland Community Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Rush University Medical Center	Level 3 NICU	60	Academic Medical Center - Children's Hospital w/I Hospital
Rush-Copley Medical Center	Level 3 NICU	27	Academic Medical Center - Non-Children's
Saint Anthony Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Sarah Bush Lincoln Health Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Silver Cross Hospital	Level 2 NICU	17	Community Hospital - Non-Children's
St. Alexius Medical Center Hoffman Estates	Level 3 NICU	16	Community Hospital - Non-Children's
Stroger Hospital of Cook County	Level 3 NICU	52	County Hospital - Non-Children's
Swedish American Hospital	Level 3 NICU	10	Community Hospital - Non-Children's
Swedish Covenant Hospital	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Unity Point Health - Trinity	Level 2 NICU	Unknown	Community Hospital - Non-Children's
Unity Point Health - Methodist	Level 2 NICU	9	Community Hospital - Non-Children's
Univeristy of Chicago - Comer Children's	Level 3 NICU	47	Academic Medical Center - Children's Hospital w/I Hospital
University of Illinois Hospital	Level 3 NICU	52	Academic Medical Center - Children's Hospital w/I Hospital
West Surburban Medical Center	Level 2 NICU	Unknown	Community Hospital - Non-Children's

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6/2025 Neonatology Resources

INDIANA	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
Peyton Manning Children's Hospital	Level 4 NICU	97	Community Hospital - Children's Hospital w/i Hospital
Riley Hospital for Children	Level 4 NICU	60	Academic - Children's Hospital w/i Hospital
Ball Memorial Hospital	Level 3 NICU	21	Community Hospital - Non-Children's
Community Hospital	Level 3 NICU	32	Community Hospital - Non-Children's
Community Hospital - North	Level 3 NICU	36	Community Hospital - Non-Children's
Community Hospital East	Level 3 NICU	16	Community Hospital - Non-Children's
Community Hospital South	Level 3 NICU	32	Community Hospital - Non-Children's
Deaconess - The Women's Hospital	Level 3 NICU	24	Community Hospital - Non-Children's
Dupont Hospital	Level 3 NICU	25	Community Hospital - Non-Children's
Franciscan Health Crown Point	Level 3 NICU	20	Community Hospital - Non-Children's
Franciscan Health Lafayette East	Level 3 NICU	14	Community Hospital - Non-Children's
Franciscan St. Francis Health	Level 3 NICU	24	Community Hospital - Non-Children's
IU Health Arnett Hospital	Level 3 NICU	12	Community Hospital - Non-Children's
IU Health Bloomington	Level 3 NICU	15	Community Hospital - Non-Children's
IU Health Methodist Hospital	Level 3 NICU	38	Community Hospital - Non-Children's
Lutheran Hospital	Level 3 NICU	21	Community Hospital - Children's Hospital w/i Hospital
Memorial Hospital	Level 3 NICU	36	Regional - Children's Hospital w/i Hospital
Methodist Hospital Northlake	Level 3 NICU	11	Community Hospital - Non-Children's
Parkview Women's and Children's Hospital	Level 3 NICU	31	Academic Children's - Non-Children's
Porter Regional Hospital	Level 3 NICU	14	Community Hospital - Non-Children's
Riley Hospital - IU Health North	Level 3 NICU	20	Community Hospital - Children's Hospital w/i Hospital
St. Joseph Mishawaka Medical Center	Level 3 NICU	22	Community Hospital - Non-Children's
St. Vincent Carmel	Level 3 NICU	12	Community Hospital - Non-Children's
St. Vincent Evansville	Level 3 NICU	31	Community Hospital - Non-Children's
Terre Haute Regional Hospital	Level 3 NICU	15	Community Hospital - Non-Children's
Baptist Health Floyd	Level 2 NICU	6	Community Hospital - Non-Children's
Clark Memorial Hospital	Level 2 NICU	7	Community Hospital - Non-Children's
Columbus Regional Health	Level 2 NICU	Unk	Community Hospital - Non-Children's
Elkart General Hospital	Level 2 NICU	Unk	Community Hospital - Non-Children's
Eskenazi Health	Level 2 NICU	30	Community Hospital - Non-Children's
Franciscan Health Hammond	Level 2 NICU	Unk	Community Hospital - Non-Children's
Franciscan Health Mooresville	Level 2 NICU	Unk	Community Hospital - Non-Children's
Franciscan Health Olympia Fields	Level 2 NICU	Unk	Community Hospital - Non-Children's
Hendricks Regional Health	Level 2 NICU	Unk	Community Hospital - Non-Children's
Margaret Mary Community Hospital	Level 2 NICU	Unk	Community Hospital - Non-Children's
Marion General Hospital	Level 2 NICU	Unk	Community Hospital - Non-Children's
Methodist Hospital Southlake	Level 2 NICU	20	Community Hospital - Non-Children's
St. Mary Medical Center	Level 2 NICU	10	Community Hospital - Non-Children's
Union Hospital	Level 2 NICU	15	Community Hospital - Non-Children's

6/2025 Neonatology Resources

IOWA	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
University of Iowa Children's Hospital	Level 4 NICU	49	Academic - Children's Hospital
Blank Children's Hospital	Level 3 NICU	44	Community Hospital - Children's Hospital
MercyOne Des Moines Medical Center	Level 3 NICU	62	Community Hospital - Children's Hospital w/i Hospital
St. Luke's Hospital	Level 3 NICU	22	Community Hospital - Non-Children's
UnityPoint - St. Luke's Sioux City	Level 3 NICU	20	Community Hospital - Non-Children's
Allen Memorial Hospital	Level 2 NICU	10	Community Hospital - Non-Children's
Genesis Medical Center - Davenport	Level 2 NICU	20	Community Hospital - Non-Children's
Mercy Medical Center	Level 2 NICU	Unk	Community Hospital - Non-Children's
MercyOne Dubuque Medical Center	Level 2 NICU	Unk	Community Hospital - Non-Children's
MercyOne Waterloo Medical Center	Level 2 NICU	16	Community Hospital - Non-Children's
UnityPoint Health - Allen Hospital	Level 2 NICU	7	Community Hospital - Non-Children's
UnityPoint Health - Finley Hospital	Level 2 NICU	7	Community Hospital - Non-Children's
UnityPoint Health - Methodist West Hospital	Level 2 NICU	Unk	Community Hospital - Non-Children's
UnityPoint Trinity	Level 2 NICU	Unk	Partnership with Blank Children's

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6/2025 Neonatology Resources

KANSAS	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
Ascenion via Christi St. Joseph	Level 3 NICU	28	Community - Non-Children's
Overland Park Regional Medical Center	Level 3 NICU	70	Community - Non-Children's
Shawnee Mission Medical Center	Level 3 NICU	24	Community - Non-Children's
University of Kansas Hospital	Level 3 NICU	40	Academic - Non-Children's
Wesley Medical Center	Level 3 NICU	24	Community - Children's Hospital w/i hospital
Ascension via Christi Manhattan	Level 2 NICU	8	Community - Non-Children's
Geary Community Hospital - Junction City	Level 2 NICU	--	Community - Non-Children's
Hays Medical Center	Level 2 NICU	6	Community - Non-Children's
Lawrence Memorial Hospital	Level 2 NICU	Unk	Community - Non-Children's
Menorah Medical Center	Level 2 NICU	7	Community - Non-Children's
Newton Medical Center	Level 2 NICU	Unk	Community - Non-Children's
Olathe Medical Center	Level 2 NICU	14	Community - Non-Children's
Providence Medical Center	Level 2 NICU	Unk	Community - Non-Children's
St. Catherine Hospital	Level 2 NICU	7	Community - Non-Children's
Storemont Vail Medical Center	Level 2 NICU	27	Community - Non-Children's
Western Plains Medical Complex	Level 2 NICU	21	Community - Non-Children's
		276	

6/2025 Neonatology Resources

KENTUCKY	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
Norton Children's Hospital	Level 4 NICU	101	Academic - Children's Hospital
University of Kentucky Children's Hospital	Level 4 NICU	70	Academic - Children's Hospital
Baptist Health Lexington	Level 3 NICU	32	Community Hospital - Non-Children's
Baptist Health Paducah	Level 3 NICU	14	Community Hospital - Non-Children's
CHI Saint Joseph East	Level 3 NICU	16	Community Hospital - Non-Children's
Jennie Stewart Medical Center	Level 3 NICU	6	Community Hospital - Non-Children's
King's Daughters Medical Center	Level 3 NICU	13	Community Hospital - Non-Children's
Medical Center at Bowling Green	Level 3 NICU	12	Community Hospital - Non-Children's
Methodist Hospital	Level 3 NICU	15	Community Hospital - Non-Children's
Norton Hospital	Level 3 NICU	44	Community Hospital - Non-Children's
Owensboro Health Regional Hospital	Level 3 NICU	20	Community Hospital - Non-Children's
St. Elizabeth Healthcare	Level 3 NICU	30	Community Hospital - Non-Children's
University of Louisville Hospital	Level 3 NICU	28	Academic - Non-Children's Hospital
Baptist Health Louisville	Level 2 NICU	8	Community Hospital - Non-Children's
Baptist Health Madisonville	Level 2 NICU	12	Community Hospital - Non-Children's
Frankfort Regional Medical	Level 2 NICU	4	Community Hospital - Non-Children's
Hardin Memorial Hospital	Level 2 NICU	6	Community Hospital - Non-Children's
Pikeville Medical Center	Level 2 NICU	8	Community Hospital - Non-Children's
		439	

6/2025 Neonatology Resources

NEBRASKA	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
Children's Hospital & Medical Center	Level 4 NICU	40	Children's Hospital
University of Nebraska Medical Center	Level 4 NICU	38	Academic - Non-Children's
Bergan Mercy Medical Center	Level 3 NICU	36	Academic - Non-Children's
Bryan Medical Center East Campus	Level 3 NICU	25	Community Hospital - Non-Children's
CHI St. Elizabeth	Level 3 NICU	30	Community Hospital - Non-Children's
Methodist Women's Hospital	Level 3 NICU	51	Community Hospital - Non-Children's
Bellevue Medical Center	Level 2 NICU	4	Academic - Non-Children's
CHI Health Good Samaritan	Level 2 NICU	9	Community Hospital - Non-Children's
CHI Health Lakeside Hospital	Level 2 NICU	7	Community Hospital - Non-Children's
CHI Health St. Francis	Level 2 NICU	9	Community Hospital - Non-Children's

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6/2025 Neonatology Resources

TENNESSEE	Neonatal Specialty Level of Care	Licensed NICU Beds	Comment
Children's Hospital at Erlanger	Level 4 NICU	58	Community Hospital - Children's Hospital w/i Hospital
Le Bonheur Children's Hospital	Level 4 NICU	60	Children's Hospital
Vanderbilt Children's	Level 4 NICU	116	Academic - Children's Hospital
Baptist Hospital for Women	Level 3 NICU	40	Community Hospital - Children's Hospital w/i Hospital
East Tennessee Children's Hospital	Level 3 NICU	60	Children's Hospital
Jackson-Madison County General Hospital	Level 3 NICU	34	County Hospital - Children's Hospital w/I Hospital
Johnson City Medical Center	Level 3 NICU	39	Community Hospital - Children's Hospital w/i Hospital
Methodist Le Bonheur Germantown Hospital	Level 3 NICU	24	Community Hospital - Non-Children's
Parkridge East Hospital	Level 3 NICU	22	Community Hospital - Non-Children's
Regional One Health Medical Center	Level 3 NICU	65	Regional - Non-Children's
Saint Francis Hospital	Level 3 NICU	10	Community Hospital - Non-Children's
Saint Thomas Midtown	Level 3 NICU	52	Community Hospital - Non-Children's
Tristar Centennial Hospital	Level 3 NICU	60	Community Hospital - Children's Hospital w/i Hospital
University of Tennessee Medical Center	Level 3 NICU	67	Academic - Non-Children's
Erlnager East Hospital	Level 2 NICU	6	Community Hospital - Non-Children's
Hendersonville Medical Center	Level 2 NICU	6	Community Hospital - Non-Children's
Horizon Medical Center	Level 2 NICU	6	Community Hospital - Non-Children's
Maury Regional Medical Center	Level 2 NICU	8	Community Hospital - Non-Children's
Methodist South Hospital	Level 2 NICU	Unk	Community Hospital - Non-Children's
Nashville General Hospital	Level 2 NICU	10	Community Hospital - Non-Children's
Saint Francis Hospital Bartlett	Level 2 NICU	10	Community Hospital - Non-Children's
Saint Thomas Rutherford Hospital	Level 2 NICU	16	Community Hospital - Non-Children's
Summit Medical Center	Level 2 NICU	10	Community Hospital - Non-Children's
Tenova Health Clarksville	Level 2 NICU	12	Community Hospital - Non-Children's
Tristar Stonecrest Medical Center	Level 2 NICU	8	Community Hospital - Non-Children's
Vanderbilt Tellahoma-Harton Hospital	Level 2 NICU	--	Community Hospital - Non-Children's
Williamson Medical Center	Level 2 NICU	5	Community Hospital - Non-Children's

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Triage by Resource Allocation for Inpatients (TRAIN) – NICU Patient Population

N = 110

Triage Classification	Mobility	Minimum Staff Required	Life Support
Green (65)	Open crib (Role: 1 nurse (non-licensed: milk tech, PCT, labor pool, visitors, cuddlers, providers not utilized for higher acuity)	11 RN (2 personnel 1 RN to up to 6	Minimal = RA, Low Flow Cannula O2,, saline lock PIV, open crib
Yellow (42)	Crib/incubator/open table	13 staff 1 staff to 1-2 patients depending on evac route	Moderate = CPAP/BiPAP/Hi-Flow/NIV, Central line, Peritoneal Dialysis (can be disconnected), external heat source required
Orange (10)	Required Equipment	13 staff 1 staff to 1 patient	Maximal = Intubated conventional vent, chest tube, trach no support, medically necessary infusion, AKRT on break from therapy, continuous PD
Red (15)	Required Equipment	ECMO – 7 (RT, perfusion, 2 RN, 1-2provider, PCT) 6 staff RN, 3 RT, 3 PCT 2 or more staff to 1 patient RT reserved for this level	Maximal = Highly specialized equipment (e.g. – HFOV, ECMO, iNO, Trach with support, AKRT on active therapy, therapeutic hypothermia)

Notes:

- Medics have same credentials as RNs
- Respiratory Therapists and Perfusionists are a limited resource
- Utilize Center for Families/family partners to assist with family communication and advocacy

No Tiny Feet

- Located in St. Louis Metropolitan area
- Referral hospital for 6 states
- Pediatric academic hospital
- Seventh oldest hospital in US
- Licensed Beds: 455
  - 150 NICU beds
- Employees: 3,423
- Physicians: 881
- Volunteers: 1,300

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In 1997, St. Louis Children's Hospital experienced a fire that necessitated the evacuation of 137 patients from various levels of the facility, including the NICU. Traditional evacuation models classify NICU patients as yellow or red evacuees, indicating they require significant resources and are usually among the last to be evacuated. In response, SLCH initiated development of a parallel evacuation model.

The goals were to:

- Create plans and processes for evacuating a 150-bed NICU using a multidisciplinary approach

- Develop specific, suitable, and multi-level evacuation and Incident Command System (ICS) models for intensive care units while simultaneously evacuating the entire hospital
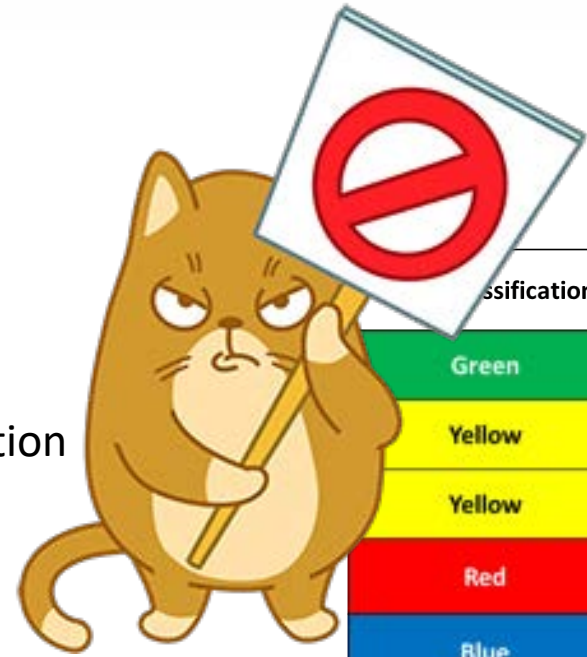
Motivation – The "Why"

What keeps you up at night?

- Cyberattack? Active Shooter? Evacuation? Utility Failure?
- Previous experience or events
- 150-bed NICU
- Not if, when

Order of Evacuation
Green
Yellow
Red

Classification	Mobility	Minimum Staff Required
Green	Ambulatory	1 staff to 8-20 patients
Yellow	Wheelchair/Stretcher	1 staff to 1 patient
Yellow	Infants/Neonates	1 staff to 1-2 patients
Red	Confined to Bed and/or Required Equipment	2 or more staff
Blue	Psychiatric/Behavioral Patients	Based on acuity/diagnosis

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Objectives

IDENTIFY
Critical Stakeholders

DEVELOP
Integrated Evacuation Strategies

IMPLEMENT
Tools: Planning & Communication

CONDUCT
Effective Drills

Collaboration

- Internal Partners
    - Executive leaders
    - Clinical leaders
    - Physicians
    - Ancillary services (RT)
    - Family Partners
    - Emergency Management leaders

Collaboration

- External Partners (regional, state, federal)
  - Other hospitals/systems
  - Emergency Management
  - Emergency Medical Services
  - Transport Teams
  - Hospital associations

Collaboration

- Consideration for rural institutions. Level I and Level II nurseries will still need to be evacuated, but shareholders may be different
    - OB nursing staff
    - Emergency department staff
- Outside collaboration may be even more important
    - EMS Agencies
    - Healthcare coalitions
    - Local children's hospital

Objectives

IDENTIFY
Critical Stakeholders

DEVELOP
Integrated Evacuation Strategies

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Tools: Planning & Communication

CONDUCT
Effective Drills

Develop Integrated Evacuation Strategies

How Does it Work?

- First step is to get everyone in a room

- Assess the current situation

- Lean on those with some incident command experience to help draft the NICU specific concurrent incident command

Integrated Evacuation Strategies
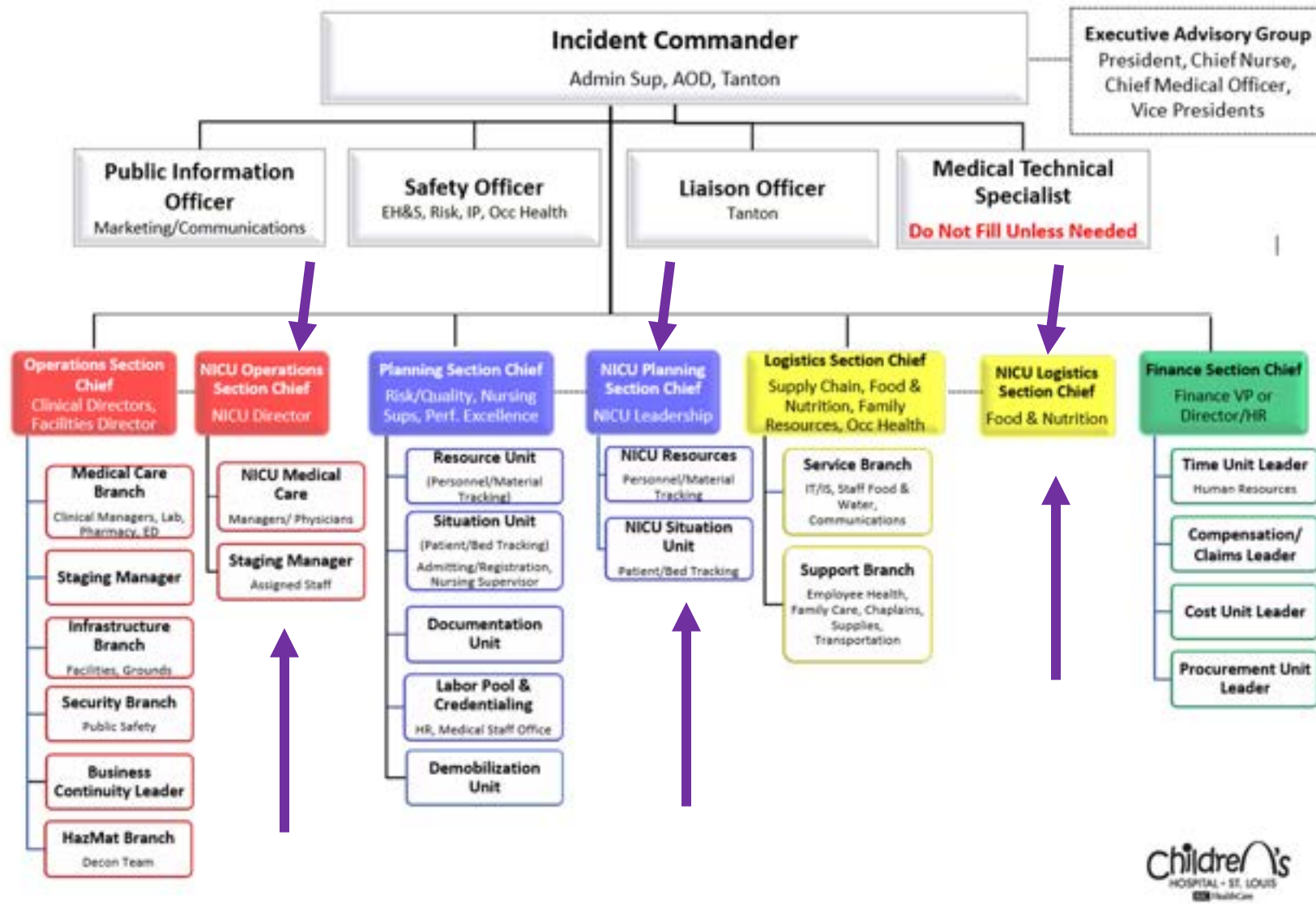
Parallel Incident Command
- Main hospital command
- NICU command

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Integrated Evacuation Strategies

How Does it Work?

- Facilitators
  - Hospital = Incident Commander
  - NICU = NICU Operations Section Chief (functions as Incident Commander at NICU level)

- NICU Medical Care (RN managers/MD leader)

- NICU Staging Manager

- Hospital Planning Section to NICU Planning Section
  - NICU Resources (personnel/material tracking)
  - NICU Situation Unit (patient/bed tracking)

- Hospital Logistics to NICU Logistics
  - NICU Food & Nutrition

Integrated Evacuation Strategies
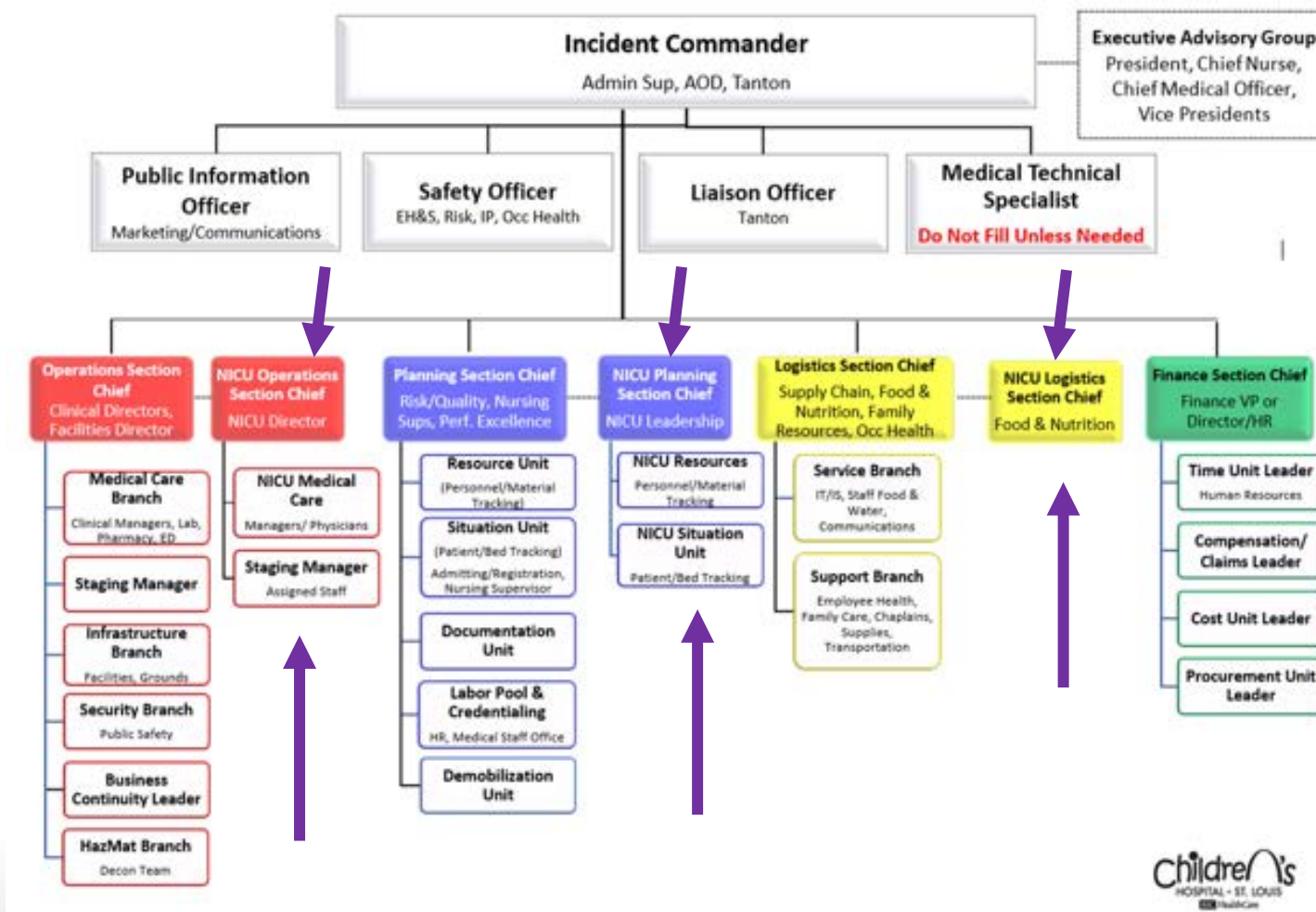
For rural hospitals:

- How use the resources of incident command to do this concurrently?

- Keep NICU or nursery leadership at the table

Integrated Evacuation Strategies

- Our successes
  - Increased NICU leadership presence and resources
  - Increased interest and engagement
  - Reduced communication delays (playing telephone)

- Our barriers
  - Concern with non-traditional Incident Command approach
  - Training and awareness of plan and process
  - Scheduling education/drills – always surging
  - Development for additional departments (time challenge)

Objectives

IDENTIFY
Critical Stakeholders

DEVELOP
Integrated Evacuation Strategies

IMPLEMENT
Tools: Planning & Communication

CONDUCT
Effective Drills

Tools

- You have the people
- You have the layout
- Now you need the tools!

Transforming NICU Evacuation – Tools

Prepare – Ready All the Time
Triage based on mobility and needed resources every shift

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Transforming NICU Evacuation - Tools

Triage by Resource Allocation for Inpatient (TRAIN)

Triage Classification	Mobility	Minimum Staff Required	Life Support
Green (65)	Open crib (Role: 1 nurse (non-licensed: milk tech, PCT, labor pool, visitors, cuddlers, providers not utilized for higher acuity)	11 RN (2 personnel 1 RN to up to 6	Minimal = RA, Low Flow Cannula O2, saline lock PIV, open crib
Yellow (42)	Crib/isolette/open table	13 staff 1 staff to 1-2 patients depending on evac route	Moderate = CPAP/BiPAP/Hi-Flow/NIV, Central line, Peritoneal Dialysis (can be disconnected), external heat source required
Orange (10)	Required Equipment	13 staff 1 staff to 1 patient	Maximal = Intubated conventional vent, chest tube, trach no support, medically necessary infusion, AKRT on break from therapy, continuous PD
Red (15)	Required Equipment	ECMO – 7 (RT, perfusion, 2 RN, 1-2provider, PCT) 6 staff RN, 3 RT, 3 PCT 2 or more staff to 1 patient RT reserved for this level	Maximal = Highly specialized equipment (e.g. –HFOV, ECMO, iNO, Trach with support, AKRT on active therapy, therapeutic hypothermia)

Transforming NICU Evacuation - Tools

Transforming NICU Evacuation - Tools

Create Job Role Cards
- Create for major tasks
- Avoid duplication of tasks

Physician/APN Leaders (Attending, Fellow, APN Resource)

Date	Time	Initials	Task
			On-Call Attending, Medical Control Fellow, & APN Resource collaborate with Evacuation Manager/Charge Nurse to allocate provider resources for evacuation of most critical patients.
			Assist in preparing patients for potential evacuation. *DO NOT EVACUATE WITHOUT ORDER AND GUIDANCE TO DO SO FROM HOSPITAL OR NICU INCIDENT COMMAND*
			Collaborate with Evacuation Manager/Charge Nurse in assigning a practitioner to evacuation areas/sites with the first infants and act as coordinator
			Assist with stabilization and transport of the sickest infants
			Delegate providers to call sign out for patients transferred to other facilities.

Providers (APNs, Residents)
Job Action Card

Date	Time	Initials	Task
			Assist in preparing patients for potential evacuation. *DO NOT EVACUATE WITHOUT ORDER AND GUIDANCE TO DO SO FROM HOSPITAL OR NICU INCIDENT COMMAND*
			Collaborate with physician/APN leaders in assigning a practitioner to evacuation areas/sites with the first infants
			Assist with stabilization and transport of the sickest infants
			Call sign out for patients transferred to other facilities as directed by physician/APN leaders

Milk Room
Job Action Card

Date	Time	Initials	Task
			Report to the Evacuation Manager/Charge Nurse to receive instructions
If instructed by Evacuation Manger/Charge Nurse to Assist with Milk Evacuation, follow these steps:			
			Ensure that all bins are labeled with updated patient identifier
			Load breast milk, donor milk and Prolacta onto carts in labeled individual patient bins. • If coolers are available, place refrigerated milk in cooler. • Do not mix refrigerated and frozen milk in a cooler.
			Transport breast milk, donor milk and Prolacta in individual labeled bins to evacuation areas/sites
			Assist with use of evacuation devices (just in time training materials are provided with equipment)

Transforming NICU Evacuation - Tools

Modify HICS Forms to Meet Needs

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Transforming NICU Evacuation – Tools

Build a Directory of Resources

10/04/2024 09:16 MO Pediatric View Snapshot

St. Louis Hospital ED	ED Designation	OB Level of Care	Neonatal Level of Care	Neonatal Specialty Level of Care	Pediatric Level of Care	Ped Specialty Care PICU	Licensed NICU Beds	Comment
BARNES - JEWISH HOSPITAL —L-1	Trauma Center	Level 2 Specialty Care	Level 1 Well Nursery	Level 2	Pediatric Capable	No		
Barnes - Jewish St. Peters Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Barnes - Jewish West County Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Christian Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	N/A	No		
Homer G. Phillips Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
Mercy Hospital Jefferson	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Mercy Hospital Lincoln	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Mercy Hospital South—L-II	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No	12	Level 2 Trauma Center,
Mercy Hospital St. Louis—L-1	Trauma Center / Burn	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	Yes	121	
Mercy Hospital Washington—L-III	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No		Level 3 Trauma Center
Missouri Baptist Medical Center	Emergency Care Capable	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 3 NICU	Designated Peds Beds	No	25	
Northwest Health Care	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
ParkLand Health Center - Bonne Terre	Emergency Care Capable	N/A	N/A	N/A	Pediatric Capable	No		
Parkland Health Center - Farmington	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
Pike County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Pediatric Capable	No		
Progress West Hospital	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No	9	
SSM Cardinal Glennon Children's Hosp L-1	Pediatric Trauma Center	Emergency Care Only	Emergency Care Only	Level 4 NICU	Designated Peds Beds	Yes	65	
SSM DePaul Hospital-St. Louis	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Emergency Care Only	No		
SSM Health Saint Louis Univ. Hosp. L-1	Trauma Center	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		
SSM St. Clare Hospital- St. Louis	Emergency Care Capable	Level 2 Specialty Care	Level 1 Well Nursery	N/A	Pediatric Capable	No		
SSM St. Joseph Hospital- St. Charles	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No	0	
SSM St. Joseph Hospital- Wentzville	Emergency Care Capable	Level 1 Basic Care	Level 1 Well Nursery	N/A	Emergency Care Only	No		
SSM St. Mary's Hospital-St. Louis	Emergency Care Capable	Emergency Care Only	Emergency Care Only	Level 3 NICU	Pediatric Capable	No	42	
SSMSt.Joseph Hospital-LakeSt.Louis-L-III	Trauma Center	Level 1 Basic Care	Level 1 Well Nursery	N/A	Designated Peds Beds	No		Level 3 Trauma Center
St. Louis Children's Hospital L-1	Pediatric Trauma Center	Emergency Care Only	Level 1 Well Nursery	Level 4 NICU	Designated Peds Beds	Yes	150	
St. Luke's Des Peres Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		emergency care capable
St. Luke's Hospital	Emergency Care Capable	Level 3 Subspecialty Care	Level 1 Well Nursery	Level 2	Designated Peds Beds	No	12	
VA St. Louis Health Care System	Emergency Care Capable	N/A	N/A	N/A	N/A	No		
Washington County Memorial Hospital	Emergency Care Capable	Emergency Care Only	Emergency Care Only	N/A	Emergency Care Only	No		

Communications

- Electronic and printed
- Mass notification systems
- Team members
- Social media
- Regional systems
- Healthcare coalition resources
- Credentialing
  - Staff and physicians
  - Volunteers

Objectives

IDENTIFY
Critical Stakeholders

DEVELOP
Integrated Evacuation Strategies

IMPLEMENT
Tools: Planning & Communication

CONDUCT
Effective Drills

Plan in Action – Drills

- Decide
  - Brainstorm with multidisciplinary team
  - Create multi-year plan
- Commit
  - Planning – every other month
  - Drill – every year
- Implement – make it real
  - Tabletop
  - Baby steps
    - One focus at a time; add a new focus each time

Plan in Action – Drills

- Emergency management
- Emergency department/disaster MD
- Medical director NICU MD
- Admin supervisor RN
- PICU nurse director

Plan in Action – Drills

- Engagement & Inclusion
  - Community and regional partners
- Include everyone
- Make it fun!
  - Operation Red-Nosed Reindeer
  - Operation Santa Baby
  - Operation Baby Bundle
  - Operation Pumpkin Spice
  - Operation Honeysuckle

Results

After two years of initial planning and evaluating operational plans, the hospital successfully evacuated 20 patients within three hours of notification during their first exercise.

This included:

- Utilizing available equipment and resources
- Identifying suitable transfer locations
- Transporting patients from the NICU to transport vehicle

Fast Forward to 2025

- Evacuated 20 patients; 2 to receiving hospital
- Reconciled patient, equipment, location, notification
- Developed family reunification
- Over 75 active drill participants

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Hardwiring Success

IF AT FIRST YOU
DON'T SUCCEED,
TRY,
TRY,
TRY AGAIN.

-William Edward Hickson

WHEN YOU TRY
SOMETHING,
YOU RISK FAILURE.

BUT WHEN
YOU DON'T,
YOU ENSURE IT.

- Stay the course

- Build on existing plans

- Test something new

From Protocol to Best Practice

June 4, 1997
Partial Evacuation

August 2019
Live Exercise

December 2023
Live Exercise

June 2025
Live Exercise

NICU evacuation plan drafted

Q1 2019

Tabletop Exercise
December 2021

Live Exercise
October 2024

- Develop specific Operations Plans
- Create Tools & Aids for Support
- Conduct Annual Progressive Drills & Exercises
- Continue Engagement & Updates
- Provide Opportunities to Engage & Share Resources

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Conclusion

- Internal and external engagement and inclusion is essential

- Development of department-specific operations plans allows for seamless integration into overall hospital plans

- Yearly evacuation exercises reinforce education and provide opportunities for growth

- Stay the course – if something doesn't work the first time, try something else

Contact Information

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**Collaborate with passion, Innovate with creativity,
Evaluate with precision, and Practice with dedication**

Thank You!

Disclosure

The content provided reflects the authors'; viewpoints and perspectives. It does not represent the official views or endorsements of the Administration for Strategic Preparedness and Response (ASPR), the Department of Health and Human Services (HHS), or the United States Government. Region V for Kids Pediatric Disaster Center of Excellence is funded by a grant from the Administration for Strategic Preparedness and Response (ASPR) within the U.S. Department of Health and Human Services (#U3REP190615-10-13). The authors are supported by this grant. For more information, visit ASPR.gov.

Biography
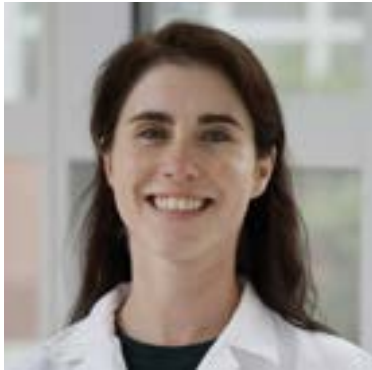
Ohio State Emergency Medicine

Nationwide Children's Pediatric Emergency Medicine

UH Rainbow Babies and Children's Hospital

Cleveland, OH

Region V for Kids Project Manager

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Region V for Kids

The mission of Region V for Kids is to build on existing foundations in pediatric clinical care and emergency response by enhancing coordination mechanisms and incorporating relevant capabilities at the local, state and regional levels.
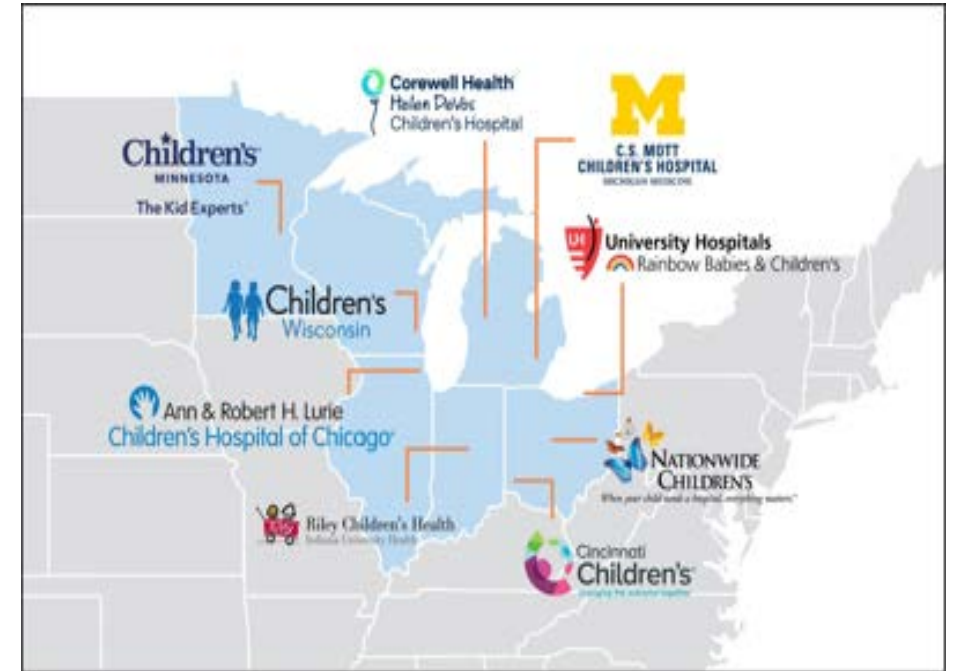
The overall goal is to harness and develop best-practices around pediatric disaster preparedness and response

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Region V for Kids

It's one of only three **Pediatric Disaster Centers of Excellence** in the country, supported by the **Assistant Secretary for Preparedness and Response (ASPR)**. Focused on improving pediatric readiness before, during, and after disasters by:

- Strengthening **pediatric disaster planning** for hospitals, EMS, and public health.
- Building **regional coalitions** to coordinate care for children in emergencies.
- Providing **education, training, and resources** to healthcare professionals.
- Conducting **research and innovation** in pediatric disaster preparedness.
- Supporting **PECCs (Pediatric Emergency Care Coordinators)** to improve readiness at the local level.

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Region V for Kids

Region V for Kids is a regional network designed to make sure children are better protected and cared for in disasters and public health emergencies.

Who are you? (Poll Everywhere)

Choose your primary role

- Healthcare Coalition
- Emergency Management professionals.
- Government personnel
- Public health officials
- Volunteer organizations
- Hospital and healthcare system staff
- First responders
- Other

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Pediatric Readiness

35 MILLION children seek emergency care each year,[1]

BUT...

80%

- of EDs treat fewer than 10 children per day[2]
- of EMS agencies treat fewer than 8 children per month[3]

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Every Second Counts

30+ minutes — 66% of families are 30+ minutes from an ED fully prepared for children[1]

3 hours — if a child dies, the average time to death is 3 hours[2]

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What region are you from? (PollEv)

Region 1
Region 2
Region 3
Region 4
Region 5
Region 6
Region 7
Region 8
Region 9
Region 10
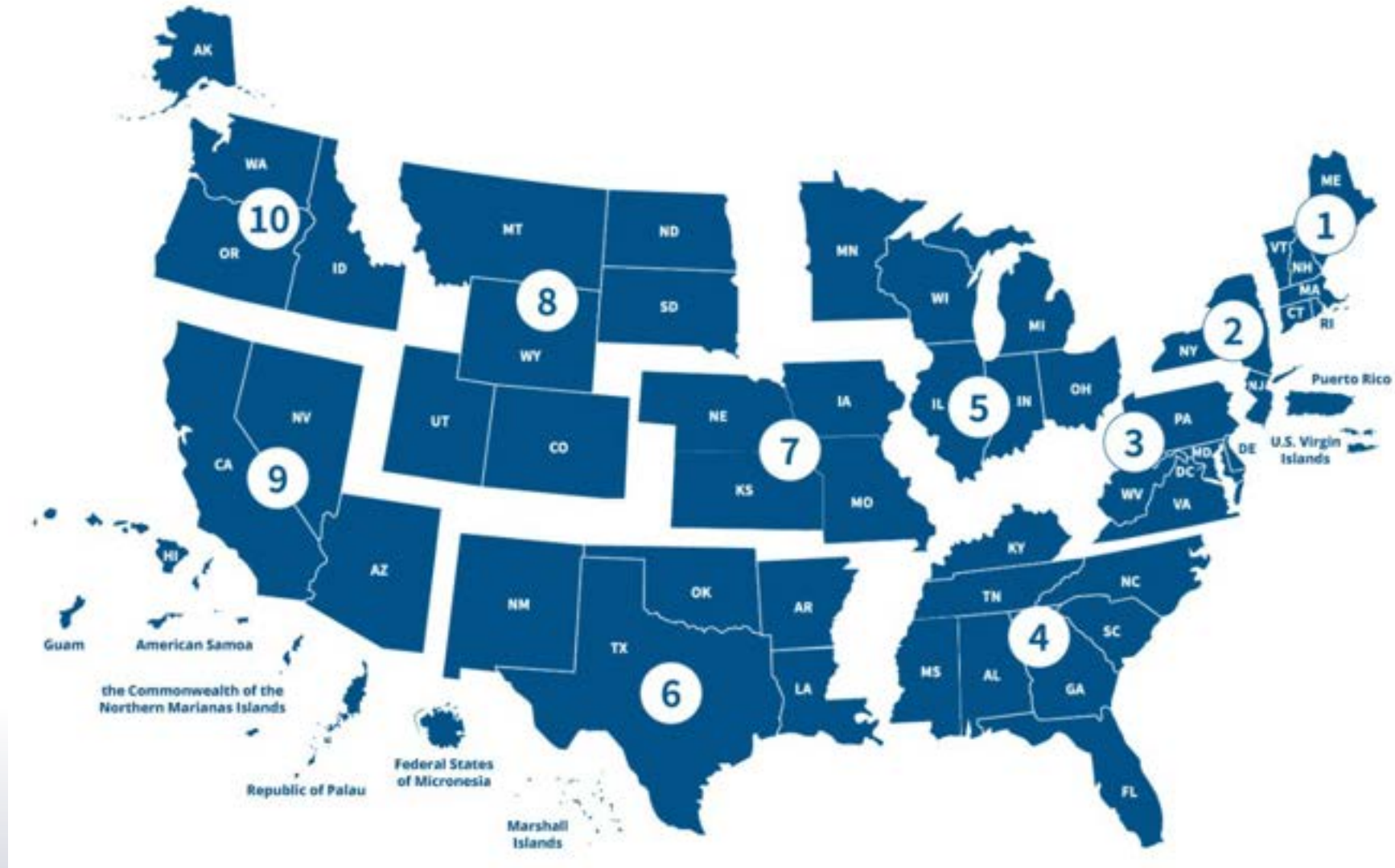
Pediatric Disaster Preparedness

Children in Disasters

- Weather events
  - Hurricanes such as Harvey impacted an estimated 3 million children[1]
- Wildfires
  - California fires residents and children were displaced
    - Effects on children with asthma
- Gun Violence
  - Mental health and academic performance
- Floods
  - Loss of life, displacement and mental health

1. Harms, R. (2019, January 28). *Hurricane Harvey's impact revealed the unique needs of children during a disaster.* Children's Recovery ("Hurricane Harvey") blog. Retrieved July 16, 2025, from Children at Risk website: https://childrenatrisk.org/hurricane-harvey-unique-needs-of-children/

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Gaps in Pediatric Disaster Readiness

2021 NPRP Assessment:

Only 47.5 % of hospitals have adisaster plan that includes pediatric considerations:
- ○ Low Volume Hospitals **38%**
- ○ Medium Volume Hospitals **50%**
- ○ Medium High Volumes **61%**
- ○ High Volume 83%

Background: 2022-2023 "Tripledemic"

- Winter 2022-2023

- Influenza, Covid-19, RSV "Tripledemic"

- Children's hospitals at capacity

- Increased ED visits and boarding at general EDs

Background: Tripledemic

D Rural ED (n=6)

Janke AT, Mangus CW, Fung CM, et al. Emergency Department Care for Children During the 2022 Viral Respiratory Illness Surge. *JAMA Netw Open.* 2023
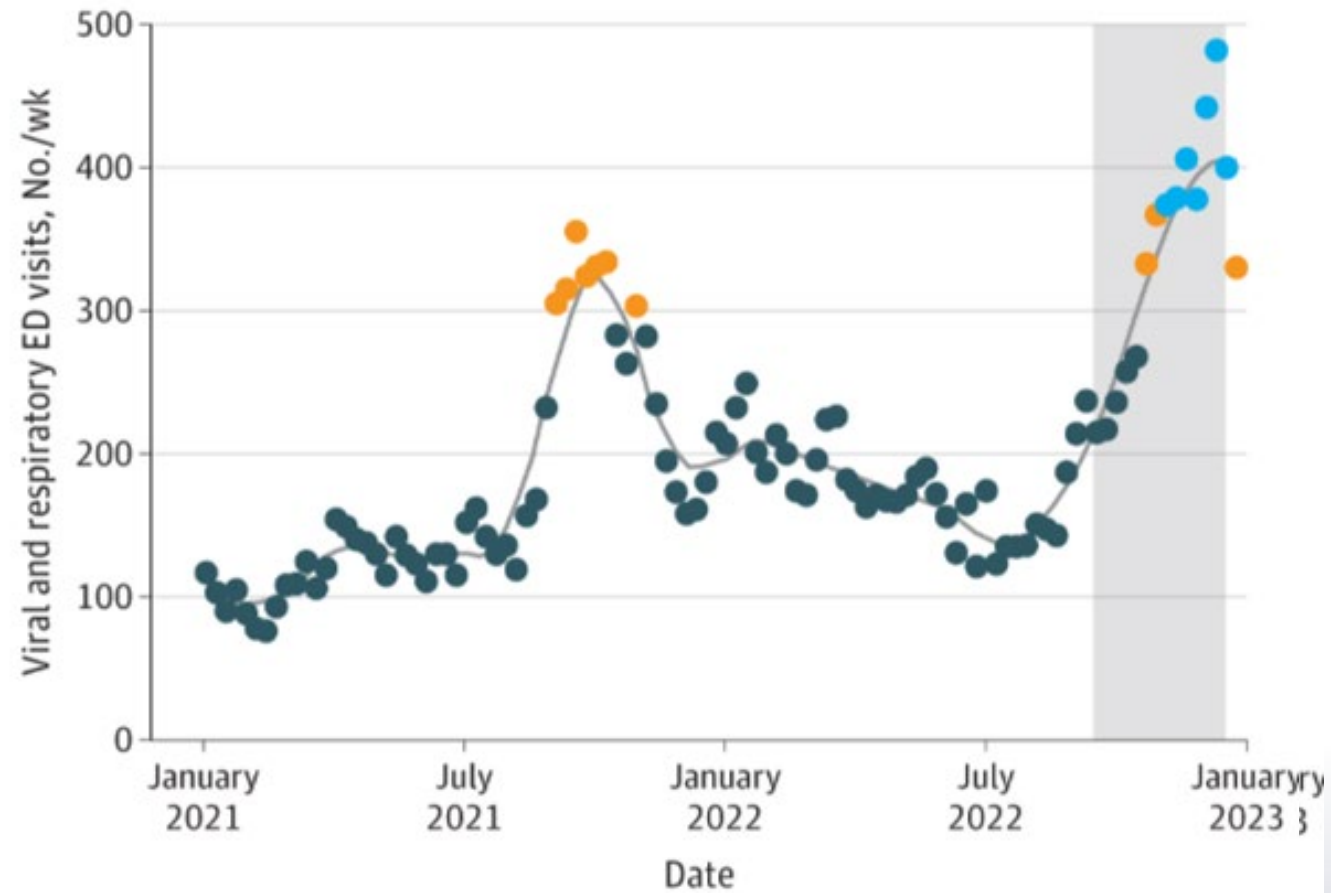
Background

- Little is known about the lived experience of pediatric readiness and disaster preparedness at rural and CAH
- Qualitative and mixed-methods research allows us to interview front-line clinicians and medical educators
- Our mixed-method study included a survey and virtual focus groups

Aim

By engaging directly with healthcare providers in CAHs and rural community hospitals, we aimed to identify existing strengths and barriers to effective pediatric preparedness and identify opportunities to enhance CAH and rural hospitals' ability to respond effectively to complex and evolving pediatric emergencies

Methods

- Survey and focus group guide developed by the study team, including qualitative experts
- Snowball and purposive sampling for recruitment
- Survey distributed through EMSC and healthcare coalition email lists, eligible participants identified from rural and CAHs
- Respondents included emergency managers, medical directors, hospital administrators, nurses, and trauma coordinators

Methods: Survey

Survey questions:

- Respondent role
- Hospital characteristics
  - What pediatric chief complaints do they frequently transfer?
- Hospital disaster plan characteristics
- Requested resources
  - Education
  - Clinical guidelines

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Methods: Focus Groups

- 5 focus groups, conducted via Zoom
- Facilitated by qualitative experts
- Clarifying questions from study members
- Groups were scheduled for participant convenience
- 19 participants across 5 states from Region V

Methods: Focus Groups

- Focus group recordings were de-identified and transcribed
- Analyzed with mixed-methods analysis software using constant comparative methods
- Codebook developed deductively
- Three qualitative team members coded one focus group independently and reviewed codes for consistency
- The remaining four focus groups were then coded and analyzed for themes

Themes from the Focus Groups

Strengths of Staff and Surrounding Community at Rural & CAHs

Staffing Limitations as a Barrier to Pediatric Education

Desire for Specific Pediatric Resources for Rural & CAHs

Desire for Guidance for Developing Pediatric Disaster Plans

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Quotes

"The biggest issue we have is trying to do trainings internally, getting staff willing to become instructors. So, I'm a paramedic that works in the quality department, formerly environmental care. And I'm one of two PALS and ACLS instructors in a 700-person organization."

"One of the things we struggle with is keeping supplies on hand for pediatrics because you have to buy them in a large quantity. There's not an option to buy small quantities and they're expensive and we expire them out."

"If we had a surge incident with pediatric patients coming in unidentified or without patients, we don't really have a solid plan in place for that, it's pretty terrifying."

Quotes

"So, I will reach out to people and they're hesitant to give me any information. Despite being partners because everybody thinks that, "That these are our protocols, these are our babies, they can't leave this content, can't leave this facility."

"A barrier is that when we go to the larger facility to do that training, we're looked at as lower level. We're asked, oh, you're one of them from that facility, like you don't have anything, or you don't know anything and it's very demeaning."

"Sometimes I'm in the ER for four hours, sometimes I'm on the floor for the next four hours and then at the end of my shift I'll deliver a baby. So, yeah, we just do a lot of everything."

RV 4 Kids
PEDIATRIC DISASTER CENTER OF EXCELLENCE

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Results

Annual ED Pediatric Volume
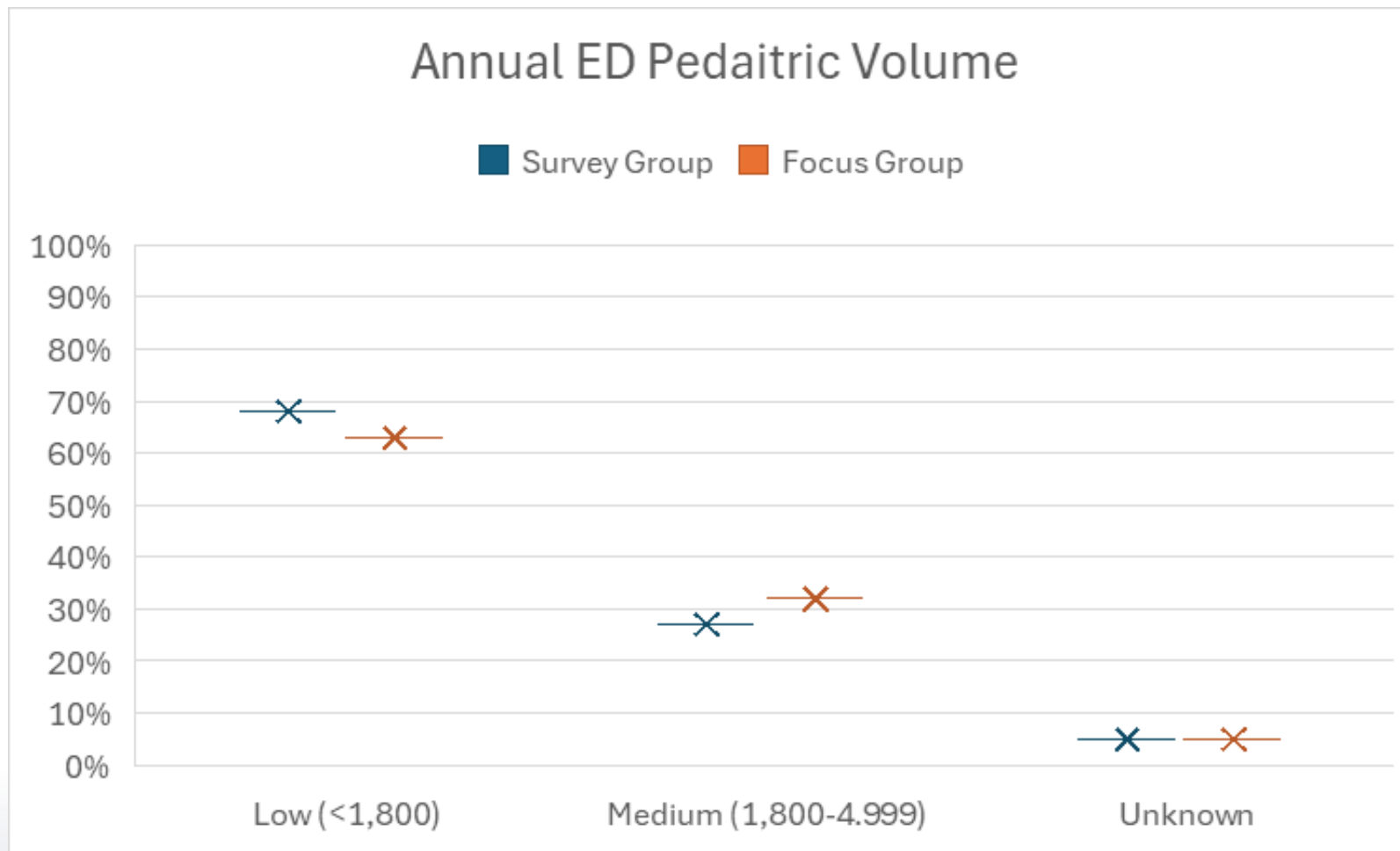
Results

Disaster Plan Contains Pedaitric Considerations

- Yes
- No
- Unsure

41% Yes, 36% No, 22% Unsure

Results

Hospital's Incident Command Structure has Pediatric SME — Focus Group 11%, Survey 10%
Hospital Includes Pediatric Victims in Disaster Drills — Focus Group 79%, Survey 71%
Children and Youth with Special Healthcare Needs — Focus Group 16%, Survey 10%
Pediatric Mental and Behavioral Health — Focus Group 5%, Survey 10%
Pediatric Patient Volume Surge — Focus Group 21%, Survey 17%
Children's Unique Needs with Decontamination — Focus Group 11%, Survey 10%
Space and Staff for Unaccompanied Children — Focus Group 21%, Survey 22%
Pediatric Patient Tracking and Family Reunification — Focus Group 32%, Survey 32%

Focus Group (n=19) Survey (n=41)

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Requested Resources

Resource Development

- What clinical guidelines and pathways currently exist in Region V?
- Are they publicly available?
- Are they relevant to rural and CAH?
- Can they be modified to be relevant to rural and CAH?

Resource Development

- What pediatric emergency medicine educational material is publicly available?
- What pediatric disaster planning material is publicly available?
- Are these resources applicable to rural and CAH?

Conclusions

- Prior quantitative studies have demonstrated significant challenges to pediatric readiness at low volume hospitals
- By engaging with clinicians at these hospitals directly, we have identified facilitators and barriers to pediatric readiness
- These results will be used to develop pediatric resources specifically for rural and CAH EDs

What tips do you have for disseminating information to Rural & Critical Access Hospitals?

QUESTIONS??

Resources

Professional Resources

Region V for Kids

Supporting Infant and Young Child Feeding in Emergencies

A Collaborative Approach

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Chair, NCBfC

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Objectives

- Explain the importance of Infant and Young Child Feeding in Emergencies (IYCF-E)

- Describe chest/breastfeeding, lactation and human milk's role in emergencies

- Identify IYCF-E challenges and solutions

- Describe response efforts in Western North Carolina and collaborative efforts of the North Carolina Breastfeeding Coalition SAFE Team during Hurricane Helene

Introductions, Disclosures, and Conflicts of Interest

- We have been personally involved and impacted by numerous disasters, so this is a topic of extreme passion.

- This presentation includes pictures of bottles and teats due to the content and risk of use, not as promotion of bottles/teats.

- Infant and Young Child Feeding in Emergencies efforts include the protection and support of optimal feeding for infants and young children in all types of emergencies globally. This presentation is given by presenters with experience in implementation in the US, mainly in response to weather related disasters.

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About CGBI
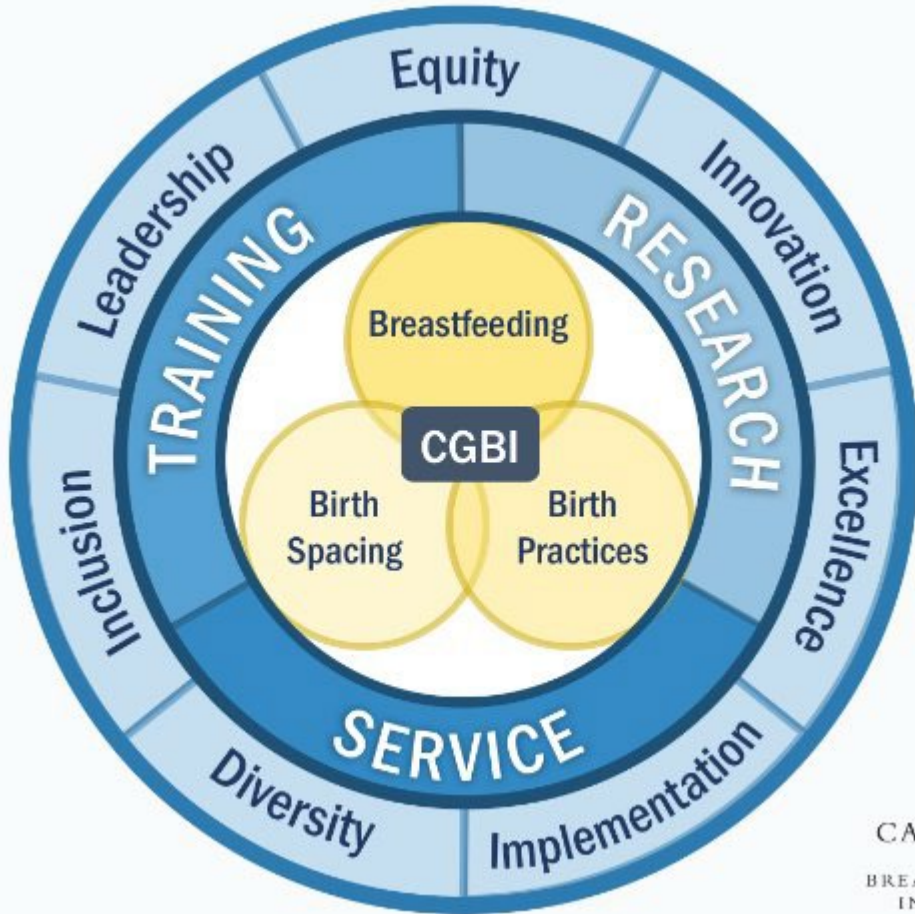
breastfeeding.unc.edu

About the North Carolina Breastfeeding Coalition
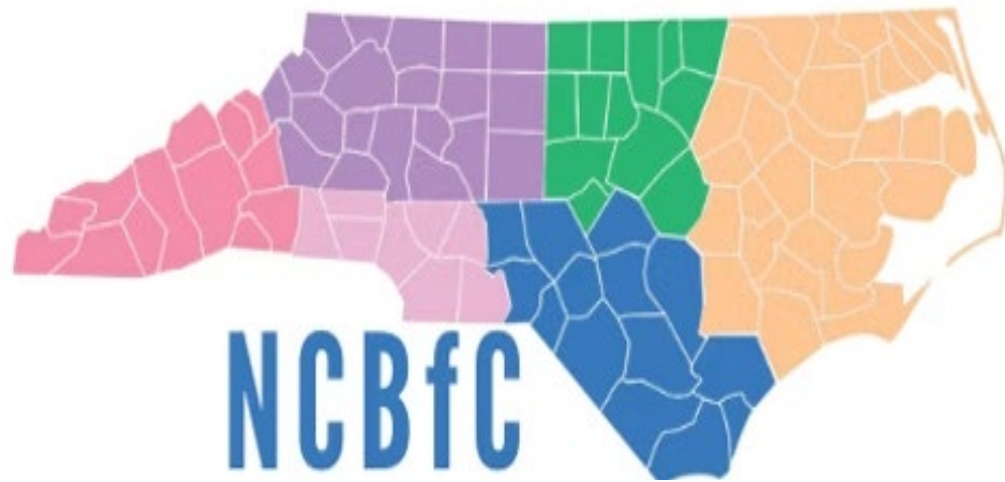
Our Vision:

Vibrant communities where breastfeeding and human milk feeding are part of the fabric of life.

Our Mission:

The mission of the NCBC is to promote, protect and support breastfeeding through a cooperative network of individuals, coalitions, agencies, and organizations.

https://www.ncbfc.org/

SAFE Team: **S**upport and **A**dvocacy for Infant **F**eeding in **E**mergencies

NC Breastfeeding Coalition

Breastfeeding Friendly Communities

WNC Families

Gillings/UNC-CH-Carolina Global Breastfeeding Institute

Stakeholders & Volunteers

(local, national)

https://www.ncbfc.org/safe
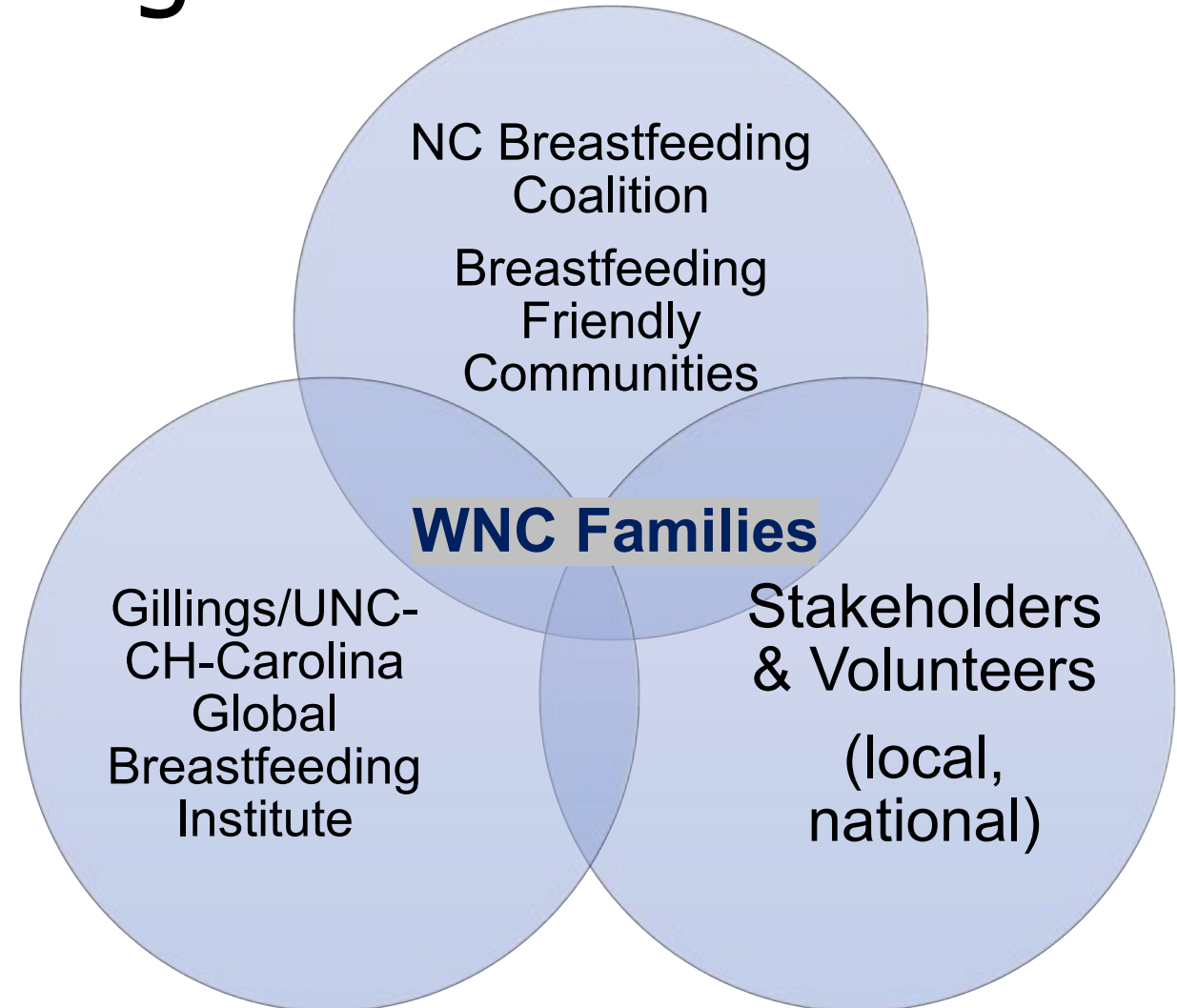
Infant and Young Child Feeding in Emergencies

Definitions, Core Concepts, and Why it Matters

Julia Bourg, BSN, RN, IBCLC

Healthcare Manager/ Project Director

Gillings School of Global Public Health

UNC Chapel Hill

juliabourg@unc.edu

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How would you rate your current knowledge about Infant and Young Child Feeding in Emergencies?

CHECK IN

"I'm a newbie here!"

"I'm familiar with concepts, but no experience with application"

"I'm knowledgeable of concepts and have limited experience with application"

"Well versed in concepts and firsthand experience in application"

0
Novice

1
Basic

2
Intermediate

3
Advanced

IYCF (Infant and Young Child Feeding)

Birth up to 11 completed months of age

12 to up to 23 completed months of age

Infant

Young Child

Key IYCF Principals for Optimal Feeding

- Human milk feeding within one hour of birth

- Exclusively feeding human milk for the first 6 months of life then provide solid foods when developmentally ready with the continuation of chest/breast/human milk feeding for 2 years and beyond

- Safe infant and young child feeding practices promote the growth, health, and appropriate development

The **first 1000 days** (conception until 2 years of age) is a critical window

Infants, children, pregnant and lactating people are vulnerable to undernutrition especially during emergencies

IYCF-E (Infant and Young Child Feeding in Emergencies)

What IYCF-E <u>is</u>:

Protection and support of optimal feeding for infants and young children in all types of emergencies globally

What IYCF-E is <u>NOT</u>:

Coercing people into breastfeeding or making feeding choices that are against or beyond their capacity, circumstance, or individual will
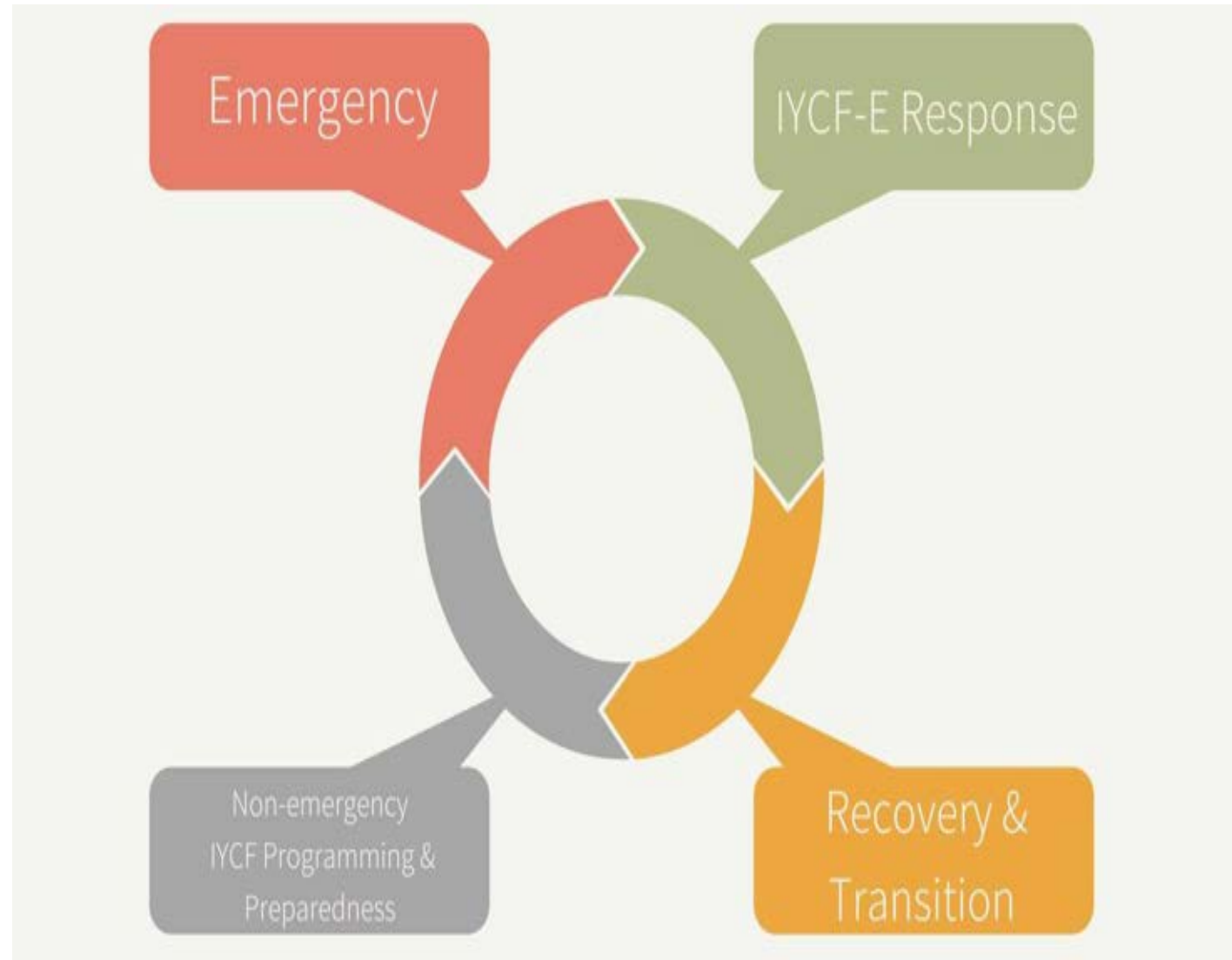
Disasters and Emergencies Happen Everywhere

Natural/ Weather Related
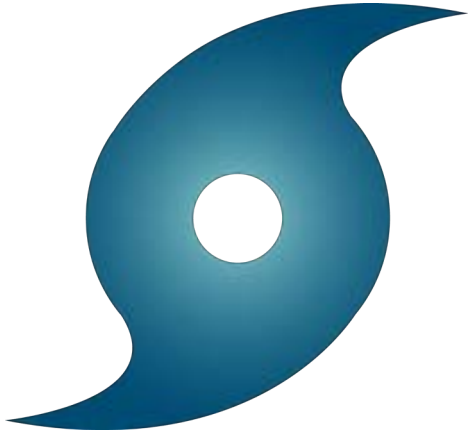
Public Health Emergencies

Personal or Family Crisis

Fires

Power Outages
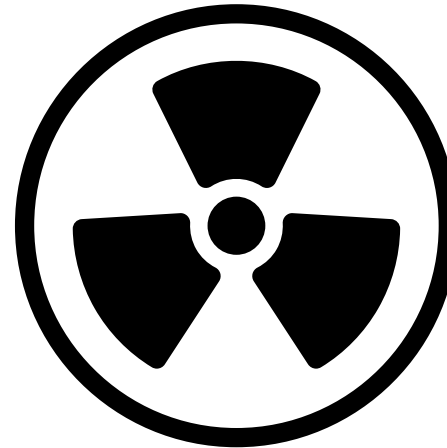
Nuclear/ Radiation

Can you think of others?

What are common disasters that impact your area?

Resource

Nuclear Detonation Preparedness: Communicating in the Immediate Aftermath

April 2024

FEMA

Nuclear Detonation Preparedness: Communicating in the Immediate Aftermath
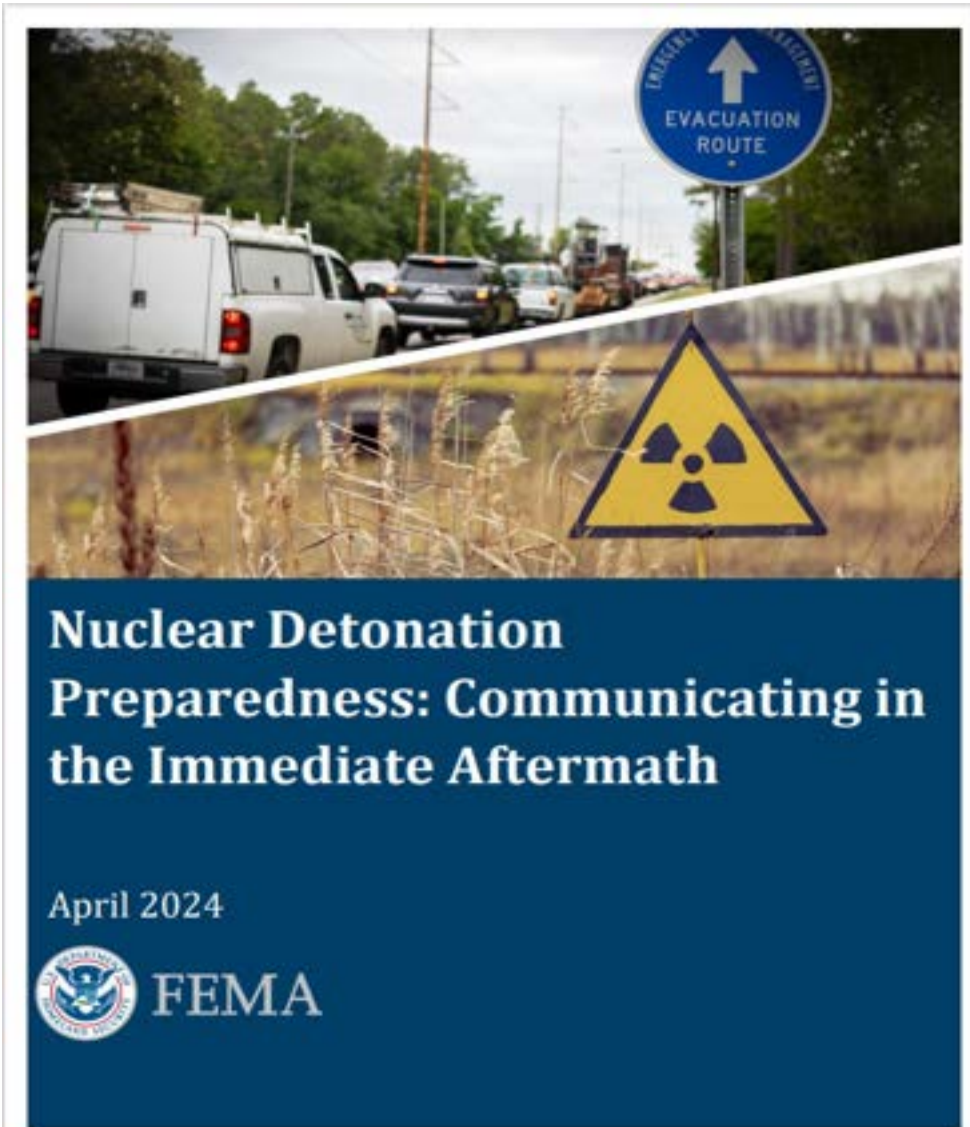
Chapter 13 includes section on infant feeding and safety

Infant and Young Child Feeding in Emergencies (IYCF-E)

Direct chest/ breastfeeding is the **SAFEST** feeding option especially during emergencies

The risk of using commercial infant formula and other feeding **devices SIGNIFICANTLY increase** during emergencies and can lead to serious illness

How Do Emergencies Create Challenges for Safe Feeding?

Families can be separated

Limited resources: medical aid, food items, supplies

Loss of clean, private, comfortable places to feed or prepare food

Families that have been marginalized are the most impacted : Emergencies worsen existing disparities in accessing care in resources

Loss of power creates challenges for storing human milk or commercial infant formula and the ability to use electric breast pumps

Water sanitation concern: preparing formula, food, and proper disinfecting of feeding items

Can you think of others?

Story behind that photo of a mother and baby carried to safety during Harvey – New York Daily News. Accessed November 29, 2022. https://www.nydailynews.com/news/national/behind-photo-mother-baby-carried-safety-harvey-article-1.3460731

HOW BREASTFEEDING SAVES LIVES

"Around the world, infants who are not exclusively breastfed in the first 6 months of life are 14 times more likely to die than exclusively breastfed infants. In complex humanitarian crises and emergencies the risks of not being breasted are exacerbated." (UNICEF)

Risk of diarrheal illness increases 5x for infants during crisis

Emergency conditions increase mortality rates across populations.

Optimal breastfeeding could prevent over **800,000 child deaths annually**, underscoring its critical role in emergency preparedness.

**True or False:
The United States has federal policies which incorporate IYCF-E principles?**

Show of thumbs

No

Yes

Figure 21: The state of infant feeding during emergencies in 84 countries on a scale of 0-10
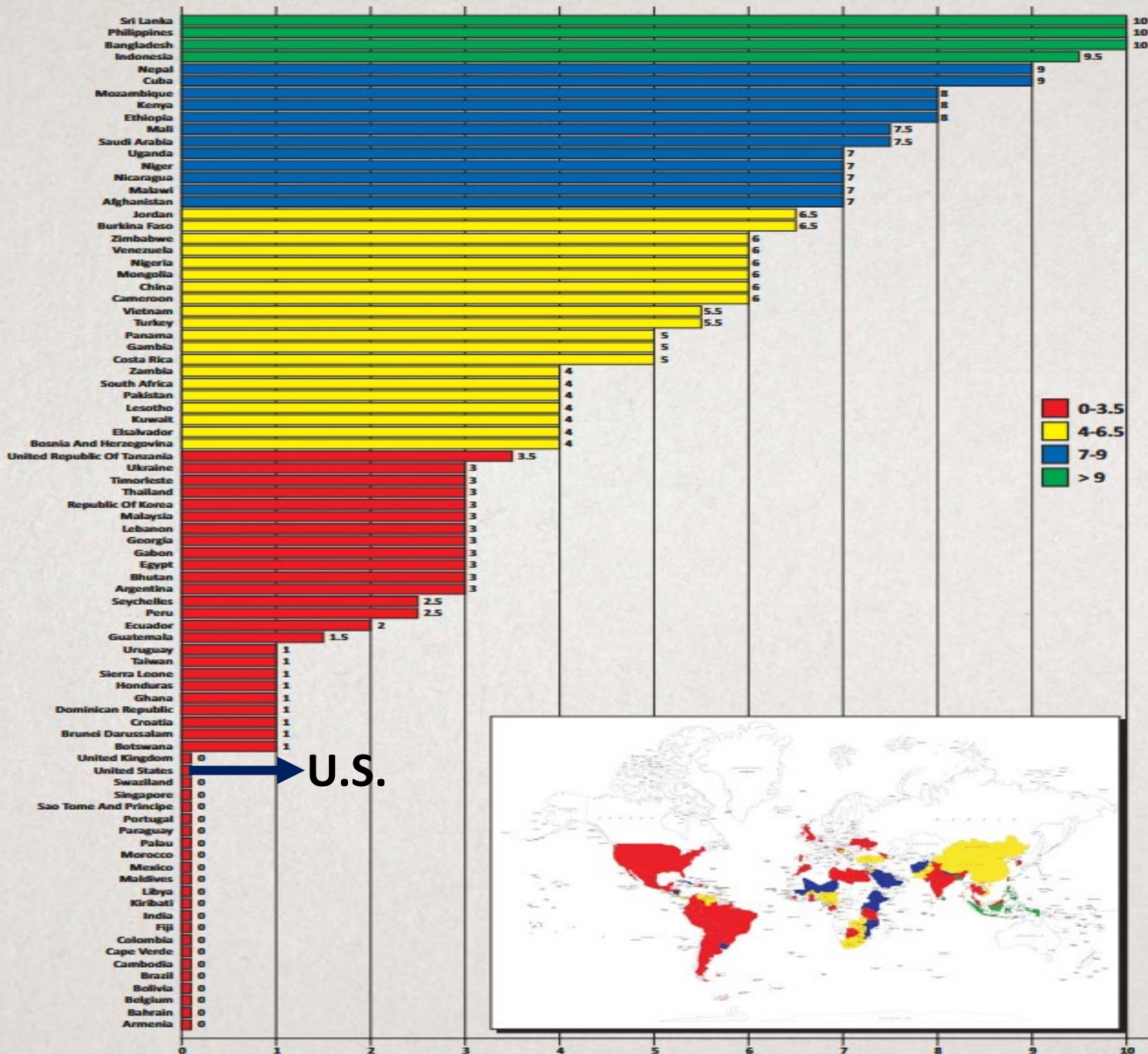
- The IYCF-E indicator scored the **lowest average of all indicators** at 3.43 out of 10.

- 4 out of 84 countries scored 9.5-10, having prioritized IYCF-E & included it in their policy on chest/breastfeeding & IYCF.

- **The majority, 48 countries are coded red, with the US and 22 other countries scoring zero.**

- For the complete 84-country WBTi report, click here.

Lactation Physiology

Hormonally regulated:
Prolactin-"milk maker"
Oxytocin-"milk ejector"

Supply and Demand:
More demand=more supply and vice versa
"Move it or lose it" *(well kinda....)*

Abrupt cessation of breastfeeding/lactation can lead to breast illness and complications
Physiological (engorgement, mastitis, infection)
Psychological (depression, distress, etc.)

Myth Busters

Presenting case:	✕ Misconception:	★ Reality:
A person experiencing stress...	Will have their milk "dry up"	Can and should chest/breastfeed
A malnourished person...	Will not produce milk or milk will be "suboptimal"	Can and should chest/breastfeed
A crying or irritable infant...	Is hungry	Cries for many reasons & will feel soothed through breastfeeding & closeness
A person in unsanitary conditions...	Will have "bad" milk	Human milk has protective properties

Relactation: Mothers may be able to start breastfeeding again

Nipple stimulation

Milk removal

Monitoring and support from a lactation support provider

Realistic expectation based on individual circumstances

General guidance when troubleshooting feeding plans during emergencies

- Pre-emergency feeding plans should be maintained if they can be done so safely

- Remove barriers and provide support for safest feeding possible on an individual basis

- Mitigate risks and empower caregivers!

Counseling: Emergency vs Non-Emergency

Non-emergency priorities/ approach	Emergency situations
L-isten **O**-bserve **V**-alidate **E**-ducate	**S**-upport **A**-ssess **F**-eed *As safely as possible* **E**-mpower
Grounded in empathetic listening and understanding and centering the needs of nursing dyads and their family	Empathetic listening, understanding and centering needs are still upheld, but in emergencies, counseling is part of overall risk mitigation and ensuring timely delivery of lifesaving information/supplies

Safety of Feeding

MOST
safe

↓

LEAST
safe

1. Chest/breastfeeding
2. Expressed human milk from mother/lactating parent
3. Expressed donor milk (if available)
4. Ready to feed formula
5. Powdered infant formula
6. Whole cow's milk (**ONLY** for infants older than **6 months of age**)

⚠ The use of homemade formulas and staged/toddler commercial formulas are **not** recommended and should be discouraged

Cautions of Concentrated Commercial Infant Formula

o Require additional steps, including proper mixing using safe water

o Packaged similarly to ready-to-feed formula

o Can be very confusing to families

o Can you think of other risks?

When feeding supplies are used:

Clean

- After every use

- With safe water not used for anything else

- Discard hard to clean and/or contaminated items

Sanitize
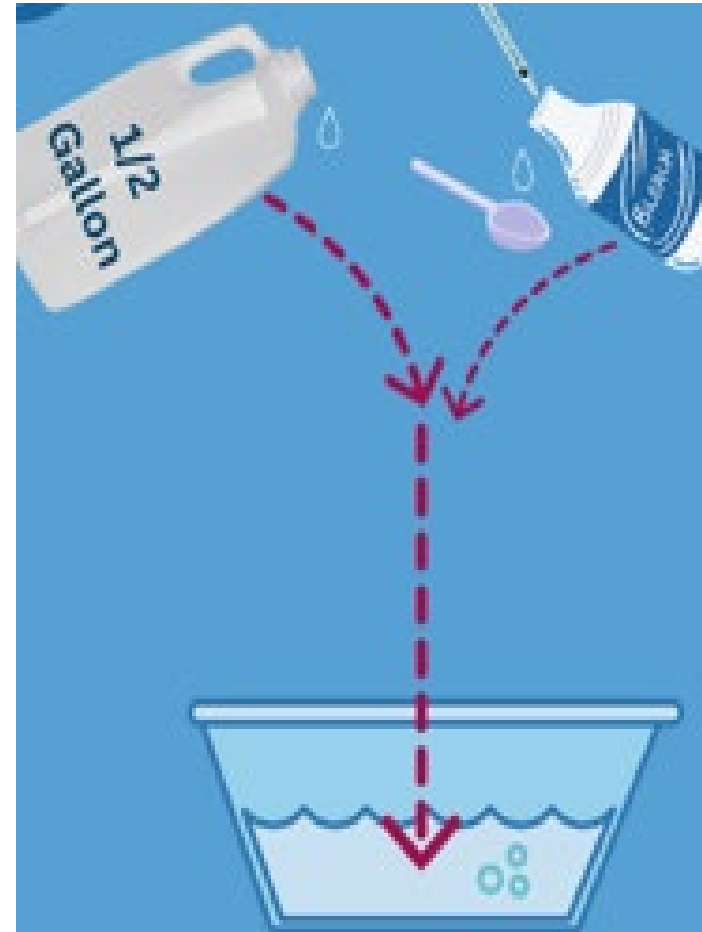
- Infants < 2 mos old or sick

- At least 1x per day

Source: https://www.cdc.gov/infant-feeding-emergencies-toolkit/php/how-to-clean-infant-feeding-items-during-emergencies.html

Making Water Safe

When possible,
use **BOTTLED** water
Unopen~~ed~~ ~~com~~mercially
bottled ~~water~~

BOIL
Kills bacteria, viruses, and

DISINFECT
Kills most viruses and

FILTER
Can remove parasites
Most portable water filters do

remove
~~manu~~facturers
~~ad~~ditional

Water contaminated with harmful chemicals, toxins, or radioactive agents cannot be made safe by boiling, disinfecting, or filtering

Water options from **MOST** safe ➡ to **LEAST** safe

Hurricane Response: Feeding Sanitation Kits

Photo Source: NCBfC SAFE Team

Community Milk Sharing: Tips to minimize risks
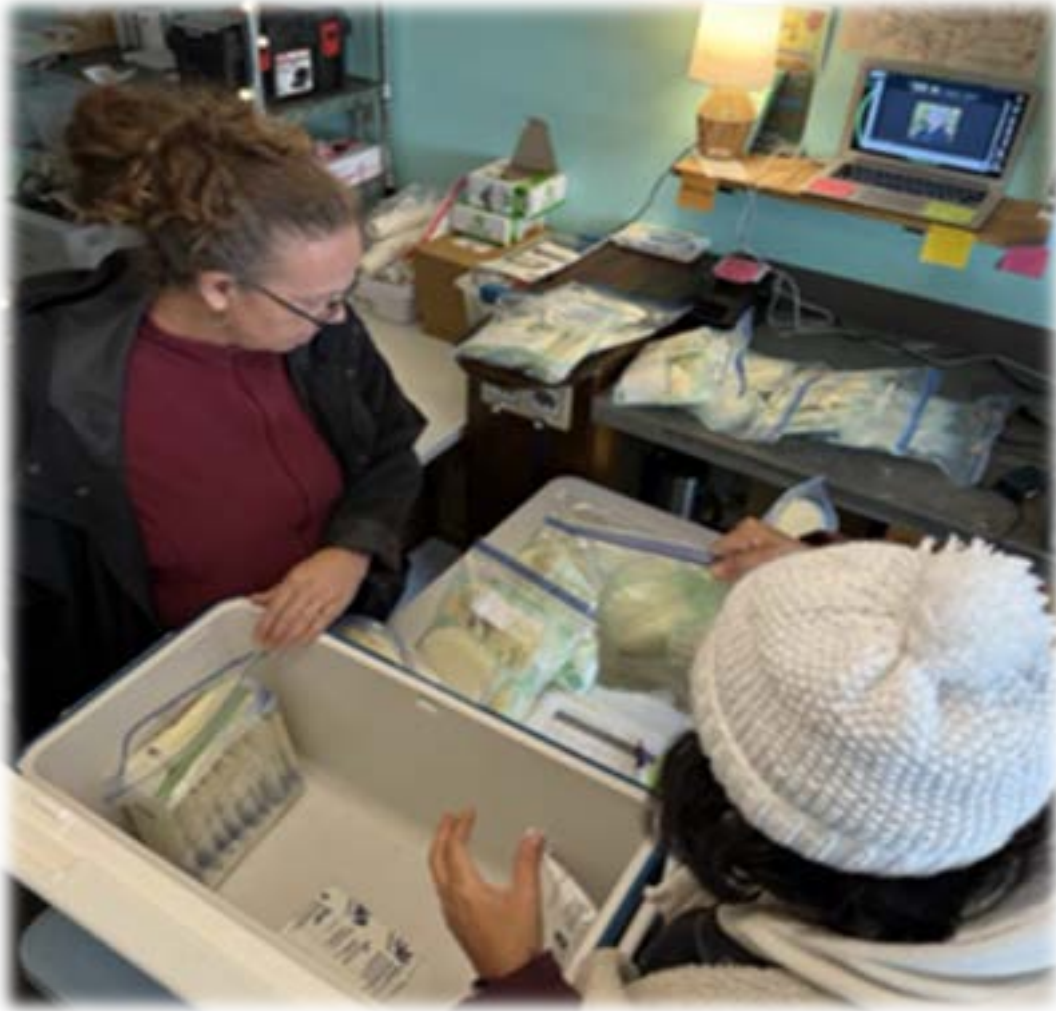
Photo Source: NCBfC SAFE Team

o Know donor's health and lifestyle

o Know who shouldn't donate human milk

o Have a screening process in place

o Connect donors with recipients

o Work with donors to ensure that human milk is handled stored and transported safely

o Advise families NOT to purchase human milk online

Source: PSBC Family Information: Informal (Peer-to-Peer) Milk Sharing

Hurricane Helene and Western North Carolina Response

SAFE Team Formation and Outcomes

Love Anderson

CEO Breastfeeding Friendly Communities

Chair, NCBfC

Love@breastfeedingcommunities.org

#NHCPC25

Setting the Scene: Hurricane Helene

- Landfall in Florida Big Bend Region as category 4

- Catastrophic flooding, storm surge and tornadoes devastating southeastern U.S. and southern Appalachians

- 249 fatalities=Deadliest hurricane in the contiguous U.S. since Katrina in 2005
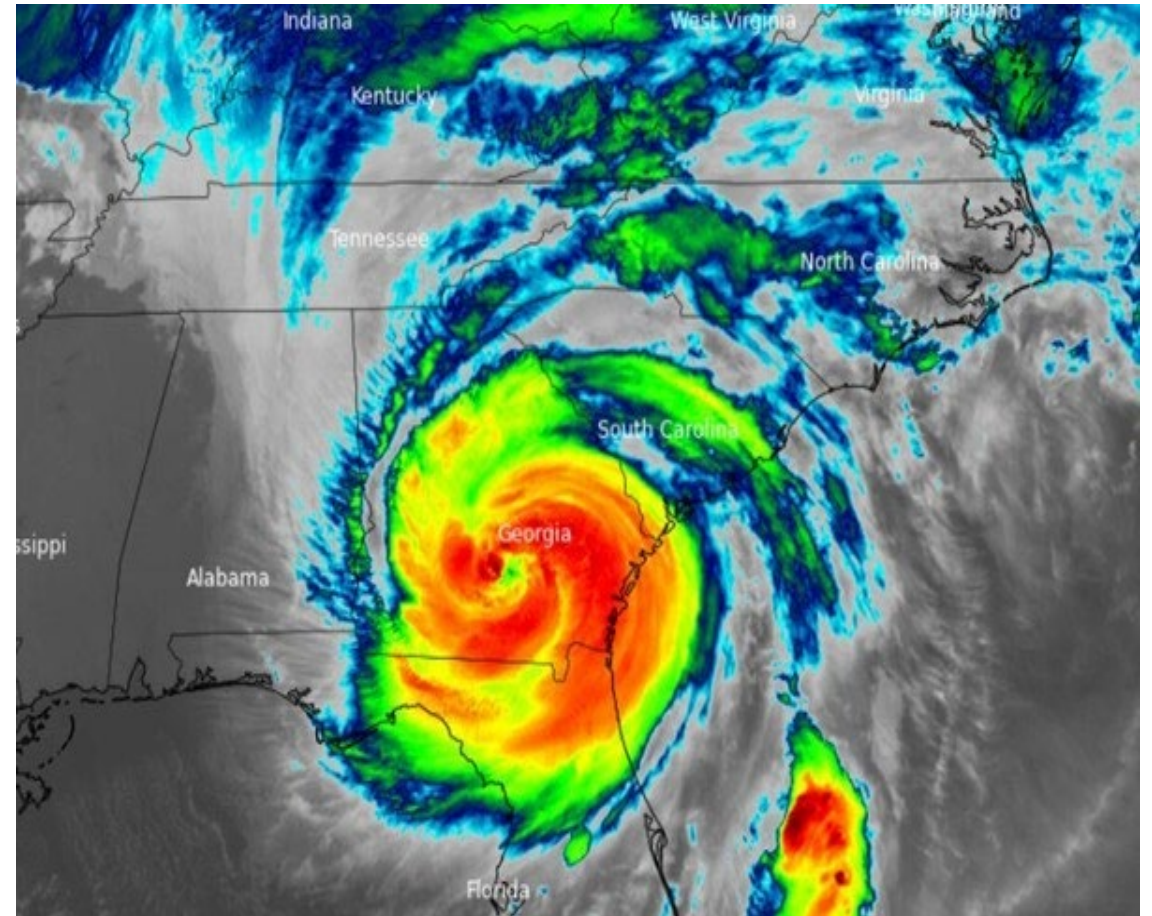
https://www.nhc.noaa.gov/data/tcr/AL092024_Helene.pdf

Hurricane Helene: Western North Carolina (WNC)

- Unprecedented and unexpected devastation

- People and communities without basic needs for survival

- Immediate infant feeding crisis

Flooding from the Swannanoa and French Broad rivers in Biltmore Village in Asheville, NC after Helene swept through on 27 September 2024. Image courtesy of Colby Rabon and the Carolina Public Press.

Community-led response began within hours

National News Story of WNC

Read full story here
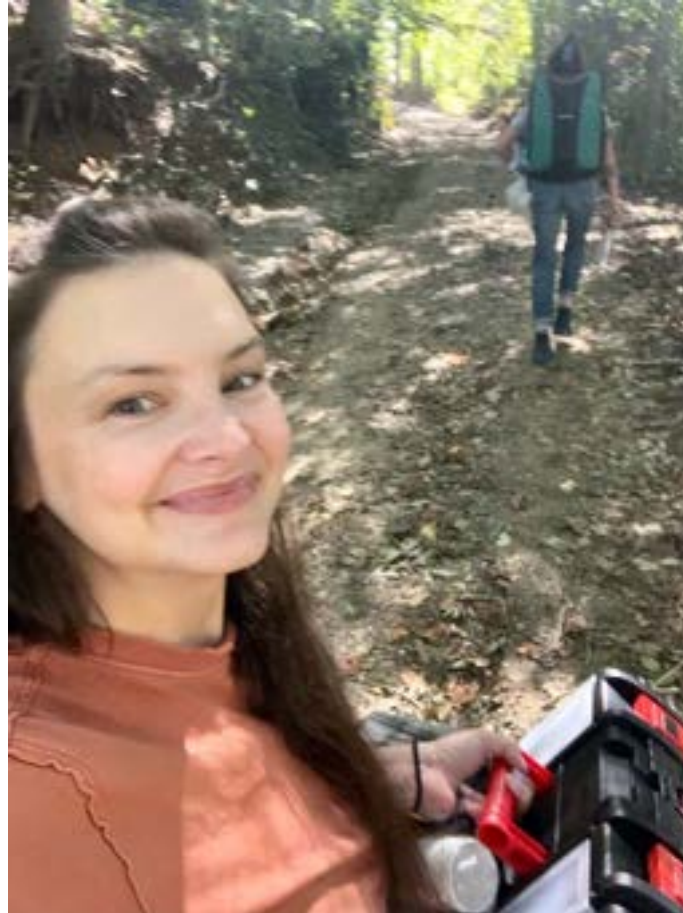
Brandi Harrison and Jayne Carpenter hike uphill to deliver supplies and support to families who are stranded.

Volunteers assemble cleaning/sanitizing kits for families with infants and young children

Infant Feeding Response Timeline:

9/27/2024
Helene hits WNC

9/30/2024
North Carolina Breastfeeding Coalition (NCBfC) hosts emergency Zoom call inviting all stakeholders statewide/nationally

10/6/2024
23 Infant Feeding Specialists on the ground in Asheville

9/29-9/30/2024
Local infant feeding experts deploy, collaborate, activate

10/2/2024
Stakeholder collaborations become formal & organized
(i.e. communication platforms, donations, coordinated messaging to public, call for volunteers)

10/2024-12/2025: Acute Response
1/2025-3/1/2025: Long term recovery response/ planning
3/2025-Present: Continued recovery and mitigation

SAFE Team: **S**upport and **A**dvocacy for Infant **F**eeding in **E**mergencies

NCBFC SAFE TEAM

NC Breastfeeding Coalition

Breastfeeding Friendly Communities

WNC Families

Gillings/UNC-CH-Carolina Global Breastfeeding Institute

Stakeholders & Volunteers (local, national)

Training as a response strategy in WNC

eLearning Modules (asynchronous)

Introduction to IYCF-E

Feeding Basics

Ideally, prior to arrival, but maybe done as review while onsite

"Classroom" Training & Interactive Skills Practice

SKILLS

Immersive Application in Community

Assembling & delivering supplies/resources

Offering a helping hand and providing care/counsel

Documenting Training Progress, Reflections, and Questions

SAFE Training™ Learning Packet

Training in action:

SAFE Impact Since September 2024

- Facilitated **250,000 oz** of <u>human milk</u>, equivalent to 83,000 infant meals

- Distributed **7,000+** <u>sanitation kits</u>

- Conducted **5,000+** <u>rapid needs assessments</u>

- Trained **500+** <u>emergency and perinatal support personnel</u>

- Directly supported **~260** <u>individual feeding visits</u>

- Collaborated with **~300** <u>relief organizations</u>

- Shared **countless** <u>infant carriers</u>

Nourishing Resilience
SAFE Infant Feeding in Crisis

1 pm ET
2nd Tues.
Begins September

NCBFC
SAFE TEAM

SCAN HERE

Grant-Funded Educational Opportunity for:

Healthcare providers, lactation & childbirth professionals, first responders, community health workers, and volunteers.

Sep. 9, 2025, 1 PM - **History, Mindset, Rapid Needs Assessment, Stress**
Oct. 14, 2025, 1 PM - **Rapid Needs Assessment Practice, Safe Water**
Nov. 11, 2025, 1 PM - **Mitigating Risks – Donations; Safer Formula Feeding**
Dec. 9, 2025, 1 PM - **Mitigating Risks – Families with Babies & Kids Under 3**
Jan. 13, 2026, 1 PM - **Creating Safer Congregate Areas**
Feb. 10, 2026, 1 PM - **Kit Details, Advanced RNA, Support**
Mar. 10, 2026, 1 PM - **Preparing Resilient Communities Pre-Disaster (pt 1)**
Apr. 14, 2026, 1 PM - **Teaching Families, Volunteers, & Site Staff**
May 12, 2026, 1 PM - **Managing On-the-Ground Response**
Jun. 9, 2026, 1 PM - **Preparing Resilient Communities Pre-Disaster (pt 2)**
Jul. 14, 2026, 1 PM - **Influencing Policies for Better Preparedness**

https://us05web.zoom.us/meeting/register/XaVtlONNSZq1OHcVsDpVew

Infant and Young Child Feeding in Emergencies Virtual Interactive Workshops

Free Training Series

Lessons Learned and Action Ideas

What is needed to inform, advocate and implement change

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Chair, NCBfC

Love@breastfeedingcommunities.org

#NHCPC25

Donation Control is VERY important

Your Trash ≠ Treasure

Ideas

Clear messaging and communication strategies about feeding donations

Organizational policy statement on feeding donations

Processes for intercepting unsafe donations

Can you think of others?

ONLY
Accepting
Supplies for Emergency
Infant Feeding Cleaning
Kits

What First Responders Need to Know

Food security INCLUDES infant feeding

Prepared communities respond better

Peer-to-peer and community support is important and powerful

Networking is not "fluff"—it's survival

Cultural humility and equitable practices are essential. Emergencies expose inequities!

Repositories/ resource lists of support contacts within community and surrounding areas is essential

What's still missing?

Awareness

Advocacy

IYCF-E training and education

Lactation support providers/ infant feeding specialists part of response team & deployment processes

Long-term policy and funding support and investment

?

What else?

Can you think of others?

How to get involved and connected:

- Local and state breastfeeding coalitions
- Become a member of your state/ local VOAD (Voluntary Organizations Active in Disaster) or COAD (Community Organization Active in Disaster)
  - NYVOAD and Resources
- Local and state emergency response and preparedness, Departments of Health
- Know your community key players and collaborate
- Do not underestimate the power of networking and collaboration opportunities!
- Do the preparation work in the off season-be proactive, not reactive
- Support key legislation and policy:
  - United States Breastfeeding Committee
  - Global Breastfeeding Collective (WHO and UNICEF)
- Organizations dedicated to IYCF-E
  - IFE Core Group
  - Save the Children
  - ASI-Alimentacion Segura Infantil (Puerto Rico)

What questions do you have?

Love Anderson

CEO Breastfeeding Friendly Communities

Chair, NCBfC

Love@breastfeedingcommunities.org

North Carolina Breastfeeding
Coalition | breastfeeding
advocacy and awareness

Julia Bourg, BSN, RN, IBCLC

Healthcare Manager/ Project Director

Gillings School of Global Public Health

UNC Chapel Hill

juliabourg@unc.edu

Resources - UNC Gillings
School of Global Public
Health

References

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Aunchalee E.L. Palmquist, PhD, MA, IBCLC, Presentation, Mitigating the Risks of Formula Feeding, Jan. 2022

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emergency/about/index.html

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toolkit/php/index.html

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emergencies-toolkit/php/how-to-clean-infant-feeding-items-during-emergencies.html

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https://www.ennonline.net/resources/operationalguidancev32017

In a Natural Disaster or Public Health Emergency. (2020). https://downloads.aap.org/AAP/PDF/DisasterFactSheet6-2020.pdf

SAFE Infant Feeding | ncbc. (2024). Ncbc. https://www.ncbfc.org/safe

#NHCPC25

TRANSFORMATIVE PEDIATRIC & SURGE READINESS:

Catastrophic Capable in Changing Landscape SAVES LIVES

Cynthia Frankel, RN, MN

#NHCPC25

PRESENTERS

- **CYNTHIA FRANKEL, RN, MN**
  - Pediatric Surge Lead, ReddiNet, & EMSC Coordinator
  - Disaster Preparedness Healthcare Coalition (DPHC), Alameda County EMS, California
  - Advisor to Executive Committee, National Pediatric Disaster Coalition
  - Contributes to ASPR Western Regional Alliance for Pediatric Emergency Management
  - California EMSC Technical Advisory Committee

- **SHIRA A. SCHLESINGER, MD, MPH, FACEP, FAEMS**
  - Director of Education & Innovation, Los Angeles County EMS Agency
  - Program Director, Harbor-UCLA - L.A. County EMS Fellowship
  - Emergency Medicine Faculty Harbor-UCLA Medical Center
  - Medical Director, Newport Beach Fire Department.
  - Chair, California EMS for Children Technical Advisory Committee
  - Co-Vice Chair, ACEP EMS Committee
  - Board of Directors of the Council of Accreditation of EMS Programs.

DISCLOSURES

COLLECTIVE DELIVERABLES
- Identifying Pediatric Surge Planning Gaps & Solutions
- Optimizing Access to Best Practices for Multi-Jurisdiction Pediatric Surge PLANS
- Maximizing Readiness & Response Capabilities

RAISING THE BAR: PEDIATRIC SURGE CATASTROPHIC CAPABLE

TRANSLATING MULTI-LEVEL READINESS PLANS INTO EFFECTIVE OPERATIONAL ACTION

TARGET GROUP: EMS for Children (EMS-C), HCC Coalitions, Hospitals, & EMS Providers

➤ **GOAL**: To **strengthen & increase health care system** children's **surge response capability & capacity across state, multi-jurisdiction & health system boundaries & borders**

- o Prioritize children in changing landscape

➤ **MISSION**: To **inspire & leverage** surge & disaster pediatric preparedness plan implementation & **response capability**

- o **Using collective state & multi-jurisdiction pediatric champions & partners**
- o Resulting in response that matches resources to needs for best outcomes

GOALS

DRIVING READINESS & ACTION IN DYNAMIC TIMES

1. Share proposed **"Pediatric Readiness, Surge, & Disaster" components & resources** — **to reframe inclusive & effective pediatric surge plans** & enable optimal health system pediatric surge response

2. Provide **multiple approaches, strategies with benchmarks, & pediatric SME alliances** to support health system plan development & **disaster-resilient health care systems**

3. Facilitate **transformative & sustainable pediatric readiness & surge response recommendations & tools to support Local Concept of Operations (CONOPs)**

https://www.canva.com

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 limited** (including specialty pediatric burn centers & concentration in 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

https://www.canva.com/

- 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 disproportionally affected**
- Benign Neglect
  – Previous National Commission on Children & Disasters Report

Expect children to be impacted in high-consequence disasters

FIRES & RISK TO CHILDREN
EMS & Hospital Challenges 1/8/2025

Eaton Canyon Fire

What is happening with the children & healthcare system?

HEALTHCARE EXECUTIVE

CNN Health

A firefighter battles the Eaton Fire on January 8 in Altadena, California. Ethan Swope/AP

Los Angeles area fires affect hospitals, delaying surgeries and closing clinics

January 10, 2025
By Ron Southwick

Foster Youth in Residential Treatment Forced to Flee Los Angeles Fires in Yet Another Displacement

BY SARA TIANO

SCHOOLS DESTROYED IN WILDFIRES
LOS ANGELES, CA

Fires Burn Los Angeles Schools and Destroy Outdoor Education Sanctuaries

The wildfires tearing through Los Angeles have taken lives and thousands of homes.

Doctors, nurses press ahead as wildfires strain Los Angeles' health care

SUPPLY CHAIN ISSUES: IV SOLUTION SHORTAGE

WHAT HAPPENED?
Specialty Children's Hospitals Prioritized

Baxter's North Cove facility produces **60%** of nations & peritoneal dialysis solution

- Facility's production halted.
- Employees were unaccounted for.
- Flooding & infrastructure breakdown

9/26/2024 - Category 4 hurricane named Helene made land fall near Perry, Florida.

HURRICANE HELENE
11 PM ADVISORY

| PH | PRESS: 938mb | NNE at 24mph | 30.0 N 83.7 W |

Tallahassee
Jacksonville
Gainesville
Daytona Beach
Deltona
Spring Hill
Orlando
Tampa
Palm Bay

HOSPITAL NEAR MISSES & CHALLENGES:

- **Select hospitals & health facilities required evacuation & relocation due to flooding.**
- While remaining operational, many local healthcare providers expressed serious concerns & relied on mobile clinics to reach affected populations.
- **Challenges included potential disruption of supply chains, power outages affecting medical equipment dependent on electricity, & difficulties in accessing healthcare -** potential for long-term health impacts (e.g. chronic & respiratory illnesses due to mold growth in flooded areas).
- **Children face increased risks for depression, anxiety, & post-traumatic stress symptoms due to disruption, displacement, & parental stress**

POSITIVE ASPECTS & RESPONSE:

- **Hospitals in affected areas demonstrated resilience & continued to operate**.
- Direct Relief delivered over medical aid to healthcare providers, including medications for chronic conditions, & other essential supplies.

https://www.cnn.com/2025/07/09/health/anxiety-summer-camps-texas-flooding-wellness

https://www.cnn.com/2025/07/05/us/gallery/deadly-flooding-texas

RGV TIMES

MCALLEN MEDICAL CENTER ADDRESSES FLOODING ISSUES,
TEMPORARILY HALTS VISITATION AND DIVERTS PATIENTS
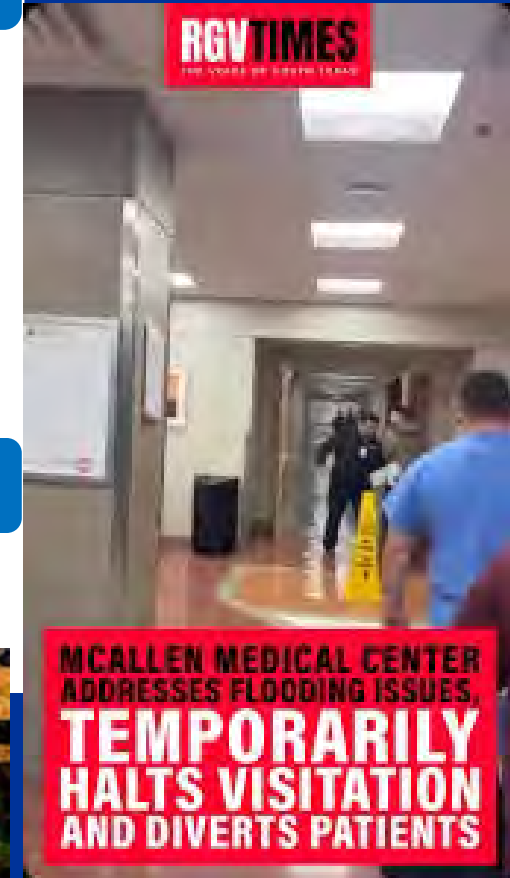
H5N1 Pediatric Risk
EMS & Hospital Challenges

U.N. agency warns bird flu spreading at 'unprecedented' scale, calls for global response

A United Nations health agency has called the spread of H5N1 bird flu "unprecedented" and called on world leaders to coordinate a global response.

By Chris Benson, UPI

Published Mar 19, 2025 9:18 AM EDT | Updated Mar 19, 2025 9:18 AM EDT

Current antivirals likely less effective against severe infection caused by bird flu in cows' milk

Scientists at St. Jude Children's Research Hospital have found that frequently used antivirals do not work well against the H5N1 avian influenza virus in cows' milk.

Memphis, Tennessee, March 17 2025

First U.S. H5N1 Death Sparks Urgency: Scientists Warn That Bird Flu Is Mutating Faster Than Expected

BY TEXAS BIOMEDICAL RESEARCH INSTITUTE – JANUARY 19, 2025 · 4 COMMENTS · 3 MINS READ

As H5N1 Is Detected In San Francisco, A Panel Discusses Next Steps

Last week, the San Francisco Department of Public Health (SFDPH) confirmed that a child in the city became the first case of Avian Influenza-Bird Flu (H5N1). With the Biotech Showcase™ conference

Risk of Highly Pathogenic Avian Influenza A/H5N1 Virus in Pediatrics

C Mary Healy [1]

Affiliations + expand

PMID: 40289622   DOI: 10.1093/jpids/piaf035

Abstract

Highly Pathogenic Avian Influenza A/H5N1 Virus has been found in multiple US states since 2024. While human infection risk is currently low, children are a high-risk group for severe infection as the virus evolves. Preventive efforts should prioritize children in vaccine and therapeutic clinical trials and vaccine implementation strategies.

H5N1 disease in people: H5N1 in people in the US is typically mild, including in children, but there is potential for severe illness.

H5N1 cases in children have been infrequent. Although ages of patients not formally reported by the CDC, it is thought that two of the 70 cases of H5N1 in the US were in children, and both were very mild illnesses. However, a severe case of H5N1 was reported in adolescent in British Columbia, Canada, highlighting the potential for H5N1 to cause severe disease in children.

https://pedspandemicnetwork.org/our-work/h5n1-influenza-information-and-resources/

August 2025, Minneapolis hospital pediatric trauma surge following mass shooting at Annunciation Catholic School.

Gunman fired into church while students & parishioners were attending a back-to-school Mass.

Two primary hospitals involved were Hennepin Healthcare (HCMC) & Children's Minnesota.

Healthcare staff & systems were overwhelmed by sudden influx of patients, requiring treatment for all.

Hospital system swiftly managed high volume of trauma patients, & all 14 children who were injured are expected to survive.

Significant strain for hospitals & staff, in line with established challenges following mass casualty incidents.

Two children dead & 18 others injured, with area hospitals treating a total of 20 victims.

Mourners sign memorial crosses for two children killed in a mass shooting at Annunciation Catholic Church and School in Minneapolis, during a vigil at Academy of Holy Angels in Richfield, Minn.
Tom Baker/AFP via Getty Images

"PEDIATRIC NEAR MISS"
SURGE CAPACITY & CAPABILITY CHALLENGES

Hospitals are safe from Earthquakes, but Access to Health Care Is at Risk
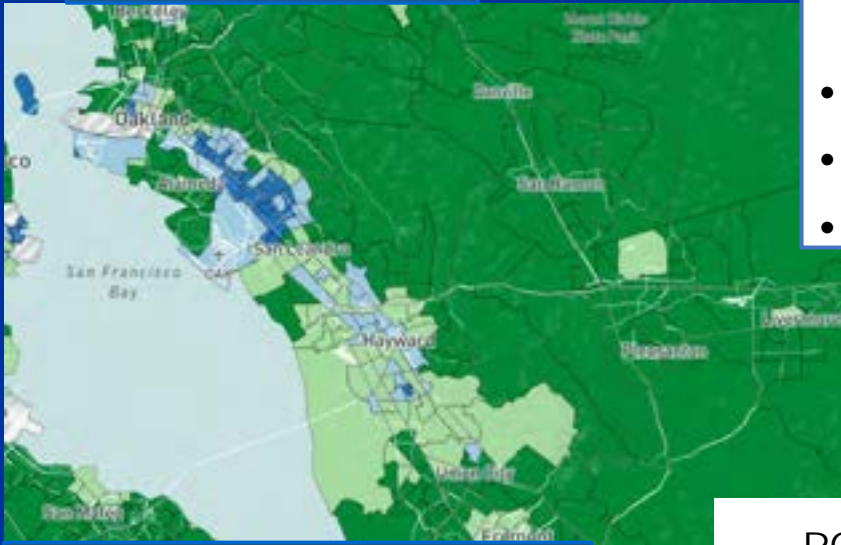
A magnitude 7.0 earthquake struck just off coast near Petrolia, Humboldt County at 10:44 a.m. PST on 12/6/2024.

LESSONS LEARNED

- **LA Fires 2025**
- **RSV & Resp. Pediatric Surge (2022) ***
  - **"Pediatric Tripledemic"**
- **COVID-19 Pandemic – Hospital Surge**
- **Northern CA Firestorms (2017-2022)**
- **H1N1 (2009) ***

The Northern California Earthquake: A Wake-Up Call

Juvare Staff   December 6, 2024

POTENTIAL RISK

- **Civil Unrest 2025**
- **H5N1**
- **Climate Change**
- **Earthquake**
- **Pandemic**

Hayward Fault has documented record of producing magnitude 6.5 to 7 earthquakes about every 140 to 150 years.
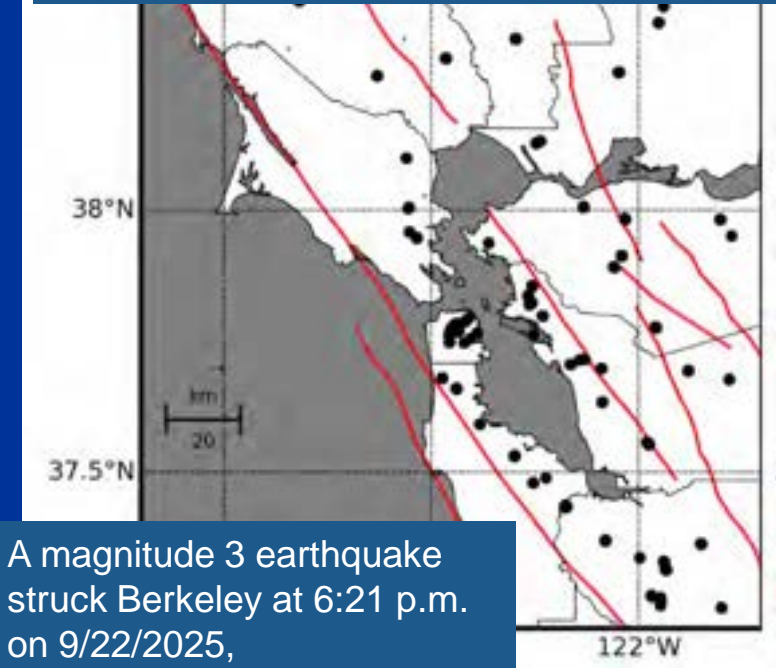
A magnitude 3 earthquake struck Berkeley at 6:21 p.m. on 9/22/2025,

POTENTIAL HOSPITAL IMPACT

- What if <u>increase</u> in need for pediatric critical care beds & limited PICU bed availability?

  (33 PICU BEDS ALAMEDA COUNTY)

California Hospital Association

DISASTER SCENARIOS – Not Catastrophic Enough
WHAT IF PEDIATRIC SURGE?

- **SIMULTANEOUS COMPLEX EVENTS**
  - **RESULTS IN ADULT & PEDIATRIC PATIENT SURGE IN ICU/PICU**
- **PEDIATRIC MCI IN SCHOOLS OR MASS GATHERING EVENT AT MULTIPLE SITES**
- **PEDIATRIC SPECIALTY CENTER HOSPITAL EVACUATION**
- **VIRULENT NOVEL STRAIN &/OR MCI (s)**
  - **IMPACTS PEDIATRIC CRITICAL CARE BED AVAILABILITY**

- **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 <u>local needs & pediatric resource matching</u> 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:**
    - Disruption incident management chains of command
    - A contaminated or contagious environment
    - Loss of infrastructure — Poor situational awareness
    - Interruption Supply Chain

https://www.canva.com/

Requires connected robust Pediatric Readiness & Surge "PLAYBOOK" or "FRAMEWORK"

- Prepared collectively across regions & health systems
- Identifies OPERATIONAL RECOMMENDATIONS FOR ACTION to support State, Multi-Jurisdiction, Coalitions & 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 heath 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

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- **Customize to divergent regions** & operational sections of other plans
- **High-level synthesis & support for many existing plans** – e.g. EOCs, Medical Operation Coordination Cells (MOCCs), HICS – not siloed

Starting Point – PEDIATRIC SURGE FRAMEWORK
CATASTROPHIC CAPABLE

1. **GUIDELINE FRAMEWORK** – **NOT A CONOPS – PROPOSED TOOLS**

   - Recommendations & strategies are provided at a high-level as needs

     & resources of impacted communities will vary dramatically

2. **PILLARS OF SUPPORT for OPERATIONAL RESPONSE**

   - TARGET GROUP: ICS government organizations & EOCs with benefits to healthcare system

3. **DESIGNED TO INFORM "REAL TIME" DECISIONS IDENTIFIES EVIDENCE-BASED CUSTOMIZED PEDIATRIC SURGE SOLUTION OPTIONS**

   - Event specific strategic recommendations, & "best practice" resources for time-sensitive needs

https://www.canva.com/

4. **PROMOTES UNIVERSAL OPERATIONAL TOOLS (standard operating procedures, & guidance for state & multi-jurisdiction ICS with Pediatric Advisor Subject Matter Experts & Resources)**

   PRIORITY COMPONENTS - MODELS, PARADIGMS, & MISSION SETS

   - **PATIENT TRANSFER – Patient Triage, Tracking, Communications, & Load-balancing**
   - **CRITICAL CARE EXPANSION SOLUTIONS - - Across healthcare facilities & systems**
   - **BEHAVIORAL HEALTH**
   - **EVACUATION**

COMPONENT 1
PEDIATRIC READINESS "Day to Day"
Leverage Hospitals & EMS Provider PECCs
Standardized Pediatric Definitions & Tiers
EMSC Regulations & CA Med/Health EOM

COMPONENT 2
PEDIATRIC SURGE PLANS
HOSPITAL SURGE EXPANSION (Critical Care),
Patient Movement, Incident Response Guides, &
Coordinating Pediatric Resources for Critical Needs

COMPONENT 3
PEDIATRIC ICS INTEGRATION
GOVERNMENT CONCEPT OF OPERATIONS ESF8
Hospitals & Prehospital Command Centers (adapt &
support EOCs, HICS, MOCCs)

PEDIATRIC READINESS & SURGE STRATEGIES IN ACTION
BEST PRACTICE RECOMMENDATIONS

Adapt for EOCs, HCC Coalitions, Hospitals,
& EMS Providers

COMPONENT 4
PEDIATRIC SYSTEM-WIDE COORDINATION FUNCTIONS
MHOAC PROGRAM LEVERAGES PEDIATRIC SMEs
(Integrate HCFs, EMS; Behavioral Health, Public Health
(Maternal Child Health), & Social Services)

COMPONENT 6
PEDIATRIC EDUCATION, TRAINING, & EXERCISES
PEDIATRIC SMES & PECCS engaged in Surge
Simulations & Drills across OA Regions

COMPONENT 5
PEDIATRIC CAPACITY & CAPABILITY SITUATION AWARENESS, COMMUNICATIONS, & RESOURCE MATCHING
"BIG PICTURE REAL TIME"– DASHBOARDS; SMART
Sheets; – Utilize Real Time Data with HCC Coalitions,
PECCs & SMEs

Alameda County EMS for Children System Plan
Supports Federal & CA EMSC Program Goals & Regulations

EMSC PARTNERSHIP PROGRAM GOALS

Expand pediatric readiness in hospitals (EDs) & prehospital systems (EMS) by establishing:
1. Standardized pediatric readiness recognition (designation)
2. Pediatric emergency care coordinators (PECCs)
3. Disaster plans address needs of children

Pediatric Emergency Care Coordinator (PECC) Champion
- Oversees pediatric emergency care
- Ensures national/state recommendations for pediatric emergency care (including pediatric-specific policies/protocols, quality improvement, equipment / supplies, & disaster planning).

Hospitals - National Pediatric Readiness Project (NPRP)
Initiative to ensure **EDs** open 24/7 have essential resources to provide effective emergency care for children.

Prehospital Pediatric Readiness Project (PPRP)
Initiative ensures all prehospital EMS agencies that respond to 911 calls have essential resources to provide effective emergency care for children.

"Pediatric Ready"
NPRP/PPRP empowers EDs/EMS to improve capability to provide high-quality care for children.
https://emscimprovement.center/domains/pediatric-readiness-project/

GOAL / PURPOSE

To ensure children receive adequate & appropriate EMS to prevent loss of life & human potential, creating EMSC program.

- To protect welfare, health, & safety of pediatric patients.

- To provide **consistent, equitable, & standardized** criteria statewide

- Provide direction/requirements to local EMS for implementation of EMSC programs

- Clarify **Requirements for LEMSA** to develop & implement EMSC programs

- Create quality improvement for **Pediatric Facility Designations**

- Facilitate **Resources & Training** for prehospital providers & hospital EDs

- **Ensure preparedness (disaster) for providing medical care to pediatric patients, from neonates to adolescents.**

California EMS Authority Regulations (effective January 1, 2025) and Chapter 6.4. Emergency Medical Services for Children

CA EMSC REGULATIONS Pediatric Receiving Center (PedRC) Designation

Pat Frost, Lead
Contractor, Executive Director NPDC, Recommends PedRC Designation Recognition to Alameda County EMS

COMPREHENSIVE

Inpatient resources - NICU & PICU

California Children's Services (CCS) tertiary hospital

- Transfer agreements & regional referral center for specialized care pediatric patients.
- Can provide comprehensive care to any pediatric medical & surgical care child

ADVANCED

Community neonatal intensive care unit (NICU) or as an intermediate NICU

- ED able to stabilize critically ill or injured infant, children, & adolescents prior to admission to PICU or transfer to Comprehensive PedRC facility.
- Establish formal agreements with minimum one Comprehensive PedRC for education/consult
- Participate with Comprehensive PedRC for pediatric education;
- Establish transfer agreements with Comprehensive PedRC
- Establish transfer agreements for pediatric patients needing specialized care
- Specialties on-call & available for consult to ED within 30 minutes: Radiologist – with pediatric experience; neonatologist; general surgeon with pediatric experience; otolaryngologist with pediatric experience.

GENERAL

- Participate with Comprehensive &/or Advanced PedRC for pediatric emergency education
- Establish agreements with Comprehensive PedRC &/or Advanced PedRCs as approved by local EMS Establish transfer agreements for pediatric patients needing specialized care
- Have physician &/or nurse PECC which may be shared with other PedRCs.

BASIC

- Establish agreements with at least one Comprehensive PedRC; Establish agreements with Advanced or General PedRCs; Establish transfer agreements for pediatric patients needing specialized care

CA ALAMEDA COUNTY EMSC PEDIATRIC READINESS SITE VISIT PROJECTS
(INCLUDES SIMULATION TRAINING, & SURGE/DISASTER PREPAREDNESS ASSESSMENT)

GOALS – Positive & Collaborative

- **To conduct assessment of hospital & EMS Provider pediatric readiness**
  - Leverage "Day-to-Day" & Disaster / Surge Event Planning
- **To review NPRP site-visit self-assessment tool & Disaster Checklist**
  - Support CA EMSC regulations, NPRP, & NPPRP process
- **To gather pediatric data per CA EMSC Regs QI**
  - Using hospital data metrics collection tool
- **To conduct in-situ pediatric simulations (ImPACTS) –** includes EMS Patient Transfer of Care
  - Provide expert feedback, recommendations, & opportunities for improvement.
- **To facilitate "Just in Time" pediatric expertise, on-going collaboration & future training**
  - Use SMEs - UCSF Benioff Children's Hospital & ALCO EMS.
- **To inform hospital PedRC Designations**

Target Group – Hospitals & EMS Providers

- EMS Liaisons, PECCs, ED Managers, Medical Directors, & Other Pediatric Experts
- Pediatric Intensivist & Pediatric SMEs
- Emergency Preparedness & Administration

SIM Site Visit Team

UCSF Clinical Pediatric SMEs & ALCO EMS

- Shruti Kant, MD, UCSF Benioff Children's Hospitals, SF
- Daniel Lam, MD, Pediatric Emergency Medicine
- Inder Narula, RN, MSN, FNP, Pediatric ED Educator
- Mary Cervantes, Director/Safety Officer
- Cynthia Frankel, RN & Alameda County & EMS Directors at select sites

HOSPITAL PEDIATRIC SIMULATIONS & DEBRIEF

INCLUDES EMS PATIENT TRANSFER OF CARE TO ED CLINICAL TEAM

**Specialty Children's Hospitals
Not Available – Closed**

Pediatric Scenario Cases Benefits – COMBINED Partners
- Opportunity for In hospital clinicians to observe how EMS/Fire providers conduct prehospital care & interventions, transport, & give full turnover reports to receiving hospitals
- Opportunity for Prehospital providers to observe how critical patients receive care at hospitals

CUSTOMIZED PLAYBOOK INTEGRATES CALIFORNIA PEDIATRIC SURGE PLAN & EOM

RIGHT
- Right Patient, Right EMS Resource, Right Destination

LEVERAGE & INTEGRATE
- Leverage & integrate CA state & regional pediatric medical surge plans with coalitions, patient movement plans; & coordinate ESF8

ENSURE
- Ensure best utilization of region's pediatric resources

MAXIMIZE
- Maximize every asset at all levels of capabilities for all hospitals (including Trauma, PICU,& NICU)

RECOGNIZE
- Recognize coordinated & integrated response requires state ICS; Regional Disaster Medical / Health Coordinator (RDMHS); & Medical/Health Operational Area Coordinator (MHOAC)

STRIVE
- Strive to equitably maximize # of children receiving appropriate level of care (at pediatric & adult hospitals)

CALIFORNIA PLAYBOOK EVOLVING
Integrate California Pediatric Surge Plan

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

September 2021

CDPH
PublicHealth

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**

LOCAL & REGIONAL PEDATRIC SURGE ANNEX

HPP HEALTHCARE COALITION & HOSPITAL RECOMMENDATION

SECTION 2 – CONCEPT OF OPERATIONS - RESPONSE

2.1	Command and Mutual Aid Organizations (include Situation Awarenes; 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

ALAMEDA COUNTY
DISASTER PREPAREDNESS HEALTH COALITION

ALAMEDA COUNTY
DISASTER PREPAREDNESS HEALTH
COALITION (DPHC)
- HCC RESPONSE PLAN -

PEDIATRIC MEDICAL SURGE ANNEX
NOT FOR DISTRIBUTION - WORKING DRAFT - DECEMBER 29, 2020
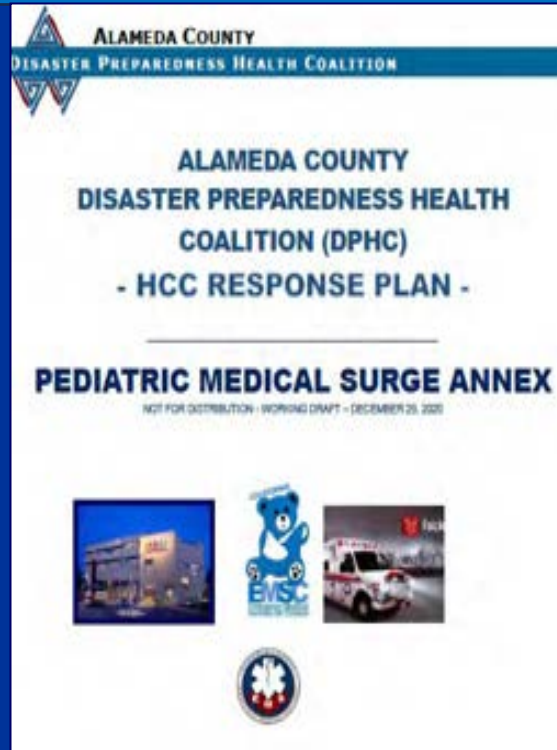
2.5	SPECIAL CONSIDERATIONS – EVENT SPECIFIC
	2.5.1 Behavioral Health
	2.5.2 Decontamination
	2.5.3 Evacuation
	2.5.4 Specialty Pathogens / Infection Control / COVID-19
	2.5.5 Security
	2.5.6 Special Needs
	2.5.7 Burns
2.6	OPERATIONS – MEDICAL CARE & PATIENT MOVEMENT
	2.6.1 Triage
	2.6.2 Treatment / Medical 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

PATIENT EVACUATION TRANSFER FORM

Pediatric Surge PLAYBOOK Tool

ICS PEDIATRIC SME ADVISOR

WRAP-EM
Western Regional Alliance for
Pediatric Emergency Management

PEDIATRIC SURGE PLAYBOOK 2023

Version 1.0
July 25, 2023

Objective: The Pediatric Surge SME makes data-and stakeholder-informed decisions to balance patient load and ensure high-quality care. decisions may direct the movement of pediatric patients (and potentially other resources) from one facility to another, or re-direct referrals that would usually go to an overwhelmed facility or system to one with capacity.

Mission: Advise the Incident Commander or Section Chief, as assigned, on issues related to pediatric care, pediatric transport, and surge response. The **objective priorities** include:
- Collecting, analyzing, and disseminating pediatric healthcare information
- Acting as a single point of contact (POC) for pediatric referral requests exceeding a state's or regions capacity
- Integrate pediatric patient transfer operations and healthcare system monitoring / information management as a function of the state or regional response

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

---

Immediate Response (0 – 2 hours)	T
Receive appointment	

Receive appointment
- Obtain a briefing from the State and/or Regional Incident Commander on:
  - Size, location (s) and complexity of the pediatric incident (s)
  - Expectations of the Incident Commander
  - Incident objectives
  - Involvement of state, regional outside agencies, Health Officer, stakeholders, regional health systems, transfer centers, and other organizations
  - The situation, incident activities, and any special concerns
- Assume the role of Medical-Technical Specialist: Pediatric Surge Advisor SME
- Review this Job Action Sheet
- Put on position identification (e.g., position vest). Position may be in the State/Regional EOC, MOCC, and or PCCC or from a remote virtual location
- Notify WRAP-EM, PPN, and your usual supervisor of your assignment

Assess the operational situation
- Assess/monitor state and/or multi-jurisdiction pediatric situation status and capabilities
  - Hospitals
  - Pediatric Specialty Centers
  - Health System Hubs
  - Transfer Centers
  - Transport Availability and Resources
  - EMS
- Review information as available:

Is the Pediatric SME Advisor assessing EMS Pediatric Capability & Patient Movement Transport Needs in Disasters?

Hospital Incident Command System (HICS)

JOB ACTION SHEETS – Medical-Technical Specialists

Determine availability of transport assets for evacuation or secondary transport. Identify if competition for transport resources &/or if access is regionally coordinated.

Establish time required to mobilize transport assets, if available.

Identify pediatric capabilities of EMS. *

Determine if staff will need to accompany patients & establish how to track/ repatriate staff who assist with patient transport & care.

Verify if transport vehicles are compatible with life support systems needed to keep pediatric patients safe.

Identify equipment required to send with transport for continuing safe care of pediatric patients & establish how to track & repatriate equipment.

Determine duration of transport.

Multi-Sectoral Rescue Chain

Prehospital Disaster Response Plan

Hospital Disaster Response Plan

Patient Distribution

Impact Zone
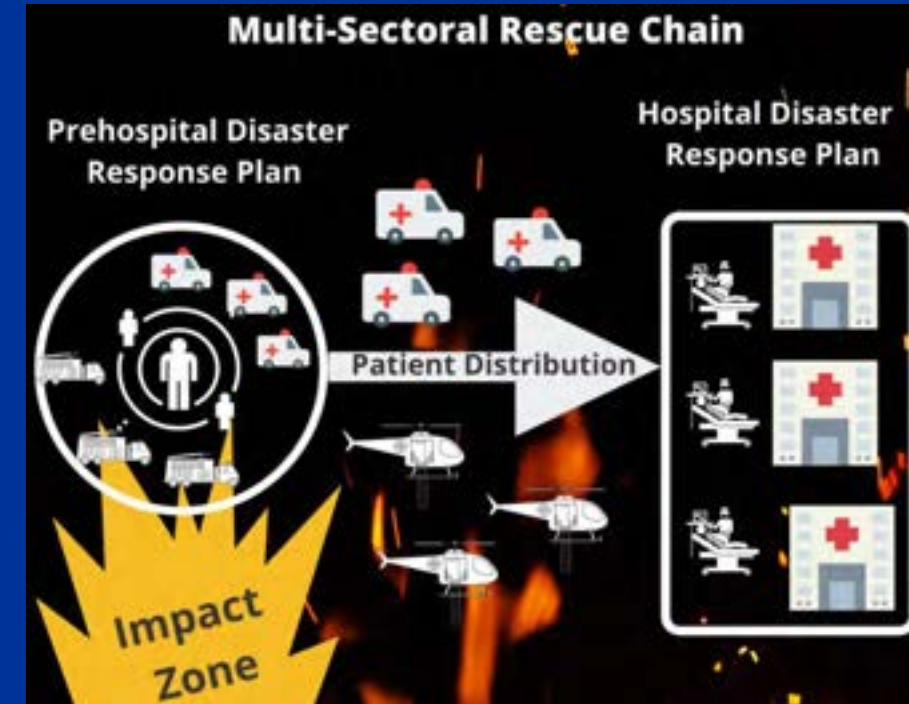
HAvBED

View by: ● Categories ○ Facilities

Available Staffed Beds

Additional Available Staffed Surge Beds

Bed Types	Staffed Beds	Surge Ability
Med/S	49	24
Tele	46	17
ICU	26	14
PICU	2	4
NICU	10	19
PEDS	10	13
OB/GYN	20	23
Trauma	4	7
Burn	0	0
Isolation	27	12
Psych	1	1
OR	10	10
ED	59	52
Other	67	12

ALAMEDA COUNTY HOSPITAL
PEDIATRIC SURGE CUSTOMIZED POLL
Situation Awareness during RSV & Resp. Illness Surge

Reporting Party POC Hospital Name / POC - Date

# of Pediatric Holds or Boards at 4pm yesterday

# of PICU admits boarding in ED

# of NICU Admits boarding in ED

# of Pediatric Transfer Holds

# of Pediatric Critical Care Transfer Requests

# of Pediatric Critical Care Transfer Requests Denied

Is the Pediatric SME Advisor asking the right questions?

# of Staffed Available Pediatric M/S Beds (include Surge Beds

# of Staffed Available PICU Beds (including Surge Beds)

What are your anticipated pediatric surge needs?

Have you submitted a pediatric Resource Request RR? Have you activated Hospital Command Center?

Is your Adult ICU accepting pediatric Critical Patients?
· Is your Adult Gen. M/S accepting Pediatric M/S patients?

Are you using Telehealth for pediatric patients?

PEDIATRIC SURGE EXPANSION MODELS
PANDEMIC – 4Ss OPTIONS

	Decreasing ← Morbidity and Incident demands → Increasing		
	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

Normal ← Operating Conditions → Extreme

CONTINGENCY

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

CALIFORNIA - ALAMEDA COUNTY PEDIATRIC SURGE PLAN
PROPOSED EMS INTERVENTIONS
CRITICAL CARE EXPANSION MODELS — OPTIONS
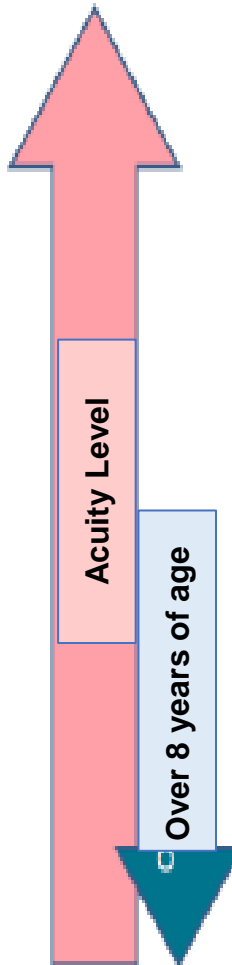
1. Hospitals increase pediatric beds by **5%** above total licensed beds
2. Hospitals with ICU & PICU **double** numbers of staffed beds
3. Hospitals take **5 additional patients** in their ICU & PICU
4. Hospitals increase bed capacity by **10%–20% above licensed beds**

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

CALIFORNIA - ALAMEDA COUNTY PEDIATRIC SURGE PLAN
CRITICAL CARE EXPANSION MODELS — OPTIONS

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 PEDIATIRC BEDS	
NO INPATIENT IN-PATIENT PEDIATRIC BEDS	
- NO PEDIATRIC CRITICAL CARE; NO PEDIATRIC BEDS - - - - - EMERGENCY ROOM ONLY	

Acuity Level

Over 8 years of age

Pediatric Bed Decompression & Expansion Load Leveling

All Community Emergency Departments

Pedi ED Boarding 0-14 yrs

Community Hospitals with No Pediatric Capacity

Pedi Inpatient Bed Expansion >12-14 yrs

Community Hospitals with Nsy/NICU Capacity

Pedi Inpatient Bed Expansion 0-1 yr

Community Hospitals with Pediatric Units

Pedi Inpatient Bed Expansion 0-12 yrs

Pediatric Regional Center

PICU/Complex Care Bed Expansion 0-12 yrs

Expansion

Decompression

scan to Join NPDC

https://npdcoalition.org/

HEALTHCARE COALITION PEDIATRIC SURGE SCENARIOS

Triggers for Pediatric Regional Bed Expansion

https://npdcoalition.org/

Critical Clinical Prioritization – CRRT, ventilator type, IMCU care

Use of PICU beds for appropriate adults age < 25-30

Tele-ICU services added or augmented

Staff shortages with inability to utilize every ICU bed space

Non-emergent surgeries or procedures limited

Adapted staffing plans implemented

Surge ICU bed spaces in use

Contingency

Conventional

- The Minnesota Critical Care Working Group 1: Monitoring and coordinating statewide critical care surge response in the COVID-19 pandemic, March 2020 through July 1, 2021. published Chest online Nov 2024
- Mass Critical Care Surge Response During COVID-19: Implementation of Contingency Strategies – A Preliminary Report of Findings From the Task Force for Mass Critical Care. CHEST 2022; 161(2):429-447

https://npdcoalition.org/

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

LINK WITH MEDICAL HEALTH OPERATIONAL AREA COORDINATOR (MHOAC) PROGRAM

Coordinate with EMS Procurement Center for Pediatrics

Coordinate with pediatric experts in **Regional Healthcare Hubs**, **Hospital HICS**, **Transfer Centers**, & **Jurisdiction ICS** to engage in decision-making

Children's Specialty Center SMEs - **Advise for Effective Decisions**

EXERCISES & PLANNING - CONTINUOUS PROCESS
INTEGRATE PEDIATRIC RESILIENCY & TEST CAPABILITIES with PECCs

2025 "REAL WORLD" CHLORINE PEDIATRIC EXPOSURE AT COMMUNITY POOL - MCI

4/17/25 MRSE Exercise - Chemical / Mass Casualty Incident

Pediatrics are one of the special populations with greater sensitivity

Impacts of Climate Change on Human Health

Rising Temperatures • Mental Health Impacts • Increasing GHG Levels • Rising Sea Levels • More Extreme Weather

Stress, anxiety, depression, sense of loss, post-traumatic stress disorder, strains on social relationships

Air Pollution & Increasing Allergens — Asthma, allergies, cardiovascular and respiratory diseases

Extreme Heat — Heat-related illness and death, cardiovascular failure

Drought — Water supply impacts, dust storms, Valley Fever

Environmental Degradation — Forced migration, civil conflict, loss of jobs and income

Wildfires & Smoke — Injuries, fatalities, loss of homes, cardiovascular and respiratory diseases

Degraded Living Conditions & Social Inequities — Exacerbation of racial and health inequities and vulnerabilities, loss of employment

Changes In Vector Ecology — Lyme disease, West Nile Virus, hantavirus, malaria, encephalitis

Food System Impacts — Malnutrition, food insecurity, higher food prices, foodborne illness

Severe Weather & Floods — Injuries, fatalities, loss of homes, indoor fungi and mold

Water Quality Impacts — Harmful algal blooms, campylobacteriosis, cryptosporidiosis, leptospirosis

CDPH

(Adapted from CDC; J. Patz)

https://www.cdph.ca.gov/Programs/OHE/Pages/Climate-Health-Equity/Health-Impacts.aspx

WRAP-EM Website: Sharing resources

https://wrap-em.org/index.php/pandemics/765-wrbdc-burn-injury-guidelines-for-care-2

Region V for Kids Pediatric Disaster Center of Excellence

Pediatric Disaster Center of Excellence

REGION V FOR KIDS

The mission of Region V for Kids is to build on existing foundations in pediatric clinical care and emergency response by enhancing coordination mechanisms and incorporating relevant capabilities at the local, state and regional levels.

Great Lakes Region (Indiana, Illinois, Michigan, Minnesota, Ohio, and Wisconsin).

Legal Considerations for Providing Pediatric Healthcare During a Disaster

Pediatric Disaster Education

This curriculum will lay the framework for future development of accessibility and engaging educational programs to improve the outcomes of children in disasters, with opportunities to expand to all providers who care for children.

https://www.regionvforkids.org/professional-resources

Legal and Ethics
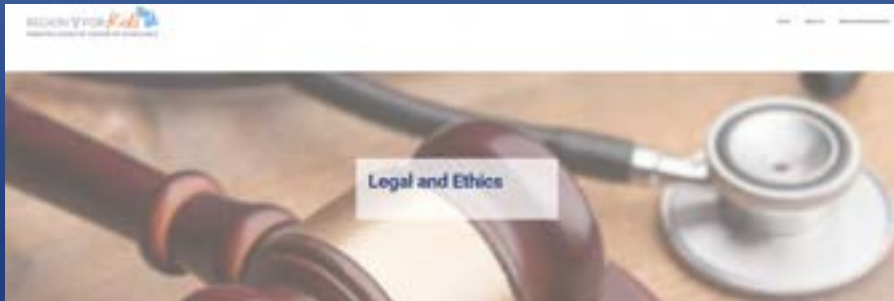
Education

Empowering Pediatric Emergency Preparedness

Disaster Exercises

Preparing for the Unexpected

Resources

Essential Tools for Pediatric Emergency Care

https://www.regionvforkids.org/legal-ethics

https://www.regionvforkids.org/exercises

NATIONAL PEDIATRIC DISASTER COALITION
NPDC BIG TENT MULTI-DISCIPLINARY WHOLE COMMUNITY

IMPROVING PEDIATRIC DISASTER PREPAREDNESS

IMPROVING PEDIATRIC DISASTER PREPAREDNESS

WHAT WE DO

Whereas children comprise approximately one quarter of the US population the mission of NPDC is to advance community preparedness, mitigation, response and recovery for infants and children and their families in disasters.

HOW WE DO IT

We connect diverse individuals, families, communities, and disciplines to evidence-based best practices from the pediatric emergency management and disaster science communities.

Patricia (Pat) Frost RN, PHN, MS, PNP, NPDC Chair
Connecting Novice to Expert Since 2015

https://npdcoalition.org/resources/schools-childcare/

SCAN ME

Risk Assessment Tools and Children

Pediatric Hazard Vulnerability Analysis (HVA)

Impact Score	Determines a hazard's impact on children. Broken into pediatric-specific *impact / severity* categories that mirror PHRAT (*human, healthcare system*, and *community safety infrastructure* impacts) and then novel sub-categories that apply to children.
Vulnerability Score	Incorporates hazard probability into the '*impact score*'.
Overall Risk Score	Allows managers to input their region's and/or hospital's preparedness (using the same categories as the '*impact score*' to gauge overall hazard preparedness.

https://asprtracie.hhs.gov/technical-resources/resource/9972/pediatric-hazard-vulnerability-analysis-template

Child & Youth With Disabilities & Medical Needs
Child Trends Report 2020

Family Poverty

Disparities in Accessing a Medical Home
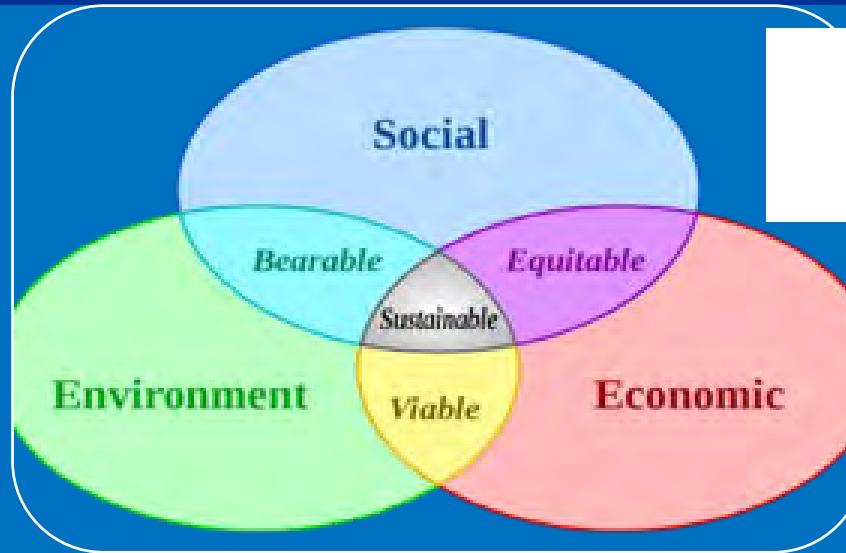
Gaps in Economic Resources

Child Care Difficulties

Miss School & Repeat Grades

1 in 34 Have No Insurance

51

CARE MAPPING

- A visual tool to show the various areas of care families have to navigate

- A way to organize all of the areas of care

- An advocacy tool to show the everyday impacts of caring for individual with complex needs

How to create a Care Map – Boston Children's Hospital
https://www.childrenshospital.org/integrated-care/care-mapping
Video tutorial from Family Voices in Wisconsin
https://www.youtube.com/watch?v=8tuMwj28o00

https://npdcoalition.org/#

NYC Pediatric Disaster Coalition

- Established in 2008 to prepare NYC for a catastrophic pediatric mass casualty event
- Funded by U.S. Department of Health and Human Services, Administration for Strategic Prepa Response/Hospital Preparedness Program via the NYC Department of Health and Mental Hygiene
- Originally part of Schneider Children's/Long Island Jewish Medical Center (2008 – 2012)
- Headquartered at Maimonides Medical Center in Brooklyn, NY since 2013
- Serving approx. 20% of NYC's total population - includes over 1.74 Million residents under 18 yrs old (est.)

NYCPDC Membership / Network In beginning 2008!

28 Hospitals, OEM=NYCEM
New Names New Systems

NYCPDC Coalition Based Regional Planning and Response

- NYC Pediatric Disaster Plan (Draft)
- **24/7 Pediatric Intensive Care Response Team for SME and Response, including patient prioritization, triage for transport**
- Developed ASPR Pediatric Surge Annex to overall NYC Disaster Plan
- Exercise and disaster planning toolkit
- **Disaster planning implementation – PICU, NICU, pediatric unit, outpatient, obstetrics, long term care**
- Exercise planning and conduct (operations and discussion based)
- Essential elements of information – primary and secondary transport
- **Pediatric Fundamentals of Critical Care Support Courses**

- Pediatric webinar series
- NYC pediatric infectious disease annex
- **NYC pediatric burn annex**
- NYC pediatric chemical and radiation annexes
- **Pediatric NYC gap analysis**
- Pediatric NYC needs assessment survey
- Pediatric NYC home care preparedness survey
- **Pediatric Medical Operations Coordination Cell (Still to be finalized and operational)**
- Borough of Queens Pediatric Data Collection
- Countless lessons learned and sharing of best practices
- The list goes on!

https://www.programinfosite.com/pediatricdisastercoalition/about-us/

REGIONAL PEDIATRIC PRIORITY SURGE PLANNING
CALL TO ACTION
Momentum into the Evolving Future

TRANSLATING EFFECTIVE PLANS INTO OPERATIONAL REGIONAL ACTION

- **Customize & Implement PLAYBOOK components "day to day" with response partners**
- Integrate Pediatric Surge PLAYBOOK in Health System-Wide EOPs not just Coalition Plans
- **Coordinate & integrate collective health system corporate command & coalitions**
- **Test pediatric PLAYBOOK/CONOPS (coordinating Pediatric EEIs across regions)**
- **Use Hospital Pediatric Site Visits & Pediatric Emergency Care Coordinators (PECCs)**
- **Use Operational "Just in Time" Tools (e.g. Activation, Expansion, & Behavioral Health)**
- **Join WRAP-EM, NPDC, PPN, & Regional Alliances; Connect across states & coalitions**
- Expand CONOPs & partners for changing landscape & new baseline for catastrophic events
- **Campaign to inspire & strengthen regional pediatric surge response capability**

https://www.canva.com

DRIVING PEDIATRIC READINESS ACTION INTO THE FUTURE

https://www.canva.com

With new challenges amid rapidly changing landscape & implications for how we approach pediatric & surge readiness, continue with heart, purpose, & commitment to make a difference for children.
~Thank you ~

- **CYNTHIA FRANKEL, RN, MN**

- EMS for Children, Pediatric Surge Lead, ReddiNet, & EMS Coordinator

- Alameda County Emergency Medical Services, California

- (510) 295-9601 (cell); Cynthia.Frankel@acgov.org

- --

- **Western Regional Alliance for Pediatric Emergency Management (WRAP-EM)**
  - **https://wrap-em.org/**
- **Pediatric Pandemic Network (PPN) https://pedspandemicnetwork.org/**
- **National Pediatric Disaster Coalition (NPDC) https://npdcoalition.org/**
- **National Pediatric Readiness Project (NPRP) for Hospitals**
  - **https://emscimprovement.center/domains/pediatric-readiness-project/assessment/**
- **National Prehospital Pediatric Readiness Project (PPRP) for EMS Providers**
  - **https://emspedsready.org/**

So how does it work?

https://npdcoalition.org/#

How L.A. County Improved Pediatric Readiness
 (with resources you can use)

People Doing the Work Presented

Erika Cheung, MSN, RN, CPN
Emergency Preparedness Manager
Children's Hospital Los Angeles (CHLA)

Alex Lichtenstein
Assistant Director, Office of Emergency Preparedness

Kurt Kainsinger
Director, Office of Emergency Preparedness

Ronald Reagan-UCLA Medical Center

Essence Wilson, BSN, PHN, MICN
Disaster Program Manager
L.A. County EMS Agency,
Disaster Services Section

Steve Shrubb, RN, BSN
Disaster Coordinator
Miller Children's & Women's Hospital Long Beach

2009 H1N1 Influenza Pandemic

- In the USA, 317 children died of H1N1 during 2009 pandemic
    - Of 838 admitted to PICUs , 67.3% required ventilation (564)
- Pediatric death rates up to 10x the rates for seasonal influenza

PEDIATRICS

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

▶ Pediatrics. 2011 Dec;128(6):e1450–e1458. doi: 10.1542/peds.2011-0774 ⧉

Critically Ill Children During the 2009–2010 Influenza Pandemic in the United States

Adrienne G Randolph [a,b,æ], Frances Vaughn [c], Ryan Sullivan [a], Lewis Rubinson [c], B Taylor Thompson [d], Grace Yoon [a], Elizabeth Smoot [d], Todd W Rice [e], Laura L Loftis [f], Mark Helfaer [g], Allan Doctor [h], Matthew Paden [i], Heidi Flori [j], Christopher Babbitt [k], Ana Lia Graciano [l], Rainer Gedeit [m], Ronald C Sanders [n], John S Giuliano [o], Jerry Zimmerman [p], Timothy M Uyeki [q]; for the Pediatric Acute Lung Injury and Sepsis Investigator's Network and the National Heart, Lung, and Blood Institute ARDS Clinical Trials Network

H1N1 VACCINATION CLINIC TODAY 12-22-09 10AM-7 PM

This APPROPRIATELY SCARED us!

- What if… a surge of children requires ventilation?
- What if… kids show up to community hospitals?
- What if… we don't have capacity to effect the transfers…?
- We weren't prepared…

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- What if… a surge of children requires ventilation?
- What if… kids show up to community hospitals?
- What if… we don't have capacity to effect the transfers…?
- We weren't prepared…

L.A. County Pediatric Surge Plan

- Regional plan, multilateral partnership
  - Led by the LA County EMS Agency
  - Involving the main children's hospitals
    - Children's Hospital Los Angeles (CHLA),
    - Mattel Children's Hospital
    - Miller Children's & Women's Hospital
  - Representatives of facilities with limited pediatric capabilities

Los Angeles County
Pediatric Acute Surge Plan

EMERGENCY MEDICAL
SERVICES AGENCY
LOS ANGELES COUNTY

Effective: May 2013
Last Edited: August 2024

APPROVED: _Richard Tadeo_
Director, EMS Agency

Medical Director, EMS Agency

L.A. County Pediatric Surge Plan

- Regional plan, multilateral partnership
- Includes justification & gap analysis
- Considers children with special needs
- Tiered response
- ALL hospitals involved
  - Lower tier hospitals for stable and decompression

Figure 1 - Population density map

Number of children per zip code

10,000

4,000

0
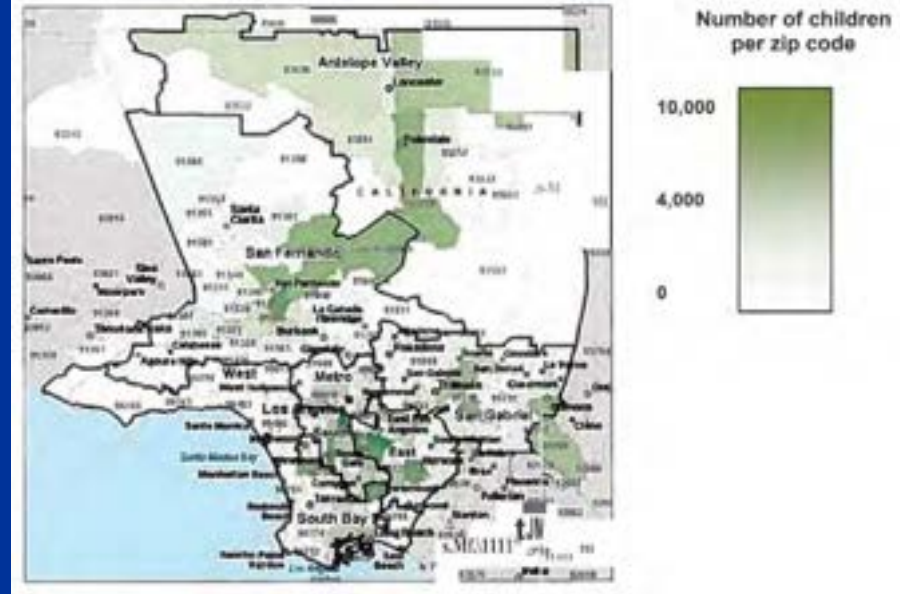
Figure 2 - Population and beds by Service Planning Area

Service Planning Area (SPA)	Pediatric Population	Licensed PICU Beds	Total Capacity During Pediatric Surge	Licensed Beds per 100 Children
Antelope Valley	113,511	0	22	0.19
East	379,976	0	105	0.28
Metro	283,977	97	385	1.36
San Fernando	532,864	18	90	0.17
San Gabriel	459,786	8	11	0.24
South	340,370	0	14	0.04
South Bay	388,105	30	199	0.51
West	107,981	24	57	0.53

Figure 5 - Surge target goals

Bed Type	Current Staffed Beds	Surge Goal- 100% of surge capacity	Total Capacity During Pediatric Surge
PICU	141	141	282
Pediatric Acute Beds	806	806	1612

Source: OSHPD Year Ending June 2010

L.A. County Pediatric Surge Plan

- Regional plan, multilateral partnership
- Includes justification & gap analysis
- Considers children with special needs

Emergency Empower Squad™: An Access and Functional Needs Response Team

Empower Pack – Reference Guide

L.A. County Pediatric Surge Plan

- Regional plan, multilateral partnership
- Includes justification & gap analysis
- Considers children with special needs
- Tiered response
- ALL hospitals involved
  - Lower tier hospitals for stable and decompression

Figure 1 - Overview of Patient Distribution by Tier

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

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 Inpatient Bed
Tier 5	Emergency Department Approved for Pediatrics (EDAP) do not provide inpatient pediatric services
Tier 6	No Pediatric Services
Tier 7	No Emergency Services/ Specialty Centers

Acuity Level

Over 8 years old

All Hospitals Incorporated in Surge Response

Changing with the Changing Landscape

- **2022 Tripledemic**
  - RSV, COVID & Flu, oh my!

- **2023 Medical Response Surge Exercise**
  - Scenario: Pediatric trauma surge

- 2013 plan → 2024 plan

RESEARCH AND BREAKTHROUGHS

U.S. Hospitals Lost Almost 30% of Pediatric Inpatient Capacity Over a Decade

January 6, 2025 | by Wendy Wolfson

Changing with the Changing Landscape

- **2022 Tripledemic**
  - RSV, COVID & Flu, oh my!

- **2023 Medical Response Surge Exercise**
  - Scenario: Pediatric trauma surge

- 2013 plan → 2024 plan

Los Angeles County
Pediatric Acute Surge Plan

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Effective: May 2013
Last Edited: August 2024

APPROVED: *Richard Tadeo*
Director, EMS Agency

Medical Director, EMS Agency

Great for Los Angeles, but what about…

Steps that regions and hospitals can take

Resources Exist to Support Pediatric Preparedness

- Public-private collaborations

- ASPR Funded

- Sharing best practices & resources in preparedness, response, & recovery

Gulf-7 **Pediatric Disaster Network**	**Region V or Kids**	**Western Regional Alliance for Pediatric Emergency Management (WRAP-EM)**
Awarded in 2022	Awarded in 2019	Awarded in 2019
Anchored at Texas Children's Hospital (Houston, TX)	Anchored at UH Rainbow Babies & Children's Hospital (Cleveland, OH)	Anchored at UCSF Benioff Children's Hospital (Oakland, CA)
7 U.S. states/territories: AL, FL, GA, LA, MS, TX, Puerto Rico	6 U.S. states: IL, IN, MI, MN, OH, WI	6 U.S. states: AZ, CA, NV, OR, UT, WA

Template Are Ready

- Creating a plan *de novo* is lengthy and unnecessary
- You can use an AI "friend" to create the bones of yours
  - Requires HUMAN evaluation and adjustment!!

https://lapedsready.org/index.php/clinical-care-resources/

Where should we begin?

create a pediatric surge plan for a 64 bed hospital that normally has 6 licensed pediatric beds and no PICU but does have a 4 bed NICU
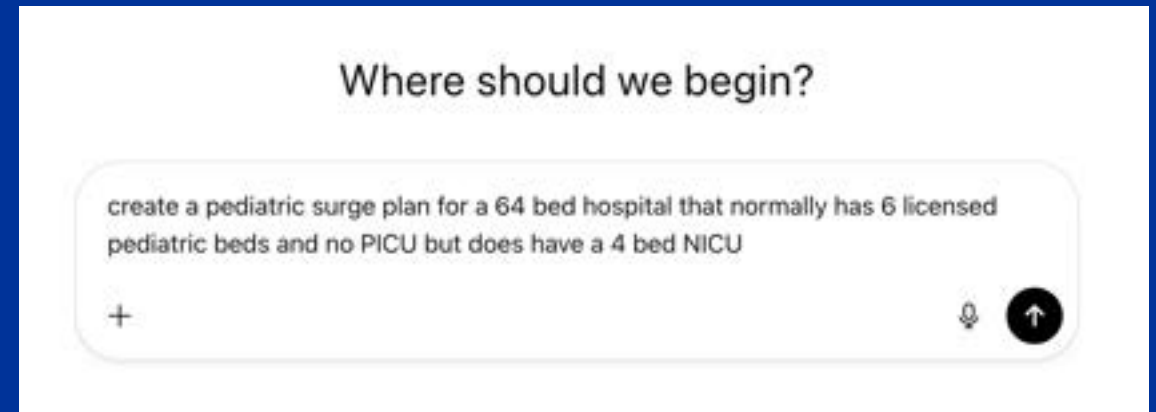
Empower EMS Agencies to Participate in Surge Response

https://emscimprovement.center/domains/prehospital-care/prehospital-pediatric-readiness/pprp-toolkit/

Package Cross-Training & Tools

- Prepare for role-flexing adult to pediatric care

https://www.regionvforkids.org/peds-disaster-edu

Package Cross-Training & Tools

- Prepare for role-flexing adult to pediatric care
- Adapt existing education & resources

https://wrap-em.org/

Package Cross-Training & Tools

- Prepare for role-flexing adult to pediatric care
- Adapt existing education & resources

Emergency Empower Squad™: An Access and Functional Needs Response Team

Children's Hospital LOS ANGELES

Patient Communication Script: General Reassurance and Comfort

Age Group	Example Script	"Preparing to Go" Language	"We Need to Go" Language
Ages 3-7	Hey there! Sometimes places feel a little too bright or noisy, and that's okay! I have some cool sunglasses and super-soft headphones that might help you. If you need a little break, we can take a deep breath together. I'll be right here!	If we ever need to leave [this room or this building], don't worry - I'll be with you every step of the way, just like a superhero team!	To stay safe, we're going to go together to a new place. I'll bring your favorite toy or comfort item with us.
Ages 8-12	Sometimes places can feel busy or loud, and that's okay! When you feel this way, it might help you to find a quiet spot or just take a deep breath. I have some headphones and sunglasses that might help you. Let me know if you need some help.	If we ever need to leave [this room or this building], I'll help guide you to a safe spot. We'll stick together.	To stay safe, we're going to go together to a new place. If you need anything like your fidget toy or backpack, I'll make sure you have it before we go.
Ages 13-18	I know things can feel overwhelming sometimes. When you feel this way, it might help you to pause and take a deep breath. If you need a quiet space, headphones, or other tools, let me know. I'm here to help.	If we need to leave [this room or this building], I'll let you know what's happening and help you get to where we need to go.	To stay safe, it's time to move to another area. I'll make sure you have anything you need - just let me know what helps you feel most comfortable.

Southern California Wildfires of 2025

- Pediatric expertise, community preparation
- **Children's Hospital Los Angeles (CHLA)**
  - Prepared for surge of respiratory cases
  - Advised local schools on outdoor activity safety.
- **Miller Children & Women's Hospital**
  - Shared pediatric resources to proximate hospitals
- **Ronald Reagan UCLA Medical Center (RR-UCLA)**
  - Reviewed pediatric evacuation plans with fire leadership
  - Coached NICUs on reverse triage & evacuation

In Summary

- Pediatric Readiness and Response plans provide a framework to save lives in pediatric surge
- Constitute resilient, sustainable, and flexible solutions
- Can align with existing plans & established infrastructure
- Benefit from regional cooperation, pediatric expertise, and input from end-users
- Templates & resources exist for your facility/agency