**Healthcare Coalition**

**Pediatric Medical Surge Event**

**Annex**

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**Approved:**

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# FOREWORD

The Bluegrass Healthcare Coalition (BGHCC) Pediatric Medical Surge Event (PMSE) Annex was developed through collaboration between the Kentucky Department for Public Health, Emergency Support Function #8 (ESF #8) partners and Coalition Members.

A pediatric medical surge event is defined as an incident where an unusual event overwhelms local and/or regional healthcare system capacity to triage, stabilize, and/or transfer pediatric patients to a treatment facility, thereby requiring special operations and additional assistance. The BGHCC PSME Annex provides the guidelines necessary to coordinate support when assistance is requested.

# APPROVAL AND IMPLEMENTATION

The BGHCC Pediatric Medical Surge Event (PMSE) Annex was developed through coordination with local, state, and federal agencies in Fiscal Year 2019-2020 and is hereby approved for implementation. This plan may be amended by the BGHCC as outlined in the [Plan Development and Maintenance](#_PLAN_DEVELOPMENT_AND_2) section of this plan.

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Bluegrass Coalition Chairperson

Bluegrass Coalition – Regional Response Coordinator

Bluegrass Coalition Medical Advisor

*Note: The original, signed version of this plan is maintained on file in the BGHCC Readiness and Response Coordinator (RRC) Office.*

# RECORD OF CHANGES

The BGHCC Readiness and Response Coordinator (RRC) will ensure any changes made to this plan outside the official cycle of plan review and update are documented and distributed using the Document Change Record in *Table 1* as outlined in the [Plan Development and Maintenance](#_PLAN_DEVELOPMENT_AND_2) section of this plan.

Table 1 - Document Change Record

| **Date** | **Page(s)** | **Revision Description(s) (Include Section/Paragraph)** | **Who Posted** |
| --- | --- | --- | --- |
| 3/27/23 | Atch - 3 | Updated HPP Map of Coalitions | Dave C |
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# OVERVIEW

BGHCC Member Organizations – Core Members in Bold

* **Medical Centers and Hospitals**
* **Emergency Medical Services (EMS)**
* **Emergency Management Agencies (EMA)**
* **Local Health Departments (LHD)**
* Long Term Care Facilities (LTC)
* Outpatient Services Facilities
* Fire / Rescue Agencies
* Amateur Radio Operators
* Federal, State and Local Governmental Agencies
* Non-Governmental Agencies (NGO)
* Volunteer Organizations
* Professional Organizations
* Agencies that support any Emergency Support Function (ESF)

Purpose

The purpose of this support plan is to supplement existing guidance with specific information regarding the management of pediatric patients during a Pediatric Medical Surge Event (PMSE). BGHCC Pediatric Medical Surge Annex identifies the roles and responsibilities of regional and local agencies and partnering organizations for providing regional and local-level support to a jurisdiction during the preparedness, response, and recovery phases for a PMSE.

The ESF #8 Primary and Support Agencies listed in this plan will also reference the BGHCC Preparedness and BGHCC Response Plans, and other relevant plans as listed in the [Authorities and References](#_AUTHORITIES_AND_REFERENCES_2) section when preparing for, responding to, and recovering from a PMSE

Scope

This plan is a supplement to, not a replacement for, the response actions and resources described in the coalition, facility, or agency Emergency Operations Plan and provides additional details relevant to an incident that involves significant numbers of pediatric victims.

For the purpose of this plan and for the purpose of HCC planning and response, a pediatric medical surge event (PMSE) is defined as:

*“An incident where an unusual event overwhelms local and/or regional healthcare system capacity to triage, stabilize, and/or transfer pediatric patients to a treatment facility and assistance will be requested from the HCC”;*

This plan is under the assumption that general acute care facilities have exhausted all day-to-day agreements, MOUs and vendor agreements prior to requesting assistance from the Coalition.

The circumstances of the incident that leads to the activation of this plan can range from a large, unexpected, and potentially life-threatening incident involving the pediatric population (e.g., earthquake) to a slow, gradually building or preplanned incident (e.g. partial or full planned evacuation). This plan covers injuries and illnesses due to any all-hazards incident to include, but not limited to, criminal incidents, disease outbreaks (acute), hazardous material incidents, industrial accidents, natural disasters; radiological incidents, terrorism, and transportation accidents.

However, this plan *does not* cover the BGHCC-level response to pandemic influenza or other long-term infectious disease outbreaks. This is covered under the BGHCC Local Health Department’s (LHDs) Disease Outbreak Support Plan (DOSP) and the BGHCC response plan annex related to infectious diseases.

Background

Kentucky is unique in its provision of emergency care to treat the pediatric population in terms of its geography and its designation of pediatric care facilities. There are currently two Level I Pediatric facilities in the state and they are:

* Kentucky Children’s Hospital, Lexington
* Norton Children's Hospital, Louisville

Kentucky is bordered by several states that have facilities that commonly accept transferred pediatric patients. Surrounding pediatric facilities are listed below:

**Facilities Within Four Hours from Kentucky’s Level I Pediatric Facilities**

| **Facility Name** | **State** | **ACS Ped Trauma Level** | **# PICU Beds** | **NICU Level and # beds** | **# pediatric beds** | **Transport Service (Y/N)** | **Pediatric Burn (Y/N)**  **# of Beds** | **Obstetric Services (Y/N)** | **Transfer Agreement (Y/N)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| James Whitcomb Riley Hospital for Children, Indianapolis | Indiana | I | 36 | IV, 60 | 379 | Y | Y, 10 | Y | N/A |
| Peyton Manning Children’s Hospital at St. Vincent’s, Indianapolis | Indiana | II | 23 | IV, 97 | 163 | Y | N | Y | N/A |
| Cardinal Glennon Children’s Hospital, St. Louis | Missouri | I | 21 | IV, 65 | 195 | Y | N | Y | N/A |
| St. Louis Children’s Hospital, St. Louis | Missouri | I | 41 | IV, 125 | 390 | Y | Y, 4 (ICU | Y | N/A |
| Shriners Hospitals for Children, St. Louis (orthopedics) | Missouri | NC | NO PICU | NO NICU | 120 | Y | N | N | N/A |
| Cincinnati Children’s Hospital Medical Center, Cincinnati | Ohio | I | 35 | IV, 59 | 700 | Y | N | Y | Y |
| Dayton Children’s Hospital, Dayton | Ohio | II | 15 | III, 41 | 155 | Y | N | N | Y |
| East Tennessee Children's Hospital, Knoxville | Tennessee | IV | 13 | III, 60 | 152 | Y | N | Y | N/A |
| Monroe Carell Jr. Children's Hospital at Vanderbilt, Nashville | Tennessee | I | 24 | IV, 98 | 267 | Y | N | Y | Y |
| Charleston Area medical Center, Women and Children's Hospital, Charleston | West Virginia | I | 10 | IV, 26 | 30 | Y | N | Y | N/A |

**Facilities Further than Four Hours from Kentucky’s Level I Pediatric Facilities**

| **Facility Name** | **State** | **ACS Ped Trauma Level** | **# PICU Beds** | **NICU Level and # beds** | **# pediatric beds** | **Transport Service (Y/N)** | **Pediatric Burn (Y/N)**  **# of Beds** | **Obstetric Services (Y/N)** | **Transfer Agreement (Y/N)** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Memorial Children’s Hospital, South Bend | Indiana | II | 12 | III, 36 | 445 | Y | N | Y | N/A |
| Advocate Hope Children’s Hospital, Oak Lawn | Illinois | I | 15 | III, 60 | 129 | Y | N | N | N/A |
| Advocate Lutheran Children’s Hospital, Park Ridge | Illinois | I | 15 | III, 54 | 129 | Y | N | N | N/A |
| Ann and Robert H. Lurie Children’s Hospital of Chicago, Chicago | Illinois | I | 48 | III, 64 | 360 | Y | Y (Minor Burns Only and <20% BSA) | Y | N/A |
| The Children’s Hospital of Illinois at OSF Saint Francis Medical Center, Peoria | Illinois | I | 32 | III, 64 | 136 | Y | N | Y | N/A |
| La Rabida Children’s Hospital, Chicago | Illinois | NC | NO PICU | NO NICU | 49 | Y | N | N | N/A |
| Rush Children’s Hospital, Chicago | Illinois | I | 18 | III, 60 | 125 | Y | N | Y | N/A |
| St. John’s Children’s Hospital, Springfield | Illinois | II | 8 | III, 40 | 80 | Y | N | Y | N/A |
| Shriners Hospitals for Children, Chicago (orthopedics, spinal cord injury, cleft lip and palate) | Illinois | NC | 6 | N | 60 | N | N | N | N/A |
| The University of Chicago Comer Children’s Hospital, Chicago | Illinois | I | 30 | III, 47 | 172 | Y | Y, 8 | Y | N/A |
| Children’s Mercy Hospital, Kansas City | Missouri | I | 41 | IV, 80 | 367 | Y | Y, 13 | Y | N/A |
| Mercy Children’s Hospital, St. Louis and Springfield | Missouri | I | 16 | III, 98 | 165 | Y | Y, 12 | Y | N/A |
| Ranken Jordan Pediatric Bridge Hospital, Maryland Heights | Missouri | NC | NO PICU | NO NICU | 60 | Y | N | N | N/A |
| University of Missouri Women’s and Children’s Hospital, Columbia | Missouri | I | 13 | III, 48 | 43 | Y | Y, 14 (ICU) | Y | N/A |
| Akron Children’s Hospital, Akron | Ohio | II | 23 | III, 59 | 253 | Y | Y, 12 | Y | N/A |
| Cleveland Clinic Children’s Hospital Rehabilitation Center, Cleveland | Ohio | II | 10 | III, 80 | 429 | Y | N | Y | N/A |
| Mercy Children’s Hospital, Toledo | Ohio | I | 16 | III, 30 | 72 | Y | N | Y | N/A |
| LeBonheur Children's Medical Center, Memphis | Tennessee | I | 20 | IV, 60 | 255 | Y | N | Y | N/A |
| Niswonger Children's Hospital, Johnson City | Tennessee | I | 10 | III, 39 | 69 | Y | N | Y | N/A |
| Children's Hospital at Erlanger, Chattanooga | Tennessee | I | 14 | IV, 58 | 120 | Y | N | N | N/A |
| Carilion Clinic Children’s Hospital, Roanoke | Virginia | I | 8 | III, 60 | 92 | Y | N | Y | N/A |
| Children’s Hospital, Richmond | Virginia | I | 21 | IV, 32 | 86 | Y | Y, 16 | N | N/A |
| Children’s Hospital of The King’s Daughters, Norfolk | Virginia | I | 25 | IV, 64 | 206 | Y | N | Y | N/A |
| INOVA Children’s Hospital, Falls Church | Virginia | I | 26 | IV, 108 | 226 | Y | N | N | N/A |
| Saint Mary’s Children’s Hospital, Richmond | Virginia | I | 14 | IV, 21 | 391 | Y | N | N | N/A |
| West Virginia University Children's Hospital, Morgantown | West Virginia | II | 19 | IV ,39 | 155 | Y | N | Y | N/A |

The normal referral system is highly functional during ordinary conditions; the daily occupancy rates at these facilities will dictate that a surge of pediatric patients in a mass casualty event will quickly overwhelm the system.

Patients can be initially triaged and/or stabilized at any facility and may be transferred to a higher level of care as needed. Most hospitals in the BGHCC region have limited capability to treat pediatric patients and generally do not admit pediatric patients. All BGHCC hospitals do have the capability to provide intermediate care and can provide common interventions and care for conventional pediatric conditions.

Emergency Medical Services (Ambulances)

All ambulances and licensed EMS personnel operating within the State of Kentucky must meet certain pediatric standards. Currently, there are two specialized pediatric transport teams: Kentucky Kids Crew at the Kentucky Children’s Hospital in Lexington and Just for Kids at Norton Children’s Hospital in Louisville. Both of the Specialized EMS transport resources are accessed by their respective facilities through a facility-to-facility transfer process based on the needs of the patient and the facility and when required, the Healthcare Coalition. Air and ground transport are available.

See BGHCC Response Plan Appendix D for Regional Ground, Air and Specialty Medical Transport Resources.

Risk Profile

Population wise, the hazard potential for most types of disasters is greatest in Kentucky’s metropolitan and micropolitan areas - simply because more people would likely be affected in the event of a disaster. This is not to say that these areas are necessarily more likely to be stricken by disaster or an emergency event than rural areas, although certain factors and conditions do make urban centers more prone to certain types of hazards.

An unusually high percentage of transportation accidents seem to occur in the state's urban areas, where the potential for major disaster or emergency event is greatest. Explosions (chemical, gas, industrial, etc.) and chemical leaks or spillages are most likely to occur in the metropolitan areas due to the heavy concentration of plants and transportation facilities in or near these areas.

Human-related emergencies (resulting from accidents, fires, explosions, etc.) would also be more likely to occur in the larger urban areas as a result of transportation and industrial concentrations, or extreme smog conditions. Mass poisonings, epidemics, and water pollution threats would also be greatest for these centers; urban centers would also be most susceptible to power and water shortages/outages. Other disasters, such as tornadoes, thunderstorms, earthquakes, etc., usually occur without regard to urban-rural classifications; however, their hazard potential is much greater when they strike urban areas. Forest fires, or wildfires, are more likely to occur in rural areas; these generally do not affect large numbers of people.

For Kentucky Region 5 BGHCC area the following risk, hazards, or events were identified, which may result in an event that adversely affects a large number of pediatric patients:

* Large school districts within region
* Specialty schools within region, to include:
  + Kentucky School for the Deaf, Danville, KY
  + Stewart Home, Frankfort, KY
* High School / Middle School sporting events and games
* Attendance at local, college or university sporting events and games
* County Fairs
* Concert or entertainment events
* Recreation areas such as community pools or parks
* Bluegrass Army Deport chemical weapons storage, handling and destruction
* Concentrated manufacturing areas with hazardous chemicals
* Main-line railroad systems and marshalling yards near schools
* Major Interstates, Parkways and high volume traffic areas

The Pediatric planning group identified the top (3) classes of injuries that pose the greatest challenge for local healthcare facilities to address during a pediatric surge. The following injury classifications were identified as the largest gap for the county’s ability to stabilize, treat, and transport pediatric patients in a disaster:

* Blunt force traumas
* Gunshot wounds
* Burns

|  |  |
| --- | --- |
| 2018 Kentucky Population Estimates | |
| Total Population Estimate | 4,468,402 |
| Persons under 5 years, percent | 6.2% |
| Persons under 18 years, percent | 22.6% |

US Census Bureau

Assumptions

The following assumptions have been made in the development of this plan:

* Appropriate State, Regional, Local, affected Hospital and/or Agency Emergency Operations and Response Plans have been activated.
* The age range for children that meet the definition of a pediatric patient in this plan is birth through 16 years of age.
* Local government will provide the initial response to any emergency or disaster in accordance with local emergency operations plans, procedures, and policies.
* Assume that general acute care facilities have exhausted all day-to-day agreements, MOUs and vendor agreements prior to requesting assistance from the State.
* A PMSE can happen very quickly and without warning in any part of the state due to natural or manmade disasters.
* Some communities will have fewer resources than others to deal with a PMSE and thus an overwhelming PMSE for one area may be within the capabilities for another.
* Triage and patient distribution decisions done in the field will have a significant impact on the subsequent healthcare surge capacity system.
* There may be a significant problem locating and providing information on displaced family members as well as victims and may require family reunification services.
* The management of pediatric patients is a part of the same overall system that is responsible for providing disaster management and medical care to other patients, regardless of age or condition.
* There are designated facilities in the state that specialize in pediatric care but these are almost exclusively located in highly populated areas and census at these facilities are normally very high. This leaves little capacity for creating surge in these facilities when influxes of pediatric patients occur. In addition, the geographic locations of these facilities make them very difficult to access from rural areas of the state.
* All hospitals have some capability for managing pediatric patients, this capability is often limited. General acute-care facilities usually transfer critically injured pediatric trauma patients to specialty hospitals under normal circumstances.
* Facilities already have transfer agreements in place to ensure appropriate levels of care for pediatric patients.
* The resources required to transport pediatric patients between facilities (or from scenes to facilities) are limited to ground and air ambulances. Most EMS agencies experience shortages on a daily basis and transportation for patients is frequently delayed, even under normal circumstances;
* Pediatric care is part of the overall disaster response, using the same communications, command and control structures and logistical resources as all other disasters. Except for the role that pediatric emergency care facilities play in managing these patients, very few unique considerations are required;
* Major disasters will likely result in immediate local and regional shortages of critical medical resources due to supply chain disruption and/or a higher utilization rate that exceeds on-hand supplies. Additionally, local and mutual aid capacity for patient transport will be overwhelmed. This is especially true during events involving a large number of pediatric patients;
* When it is anticipated that local capabilities will be exceeded, including those available through mutual aid agreements and volunteer resources, assistance will be requested from the state. Kentucky’s response partners will honor any existing formal agreements;
* Hospitals in the impacted area may implement medical surge plans to expand health care system capacity in response to a PMSE;
* The initial notification and request for assistance to the state will be through the state’s 24-Hour Warning Points. Some counties do not have a dispatch center and may notify the state through other agencies (i.e. Regional 911 Centers or Kentucky State Police);
* The BGHCC’s level of response will be determined based upon the local jurisdiction’s request for assistance and the needs of the incident;
* Local agencies will conduct emergency operations in accordance with the direction and guidance published in Local Jurisdiction’s EOPs, support plans and supporting ESF Annexes.
* Management and coordination of medical resources, personnel, equipment, and communications will take place through the Incident Command System (ICS) using the concepts within the National Incident Management System (NIMS);
* Hazardous materials or other factors involved in a PMSE may require additional response capabilities;
* PMSEs will produce a need for psychological first aid and/or behavioral health services for response personnel, as well as disaster casualties and their families.

# CONCEPT OF OPERTIONS

General

The agencies and organizations listed in this plan will maintain the ability to support and respond to a PMSE as outlined within the Local Jurisdiction’s EOPs and support plans. The acronyms in [Attachment 1](#_Attachment_1:_Acronym) may be used in all communications, both written and oral.

Notification

In the event of a PMSE, local healthcare agencies and ESF #8 Partners shall attempt to notify one of the following: the BGHCC Readiness and Response Coordinator (BGHCC RRC), Healthcare Preparedness Coordinator (HPC), Regional Preparedness Coordinator (RPC) or the Preparedness Branch Manager. Local agencies can notify the state’s 24-Hour Warning Point at 800-255-2587 for any PMSE requiring state assistance as outlined in the Kentucky EOP and/or notify KDPH’s On-Call Epidemiologist at 888-9REPORT (973-7678).

The BGHCC will also notify appropriate coalition membership and partners as described in section 3.0 of the BGHCC Response Plan.

Activation

The BGHCC RRC will activate a Coordination Center to coordinate healthcare coalition operations in accordance with this plan and the BGHCC Response Plan. The Coordination Center location will be determined by the RRC based on situational awareness and consultation with affected Emergency Management Agencies. The Primary Coordination Center for the BGHCC has been designated as the Lexington Department of Emergency Management (DEM) Public Safety Operation Center (PSOC). The HCC will operate under a defined Incident Command System (ICS) as denoted by the incident command structure established by the Incident Commander.

The incident command structure and the roll of the BGHCC Coordination Center may expand or contract based upon incident complexity, duration, and activation levels. The plan can be activated prior to a declared or proclaimed emergency. In those cases, in which the plan is activated prior to a declaration or proclamation, the gathering of information, assessment of the situation, and notification of healthcare facilities and providers will be emphasized to provide a basis for the full implementation of the plan should an emergency be declared, and surge be required.

A variety of situations may prompt the need to activate this Plan. Some examples include the following.

* Overwhelming influx or surge of pediatric/neonatal patients;
* Inadequate hospital resources for pediatric care (i.e. inpatient monitored beds, ventilators, isolation beds, burn beds);
* Damage or threats to hospital(s);
* Staffing limitations (i.e., lack of qualified and trained staff to care for pediatric /or neonatal patients);
* Activation of hospital disaster plan~~s~~ when surge capacity for pediatric/neonatal patients has been exceeded;
* Requests from bordering states to assist with a surge of pediatric/neonatal patients;
* System decompression processes outlined in this Annex.

During a PMSE, the BGHCC Coordination Center will coordinate coalition operations based upon the BGHCC Region and state ESF #8 operations will be based upon Kentucky’s ESF #8 Regions identified in [Attachment 3](#_Attachment_3:_Kentucky’s). Local agencies may request resources through mutual aid or from the state as outlined in Kentucky’s ESF #8 Resource Request Flowchart in [Attachment 6](#_Attachment_6:_ESF). The BGHCC resource request process is outlined in Section 3.0 of the BGHCC Response Plan

The impacted jurisdiction will activate the local EOC and ESFs, as applicable, in accordance with the local jurisdiction’s EOP and this plan.

# ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

The following are common specific responsibilities that pertain to pediatric surge management:

Local Agencies

1. Community Hospitals
   1. Alert applicable local and state agencies per EOP upon receiving notification of a PMSE event;
   2. Alert the BGHCC Readiness and Response Coordinator as soon as possible per section 3.1.3 of the BGHCC Response Plan upon receiving notification of a PMSE event;
   3. Maintain specific strategies, plans, and protocols for creating capacity to care for a significant surge of disaster pediatric/neonatal patients (includes expanding ambulatory and inpatient capacity beyond licensed capacity);
   4. Maintain specific plans and protocols for minimum patient documentation requirements for use during a surge incident and protocols for patient tracking;
   5. Maintain access to pediatric subject matter experts to assist with coordinating pediatric transportation, triage, and medical care;
   6. Coordinate with healthcare coalition and support the information and resource needs of healthcare facilities within coalition regions.
2. Pediatric Specialty Hospitals
3. Ensure staff involved in the handling of pediatric patients maintain the necessary competencies in accordance with federal and state guidelines;
4. Maintain specific strategies, plans, and protocols for creating capacity to care for a significant surge of pediatric/neonatal patients (includes expanding ambulatory and inpatient capacity beyond licensed capacity);
5. Maintain specific plans and protocols for minimum patient documentation requirements for use during a surge incident and protocols for patient tracking;
6. Maintain supplies, pharmaceuticals, and equipment for managing pediatric surge events;
7. Coordinate with healthcare coalition and support the information and resource needs of healthcare facilities within coalition regions.
8. County Emergency Management Agencies
   1. Coordinate with affected agencies to receive and act on requests for assistance;
   2. Maintain communications with local government officials and the Kentucky Division of Emergency Management regarding the status of response and recovery efforts;
9. Bluegrass Healthcare Coalition Readiness and Response Coordinator
10. Function as a liaison between KDPH, EMA, healthcare facilities, and EMS providers within the region;
11. Provide necessary situational awareness communications to/from the affected and/or assisting health care facility(s) within the region and to/from KDPH;
12. Coordinate with healthcare facilities and HCC membership organizations and supports the information and resource needs within the region;
13. Assist and coordinate resources to augment needs that may arise during PMSE.
14. Bluegrass Healthcare Coalition Member Organizations
15. Provide necessary situational awareness communications to/from the affected and/or assisting health care facility(s) within the region and to/from the Healthcare Coalition Readiness and Response Coordinator;
16. Coordinates with healthcare facilities and supports the information and resource needs within the region;
17. Provide resources to augment needs that may arise during PMSE;
18. Where applicable, provide access to pediatric subject matter experts to assist with coordinating pediatric transportation, triage, and medical care.
19. Dispatch Centers
20. Answer 911 calls and provides communication support for hospitals, EMS, and other first responding agencies;
21. Monitor radio traffic and receive requests for emergency response personnel and transport vehicles;
22. Dispatch and track emergency response personnel when a patient is transported to a designated hospital or a ground transfer point;
23. Maintain situational awareness and keep senior personnel informed of tactical operations.
24. EMS Agencies
25. Maintain ambulances, PPE, equipment, and supplies needed for transporting a pediatric patient;
26. Triage pediatric patients and prioritize those for transport based upon existing and agreed upon methods;
27. Transport pediatric patients to a designated healthcare facility as applicable in agency plans, policies, and procedures;
28. Transport pediatric patients to a designated location for air transport through coordination with local command operations and KBEMS (as applicable);
29. Coordinate with healthcare facilities and other applicable agencies to support patient tracking.
30. Local Law Enforcement Agencies
    1. Assist in identification, notification, protection, location, and reunification of children and their parents/legal guardians;
    2. Assist KSP and other applicable agencies in conducting missing persons investigations and ensuring effective coordination between investigative efforts and survivor and family assistance efforts;
    3. Coordinate as needed with local coroner/medical examiner for communicating death notifications to families, as required;
    4. Coordinate or support requested tasks such as law and order, crowd control, evidence collection, and casualty assistance;
    5. Coordinate and assist KSP with security and traffic control during operations involving the movement of resources or medical evacuation.
31. Mental Health/Behavioral Health Agencies
32. As determined through consultation with local and state officials, assist and provide behavioral health services for responders and impacted persons in coordination with KCCRB;
33. Request support or resources to augment services through appropriate channels.

# DIRECTION, CONTROL, AND COORDINATION

General

The PMSE Annex serves as the operational framework for coordinating coalition-level response and recovery activities for pediatric medical surge within the Bluegrass Healthcare Coalition region through the following:

* The BGHCC Coordination Center will serve as the base of direction, control, and coordination of coalition level support, in coordination with the local jurisdiction’s EOC, when activated;
* Local governments are responsible under all applicable laws, executive orders, proclamations, rules, regulations, and ordinances for response within their respective jurisdiction(s);
* Upon activation in support of pediatric medical surge operations, the agencies and organizations identified within this plan will ensure the necessary personnel and resources are available to achieve the operational objectives;
* Personnel from supporting agencies will operate in accordance with the rules, regulations, and capabilities of their respective agency or organization.

Authority to Initiate Actions

This plan and the coordinating structures and agencies named therein, maintain authority to initiate and coordinate actions to support an effective pediatric medical surge response per the BGHCC Response Plan.

Alert and Notification

1. Local agencies will notify the BGHCC RRC at 502-234-8392 and/or the state’s 24-Hour Warning Point at 800-255-2587 for any PMSE requiring possible state assistance as outlined in the Kentucky EOP and/or notify KDPH’s On-Call Epidemiologist at 888-9REPORT (973-7678) for any PMSE.
2. State agencies notified by other means will immediately notify the state’s 24-Hour Warning Point;
3. KYEM will alert all agencies that have a lead ESF role within the state EOC and applicable Regional Response Managers;
4. KDPH will notify applicable ESF #8 Primary and Support Agencies using established systems and processes as outlined in the ESF #8 – Public Health and Medical Services Annex;
5. The BGHCC RRC will notify all coalition members and partners, as appropriate, following the Coalition’s alert and notification procedures;
6. KDPH will notify other coalitions, as necessary.

Activation

* 1. Agencies assigned a lead role during a PMSE will activate upon notification from the BGHCC and staff the appropriate ESFs at the Local EOC or in the BGHCC Coordination Center, as applicable. The EOC and BGHCC Coordination Center will be activated based upon incident complexity and requests for assistance;
  2. The BGHCC RRC will alert local and regional ESF #8 agencies and partners upon notification of a PMSE requiring regional/coalition-level public health and medical support and stand up the BGHCC Coordination Center or the BGHCC RRC will report to the County EOC to assist with coordination of HCC assets, resources, and functions;
  3. KDPH will alert local, state, and federal ESF #8 agencies upon notification of a PMSE requiring state-level public health and medical support and stand up the State Health Operations Center (SHOC) to coordinate ESF #8 – Public Health and Medical Services operations. The KDPH SHOC will be activated to one of four levels based upon incident complexity and requests for assistance;

Situational Awareness

1. Agencies assigned a lead role during a PMSE will maintain situational awareness through communication with their respective counterparts and keep the BGHCC Coordination Center, state EOC, KDPH’s SHOC, and applicable ESFs aware of current conditions in the impacted area;
2. Event/incident related information will be submitted to the BGHCC Coordination Center, county EOC, state EOC and KDPH’s SHOC. Information may be obtained from:
   * Briefings
   * Health Alert Networks
   * Impact Assessments
   * Incident Action Plans
   * Onsite Reconnaissance Reports
   * Situation Reports
   * Situational updates
   * Information Sharing Platforms (WebEOC, ReadyOp, etc.)

Hospital Bed Availability and Operating Status:

Upon request, Kentucky’s hospitals will report their bed availability and operating status through the WebEOC system or Essential Elements of Information (EEI) form to facilitate allocation of beds based upon the type and number of injured patients. The map in [Attachment 5](#Figure4) graphically shows the location of hospitals within Kentucky.

Resource Management

* 1. Requests for resources (personnel, equipment, and supplies) can be requested through mutual aid from local jurisdictions and/or from the BGHCC through the BGHCC Coordination Center or from the BGHCC RRC through the SHOC or state’s EOC as outlined in Kentucky’s ESF #8 Resource Request Flowchart in [Attachment 6](#_Attachment_7:_ESF);
  2. Resource requests and tracking will be managed throughout deployment and demobilization through the use of WebEOC. Other systems or processes will be used if WebEOC is not functional;
  3. The BGHCC will coordinate with KDPH to manage the requests and deployment of state and federal medical assets, to include Strategic National Stockpile (SNS) assets;
  4. Local EMS agencies will collaborate with aeromedical providers and ambulance agencies to coordinate the movement and operations of air and ground ambulance resources;
  5. The BGHCC will coordinate with local EMA to provide support to the impacted jurisdiction for the request, deployment, and recovery of resources;
  6. Recovery of resources will be addressed in demobilization plans as required.

1135 Waivers

* 1. The affected facility and the BGHCC member organizations will coordinate with KDPH for any requests for 1135 Waivers through consultation with the Kentucky OIG upon declaration of a national emergency or disaster by the President under the National Emergencies Act or Stafford Act and upon a public health emergency determination by the Secretary of HHS under the Public Health Service Act.

Medical Evacuation

1. Medical evacuation is primarily a local responsibility. However, if casualties, patients, or residents require transport outside of the impacted jurisdiction, and assistance should be requested through the BGHCC Coordination Center or county EOC to KDPH and KBEMS. KDPH and KBEMS will coordinate with KYEM (ESF #5 – Emergency Management) and Kentucky Transportation Cabinet (ESF #1- Transportation) to determine the methods and routes to transport pediatric/neonatal patients to the nearest functional facilities;
2. KBEMS and KDPH will coordinate with local agencies when requested, for the transportation of evacuated pediatric/neonatal inpatients to decompress facilities.

Patient Tracking

1. Emergency Medical Services (EMS) and hospitals will use applicable patient tracking systems to track patients during a PMSE. This may include electronic, web-based, or paper-based patient tracking systems and processes. Regardless of the system used, all EMS agencies must have the capability to submit run reports to KBEMS through the Kentucky Emergency Medical Services Information System (KEMSIS);
2. At the state level, KDPH has made the ReadyOp Patient Tracking available for all EMS agencies and hospitals to use at no cost. KDPH, KBEMS, and KYEM will access this system to monitor patient tracking activities during a PMSE, as applicable.

Search and Rescue

1. Initial response for search and rescue will be a local effort with priorities established by local government;
2. KYEM, the lead agency for ESF #9 – Search and Rescue, will activate the statewide search and rescue task force to coordinate field operations of assigned search and rescue units;
3. KBEMS and KDPH will support mobilization of EMS assets to support ESF #9 operations.
4. The BGHCC may support efforts with assets and resources, if available.

Mass Care

* 1. The American Red Cross and ESF #8 Agencies will coordinate with the applicable agencies and organizations to provide mass care support as outlined in the ESF #6 – Mass Care, Emergency Assistance, Housing and Human Services Annex.
  2. BGHCC resources and assets may be requested to assist in mass care settings, depending upon the incident.

Reunification

1. Upon request from a local hospital or jurisdiction, the BGHCC will work with the local EMA to request activation of the jurisdiction’s Family Reunification plan. The Coalition will assist ESF #6 and/or the local chapter of the American Red Cross to support reunification services;
2. The request for State, Federal and VOAD reunification partners/resources will be coordinated jointly through KCCRB, KDPH and KYEM in cooperation with the impacted jurisdictions.

Public Information

* 1. The local jurisdiction’s PIO and the impacted health care facilities will coordinate a public information strategy. This should be coordinated through a Joint Information Center, if activated;
  2. In large scale events, the Coalition and jurisdiction’s PIOs/JIC should coordinate with the CHFS’s Office of Public Affairs for the development and release of public health and medical related information as outlined in the CHFS Emergency Communications Plan.

Behavioral Health Services

1. Behavioral health services for responders and impacted persons will be coordinated through the Coalition Coordination Center and if needed, the SHOC, as determined through consultation with local and state officials;
2. Upon request, KCCRB will coordinate with KDPH and KYEM to deploy Kentucky Community Crisis Response Teams (KCCRT) to provide onsite behavioral health assessments and counseling.

Hazardous Materials Response

1. There are varying levels of capability for hazardous materials response at the local and regional level. The county EOC or BGHCC Coordination Center should coordinate with KDPH and KYEM to request hazardous materials response support;
2. The Kentucky Department of Environmental Protection (ESF #10 Oil and Hazardous Materials) will coordinate with local, state, and federal agencies to provide state-level assistance to the affected jurisdiction as outlined in the ESF #10 - Oil and Hazardous Materials Annex;
3. The BGHCC has decontamination equipment and supplies, which may be requested and utilized by properly trained personnel during hazardous materials responses;
4. KBEMS and KDPH will support mobilization of EMS assets to support ESF #10 operations.

Public Safety and Security

1. Law enforcement will be coordinated by the responsible law enforcement entity for the respective jurisdiction;
2. KSP will work in coordination with local law enforcement to (ESF #13 - Public Safety and Security) coordinate law enforcement and security measures as outlined in the ESF #13 - Public Safety and Security Annex;
3. The BGHCC and member agencies will coordinate with KSP and local law enforcement to provide security during the deployment and recovery of response vehicles, equipment, medical supplies, and personnel.

Fatality Management

1. Fatalities resulting from a PMSE will be coordinated among the incident command structures involved in the response at the direction of the county’s Coroner;
2. Upon request, the State Medical Examiner’s Office and the Kentucky Coroner/Medical Examiner Response Team will provide support to the affected jurisdiction in accordance with the Commonwealth of Kentucky Mass Fatality Incident Plan;
3. The request for Disaster Mortuary Operational Response Teams (DMORT) and other fatality management resources external to Kentucky will be coordinated jointly through KDPH, KYEM, and the Kentucky Medical Examiner’s Office.

Deactivation/Demobilization

* 1. The BGHCC Coordination Center will remain activated during the recovery of personnel, but not necessarily during the recovery of equipment and supplies as this may be ongoing for an extended period of time;
  2. KDPH and KYEM will coordinate with ESFs and other local and state agencies to determine when KDPH’s SHOC and the State EOC will be deactivated, as applicable;
  3. Prior to deactivation, the BGHCC will develop and disseminate a Demobilization Plan. Available state-recovered assets will be reconstituted and returned to service during this period.

After Action Reporting

1. The BGHCC RRC and member organizations will coordinate with Support Agencies to evaluate and document response and recovery activities through After Action Reviews and After Action Reports/Improvement Plans (AAR/IP) per the Department of Homeland Security’s Exercise and Evaluation Program (HSEEP) guidance;
2. AAR/IPs will be written to document response and recovery activities within 60 days of an exercise or within 120 days of an incident or planned event.
3. Follow Up of Corrective Actions: Corrective actions identified in the AAR/IP will be tracked and implemented through coordination with applicable agencies per HSEEP guidance.

# 

# PLAN DEVELOPMENT AND MAINTENANCE

Maintenance

The BGHCC will conduct an annual review of this plan in coordination with the agencies and organizations identified within this document. Additional reviews may be conducted after an exercise, a significant incident/event occurs, or regulatory changes indicate a need;

* This plan will be updated or modified when there are significant organizational or procedural changes and/or when other events occur that will impact personnel, systems, and processes. The updated plan will be submitted to KDPH for publication and distribution;
* The BGHCC RRC will track and distribute any needed changes to this plan using the Document Change Record in [Table 1](#_RECORD_OF_CHANGES_1) when changes/updates are required outside the official cycle of plan review;

* Documentation of annual reviews and revisions to this plan will be maintained on file by the BGHCC RRC. Documentation should include, at a minimum, the date of the change, a description of the change with page/section number, and the name and title of the person who made the change.
* Elements of this plan will be evaluated during scheduled exercises as outlined in Kentucky’s Inter-Agency Multiyear Training and Exercise Plan.

Document Control

The original, signed master copy of the BGHCC PMSE Annex will be maintained in the office of the BGHCC RRC. The plan will also be made available to all appropriate agencies and BGHCC member organizations via electronic means.

Training

The BGHCC and member agencies should provide training for membership to ensure they have the capability and capacity to meet the needs of a PMSE. The BGHCC RRC and BGHCC Clinical Advisor will ensure coalition membership and agencies are trained on this plan. The BGHCC RRC and BGHCC Clinical Advisor will encourage training at member facilities and agencies to ensure capability and capacity to meet the needs of a PMSE, and that staff are trained on this plan.

# AUTHORITIES AND REFERENCES

Legal Authorities

* The Robert T. Stafford Disaster Relief and Emergency Assistance (Public Law 93-288) as amended;
* Homeland Security Presidential Decision 5 (HSPD-5);
* National Emergencies Act of 1976:
* Robert T. Stafford Act Disaster Relief and Emergency Assistance Act (Stafford Act);
* Section 319 of the Public Health Service Act – Declaration of a Public Health Emergency;
* Social Security Act Section 1135 Waiver Authority in National Emergencies;
* The Health Insurance Portability and Accountability Act (HIPAA) of 1996;
* Presidential Policy Directive 8 (PPD-8);

State

* Kentucky Revised Statutes (KRS), Title XVIII-Public Health;
* KRS 36.260(5) Duties of board (Crisis Response Services);
* KRS 39A.270 - Use of publicly owned resources at impending, happening, or response phase of disaster or emergency;
* KRS 39A.950 - Emergency Management Assistance Compact;
* KRS 39B.045 - Mutual aid agreements between Kentucky or its agencies or political subdivisions and units of government from another state;
* KRS 311A.170 – Paramedics – Permitted activities – Employment by hospitals – Reasonable control by employers;
* KRS 311A.175 – Exceeding scope of practice – Discipline prohibited for refusal to exceed scope of practice;
* KRS 315.500 - Emergency authority for pharmacists during state of emergency;
* KRS 411.148 - Non-liability of licensees and certified technicians for emergency care;
* 106 KAR 5:040 - Initiation of a crisis or disaster response;
* 202 KAR 7:501- Ambulance Providers and Medical First Response Agencies- Exemptions;
* 202 KAR 7:510 - Air Ambulance Services- Exemptions;
* 202 KAR 7:701 - Scope of Practice Matters- Exemptions;
* 902 KAR 2:020 – Disease surveillance;
* Kentucky Emergency Operations Plan
* Commonwealth of Kentucky EMS Patient Care Protocols;
* Cabinet for Health and Family Services’ Emergency Communication Plan;
* Kentucky Department for Public Health’s State Health Operations Center Support Plan;
* Kentucky Radiological Incident Specific Plan;
* Kentucky Department for Public Health’s Disease Outbreak Support Plan;
* Kentucky Strategic National Stockpile Support Plan

Local

* Local laws and statutes that would affect this plan are unknown at the time of this draft.

# SPECIAL CONSIDERATIONS

This section of the plan is intended to provide guidelines for healthcare providers to continue to provide treatment in an ethical manner to pediatric patients, when there may be a significant imbalance between the needs of the patients and the resources available to the healthcare provider.

Every hospital in Kentucky must be prepared to provide supportive care services to all patients regardless of age. This section of the plan identifies strategies for facilities to address critical resource shortages and the corresponding regulatory considerations that may impact critical resource allocation decision making.

**Space Surge Strategy**

Primary Goal: To maintain operations and increase capacity to preserve life and the safety of patients and ensure appropriate healthcare delivery to the community.

|  |
| --- |
| **SPACE** |
| **Strategies**   * Utilize licensed space for other types of patients * Use outpatient beds for inpatient care * Use internal skilled beds as acute patient areas * Convert adult space into pediatric space * Convert pediatric space to adult space * Increase capacity in patient rooms or hallways in patient care areas   + Two (2) patients in a single room   + Three (3) patients in a double room * Open Hospital Floors that are vacant * Use areas of the hospital for inpatients * GI Lab * Recovery Room * Outpatient Surgery * Physical Therapy * Other * Use non-traditional areas of the hospital for inpatients   + Cafeterias   + Conference Rooms   + Parking Structures * Other * Shut off floor ventilation system to make a cohort of infected patients * Use tents to create additional patient care areas   Request relaxation of nurse/patient ratios to allow occupancy of all licensed beds |

Staff Surge Strategy

|  |
| --- |
| **STAFF** |
| **Strategies**   * Cross train clinical staff * Contact Nurse Staffing Agencies (registries/traveling nurses) to assist with supplemental staffing needs * Use of non-conventional staff or expand scope of practice   + Student nurses   + Medical students   + Military licensed staff * Use of non-conventional staff * Volunteers * Paramedics * Retired health professionals with an active license * Utilize pediatric skilled RNs to supervise adult skilled patients and vice versa * Utilize families to render care under direction of a healthcare provider   Implement and/or develop just in time training for clinical staff normally assigned to non- direct patient care positions |

Supplies Surge Strategy

**Primary Goal:** Ensure adequate levels of supplies and equipment are available.

The following three (3) areas to prioritize when developing strategies for the allocation of scarce supply and equipment resources:

* Airway
* Breathing
* Circulation

|  |  |
| --- | --- |
| **SUPPLIES** | |
| Airway | Oral Pediatric Airway Nasopharyngeal Airway Laryngeal Masks  Endotracheal Intubation Tubes Laryngoscope Blades |
| Breathing | Face Masks  Non-rebreather Masks Bag Valve Mask  Invasive Mechanical Vents HFO Ventilators  OR Invasive Mechanical Ventilators Portable Invasive Mechanical  Non-invasive Ventilators  Chest Tubes  Nasogastric Tubes |
| Circulation | Intravenous Supplies  IO Supplies |
| Pediatric Specific | Broselow Bags |
| Broselow Carts |

Minimal Pediatric Equipment Recommendations for Emergency Department

When planning and purchasing pediatric equipment, hospitals should prepare for the number of patients expected based on its anticipated surge in pediatric patients. Each institution must determine what its expected surge capacity for pediatric critical patients is and should adjust inventory according to the number of patients for which it will plan.

The following recommendations suggest specific equipment emergency departments should keep on hand per one critical pediatric patient of unknown age or size.

|  |  |  |  |
| --- | --- | --- | --- |
| **Equipment Type** | **Size/Type** | **Quantity** | **Importance**  **E = Essential**  **D= Desirable** |
| Bag Valve Mask - Self Filling | Infant | 2 Each | **E** |
| Child |
| Arm Boards | Infant | 2 Each | D |
| Child |
| Blood Pressure Cuffs | Neonatal | 1 | **E** |
| Infant |
| Child |
| Chest Tubes | Infant 10F-12F | 2 Each size | **E** |
| Child 16F-28F |
| Dosing/Size Tool | Example: Broselow Tape | 2 | **E** |
| Continuous ETCO2 Detector | Pediatric | 2 | **E** |
| EKG Monitor/Defibrillator with Pediatric Pads/Paddles | Pediatric | 1 | **E** |
| ET Tubes | Cuffed 3.5mm-8.0mm | 2 Each size | **E** |
| Uncuffed 2.5mm-3.0mm | 2 Each size |
| Indwelling Foley Catheters | Sizes 6F-22F | 2 Each size | D |
| Infant Scale | Weighs in Kilogram only | 1 | D |
| Intraosseous Needles | Pink 15mm (3-39 kg) | 4 Each size | **E** |
| Blue 25mm (40 kg or above) |
| Intravenous Infusion Pumps | Neonate/Infant – Syringe Infusion Pump | 1 Each type | **D** |
| Child – Regular Infusion pump |
| Intravenous Solutions | Normal Saline 0.9% | 2 Each type | **D** |
| Dextrose 5% in Normal Saline |
| Dextrose 10% in Water |
| Intravenous Warmer  for Fluids/Blood |  | 1 | D |
| Laryngoscope Blades | Macintosh 2, 3 | 2 Each size | **E** |
| Miller 0, 1, 2, 3 |
| Laryngoscope Handles  (with extra batteries) | Pediatric | 2 | **E** |
| Laryngeal Mask Airway | Size 1-4 | 1 Each size | **E** |
| Magill Forceps | Pediatric | 1 | **E** |
| Masks: Face Masks that fits the self-inflating bag | Infant | 2 | **E** |
| Child | 2 | **E** |
| Non-Rebreather  Partial Non-rebreather for infants | Infant | 2 | **E** |
| Child | 2 | **E** |
| Nasal Cannula | Infant | 2 Each size | **E** |
| Child |
| Nasogastric Tubes | Infant 6F and 8F | 2 Each size | **E** |
| Child 10F – 14F |
| Nasopharyngeal Airways | Assorted Infant and Child sizes | 1 Each size | D |
| Newborn Kit/Obstetric/ delivery kit |  | 1 | **E** |
| Pulse oximeter | Infant | 2 Each Size | **E** |
| Child |
| Oropharyngeal airways | Size 0-3 | 2 Each size | **E** |
| Over-the-needle intravenous catheters | Angiocatheter  Sizes 20F – 24F | 4 Each size | **E** |
| Restraining Board – Papoose Board | Pediatric | 1 | D |
| Semi-rigid Cervical Spine Collars | Infant | 2 | **E** |
| Small Child | 2 | **E** |
| Child | 2 | **E** |
| Suction Catheters | Sizes 5F, 8F | 2 Each size | **E** |
| Tracheostomy Tubes | Shiley 2.5mm-5.0mm | 2 Each size (per ED not per Patient) | E |
| Warming Device (overhead warmer for newborns) | Infant and Newborns | 1 | D |
| Yankauer Suction Tip |  | 2 | **E** |

Children in Disasters: NYC DOHMH Hospital Guidelines for Pediatric Preparedness,” 3rd Edition, (2008)

*Pre-hospital ambulance providers in Kentucky carry a standard inventory of medical equipment and supplies on each Advanced Life Support (ALS) and Basic Life Support (BLS) vehicles*

# CARE AND SHELTER

In Kentucky, the care and shelter function is managed and coordinated through the KYEM and ESF #6 with support from State government, voluntary organizations, and the private sector. KYEM in partnership with the American Red Cross has developed a Mass Care and Shelter plan to be used in the event of an emergency or disaster requiring the activation of the care and shelter function. Some local jurisdictions within the BGHCC may also have Mass Care and Sheltering plans. These should be referred to during an event where mass care and sheltering may be required.

Under most circumstances, hospitals should not be utilized as the primary shelter option. It is important to ensure that the local emergency management agency communicates with the public during an emergency, to inform them of identified shelter locations. However, during a PMSE, there will be segments of the population that are not aware of pre-identified shelter locations and will seek refuge at local hospitals. Hospitals must be prepared to address the needs and concerns associated with operating a shelter inside of the hospital facility.

While the use of hospitals as shelters is not preferred, there may be times when it is unavoidable. For example, in single parent households where the parent is considered essential staff at the hospital, he or she must report for work to assist with the disaster. As a result, these parents may have no other choice but to bring their children with them. In addition, children who are technology-dependent may require access to a hospital facility’s power source, if the child’s home setting is no longer available.

Hospitals may also need to function as a shelter during a PMSE, particularly chemical/HAZMAT, biological, radioactive events or weather emergencies, where it may be advisable for employees and patients to shelter-in-place rather than evacuate the building. In these instances, hospitals must develop plans to be prepared to support the needs of staff and patients for greater than 24-hours.

The needs of children who are separated from their families should be met in a safe and developmentally sensitive manner. The Red Cross, which runs many shelters in disasters, cannot assume legal responsibility for unaccompanied minors. Children at a Red Cross shelter without a parent or legal guardian will be referred for local government services (for example, law enforcement, DCBS) to support reunification with families.

# TRANSPORTATION

Medical evacuation is primarily a local responsibility. However, if casualties, patients, or residents require transport outside of the impacted jurisdiction, the BGHCC will notify the SHOC and request assistance. Upon notification, KDPH and KBEMS will coordinate with KYEM (ESF #5 – Emergency Management) and KY Transportation Cabinet (ESF #1- Transportation) to determine the methods and routes to transport patients to the nearest functional facilities;

All hospitals should be prepared to provide extended care to children during a disaster. As part of this care, hospitals will need to transport children from one clinical area to another (including inpatient units) or to diagnostic testing locations (such as radiology, computed tomography and ultrasound areas).

Hospitals lacking specialized pediatric services may need to transfer children, after initial evaluation and stabilization, to centers with advanced pediatric capabilities. Keep in mind, however, that transfer (or evacuation, if necessary) might be impossible due to local conditions, safety concerns, lack of appropriate transport vehicles or personnel, or lack of capacity at specialty children’s hospitals.

Even when transfer to pediatric centers is possible, usual staff and equipment will be stretched thin by the disaster; therefore, hospitals should develop alternative mechanisms for safely transferring children based on the following guidelines.

# TRACKING

At the local level, Emergency Medical Services (EMS) and hospitals will use applicable patient tracking systems to track patients during a PMSE. This may include electronic, web-based, or paper-based patient tracking systems and processes. Regardless of the system used, all EMS agencies must have the capability to submit run reports to KBEMS through the Kentucky Emergency Medical Services Information System (KEMSIS).

At the state level, KDPH has made the ReadyOp Patient Tracking available for all EMS agencies and hospitals to use at no cost. KDPH, KBEMS, and KYEM will access this system to monitor patient tracking activities during a PMSE, as applicable.

Hospitals have historically served as safe havens for displaced persons during a disaster. Abandoned children are also often brought first to a hospital emergency department for evaluation. During a disaster, hospitals may again serve as safe havens and may find themselves host to displaced and unaccompanied children. As a recent example, Hurricane Katrina and the ensuing floods and chaos caused over 3,000 children to be displaced throughout the United States. These displaced children, if unaccompanied, are at increased risk for maltreatment, neglect, exploitation, and subsequent psychological trauma. Hospitals and medical clinics will therefore need to be especially alert to the safety and mental health issues of these children.

The focus of this section is to establish a standard process to identify, track, and reunify children and families and outline the roles and responsibilities of agencies involved in tracking and reunification activities. Hospitals, especially those that do not routinely take care of the pediatric population, need to pay special attention to the specific security needs of this group and take the necessary precautions to ensure proper care of these individuals while they are in the hospital.

Accompanied Children in a Disaster

There are two populations of accompanied children during a disaster that should be addressed:

* The pediatric patient who is a patient of the hospital because of the disaster and who may become separated from the responsible adult; for example, if the responsible adult is also a patient.
* The pediatric visitor who is *not* a patient of the hospital but who may be accompanying an adult person who is a patient; for example, a critical adult patient who was caring for a minor at the time of the disaster or event.

A possible solution to tracking these persons is to use a system of identification bands for the minors and corresponding responsible adults that are distributed as soon as these individuals contact the Emergency Department (ED) area. Care must be taken to quickly and correctly place bands or other identification devices on both parties.

Special attention needs to be taken to ensure that this measure is completed as soon as possible at the entry point to the hospital to reduce the possibility of human error during the matching and placing of the bands.

There are hospital policies in place for the tracking of minors from pediatric and maternity wards. These identification bands are used on all patients as they enter the hospital. The specific concern raised here is minors accompanying the adults during a disaster-level event who could easily be lost during the chaos of a disaster event.

The identification bands used should include the following information which will be useful in maintaining a tight link between pediatric patient/ visitor and adult:

* Name of pediatric patient/ visitor + Date of Birth (DOB)
* Name of adult + DOB
* Admission date of adult
* Admission date of pediatric patient
* Date of visit of pediatric visitor

In addition, a more sophisticated approach to tracking could be implemented using bar coded bracelets as identifiers that can be affixed to the pediatric patient / visitor and to the adult at the time of entry to ED or other entry point of the hospital. In this manner, the same bar code is assigned to the adult and the pediatric patient/ visitor (s) with the adult.

Displaced or Unaccompanied Children in a Disaster

Rapid identification and protection of displaced children (less than 18 years) is imperative to reduce the potential for maltreatment, neglect, exploitation, and emotional injury. A critical aspect of pediatric disaster response is effectively addressing the needs of children who have been displaced from their families and legal guardians. The separation of children from significant others is a recognized factor influencing the psychological responses of children after a disaster.

All hospitals, medical clinics, and shelters providing care to child survivors of disasters should immediately implement appropriate child-safety measures in direct response to this crisis.

Initiatives such as “Operation Child ID” implemented in Camp Gruber Oklahoma after Hurricane Katrina in 2005 have provided a rapid, systematic protocol for successfully identifying and protecting displaced children. The CDC has reviewed this protocol and considers it to be a useful resource to share with its partners to promote a safer and healthier environment for displaced children in shelters.

Protocol to Rapidly Identify and Protect Displaced Children

* Survey all children in your hospital, medical clinic, or shelter to identify children who are not accompanied by an adult; these children have a high probability of being listed as missing by family members. Find out where they are sleeping/being held and the name and age of person(s) who is/are supervising them, if available.
* Place a hospital-style identification bracelet (or, ideally, a picture identification card) on the child and a matching one on the supervising adult(s), if such an adult is available. Check frequently to make sure that the wrist band matches that of the adult(s) seen with the child in the hospital or shelter. Some children may also have a triage tag number that will accompany the child from the field to the hospital that must not be removed. If there is no supervising adult, the child should be taken to the hospital’s pre-determined Pediatric Safe Area (see following pages) where he/she can be appropriately cared for until a safe disposition or reunification can be made.
* The names of all children identified through the survey as not being with their legal guardians or who are unaccompanied should be considered at high-risk and immediately reported to the hospital’s Incident Command Center
* Coordinate with local law enforcement to identify the child and the child’s parent or guardian. If a guardian cannot be identified, the county child protective services will take actions to assume emergency custody of the child, so they may be discharged from the hospital.
* Unaccompanied children and those who are not with their legal guardians should undergo a social and health screening taking into consideration an assessment of the relationship between the child and accompanying adult, ideally performed by a physician with pediatric experience.

# REUNIFICATION

Upon request of a local hospital or jurisdiction, KDPH will assist in coordinating ESF #6. The local chapter of the American Red Cross will seek to activate their Family Reunification Services Plan. The American Red Cross, ESF #8 and ESF #13 will support local reunification services and provide reunification support as outlined in the ESF #6 – Mass Care, Emergency Assistance, Housing and Human Services Annex. The request for Federal and VOAD reunification partners/resources external to Kentucky will be coordinated jointly through KCCRB, KDPH and KYEM in cooperation with the impacted jurisdictions.

It is essential that children are definitively identified and matched to their legal custodial parent/guardian before release from the hospital. Accurate identification of children before releasing them from the hospital is key to preventing harm. Mistaken identity may lead to:

* + Release of a child to the wrong family;
  + Release of a child to an unauthorized noncustodial parent;
  + Delay of reunification with the child’s actual family (this affects both the child and the family);
  + Failure to identify significant medical and other conditions important to the care of the child.

Most children will be able to self-identify verbally, as well as identify their parents. Children who can identify both themselves and their parents can typically be released to their parents following usual hospital policies.

For those children who cannot be definitively identified, it is recommended that hospitals develop procedures to safely maintain care for all unidentified children until they can later be definitively reunited with their families. Children may not be able to self-identify if they are nonverbal because of developmental age, illness, or ability. In addition, it is possible that some children’s usual guardians may have experienced an extreme loss of resources and may be unable to safely care for the child at the time of release from the hospital.

For children unable to be reunited with a parent or legal guardian, the county child protective services should be notified to take emergency custody. Protective services will work with law enforcement personnel to continue the search for the legal custodians and will work with hospital personnel to arrange temporary placement for the child, as either a temporary social admission to the hospital or placement with a child’s relatives or a foster family. The timeline for transferring unaccompanied minors to foster care or specialized care, when applicable, differs depending on specific state criteria and the specific details of the disaster. Service options could range from immediate transfer to foster care to delayed transfer following an extended period.

To expedite the reunification process for children placed into foster care, courts may choose to issue an order stating that children may be immediately released from foster care back into their parents or legal guardians once they are located and identification is confirmed. Health care facilities should take care to familiarize themselves with state laws regarding unaccompanied minors in advance of a disaster and adjust planning efforts accordingly.

The Hospital Family Reunification Center

It is recommended that all hospitals have a plan in place to manage a surge of concerned family members, guardians, and friends that may present following a disaster, especially if large numbers of unaccompanied pediatric patients could be involved in the event. This is recommended because the volume of family members presenting to the hospital looking for their loved ones will typically overwhelm hospital lobbies and other care areas and could adversely affect clinical operations. This place where families and others may gather is often called a Hospital Family Reunification Center (HFRC). The HFRC is meant to:

* Provide a private and secure place for families to gather, receive, and provide information regarding children and other loved ones who may have been involved in the incident;
* Provide a secure area for these families away from the media and curiosity seekers;
* Facilitate efficient information sharing among hospitals and other response partners to support family reunification;
* Identify and support the psychosocial, spiritual, informational, medical, and logistical needs of family members to the best of the hospital’s ability;
* Coordinate death notifications, when necessary.

Hospitals should consider locations in their facility that are best suited to effectively and respectfully establish a family reunification center. Some considerations to keep in mind are:

* + Locate the HFRC away from the hospital Emergency Department and media staging sites as well as away from the designated pediatric safe area (see security section below);
  + Ensure there is sufficient space to accommodate many individuals.
    - Adequate space facilitates communication between designated hospital personnel and family members.
  + Provide nearby access to smaller rooms that may be used for confidential discussions, notifications, and provision of other support;
    - Distraught family members may need additional space; alcoves or additional rooms may help both psychologically and with security.
  + Ensure the space has an area for food and beverage;.
  + Ensure restrooms are easily accessible;
  + Ensure the space is accessible to patients and family members with considerations for access and functional needs;
  + Access to the HFRC can be controlled and security can be assured within the site.

The Family Reunification Site

Once identification and verification of a child and family is complete, there should be a separate area to facilitate the actual reunification of the family and child. The physical place where pediatric patients are reunited with their legal caregivers should be located away from the HFRC as well as the PSA. This is to permit the reunification to occur in a safe, well-controlled area located well away from the noise and distractions of the other areas. The family reunification site should allow for secure and simple departure from the hospital. Hospitals should also plan for reunification of patients who have been admitted to the hospital and for escorting of parents or guardians to other areas of the hospital.

Separation of the Family Reunification Site from the HFRC is also important to prevent creating additional trauma for families still waiting tin the HFRC who are not yet reunited with their children but who would otherwise be watching reunifications happening in front of them.

Families arriving at the hospital will be under a tremendous amount of stress and may have limited ability to process instructions or other information while they are looking for their children. Therefore, staff members in the HFRC must have experience in helping people under stressful conditions. Hospital staffing may include, but are not limited to, the following departments:

* Security
* Social Work
* Nursing
* Chaplaincy
* Psychiatry or Psychology
* Pediatrics
* Family Medicine
* Child Life

Information Management

In the aftermath of a disaster, people immediately try to seek information. The lack of timely information to the public about a disaster can result in more chaotic circumstances, such as increased crowds, increased call volume, and presence of anxious family members seeking their loved ones. Hospital communications plans and plans for information sharing should ensure that the hospital gathers and disseminates the best possible internally and externally available, credible, and verified information to families and staff. Ensuring that all families have regular updates to their understanding of the incident status and the hospital response relevant to them will help minimize some of the potential psychological and security concerns that are generally associated with these incidents. KDPH will coordinate with the CHFS’s Office of Public Affairs for the development and release of public health and medical related information as outlined in the CHFS Emergency Communications Plan. Public information may be released through coordination with the Commonwealth’s Joint Information Center (CJIC) as outlined in the ESF #15 - Public Information Annex. Designated ESF personnel will support the CJIC when activated, through a virtual or physical location.

Some considerations for information sharing include:

* + Information that can be shared with community representatives ahead of time;
  + How and what kinds, of critical information can be shared considering HIPAA and other laws, regulations, or policies;
  + How to rapidly implement communication processes, including pre-scripted messaging;
  + How the emergency management and public health communities will coordinate their public messaging with hospitals;
  + How to inform hospital staff regarding what information they can or cannot share;
  + How best to establish good relationships with local news agencies.

Hospitals must be able to manage the ways in which family members will utilize their existing public-facing infrastructure (such as an Information Desk, an Emergency Department Reception Area, or a Hospital Operator) as they inquire whether a loved one is present within the facility. If hospitals manage these points of contact effectively, they can support facilitation of rapid identification of survivors by family members whose presence is confirmed at the hospital

Internal sharing of information among response roles and centers is paramount to ensure a common operating picture for the facility. Hospitals should consider the following approaches to help maintain situational awareness among response roles:

* + Establish a process for the Family Reunification Branch Director to obtain updated lists of patients at regular, prescribed intervals, and distribute these lists to all appropriate staff aiding in reunification efforts.
    - Frontline staff must know when to expect the next update (i.e., every 30 minutes)
  + Maintain consistency; that is, ensure that family members seeking information receive the same correct information (when they have an appropriate right to know) whether they present in person or call on the telephone to speak with an operator.
  + Designate key points of contact for information collection and sharing in each area, including the emergency department, the HFRC, the PSA, the Family Reunification Site, and the Information Desk, to ensure proper oversight and communication among involved locations.

When family members cannot definitively be told that their relative is not present as a hospital patient, family members should then be directed to the HFRC to wait, or to other appropriate municipal reunification resources. Hospitals should include detailed contact information for municipal reunification resources (if available) in all their communications to the public and to families to assist with the family reunification process overall.

Security

Security will play an integral role in any event requiring the activation of a hospital’s family reunification plan. Many of these events could involve increased security risks, such as in the case of an active shooter scenario or terrorist activities. In addition, as families attempt to find their loved ones, crowds will form requiring an increased need for security personnel. As such, it is important to engage the institution’s security leadership early in the planning process. At a minimum, the hospital family reunification plan should include the creation of a security leader within its command structure. Hospital security personnel can also assist with coordination of interface between the institution and outside law enforcement. Ideally, an individual with preexisting relationships with law enforcement on local and regional levels, including relevant federal entities (eg, Federal Bureau of Investigation; Bureau of Alcohol, Tobacco, Firearms and Explosives), may fill this position. There will need to be a security presence in the HFRC and the PSA.

Pediatric Safe Area (PSA)

To ensure the pediatric patients’ safety, as well as to help patients cope, a Pediatric-Safe Area (PSA) should be established in an appropriate area that allows children to play and move about safely. Therefore, the hospital should preplan for, and be able to securely operate, a PSA. The PSA is a controlled and supervised space where children can play and wait safely and securely while awaiting reunification with their families. This space should be in an area separate from both the Emergency Department and the HFRC. The following are some issues to consider when determining a PSA location:

* The PSA should be away from the hospital Emergency Department and media staging sites as well as the HFRC.
* Ensure there is sufficient space to accommodate children of different ages with age- appropriate activities for each group; consider leveraging an existing infrastructure such as a child care center.
* Provide nearby access to smaller rooms or adjacent spaces that may be used for younger children such as babies or for children with sensory integration issues.
* Ensure that restrooms are easily accessible and appropriate for pediatric patients.
* Ensure the space has an area for food and beverage; ensure attention to patients with possible food allergies.
* Access to the PSA and restrooms must be able to be controlled, and security must be assured around and within the site.

# TRIAGE

Triage will occur at the local level. Disaster triage is a method of quickly identifying victims who have life-threatening injuries and who also have the best chance of survival. Identification of such victims serves to direct other rescuers and health care providers to these patients first when they arrive on the scene. The use of disaster triage involves a change of thinking from everyday care to:

* + High intensity care should go to the sickest patient doing the greatest good for greatest number.
  + Identify victims with best chance of survival for immediate intervention focusing care on those with serious and critical injuries but who are salvageable.
  + Identify victims at extremes of care by sorting those who are lightly injured and those who are so severely injured that they will not survive.
  + Immediate treatment to only those victims that procedure or intervention may make difference in survival.
  + Altered standards of care based on resource availability.

Disaster triage must be dynamic and fluid in its execution. Primary triage is done at the scene by first responders; the triage category is assigned rapidly and is based on physiologic parameters and survivability. Secondary triage occurs typically at the facility where the patient is transported. The initial triage assignments may change and evolve as the patient’s condition changes so reassessment is crucial. It is essential that medical personnel prioritize transport and treatment based on level of injury and available resources.

In Kentucky, prehospital primary triage of pediatric and adult patients is accomplished using the Simple Triage and Rapid Treatment (START) method. The first arriving medical personnel will use a triage tag to categorize the victims by the severity of their injury. The victims will be easily identifiable in terms of what appropriate care is needed by the triage tags they were administered. Once the evaluation is complete, the victims are labeled with one of the four color-coded triage categories:

* + Minor (Green) – delayed care/can delay up to three hours
  + Delayed (Yellow) – urgent care/can delay up to one hour
  + Immediate (Red) – immediate care/life threatening
  + Deceased (Black) – victim is dead, or mortally wounded/no care required

# INFECTION CONTROL

This plan *does not* cover the state-level response to pandemic influenza or other long-term infectious disease outbreaks. This is covered under the Local Health Department’s Disease Outbreak Support Plan (DOSP). The facility should contact the LHD for guidance during these types of events.

Activation of the DOSP will be coordinated with and through the KDPH SHOC (if activated). Hospital Command Centers should also activate their infectious disease response plan and coordinate response activities with the Local Health Department.

# DECONTAMINATION

When requested, the Coalition will work with local fire departments and The Kentucky Department of Environmental Protection (ESF #10 Oil and Hazardous Materials) to coordinate with local, and state agencies to provide assistance to the affected jurisdiction as outlined in the State’s ESF #10 - Oil and Hazardous Materials Annex. KBEMS and KDPH will support mobilization of EMS assets to support ESF #10 operations.

General Guidelines

The following recommendations are intended to facilitate decontamination of all children presenting to any hospital during a disaster in a timely manner. Children require special considerations that may not be addressed in a general Hospital Decontamination Plan.

Infants and children have unique needs that require special consideration during the process of hospital-based decontamination, such as:

* + Avoiding separation of families during the decontamination process;
  + Older children may resist or be difficult to handle due to fear, peer pressure and modesty issues;
  + Since parents or caregivers may not be able to decontaminate both themselves and their children at the same time, decontamination personnel may need to assist them;
  + Incorporating high-volume, low pressure water delivery systems that are “child-friendly” into the hospital decontamination showers;
  + Risk of hypothermia increases proportionally in smaller, younger children when the water temperature in the decontamination shower is below 98°F;
  + Attention to airway management, a priority in decontamination showers;
  + The smaller the child, the bigger the problem regarding any of the above considerations.

**Decontamination Recommendations Based on Child’s Age**

The following recommendations are based on the child’s estimated age of appearance, since asking may be impractical due to the limitations of personal protective equipment (PPE) and or due to a large influx of patients. These recommendations are divided into three groups by ages.

**Infants and Toddlers (0-2 years)**

Infants and toddlers are the most challenging group to treat; special needs considerations are of the utmost importance in this group. Follow the guidelines below during treatment.

1. All infants and toddlers should be placed on a stretcher and undressed by either the child’s caregiver or hospital decontamination personnel. All clothes and items should be placed in appropriate containers or bags provided by the hospital and labeled.
2. Each child should then be accompanied through the decontamination shower by either the child’s caregiver or hospital decontamination personnel to ensure that the patient is properly and thoroughly decontaminated. It is not recommended that the child be separated from family members or adult caregivers. **Caregivers should not carry the child because of the possibility of injury from a fall, or from dropping a slippery and squirming child.** Special attention must be given to the child’s airway while in the shower.
3. Non-ambulatory children should be placed on a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated (glasses, hearing aids, or other devices) should be placed in appropriate containers or bags as provided by the hospital and labeled.
4. All non-ambulatory children should then be escorted through the decontamination shower by either the child’s caregiver or decontamination personnel to ensure the patient is properly and thoroughly decontaminated. Special attention must be paid to the child’s airway while in the shower.
5. Once through the shower, the child’s caregiver or post-decontamination personnel will be given a towel and sheets to dry off the child, and a hospital gown. The child should immediately be given a unique identification number on a wristband and then triaged to an appropriate area for medical evaluation.
6. Children and their parents or caregivers should not be separated unless critical medical issues take priority.

**Preschool-Aged Children (2-8 years)**

Children ages two to eight years can walk and speak, yet (with considerable variations in physical characteristics), are clearly children.

1. Ambulatory children should be assisted in undressing with help from either the child’s caregiver or hospital decontamination personnel. All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
2. Each child should be directly accompanied through the shower by either the child’s caregiver or hospital decontamination personnel to ensure the entire patient is properly and thoroughly decontaminated. The child should not be separated from family members or the adult caregiver.
3. Non-ambulatory children should be placed in a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
4. Each non-ambulatory child on a stretcher should be escorted through the decontamination shower and assisted with decontamination to ensure the patient is thoroughly and properly decontaminated.
5. Once through the shower, each child should be given a towel and sheets to dry themselves, and a hospital gown. The child should immediately be given a unique identification number on a wristband and then triaged to an appropriate area for medical evaluation.
6. Children and their parents or caregivers should not be separated unless critical medical issues take priority.

**School-Aged Children and Adolescents (8-18 years)**

At the age of eight years and older, children’s airway anatomy approximates that of an adult. Although it is tempting to regard this age group as “small adults” there are special needs unique to this age group.

1. Ambulatory children should undress as instructed by hospital decontamination personnel. All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
2. Each child should then walk through the decontamination shower, preferably in succession with their parent or caregiver, and essentially decontaminate him or herself.
3. Non-ambulatory children should be placed on a stretcher by hospital decontamination personnel and undressed (using trauma shears if necessary). All clothes and items that cannot be decontaminated should be placed in appropriate containers or bags as provided by the hospital and labeled.
4. Each non-ambulatory child should be escorted through the decontamination shower and assisted with decontamination to ensure the entire patient is properly and thoroughly decontaminated.
5. Once through the shower, each child should be given a towel and sheets to dry themselves, and a hospital gown. The child should then immediately be given a unique identification number on a wristband and triaged to an appropriate area for medical evaluation.
6. Children and their parents or caregivers should not be separated unless critical medical issues take priority.

# BEHAVORIAL HEALTH

Behavioral health services for responders and impacted persons should be coordinated locally first and any requests for assistance will be coordinated through the KDPH SHOC. Upon notification, KCCRB will coordinate with the Coalition, KDPH and KYEM to deploy Kentucky Community Crisis Response Teams (KCCRT) to provide onsite behavioral health assessments and counseling as determined through consultation with local and state officials.

Developmental Level-Specific Guidelines

Children may respond to disaster and hospitalization in similar ways to adults, but will also experience, mediate and communicate trauma in unique ways characteristic of their developmental levels. Hospital staff should consider this when helping children cope with their hospital stay after a disaster. Staff can help children feel safer in the unfamiliar environment of a hospital by including familiar people, things and routines. Hospitals should also prepare staff for the different ways culture impacts a child’s response to trauma.

**Infants**

* + Let a parent or caregiver stay with and, when possible, hold the infant during medical procedures.
  + Use familiar objects from the baby’s home such as stuffed animals, blankets, music boxes or toys for comfort before, during and/or after a procedure.

**Toddlers and Preschool-aged Children**

* + Avoid discussing toddler or preschoolers’ care in their presence unless you include them in the conversation. Children overhear much more than adults realize and, without any explanation, information may seem terribly frightening.
  + Let a parent or caregiver stay overnight with the child if possible and let other family members, including brothers and sisters, visit (if appropriate).
  + Reassure the child that the hospitalization is not a punishment. Avoid applying good or bad labels to the child, particularly during a procedure. For example, instead of saying “See, you were so good, the doctor only had to do this once,” you can say, “You did such a good job of sitting still, I know that was hard.”
  + Allow children to handle medical equipment such as stethoscopes, blood pressure cuffs, etc. and to practice procedures on a doll. Children learn best through play— “medical play” can be particularly useful.
  + Allow the child to make choices whenever possible, but don’t offer a choice when none exist. For example, do not say, “Would you like to come into the treatment room now, so the doctor can look at you?” Instead say, “Do you want to bring your bear or blanket with you to the treatment room?”

**School-Aged Children**

* + You can give school-aged children more specific information about what they will experience; however, many medical terms can be confusing. For example, the term "I.V." could be confused with the word “ivy,” or “dye” with “die.” Give simple, specific explanations for procedures and use non-technical language.
  + This is a great age for medical play (communicating understanding, fears, etc. through play with medical equipment). Let the child reenact events through play with different kinds of toys or art materials. This will help school-aged children express their feelings and gain a sense of control over what is happening to them.
  + Encourage all staff to respect the child's privacy by knocking before entering his or her room and by being sensitive to who is around when examinations are in progress.
  + Children this age may regress or revert to behaviors that they had outgrown (thumb sucking, bed wetting, etc.) during stressful situations such as hospitalization. Do not berate (e.g., say, “come on, you’re a big girl now…”) or punish children for such behavior; instead encourage them to express their feelings and discharge emotions through play.

**Adolescents**

* + Avoid discussing teenagers’ care in their presence unless they are included in the conversation. Adolescents can understand much more about their bodies and what is happening to them than younger children and may resent being excluded from discussions.
  + Do not assume that teens manage their emotions the same way as adults. Give teens opportunities to talk to staff about what is happening and to ask questions, both with and without parents or caregivers present.
  + Encourage all staff to respect teens’ privacy by knocking before entering exam rooms and by being sensitive to who is around during examinations.
  + Adolescents are particularly concerned about body image and do not want to be perceived as “different” than peers because of an illness or injury. Be especially sensitive to the physical changes adolescents may experience when explaining any procedures, injuries or treatments

.

**Children Younger than Five Years of Age**

* + Maintain their normal routines and favorite rituals as much as possible.
  + Limit exposure to TV programs and adult conversations about the events.
  + Ask what makes them feel better.
  + Give plenty of hugs and physical reassurance.
  + Provide opportunities for them to be creative and find other ways to express themselves.

**Children Older than Five Years of Age**

* + Don’t be afraid to ask them directly what is on their minds and answer their questions honestly.
  + Talk to them about the news and any adult conversations they have heard.
  + Make sure they have opportunities to talk with peers, if possible.
  + Set gentle but firm limits for “acting out” behavior.
  + Encourage expression, verbally and through play, of thoughts and feelings.
  + Listen to their repeated retellings of the event.

**When to Consult a Mental Health Professional**

Seek psychiatric consultation if children exhibit any of the following behaviors:

Excessive fear of something terrible happening to their parents or loved ones

* + Excessive and uncontrollable worry about unfamiliar people, places or activities
  + Fear of not being able to escape if something goes wrong
  + Suicidal thoughts or the desire to hurt others
  + Hallucinations
  + Feelings of being helpless, hopeless or worthless

# ACCESS AND FUNCTIONAL NEEDS

The Coalition will work in coordination with KDPH, KCCRB and the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) to address the Access and Functional Needs (FAN) population during a PMSE.

Children are a highly vulnerable segment of the population in times of disaster. Children in this age category comprise nearly 25 percent of the U.S. population and have important and often complex planning and emergency response needs. Under normal conditions, there are components at the governmental, private and non-profit level which together form the networks on which children depend to support their development and protect them from harm. In addition to these systems, children fall under the supervision of their parents, guardians and/or primary caregivers. Once a disaster occurs, however, most or all these foundations in a child’s life may collapse.

The American Academy of Pediatrics has established that children have unique physical and emotional needs when a disaster strikes. In addition to being placed at an increased risk of physical harm, children respond to illness, injury, and treatment differently than adults do. They also rely on stable routines in their daily lives, and when a disaster occurs, the drastic changes to their known world not only endanger their safety, but also greatly frighten them. To ensure the physical security and emotional stability of children in disasters, communities must modify their emergency planning efforts to include children’s unique needs during disasters.

A critical step in preparing for any event is to gain and understanding of the extent to which an issue or situation exists. The following information on children in Kentucky may be used to assess the extent to which response agencies may need to provide support for children with disabilities and others with access and functional needs following a disaster.

**Children with Major Disabilities, by County**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **County** | **Total** | **Hearing Difficulty** | **Vision Difficulty** | **Cognitive Difficulty** | **Ambulatory Difficulty** |
| **Anderson** | 18 | 4 | 3 | 10 | 1 |
| **Bourbon** | 18 | 0 | 1 | 14 | 3 |
| **Boyle** | 90 | 67 | 3 | 12 | 8 |
| **Clark** | 52 | 3 | 6 | 35 | 8 |
| **Estill** | 11 | 1 | 0 | 10 | 0 |
| **Fayette** | 192 | 36 | 16 | 119 | 21 |
| **Franklin** | 40 | 4 | 9 | 17 | 10 |
| **Garrard** | 12 | 0 | 1 | 7 | 4 |
| **Harrison** | 15 | 3 | 1 | 6 | 5 |
| **Jessamine** | 34 | 8 | 3 | 16 | 7 |
| **Lincoln** | 30 | 1 | 7 | 18 | 4 |
| **Madison** | 86 | 24 | 11 | 42 | 9 |
| **Mercer** | 30 | 4 | 2 | 21 | 3 |
| **Nicholas** | 13 | 0 | 1 | 8 | 4 |
| **Powell** | 20 | 1 | 2 | 15 | 2 |
| **Scott** | 55 | 6 | 3 | 37 | 9 |
| **Woodford** | 34 | 4 | 5 | 19 | 6 |

**Special Education Enrollment by Disability – 2017-18**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DISABILITY DEFINED 2017-2018 | | | | | | | | | | | | | | | |
| school District/County | Total special education Students | | Students with Mild Mental Disability | Students with Functional Mental Disability | Hearing Impaired Students | Students with Speech/Language Disability | Visually Impaired Students | Students with Emotional/Behavioral Disability | Orthopedically Impaired Students | Students with other health impairment | Students with specific learning disabilities | Deaf/Blind Students | Students with multiple disabilities | Students with autism | Students with Traumatic Brain Injury | Developmentally Delayed Students |  | |
| Anderson Co. | 498 | | 56 | 10 | 4 | 155 | 3 | 18 | 0 | 83 | 40 | 0 | 7 | 33 | 1 | 88 |  | |
| Bourbon CO. | 405 | | 24 | 12 | 0 | 150 | 1 | 13 | 2 | 77 | 54 | 0 | 6 | 37 | 1 | 28 |  | |
| bourbon co. paris ind | 97 | | 10 | 2 | 0 | 25 | 0 | 2 | 0 | 14 | 21 | 0 | 4 | 7 | 0 | 12 |  | |
| boyle co. | 637 | | 33 | 5 | 2 | 105 | 1 | 20 | 3 | 200 | 144 | 0 | 11 | 38 | 2 | 73 |  | |
| boyle co. danville ind | 358 | | 42 | 7 | 1 | 84 | 1 | 30 | 1 | 70 | 27 | 0 | 4 | 14 | 2 | 75 |  | |
| boyle co. KY school deaf | 86 | | 0 | 0 | 63 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 21 | 0 | 0 | 0 |  | |
| clark co. | 833 | | 68 | 35 | 3 | 183 | 6 | 33 | 5 | 153 | 88 | 0 | 14 | 68 | 3 | 174 |  | |
| estil co. | 294 | | 50 | 10 | 1 | 92 | 0 | 4 | 0 | 20 | 48 | 0 | 9 | 19 | 0 | 41 |  | |
| fayette co. | 4880 | | 176 | 119 | 36 | 1200 | 16 | 252 | 10 | 957 | 883 | 0 | 129 | 676 | 11 | 375 |  | |
| franklin co. | 814 | | 62 | 16 | 4 | 240 | 8 | 43 | 5 | 132 | 97 | 0 | 21 | 72 | 3 | 111 |  | |
| franklin co. frankfort ind | 127 | | 16 | 1 | 0 | 31 | 1 | 5 | 1 | 16 | 26 | 0 | 3 | 13 | 1 | 13 |  | |
| garrard co. | 385 | | 23 | 7 | 0 | 103 | 1 | 25 | 2 | 66 | 92 | 0 | 1 | 25 | 2 | 39 |  | |
| harrison co. | 427 | | 66 | 6 | 3 | 97 | 1 | 25 | 4 | 68 | 82 | 0 | 4 | 26 | 1 | 44 |  | |
| jessamine co. | 1250 | | 68 | 16 | 8 | 241 | 3 | 58 | 3 | 264 | 348 | 0 | 19 | 99 | 4 | 119 |  | |
| lincoln co. | 595 | | 47 | 18 | 1 | 118 | 7 | 31 | 2 | 113 | 146 | 0 | 5 | 50 | 2 | 55 |  | |
| madison co. | 1841 | | 119 | 38 | 23 | 561 | 9 | 82 | 4 | 357 | 289 | 0 | 54 | 124 | 2 | 179 |  | |
| madison co. Berea ind | 232 | | 9 | 4 | 1 | 28 | 2 | 19 | 2 | 47 | 81 | 0 | 4 | 17 | 1 | 17 |  | |
| mercer co. | 494 | | 28 | 21 | 4 | 107 | 2 | 37 | 2 | 125 | 60 | 0 | 1 | 29 | 1 | 97 |  | |
| nicholas co. | 148 | | 23 | 8 | 0 | 60 | 1 | 7 | 4 | 5 | 18 | 0 | 3 | 9 | 0 | 10 |  | |
| powell co. | 394 | | 53 | 15 | 1 | 103 | 2 | 35 | 1 | 50 | 52 | 0 | 10 | 20 | 1 | 51 |  | |
| scott co. | 1526 | | 78 | 37 | 6 | 394 | 3 | 80 | 6 | 308 | 213 | 0 | 32 | 96 | 3 | 270 |  | |
| woodford co. | 451 | | 19 | 7 | 4 | 173 | 5 | 11 | 4 | 70 | 86 | 0 | 6 | 33 | 2 | 31 |  | |
| statewide | 101278 | | 10832 | 3057 | 661 | 25193 | 567 | 4640 | 406 | 15665 | 1799 | 13 | 2011 | 7580 | 226 | 12488 |  | |
|  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |

## 

## Attachment 1: Acronym List

| **Acronym** | **Title** |
| --- | --- |
| AAR/IP | After Action Report/Improvement Plan |
| ARC | American Red Cross |
| ALS | Advanced Life Support |
| BLS | Basic Life Support |
| CHFS | Cabinet for Health and Family Services |
| CJIC | Commonwealth’s Joint Information Center |
| DCBS | Department for Community Based Services |
| DMORT | Disaster Mortuary Assistance Team |
| DOSP | Disease Outbreak Support Plan |
| EMAC | Emergency Management Assistance Compact |
| EMEDS | Expeditionary Medical Support |
| EMS | Emergency Medical Services |
| EOC | Commonwealth Emergency Operations Center |
| EOP | Emergency Operation Plan |
| ESF | Emergency Support Function |
| HHS | Health and Human Services |
| HCC | Healthcare Coalitions |
| HFRC | Hospital Family Reunification Center |
| HIPAA | Health Insurance Portability and Accountability Act |
| HPP | Hospital Preparedness Program |
| HSPD | Homeland Security Presidential Decision |
| ICS | Incident Command System |
| KAR | Kentucky Administrative Regulation |
| KBEMS | Kentucky Board of Emergency Medical Services |
| KCCRB | Kentucky Community Crisis Response Board |
| KCCRT | Kentucky Community Crisis Response Team |
| KDPH | Kentucky Department for Public Health |
| KEMIS | Kentucky Emergency Medical Services Information System |
| KHA | Kentucky Hospital Association |
| KNG | Kentucky National Guard |
| KRS | Kentucky Revised Statute |
| KSP | Kentucky State Police |
| KYEM | Kentucky Emergency Management |
| LHD | Local Health Department |
| PMSE | Pediatric Medical Surge Event |
| PSA | Pediatric Safe Area |
| NIMS | National Incident Management System |
| PPD | Presidential Policy Directive |
| RECC | Regional Emergency Coordination Center |
| SHOC | State Health Operations Center |
| SNS | Strategic National Stockpile |

## **Attachment** 2: HCC Command Structure for PMSE Operations

**HCC Command Structure**

Insert HCC Command Structure

## 

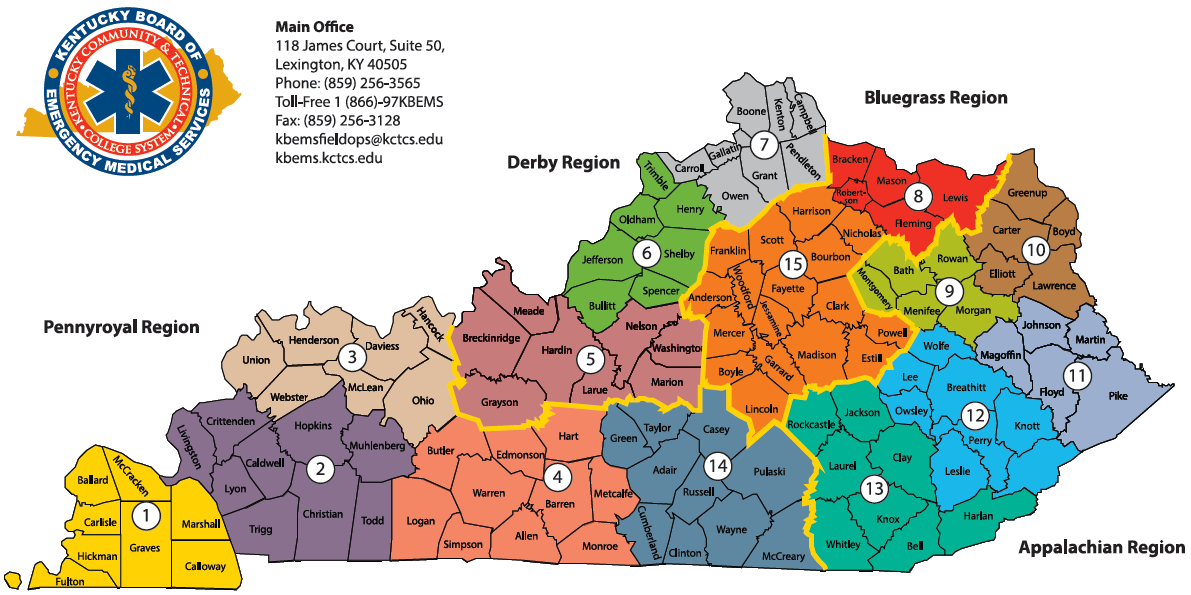
## Attachment 3: Kentucky’s Healthcare Coalition Readiness and Response Coordinators

**Map of Kentucky’s Healthcare Coalition Regions**



## Attachment 4: Map of Kentucky’s EMS Regions

**Map of Kentucky’s EMS Regions**



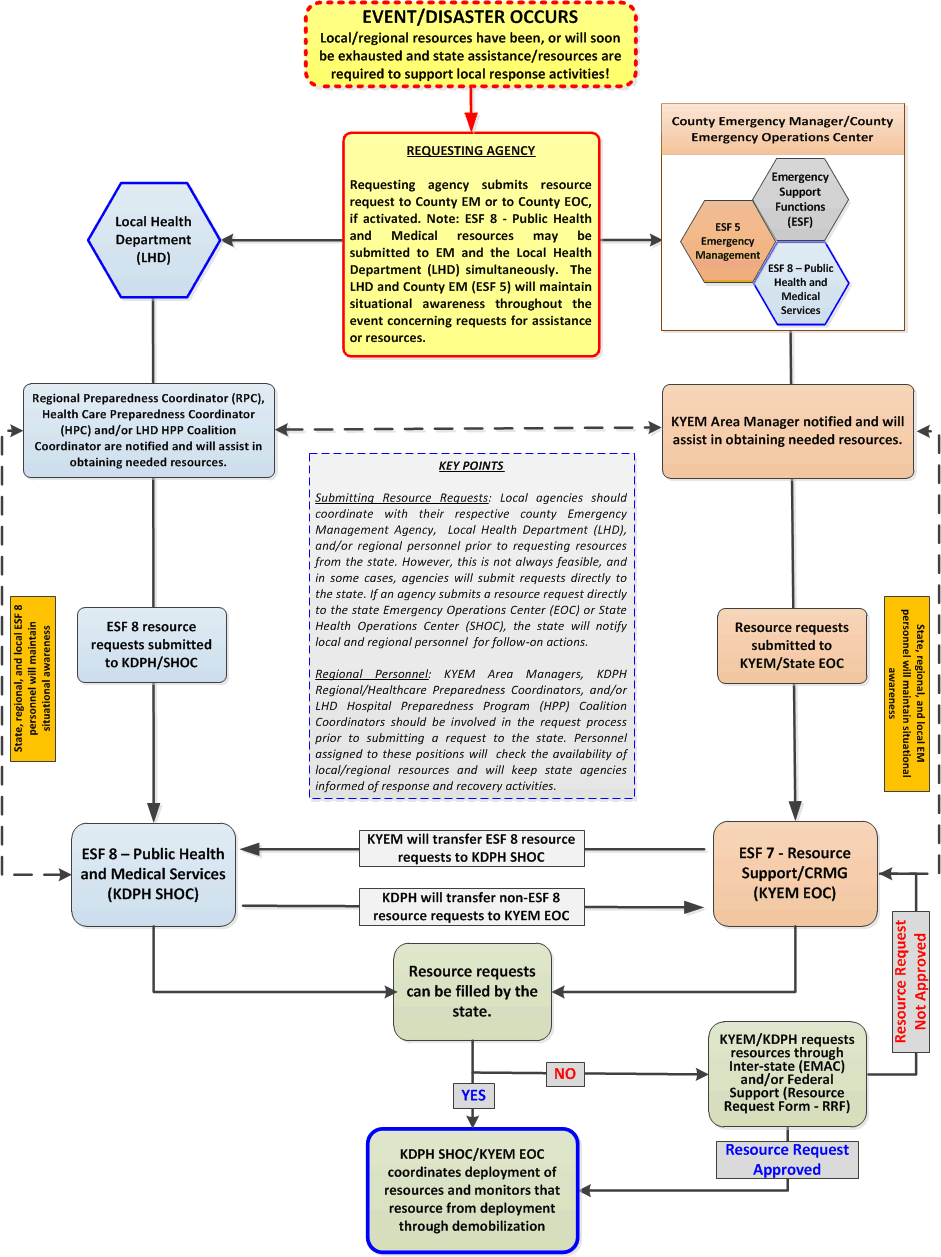
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## Attachment 5: Map of Kentucky’s Hospitals

**Map of Kentucky’s Hospitals**

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## Attachment 6: ESF #8 Resource Request Process



## Attachment 7: Region 5 BGHCC Pediatric Information

**Pediatric Referral Pattern**

During a PMSE, (Coalition) will transfer patients to the following facilities: and has agreements with those facilities for transfers during normal operations. If an event exceeds the available beds or surge capacity in the normal transfer patterns, decisions to transfer to alternate facilities will be made by (INSERT AGENCY AND/OR PERSON)

ACS Pediatric Trauma Level 1 indicates the facility has pediatric surgical capabilities 24 hours daily with pediatric orthopedics and neurosurgery 24 hours daily.

Pediatric Inpatient Capabilities including PICU/NICU and general pediatrics with a full complement of pediatric subspecialists.

* ECMO Facility – Facility provides most intensive cardiorespiratory interventions
* Pediatric Burn – Facility is a burn center that has pediatric capabilities
* Transport – Facility provide critical care transport for pediatric and neonatal patients

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility Name** | **State** | **ACS Ped Trauma Level** | **# PICU Beds** | **NICU Level and # beds** | **# General pediatric beds** | **Transport Service** | **Pediatric Burn** | **Transfer Agreement** |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |
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## Attachment 8: Region 5 BGHCC Pediatric Resources

HCC Pediatric Resources (Personnel, Equipment and Supplies)

List access to pediatric experts and any equipment and supplies the BGHCC has to support PMSE operations.

|  |  |  |
| --- | --- | --- |
| **Resource** | **Location** | **Contact** |
| University of Kentucky Health Care | Lexington, KY |  |
|  |  |  |
| Car Seats – Evacuation – 10ea | Lincoln Co. EMS / Ephraim McDowell Fort Logan Hospital |  |
| Car Seats – Evacuation – 10ea | Lexington FD Station 16 |  |
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