



Central Florida Disaster Medical Coalition Operations Plan Annex G - Pediatric Annex

Attestation:

Approved by CFDMC Board on 6-21-22

A handwritten signature in black ink, appearing to read "Eric Alberts", with a large, sweeping flourish extending to the right.

Eric Alberts, CFDMC 2022 Board Chair

Table of Contents

1. Introduction.....	5
1.1 Purpose	5
1.2 Scope	5
1.3 Background	5
1.3.1 Coalition.....	6
1.3.2 The Florida Public Health Risk Assessment Tool (FPHRAT).....	7
1.3.3 Pediatric Risks	7
1.3.4 County Level Risk Analysis	8
1.3.5 Pediatric Medical Surge Response Strategies	10
1.4 Access and Functional Needs.....	11
1.5 Planning Assumptions.....	11
1.6 Surge Event Triggers.....	12
2. Concept of Operations	12
2.1 Activation	13
2.2 Notifications.....	13
2.3 Roles and Responsibilities.....	13
2.3.1 Command and Coordination.....	13
2.4 Logistics.....	14
2.4.1 Space	14
2.4.2 Staff	14
2.4.3 Supplies	15
2.5 Regional Trauma Coordination Center	17
2.5.1 Transportation.....	17
2.5.2 Tracking	18
2.6 Sheltering Medically Complex Children	18
2.7 Reunification	18
2.8 Deactivation and Recovery.....	18
2.9 Training and Exercise.....	19
3 Legal Authorities.....	19
4 Regional Resources & References.....	20
4.1 CFDMC's Area Assets:	20

4.2 CFDMC's Subject Matter experts:	21
4.3 Acronyms/ Abbreviations	23
4.4 Resources/ References.....	24

CFMDC recognizes the members of the Region 5 Pediatric Workgroup for their leadership in updating this plan:

Robin Ritola, AdventHealth, CFDMC Pediatric Clinical Champion

Eric Alberts, Orlando Health
Shane Friedman, Cleveland Clinic
Jodie Gregory, Orlando Health
Jackie Hop. UCF
Kelley Jenkins, Lawnwood
Jason Klein, Nemours
Sven Normann, Orlando Health
Cat Sullivan, Focus Forward
Elizabeth Todak, Seminole State College
Beth Tucker, Children First
Erica Westerholm, AdventHealth

Record of Changes & Distribution

Changes	Distribution
Original annex created 5/19/20	Approved by Board, Distributed to Members, and Posted to Website
Update May 2022 (updated resources)	Sent out for 30 day member review Approved by Board 6/21/22 Posted to Website 6/30/22

1. Introduction

1.1 Purpose

The purpose of the Central Florida Disaster Medical Coalition (CFDMC) Pediatric Surge Annex is to provide a functional annex for all stakeholders involved in an emergency response within the Florida Regional Domestic Security Task Force Region 5 in order to protect children and to provide appropriate pediatric medical care during a disaster. This annex is intended to support, not replace, any agencies' existing policies or plans by providing coordinated response actions in the case of pediatric emergency. This annex enables local providers and other health care partners to plan collaboratively for the risks facing the health care community and identify available local resources.

The goal of this plan is to develop a regionwide pediatric disaster surge plan for the management of an unusual incident or event that overwhelms a local healthcare system's capacity to triage, stabilize, and transfer pediatric patients to a treatment facility outside of the affected hospital's area.

1.2 Scope

This plan is designed to provide a guide for state and local health care partners to:

- Enhance pediatric triage decision-making to prioritize transfers/ treatment.
- Enhance standardized care guidelines as needed.
- Ensure coordinated and consistent communications processes are in place.
- Support the tracking and placement of pediatric patients throughout the incident.
- Identify strategies to manage surge and scarce resources.
- Assist with the coordination of transferring acutely ill/injured pediatric patients to pediatric tertiary care centers/specialty care centers.
- Assist with the decompression from pediatric tertiary care centers/specialty care centers to make additional critical care beds available for acutely ill/injured pediatric patients.

For this plan, the following pediatric age groups were used to define the pediatric population and determine special age group related considerations:

- Neonates (Birth to 28 days of life)
- Infants/toddlers (0 - 24 months)
- Toddlers/preschoolers (2 - 5 years)
- School aged children (6 - 13 years)
- Adolescent children (14 - 17 years); and children with underlying complex medical conditions. (It is important to note that some children with special needs who are over 15 and experience chronic pediatric conditions such as cystic fibrosis, cerebral palsy, and others will likely require specialized attention during a disaster.)

1.3 Background

1.3.1 Coalition

The Central Florida Disaster Medical Coalition's (CFDMC) mission is to develop and promote health care emergency preparedness and response capabilities in the East Central Florida Domestic Security Task Force Region 5 (RDSTF Region 5), including the following nine counties: Brevard, Indian River, Lake, Martin, Orange, Osceola, Seminole, St. Lucie, and Volusia counties. Region 5, also commonly known as Central Florida, is uniquely vulnerable to a disaster/emergency impacting children. In 2019, the Central Florida population exceeded 4.2 million, with a higher than average percentage of children under age 5 (6.3 percent as compared to the national average of 6.1 percent). Central Florida has a large population of medically complex children, with more than 2,100 on a waiting list to receive services. Domestic and international tourists flock to Central Florida; with 72 million visitors in 2018, it is the number one most-visited destination in the world. Orlando International Airport had more than 47 million passengers in 2018. Visitors also arrive in Central Florida via cruises at Cape Canaveral, Florida's fastest growing port and the second busiest port in the world. These factors make Central Florida vulnerable to an emerging infectious disease. Central Florida's tourist industry specifically targets children and families. 2015 statistics (latest publicly available) showed Walt Disney World Magic Kingdom as the most visited theme park in the world, averaging almost 53,000 guests per day; and Universal Studios' attendance grew to 8.3 million annually, compared with 7.1 million in 2014. Brevard, Indian River, Martin, St. Lucie, and Volusia, counties all border the Atlantic Ocean, making these and other counties just inland vulnerable to hurricanes. The Federal Bureau of Investigation's (FBI's) investigation of the Pulse nightclub shooting in Orlando determined the perpetrator initially planned to target Walt Disney World. Central Florida also poses a unique threat in radiation exposure to pediatric patients. Medical sources such as Cesium 137 and Cobalt 60 are present in medical radiation therapy devices, and Department of Defense contractors such as Northrop Grumman and Lockheed Martin conduct research with radiological sources. Additionally, NASA has been conducting shuttle launches this year as part of their Mars exploration program, with shuttles carrying a radiological payload. All of these make the potential for a mass casualty incident impacting children in Central Florida extremely high.

Florida is the third most populous state in the US, where 20% of residents are children less than 18 years of age. Our Region has 46 acute care hospitals, 16 Stand Alone ED's and 3 actual Children's Hospitals and other hospitals with pediatric Units or capabilities. Access or transfer to pediatric care is usually easily accommodated by in-state children's hospitals, as well as burn and trauma centers.

1.3.2 The Florida Public Health Risk Assessment Tool (FPHRAT)

The FPHRAT captures information in a residual risk matrix that produces a risk, capability and resources gap analysis for each hazard by county. Access is managed to allow county planner(s) to rank capability functions, resources, and hazards. The FPHRAT is a collaborative project involving local, regional, and state partners. This tool helps planners to create jurisdictional risk assessments by assessing the 15 Centers for Disease Control and Prevention (CDC) Preparedness Capabilities and local resources, producing gap analyses; estimating the impacts of hazards to public health; healthcare, and mental health; measuring the positive effect of mitigation factors such as community resilience; producing a final matrix of residual risk; and exploring county, state and regional data queries.

CFDMC uses the FPHRAT to inform their annual planning and develop training and exercises to meet the gaps and risks outlined in the Joint Risk Assessment (JRA). The CFDMC collaborates with state and local public health, as well as Emergency Management officials and organizations to develop their annual JRA.

1.3.3 Pediatric Risks

Children have unique anatomic, physiologic, developmental and medical needs that differ from those of adults. Furthermore, pediatric patients require size-specific equipment and caregivers trained to use that equipment. These characteristics also present the caregiver with significant challenges.

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

1.3.4 County Level Risk Analysis

Unique risks for pediatric-specific mass casualty events (e.g., evacuation of a pediatric hospital, etc.) by County:

County	Risk	Number of Potential Patients	Gaps
Inland Counties	All three children's hospitals in the region are in Orange County.	Unknown	Potential to over stress region's pediatric capabilities
All	In an event, it will be difficult to identify children and safely match them with parents and guardians.	All	Need reunification process for unaccompanied minors and need to have a designated pediatric safe area at each hospital to hold

			the medically clear minor until reunification can occur.
Coastal Counties	Drownings and large beach gatherings such as spring break	Unknown	Trauma System Support Committee promotes drowning prevention activities across the region
All	Although most hospitals have identified facilities for transfer in an event, most do not have formal transfer agreements		Formalize transfer agreements
All	ECMO patients	Unknown	Additional planning
Seminole	Pediatric Pavilion Inc (407-513-3000)	32	Additional planning
All Counties	Pediatric Heavy Events i.e., Science Center, Universal, Disney, SeaWorld	Hundreds	Adequate number of staff, physicians, specialty centers. Dr Phillips ED has Peds beds if patients could be transferred there.
All Counties	Specialty events and locations such as Give Kids the World.	Hundreds	Arnold Palmer and Winnie Palmer are in Orange County. AdventHealth Celebration has a dedicated Children's Emergency Center with the capabilities of obtaining additional support during a surge event. Nemours Children's Hospital is also in Orange County.

Region 5 breakdown by age (2018):

County	0-4	5-15	0- 15	All Age Totals	% Pedi Pop (0-15)
Brevard	27,633	67,000	94,633	584,050	16%
Indian River	6,323	15,442	21,765	152,079	14%
Lake Martin	17,032	41,265	58,297	342,356	17%
Orange	84,920	186,920	271,840	1,370,447	20%
Osceola	22,882	54,932	77,814	360,426	22%
Saint Lucie	15,771	38,016	53,787	304,743	18%
Seminole	24,698	61,329	86,027	463,627	19%
Volusia	25,375	58,449	83,824	532,926	16%
Total:	205,671	480,927	686,598	3,733,433	17%

1.3.5 Pediatric Medical Surge Response Strategies

	Conventional Capacity	Contingency Capacity	Crisis Capacity
Supplies	<ul style="list-style-type: none"> <input type="checkbox"/> Facilities are able to order more supplies through normal channels. 	<ul style="list-style-type: none"> <input type="checkbox"/> Stockpiled supplies are being used. <input type="checkbox"/> Supplies are being ordered through rushed delivery methods. <input type="checkbox"/> Resource requests to local health jurisdictions and Emergency Management. 	<ul style="list-style-type: none"> <input type="checkbox"/> If local partners cannot fill demand, requests may be made up to the state level.
Space	<ul style="list-style-type: none"> <input type="checkbox"/> Cancel elective procedures. <input type="checkbox"/> Use in-place elective procedures. <input type="checkbox"/> Begin surge discharge. 	<ul style="list-style-type: none"> <input type="checkbox"/> Clear patients from pre-induction and procedure areas. <input type="checkbox"/> Fill all available beds. <input type="checkbox"/> Begin bed availability reporting. 	<ul style="list-style-type: none"> <input type="checkbox"/> Decompress hospitals. <input type="checkbox"/> Request state support of transportation resources. <input type="checkbox"/> Place patients in hallways or lobby areas, as needed. <input type="checkbox"/> Set up temporary structures in order to increase space capacity. <input type="checkbox"/> Request use of other facilities.
Staff	<ul style="list-style-type: none"> <input type="checkbox"/> Use all staff trained to care for pediatrics to provide care. 	<ul style="list-style-type: none"> <input type="checkbox"/> Request additional pediatric trained staff from other hospitals. 	<ul style="list-style-type: none"> <input type="checkbox"/> Request staff support from the state. <input type="checkbox"/> Utilize staff not trained for pediatric care after providing just-in-time training.

The Coalition has one (1) Level I trauma center and one (1) Level I pediatric trauma center, and five (5) Level II trauma centers. All hospitals within the Coalition have limited capability to provide comprehensive medical care to pediatric populations with traumatic injuries. Most hospitals within the Coalition have limited capability to provide comprehensive medical care to some pediatric populations. While some hospitals may provide care services to pediatric populations, all three of the acute care children’s hospitals in the Coalition have the capability of a Pediatric Intensive Care Unit (PICU), 12 hospitals offer Neonatal Intensive Care Units (NICU), four offer Level 3 NICU care (Advent Health, Winnie Palmer, Nemours, and Halifax). We have 12 hospitals offering Neonatal Intensive Care Units (NICU) Level 2 and four hospitals offering NICU Level 3 care with two offering ECMO services.

1.4 Access and Functional Needs

Caring for pediatric patients, as opposed to adults, may include several unique needs such as:

- Family/guardians being present while pediatric patients receive care.
- Ensuring pediatric patients are not left alone.
- Consent for health care may need to be granted before pediatric patients are transported/treated.

1.5 Planning Assumptions

This annex has been designed with the following assumptions in mind and includes, yet is not limited to, the following. These are non-binding assumptions that should be addressed at the beginning of a response and determined if applicable.

- The decision to activate this annex is based upon a real or perceived lack of capacity of a singular area hospital to support a response to a Health Care Coalition Pediatric Surge Annex without additional support.
- Planning and response under the Health Care Coalition Pediatric Surge Annex will be coordinated with the local Health Care Coalition, and local and State ESF-8, as needed.
- Planning and response under the Health Care Coalition Pediatric Surge Annex will be coordinated with other facility-specific response and emergency operations plans, as needed.
- Activation of this annex will be communicated with the Health Care Coalition, as needed.
- If a hospital's Emergency Operations Plan (EOP) has been activated, the Hospital Incident Command System (HICS) will be used throughout the duration of the hospital's emergency response.
- All hospitals providing emergency services are equipped to initially treat and stabilize pediatric patients in accordance with their available resources. All hospitals have differing capacities and capabilities of treating and stabilizing pediatric patients; however, all hospitals can at minimum provide initial triage and resuscitation for pediatric patients.
- Each hospital has an updated medical surge plan to fully maximize and leverage their facility and organization.
- Each hospital has pediatric patient transfer agreements in place.
- Whether a child meets pediatric age will be determined at the time of the incident and follow both organizational definitions and assessment of physical maturity and anatomical characteristics of the patient.
- After an incident, many loved ones will immediately call or self-report to the hospital where they believe their children may have been taken. Appropriate measures will be taken to handle the high demand for information and effectively coordinate information.
- Hospitals will plan for reunification in collaboration with other critical partner organizations' plans and systems within the community as needed (e.g., local

health jurisdictions, Department of Children’s and Families and emergency management).

- Critical access hospitals may not be able to treat critically injured pediatric patients long-term and will likely need to transport them to a facility capable of offering specialized critical care.
- In large incidents, or when access to the facility is an issue, critical access hospitals may be asked to provide ongoing care - pending availability of other transportation or treatment resources.

1.6 Surge Event Triggers

Identify triggers by County and Identified hazard type that would lead to a pediatric surge event.

Trigger for Hurricanes/ Tropical Storms
While all hospitals have plans for hurricanes/tropical storms, the plans are not pediatric specific. For all types of events, anticipated patients beyond a certain surge threshold (determined based on acuity, census and staffing) would trigger surge plans. This is considered a gap within the region.
The Coalition identified a regional gap in the capability to care for vent dependent or other medically complex children. Historically those patients were sent to hospitals for sheltering. Most hospitals have indicated that this is no longer feasible. A pediatric workgroup began meeting in 2019 and most counties have developed a plan for sheltering these children, and the other counties are working on these plans.
Trigger for Biological Disease Outbreaks
While all hospitals have plans for biological disease outbreaks, the plans are not pediatric specific. This is considered a gap within the region.
Trigger for Conventional Terrorism
While all hospitals have plans for conventional terrorism, the plans are not pediatric specific. This is considered a gap within the region.
In the event of a large-scale MCI that would exceed the capacity of the three children’s hospitals within the region, the regional trauma coordination plan would be activated for patient placement across the region and state.
Trigger for Mass Casualty Incidents
While all hospitals have plans for mass casualty incidents, the plans are not pediatric specific. This is considered a gap within the region.
In the event of a large-scale MCI that would exceed the capacity of the three children’s hospitals within the region, the regional trauma coordination plan would be activated for patient placement across the region and state.
Trigger for Mass Population Surges
While all hospitals have plans for mass population surge, the plans are not pediatric specific. This is considered a gap within the region.
Other Considerations
In most events, the worried well could be an overwhelming number of patients.
Alternate care sites (tents available) have been identified, but pediatric staffing is a gap.

2. Concept of Operations

2.1 Activation

This plan will be activated upon rapid identification and communication to the local jurisdiction of a potential pediatric incident. This plan can be initiated by any of the region's hospitals, health clinics and offices, local health departments, emergency medical services, or County Emergency Operations Centers when a potential pediatric incident occurs.

The Coalition staff activate whenever the state EOC is activated or for any event in the region that is larger than a single county. The Coalition has redundant communication capabilities with its members, including more than 2,100 individuals representing 758 organizations.

2.2 Notifications

The Coalition has redundant communication capabilities with its members and has demonstrated its effectiveness during real world incidents including the COVID-19 pandemic. During blue skies, the Coalition uses Constant Contact to share information on meetings, plans, training, and exercises with its members. During exercises and gray skies, the Coalition uses the Everbridge health alert network to share information with members. CFDMC has defined the essential elements of information (EIs) that HCC members should report to the HCC, and coordinate with other HCC members and with federal, state, local, and tribal response partners during an emergency (e.g., number of patients, severity and types of illnesses or injuries, operating status, resource needs and requests, bed availability). A platform (E-ICS) has been identified for information sharing.

2.3 Roles and Responsibilities

2.3.1 Command and Coordination

The Incident Command System (ICS) is a management system that is used to achieve optimal command and control within an organization as well as seamless inter-agency coordination during any type of emergency. It uses a clearly defined chain of command with a limited span of control. The overarching goal is to assist Emergency Management and Emergency Support Function 8 (ESF-8) with the National Preparedness Goals mission areas: Prevention, Protection, Mitigation, Response, and Recovery as it relates to healthcare disaster operations.

- **State Role:** The Florida Department of Health (FDOH) State Surgeon General is responsible for the overall direction, management and control of all Department personnel and resources committed from the state. Once the State Emergency Response Team (SERT) is activated this plan is incorporated into the established state emergency management structure.
- **Regional Role:** The State and local ICS structure will expand and contract as the situation warrants. If an area command or multi-agency coordination system (MAC) is used, it will follow Regional Domestic Security Taskforce (RDSTF) geographical boundaries.
- **Local Role:** The Health and Medical Emergency Support System (ESF - 8) will coordinate and manage the response to an incident and will utilize the incident command system (ICS).

- EMS Role: EMS agencies provide emergency medical services outside of a hospital setting.
- Hospital Role: Hospitals are responsible for acute health care service provision.
- Coalition Role: The Coalition’s role in information sharing is to monitor communications from local and State ESF8 and share information with member organizations that is not provided via other partners, such as regional status. CFDMC monitors all event systems used at the local and state levels for all disasters and shares relevant information. Informational posts are monitored, and relevant information is forwarded or included in the daily situation report. County situation reports are reviewed for situational awareness.

2.4 Logistics

Resource management includes logging, tracking, and vetting resource requests across the HCC and in coordination with the ESF-8 lead agency. This is done at the county level ESF-8. The state uses WebEOC to track all mission requests and the Coalition monitors all resource requests and attempts to find needed resources from within the region.

The state of Florida utilizes ESS software system to monitor bed availability by type. This information is shared with the Coalition and the Coalition then shares this with its member agencies. Prioritization, transfer locations and the movement of patients to other facilities or specialty transfers is done in accordance with the state of Florida Patient Movement plan and the CFDMC Regional Trauma Coordination plan.

2.4.1 Space

Alternate care sites (ACS) may be identified by local emergency management, public health, or hospitals and may be used for surge capacity. Each county has an alternate care site plan and there is a regional ACS cache available upon request.

2.4.2 Staff

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety and providing resources to assist HCP with anxiety and stress. Health care facilities should be in communication with local healthcare coalitions and federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed. The state of Florida has an approved vendor list that includes nursing and support staff through contractual augmentation. This was tested in the real-world pandemic response.

Sources of staff with potential pediatric subject matter expertise may include medical providers (physicians, nurses, physician assistants, nurse practitioners, and others) working in emergency medicine, pediatrics, family medicine, anesthesia, Otolaryngology or Ear/Nose/Throat (ENT), pediatric surgery, trauma surgery, general surgery, orthopedics, urology, neurosurgery, thoracic surgery, the Operating Room (OR), Post- Anesthesia Care Unit (PACU), Intensive Care Units (ICUs), inpatient units and outpatient clinics, pharmacy, or respiratory therapy. Additionally, staff in other categories/areas may have experience with pediatric care that provides them with a level of comfort and expertise, allowing them to assist in care during a disaster. They should be encouraged to keep current with pediatric topics and enroll in available courses and offered trainings to maintain their skills and confidence. Just-in-time training may need to be provided to train additional staff to care for pediatric patients. As needed, receiving hospitals will utilize telemedicine to access medical providers at hospitals that traditionally provide specialized care for pediatric patients.

At some hospitals, staff trained in pediatric emergency medicine and trauma care may be hard to find. In the event of an emergency that causes a surge of pediatric patients which overwhelms the hospital’s normal capabilities, those few pediatric-trained personnel may be called upon to act more as directors rather than clinicians. Each facility should identify those internal staffing resources that could be utilized during a pediatric surge to triage, coordinate care, and prioritize the transfer sequence (this/these person(s) should be certified in a pediatric medical/trauma course [Pediatric Advanced Life Support (PALS), Pediatric Emergency Assessment, Recognition and Stabilization (PEARS), Pediatric Education for Prehospital Professionals (PEPP), Advanced Pediatric Life Support (APLS), Neonatal Resuscitation Program (NRP), Pediatric International Trauma Life Support (PITLS), etc.] or a residency-trained physician [Emergency Medicine, Pediatrics, etc.]).

2.4.3 Supplies

The following categories of supplies and equipment should be available in sufficient quantities for use in the emergency room during a pediatric surge event:

1. PEDIATRIC SUPPLIES	
Airway	-Oropharyngeal Airways -Nasopharyngeal Airways -Laryngeal Mask Airways -Endotracheal Intubation Tubes -Laryngoscope blades/ handle Include NRP and PALS recommended sizes
Breathing	-Simple face masks -Non-rebreather masks -Bag-Valve-Masks (BVM’s) -Chest tubes/ Chest seals -Nasogastric tubes -Mechanical ventilators
Circulation	-Intravenous supplies (fluids, pumps, tubing, Include appropriate size IV catheters, IO gun and appropriate needles etc.)

	-Bleeding control supplies (tourniquets, hemostatic gauze, etc.) -Burn care kits/ supplies
Pediatric specific	-Broselow bags -Broselow carts -Pediatric traction splints

Most commonly deficient items and the identified strategies to address them:

SUPPLY/ EQUIPMENT GAPS	
Supply / Equipment	Strategies to fill gaps
Most major hospitals should have the equipment identified in above. There is concern that in an event, emergency care hospitals and pediatric hospitals could have supply chain issues	Identify priority gaps and address in supply chain mitigation strategy
Decontamination equipment specific to pediatrics	Prioritize for funding
The coalition has identified gaps in neonatal resuscitation supplies, pediatric code supplies, and pediatric / neonatal medical surge supplies needed at acute care hospitals and alternate care sites in a large-scale pediatric event	Seek additional grants
Ventilators, chest tubes, sterile trays i.e chest tube/thoracotomy trays, central line trays, IV fluids/tubing; blood tubing, bottled saline, kerlex, pediatric medications, antibiotics.	APH has 3 disaster carts Red; Green, and yellow (triage). The carts have supplies that could be used if our current supplies were depleted. Carts do not have ventilators or sterile trays

List of local sources to approach for car seats during a disaster:

Name/ Business/ Agency/ Organization	Contact Person & Phone #
3 Angels Foundation	Cori 407-715-0208
Center for Women	407-628-5433
Orlando Children Safety Village	407-521-4673 ext. 109
Florida SIDS Alliance (Pack and Play)	Charlene Melcher 407-242-4701
Beds for Babies	Terry Linderman 863-534-9224
Lina Chico/CPST/ Mngr Patient Transport/ APH	Lina Chico 352-874-9556
Carrisa Johns/CPST/ Orange County Safe Kids Coalition	Carissa Johns 412-523-2775

Resource management includes logging, tracking, and vetting resource requests across the HCC and in coordination with the ESF-8 lead agency. This is done at the county level ESF-8. The state uses WebEOC to track all mission requests. The Coalition monitors all resource requests and attempts to find needed resources from within the region.

The process for redistribution of available resources in the event of a medical surge event is outlined below:

- If a Coalition member organization needs assistance during a disaster response (staff, equipment, supplies, or other resources), the member organization submits a request to the County Emergency Operations Center (EOC). It is the county's responsibility to try to fulfill the organization's request.
- If the County EOC is unable to fulfill the request, the County submits requests to the State EOC through WebEOC. Once a request has been received by the State EOC from a county, it is initially processed by the County Liaison Desk under the direction of the Operations Support Branch, who verifies the information. From there, it is assigned to the proper branch for tasking to the appropriate ESF. If the ESF can meet the provisions

of the request, resource information is forwarded to the county EOC. If the ESF cannot provide the requested resources, it is then forwarded to the Logistics Section, who will work with either private vendors or through the Emergency Management Assistance Compact (EMAC) to secure the resources. If the resources are identified from private sources, the vendor information is given to the county emergency operations center.

- The Coalition monitors all resource requests and attempts to find needed resources from within the region.

If a resource requested is readily available locally through the Coalition or other member organizations, the Coalition will notify the State ESF8 desk and the local requestor of the available local resources. If directed by the State ESF8 desk, the Coalition will put the requesting organization in touch with the organization providing the resource to arrange transfer of the resource.

A new 2020 Pediatric Readiness in the ED checklist is now available based on the American Academy of Pediatrics (AAP), American College of Emergency Physicians (ACEP), and Emergency Nurses Association (ENA) 2018 joint policy statement “Pediatric Readiness in the Emergency Department”. The checklist and toolkit (<https://emscimprovement.center/domains/hospital-based-care/pediatric-readiness-project/readiness-toolkit/>) may be a useful document when developing and maintaining readiness for pediatric patients. Hospitals are encouraged to use the checklist to determine if their emergency department (ED) is prepared to care for children.

2.5 Regional Trauma Coordination Center

The Regional Trauma Coordination Center (RTCC) is an asset that is called upon for major catastrophic incidents and can be requested by the local emergency operations center. The RTCC was created to assist when the local healthcare system is overwhelmed.

The primary purpose of Regional Trauma Coordination Center is to decompress overwhelmed healthcare facilities through an equitable distribution of patients. The Trauma Coordination Center will coordinate the inter-facility transfer of patients, including to alternate care sites, if all conventional care resources in the region have been exhausted and the State ESF8 is unable to find conventional care resources in neighboring regions.

2.5.1 Transportation

The Trauma Coordination Center transport coordinator will coordinate with EMS for patient transport.

The appropriate EMS asset will be assigned based on the level of care required during the transfer, the acuity of the patient, and the destination. The Trauma Coordination Center will contact the requestor based on the appropriate level of care and bed availability information, in consultation with or by the Trauma Coordination Center medical officer.

Once a receiving facility has been identified and confirms acceptance of the patient(s), the Trauma Coordination Center transfer coordinator will coordinate a clinical provider call between the requesting facility and receiving facility.

2.5.2 Tracking

The primary purpose of patient movement and tracking within the plan is to decompress overwhelmed healthcare facilities through an equitable distribution of patients. EMResource has a patient tracking component and the region will be piloting this during 2021-2023.

2.6 Sheltering Medically Complex Children

There are a large number of medically complex children in Region 5. The Coalition identified a regional gap in the capability to care for vent dependent or other medically complex children. This is a statewide issue. Historically those patients were sent to hospitals for sheltering. Most hospitals have indicated that this is no longer feasible due to limited capacity and the need to protect capacity for higher acuity needs. Home health agencies working with these families have a requirement to ensure that families have a plan. The facility or the family and their home health agency have a responsibility for developing a plan to ensure medical care. Emergency managers and the county health departments are responsible for special needs shelters. A pediatric workgroup began meeting in 2019. In April, all counties agreed that these children would be managed by the local emergency management and county health department, using the special needs registry to identify and make appropriate plans for these children.

2.7 Reunification

Family Assistance Centers (FACs) provide information to survivors, family, and friends, coordinate access to support services, and facilitate the collection of information from families that is necessary for identification while providing a responsive and sensitive environment for those affected.

During a man-made or natural event or disaster, citizens and visitors may require several services at a FAC, some may become separated or their whereabouts since last contact may be unknown. Additionally, minor children may become separated from parents or legal guardians so family reunification may be the initial mission for team personnel when deploying and establishing an FAC.

Reunification of unaccompanied minors is a gap and a high priority for the Pediatric Workgroup for 2022-2023.

2.8 Deactivation and Recovery

Deactivation of this annex will depend upon whether the HCC Pediatric Surge Plan has been activated or not. To deactivate:

- Deactivate patient tracking (if applicable).
- Notify partners that the pediatric medical surge response has been completed.

Refer to public health and emergency management officials for more information regarding recovery, such as reunification, mental and behavioral health following trauma follow-up, etc.

2.9 Training and Exercise

The purpose of the Integrated Preparedness Planning Workshop (IPPW) is to determine State and local training and exercise gaps, including those that impact pediatric surge, identify priorities and discuss inputs for the annual Integrated Prepared Plan (IPP).

The IPPW provides an opportunity for participants from across the state to share strategies and coordinate plans for emergency preparedness and response, including planning for pediatric surge, if applicable. The setting also enhances coordination among jurisdiction officials, as well as shared proven strategies and practices, and the ability to apply lessons learned from past incidents.

3 Legal Authorities

3.1 Federal and State Authorities/Legislation

CMS and Disasters: Resources at Your Fingertips. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response. ASPR TRACIE. (2019)

The Centers for Medicare & Medicaid Services issued the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule to establish consistency for Health Care providers participating in Medicare and Medicaid, increase patient safety during emergencies, and establish a more coordinated response to natural and human-caused disasters. This document provides links to numerous related resources applicable to a variety of providers and suppliers.

EMTALA and Disasters. ASPR TRACIE (2018)

This fact sheet addresses several frequently asked questions regarding the Emergency Medical Treatment and Labor Act (EMTALA) and disasters and provides links to resources for more information, but is not intended to be used as regulatory guidance or in place of communications with or guidance from the Centers for Medicare & Medicaid Services (CMS) which oversee EMTALA compliance.

HIPAA and Disasters: What Emergency Professionals Need to Know. ASPR TRACIE (2017).

Knowing what kinds of patient information can be released, to whom, and under what circumstances, is critical for healthcare facilities in disaster response. This guide is designed to answer frequently asked questions regarding the release of information about patients following an incident.

Final Rule for Control of Communicable Diseases: Interstate and Foreign. Centers for Disease Control and Prevention. (2017)

This webpage discusses the updates to the law about quarantine and CDC's authority. The final rule improves CDC's ability to protect against the introduction, transmission, and spread of communicable diseases while ensuring due process. Details of the final rule, and links to relevant legislation are included.

Selected Federal Legal Authorities Pertinent to Public Health Emergencies. Centers for Disease Control and Prevention, Public Health Law Program. (2017)

This document summarizes a selection of key federal legal authorities pertaining to public health emergencies.

Hospital Legal Preparedness: Relevant Resources. Centers for Disease Control and Prevention. (2016)

The resources on this webpage compiled by the Public Health Law program and sorted into categories (e.g., EUA and countermeasures, HIPAA, liability and immunity) provide many resources for incorporation of legal and regulatory considerations into hospital and jurisdiction emergency plans. The page was last updated in 2016.

Emergency Authority and Immunity Toolkit. Association of State and Territorial Health Officials. (2013)

This toolkit contains a review of key emergency authority and immunity concepts; a summary of federal laws and policies pertaining to emergency planning and response; and a series of fact sheets addressing fundamental issues or legal authorities, issue briefs, and state analysis guides.

Further information may be found at: <https://asprtracie.hhs.gov/technical-resources/83/healthcare-related-disaster-legal-regulatory-federal-policy/1#federal-and-state-authorities-legislation>

4 Regional Resources & References

4.1 CFDMC's Area Assets:

CFDMC partners account for a combined pediatric capacity over nearly 1000 beds and nearly all facilities have Pediatric telehealth.

The following Facilities Have NICU units:

- AdventHealth Altamonte Springs
- AdventHealth Celebration
- AdventHealth Daytona Beach
- AdventHealth for Children
- AdventHealth Orlando
- Arnold Palmer Medical Center
- HCA Florida Lawnwood Hospital
- Holmes Regional Medical Center
- Nemours Children's Hospital
- Orlando Health, Inc.

The Following Facilities Have PICU units:

- AdventHealth for Children
- AdventHealth Orlando
- Arnold Palmer Medical Center
- HCA Florida Lawnwood Hospital
- Nemours Children's Hospital
- Orlando Health, Inc.

The following facilities offer pediatric behavioral health.

AdventHealth Celebration
 Cleveland Clinic Indian River Hospital
 AdventHealth for Children
 AdventHealth Orlando
 Arnold Palmer Medical Center
 HCA Florida Lawnwood Hospital
 Nemours Children's Hospital
 Orlando Health, Inc.

4.2 CFDMC's Subject Matter experts:

Robin Ritola, AdventHealth for Children, serves as the CFDMC Pediatric Clinical Champion. Other pediatric subject matter experts are listed below.

Pediatric SME	Contact Information	Associated Agency	Specialty
Dr. Carolina Echeverri	407-883-7795	AdventHealth for Children	Hospitalist
Dr. Kimberly Fenton	631-974-2664	AdventHealth for Children	Intensivist
Dr. Raymond Woo	352-494-7413	AdventHealth for Children	Orthopedic Surgery
Dr. Heidi-Marie Kellock	Heidimarie.Kellock.MD@AdventHealth.com	AdventHealth for Children	Pediatric Emergency Medicine
Dr. Kreangkai Tyree	210-464-0684	AdventHealth for Children	Neonatologist
Erika Westerhold	407-506-5517	AdventHealth for Children	Neonatal ICU Registered Nurse
Christyna Sterling	352-989-0068	AdventHealth for Children	Cardiac ICU Registered Nurse
Amanda Hellner	303-919-4975	AdventHealth for Children	Pediatric ICU Educator
Deborah Maka	407-303-9236	AdventHealth for Children	Pharmacist
Patricia Johnson	321-987-0025	AdventHealth for Children	Respiratory Therapist
Dr. Don Plumley	Donald.plumley@orlandohealth.com	Arnold Palmer Hospital	Trauma Surgeon
Jennifer Thelen	Jennifer.thelen@orlandohealth.com	Arnold Palmer Hospital	Peds ED/Trauma
Ernest Weishaupt	Ernest.weishaupt@orlandohealth.com	Arnold Palmer Hospital	EMS Liaison/Peds
Justin Williams	Justin.williams@orlandohealth.com	Arnold Palmer Hospital	APH COO
Christine Wallace	Christine.wallace@orlandohealth.com	Arnold Palmer Hospital	Pediatric Trauma Coordinator
Liliana Gutierrez	321-752-1080	Holmes Regional	Pediatric Infectious Disease
Shawna Cuning	3213-434-3291		
Dr. Lauren Stuart	(808) 932-3000 Lauren.Stuart@parrishmed.com	Parrish Medical	Pediatrics
Megan McFall, Cecelia Stalnaker- cauwenberghs,	772-567-4311 x35609 772-567-4311 x31770	Cleveland Clinic	Director of Women's Health Director BHC
Robin Ritola Wanda Escoffery	407-497-0475 407 754 4611	Advent Health Children's	Manager Clinical Outcomes and Nursing Operations

Mental Health SME	Contact Information	Associated Agency
The Florida Crisis Response Team added a one-day focus on pediatric trauma to their advanced team training in 2020.	fCRT1987@gmail.com	Florida Crisis Response Team (FCRT)
Angela Rojas-Watson	Angela.watson@orlandohealth.com	Arnold Palmer Hospital
John Rowe	John.rowe@orlandohealth.com	Arnold Palmer Hospital
		AdventHealth for Children

4.3 Acronyms/ Abbreviations

AAR	After Action Report
ALS	Advanced Life Support
BVM	Bag-Valve-Mask
C.A.T.	Combat Applied Tourniquet
CDC	Center for Disease Control
CEMP	Comprehensive Emergency Management Plan
CHD	County Health Department
CYSHCN	Children and Youth with Special Health Care Needs
DCF	Department of Children and Families
Decon	Decontamination
DOB	Date of Birth
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
EOP	Emergency Operations Plan
ER (ED)	Emergency Room (Emergency Dept.)
ESF	Emergency Support Function
F.A.C.	Florida Administrative Code
FDEM	Florida Division of Emergency Management
FDOH	Florida Department of Health
HCC	Health Care Coalition
HRC	Hospital Reunification Center
HICC	Hospital Incident Command Center
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
IOM	Institute of Medicine
I.V.	Intravenous
IBA	Immediate Bed Availability
ID	Identification
LEOC	Local Emergency Operations Center
MOU	Memorandum of Understanding
NICU	Neonatal Intensive Care Unit
NRP	Neonatal Resuscitation Program
OB/ GYN	Obstetrics/ Gynecologic
OR	Operating Room
PALS	Pediatric Advanced Life Support
PAT	Pediatric Assessment Triangle
PEPP	Pediatric Emergencies for Pre-Hospital Professionals
PI	Process/ Performance Improvement
PICU	Pediatric Intensive Care Unit
PITLS	Pediatric International Trauma Life Support
PPE	Personal Protective Equipment
PSA	Pediatric Safe Area
RS	Reunification Site
SALT	Sort, Assess, Lifesaving treatment, Transport
SCHIP	State Children's Health Insurance Program
SEOC	State Emergency Operations Center
START	Simple Triage and Rapid Treatment
QI	Quality Improvement

4.4 Resources/ References

1. *REDi- Regional Emergency and Disaster Healthcare Coalition (Feb 13, 2020)*. “Pediatric Medical Surge Annex”. <https://srhd.org/media/documents/REDi-HCC-Pediatric-Medical- Surge-Annex.pdf>
2. *Florida Department of Health (Dec 2019)*. “Emergency Support Function 8 Public Health and Medical- Patient Movement Support Standard Operating Guideline”. http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/preparedness-planning/_documents/patient-move-support-sog.pdf
3. *Stanislaus County Healthcare Emergency Preparedness Coalition (2019)*. “Pediatric Surge Plan”. <https://files.asprtracie.hhs.gov/documents/stanislaus-calif-pediatric-disaster-surge- plan-draft-1-23-19.pdf>
4. *Nevada Hospital Association (Oct. 2018)*. “A Day Like No Other- A Case Study of the Las Vegas Mass Shooting”. <https://nvha.net/a-day-like-no-other-case-study-of-the-las-vegas- mass-shooting/>
5. *Illinois Department of Health ESF-8 Plan (March 2017)*. “Pediatric and Neonatal Surge Annex Public Version”. <http://www.dph.illinois.gov/sites/default/files/publications/peds- neo-surge-annex-final-march2017-public-complete-file-031417.pdf>
6. *Florida Department of Health (Feb 2015)*. “Mass Casualty Incident Response Playbook”. 7. *Minnesota Department of Health*. “Minnesota Pediatric Surge Primer”. <https://www.health.state.mn.us/communities/ep/surge/pediatric/primer.pdf>
8. *U.S. Department of Health and Human Services (Sept. 2007)*. “Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies”. <https://www.phe.gov/preparedness/planning/mscc/handbook/documents/mscc080626.pdf>
9. *EMSC IIC*. “Checklist of Essential Pediatric Domains and Considerations for Every Hospital’s Disaster Preparedness Policies”. https://emscimprovement.center/documents/144/Checklist_HospitalDisasterPrepared212 5.pdf
10. *HHS- ASPRTRACIE*, “Healthcare Coalition Pediatric Surge Annex Template”; <https://files.asprtracie.hhs.gov/documents/aspr-tracie-hcc-pediatric-surge-annex- template-final-508.pdf>
11. *Florida Department of Health*, “Alternate Care Site Local Plan Development Guide”; http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/_documents/alternate-care-site-ops.PDF
12. *California Department of Public Health*. “15 ‘til 50 – Mass Casualty Incident Toolkit”. <http://cdphready.org/15-til-50-mass-casualty-incident-toolkit/>

13. Reunification resource – Family Reunification Following Disasters: A planning Tool for Health Care Facilities

[AAP Reunification Toolkit.pdf](#)