

Louisiana ESF-8 Health & Medical Preparedness and Response Network

Pediatric Disaster Surge Annex



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Record of Changes		
Date	Responsible parties	Summary of changes
May 2019	Initial Annex drafted by Dr. Gina Lagarde	Drafted version for Review – Reviewed with ESF8 Coalition Partners June 2019
September 2019	Dr. Gina Lagarde, HPP Staff	Incorporated feedback from plan review; included a table of contents, reorganized content, restructured attachments and appendices, included authorities and references

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INTRODUCTION

In Louisiana, the population estimate of children under the age of 18 years is approximately 1.1 million, which is almost one-fourth of the population (based on a total state population estimate of 4,659,978). About 6.7%, or 312,218, are under 5 years of age. Therefore, any type of mass casualty event may generate a surge of critically ill or injured pediatric patients to *all* hospitals, even those that traditionally do not care for children, are not pediatric trauma centers, and are not specialized pediatric hospitals. The magnitude of a surge event may overwhelm hospital and/or transport resources, which would limit the healthcare system's capacity to appropriately address the medical needs of pediatric patients.

PURPOSE, SCOPE, SITUATION OVERVIEW, AND ASSUMPTIONS

Purpose

The purpose of this Pediatric Surge Annex is to guide the state level planning and response as well as provide local medical services guidance on safe, coordinated care and transfer of children 17 years of age and younger in the case of a (pediatric) emergency that overwhelms the local health care system(s). This annex is designed to support, not replace, any agency or facility's existing policies/plans to increase pediatric capacity and capabilities in an emergency response. This is an Annex to the *Louisiana ESF-8 Preparedness and Response Network Coalition Plan*.

Scope

The Pediatric Surge Annex includes a general concept of operations for pre-hospital and hospital emergency/disaster response activities, for children 17 years of age and younger, regarding patient triage, patient movement (4 T's-triage, transfer, transport, tracking) and allocation of the following resources: space (bed capacity, system decompression), staff (EMS, hospital, community providers), supplies/equipment, and medication/pharmaceuticals.

The information in this plan applies to the roles and responsibilities of such ESF-8 partners as hospitals, healthcare organizations, public health (LDH OPH), Emergency Medical Services, emergency management (e.g. GOHSEP), etc. Broader health and medical response activities are covered in the *Louisiana ESF-8 Preparedness and Response Network Coalition Plan*. Additionally, Healthcare Coalitions (HCCs) are responsible for developing and maintaining HCC- level preparedness and response plans that outline how healthcare organizations will collectively respond within regional boundaries based on considerations unique to the region (see Attachment 1 Louisiana Regional Healthcare Coalition Map). This plan was developed with wide engagement among other pediatric healthcare partners and programs from across the state. Additionally, the Louisiana Department of Health ESF-8 would like to acknowledge the Illinois Department of Public Health for allowing the use of their Pediatric and Neonatal Surge Annex in the development of this document.

Situation Overview

Children are high "at risk" specialized populations because of their unique anatomic, physiologic, and behavioral vulnerabilities in a disaster situation. Therefore, it is imperative that hospitals and healthcare entities have a comprehensive, integrated, coordinated, and practiced pediatric disaster response plan, which include utilization of all hospital resources to offer the best available care for these patients.

Pediatric Planning Considerations

Table 1 illustrates some pediatric characteristics that may present as significant challenges in pediatric emergency disaster planning and response.

Table 1: Unique Consequences in Children During a Disaster, Owing to Anatomic and Physiologic Characteristics

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

Reference: Disaster Planning for Pediatrics, Richard D Branson MSc RRT FAARC, RESPIRATORY CARE • SEPTEMBER 2011 VOL 56 NO 9, <http://rc.rcjournal.com/content/respcare/56/9/1457.full.pdf>

Hazard Vulnerability Assessment (HVA)

In addition to understanding the unique physiologic and anatomic characteristics of children, it is equally important to effectively plan for disasters involving children by understanding the most probable risks to occur in Louisiana. Multiple tools are utilized by preparedness partners to understand the highest perceived impacts to the health of citizens and the consequences to the medical infrastructure.

The Jurisdictional Risk Assessment (JRA) is a process that helps to identify the relative risks posed by a specific hazard to a jurisdiction to better align healthcare, state, and regional vulnerabilities with

planning and preparedness activities. The JRA was conducted during the last quarter of 2018 (October-December) in each of the nine Louisiana Department of Health (LDH) regions. Aligning these results with the annual regional healthcare coalition HVA results which are compiled from hospital input, Louisiana's top hazards of focus for disaster planning are:

- Hurricanes and Floods
- Chemical Spills and Hazardous Materials Releases
- Infectious Disease Outbreaks

Mass Casualty Incidents (MCI's) while not explicitly listed as its own hazard, is an identified outcome of some hazardous events in which impacts to children could be exacerbated, overwhelming healthcare system's ability to care for patients. MCIs can be the result of various man-made events, i.e. explosions, shootings and school bus accidents or natural hazards, i.e. tornados and hurricanes.

ASSUMPTIONS

- The Louisiana Department of Health's nine (9) Public Health Regions (See Attachment for Regional Map) serve as the primary regional geographical organizational structure for the Pediatric Surge Annex planning and response.
- Since approximately a quarter of Louisiana's population is children 17 (vs. 15) years of age and younger, a disaster may require the triage, transport, and treatment of large numbers of children with injuries and/or illnesses.
- The pediatric surge plans should consider all types of injury or illness (including infectious disease, CBRNE events, and natural disasters) and their special requirements (e.g., supplies, pharmaceuticals, equipment, staff and other services).
- The pediatric surge plan should address the unique characteristics/circumstances of children 17 years of age and younger.
- The pediatric surge plan should be linked to the surge plans of the ED and the entire hospital and should consider all types of injury or illness and their special requirements (e.g., supplies, pharmaceuticals, equipment, staff and other services).
- In the initial stages of a mass casualty event that includes large numbers of ill and/or injured children, pediatric patients may present to any hospital, closest urgent care, or other healthcare facility, including those that do not normally treat those specialty or pediatric populations.
- With critical infrastructure disruption and/or a patient surge, transport and transfer of patients to specialized hospitals might not be immediately feasible
- All hospitals with an ED must be prepared to receive, stabilize, transfer/transport, and/or continue to care for pediatric patients in a surge event.
- Hospitals/healthcare organizations [will] have in place (and practiced) their own internal, comprehensive hospital preparedness and response plans for the management of pediatric patients during disasters.
- Hospitals/healthcare organizations [will] have inter-hospital transfer agreements in place for MCI pediatric patient movement to hospitals within and outside of their hospital organization/system. Hospitals will utilize pre-arranged transfer agreements and contracts when possible to move patients in order to off-load or make pediatric beds available for surge.
- Emergency medical transport service organizations are trained and (units) are equipped to safely manage and transport critically injured/ill pediatric patients.
- Drills on all components of the plan until adequate level of proficiency is achieved to ensure effective, safe and timely victim management
- Hospitals will activate Emergency Operations Plans (EOP) during response to any incident involving a potential surge of patients or need to evacuate patients. Hospitals should use Hospital Incident Command Structure (HICS) outlined within their EOPs which pre-identifies

staff who assume the role of medical technical specialist for pediatrics to serve as a point contact and expert during the event.

ROLES AND RESPONSIBILITIES

Hospitals

A tiering structure which predetermines capabilities based on services and bed availability will be used in planning and during response. These tiers will simply be referred to as “Peds 1 – 3” to minimize confusion with the naming conventions of other programs. Described below are examples of criteria associated with each designation:

Peds 1

- Trauma hospital that can stabilize patients of any age with trauma
- Have in-patient pediatric ICU (PICU) and medical surge capabilities
- Separate pediatric emergency departments

Peds 2

- Have pediatric medical surge capabilities
- Have an adult ward capable of accepting pediatric patients
- Sees pediatric patients in the ED and can transfer the patient internally

Peds 3

- Sees pediatric patients in the ED and can transfer patient externally
- Does not have any in-patient pediatric capability

See Attachment 2 for a crosswalk of Peds 1, 2 and 3 facilities and their capabilities to respond to specific pediatric emergencies.

Attachment 3 Pediatric Bed Capacity by Region Attachment shows pediatric and NICU bed capacities by hospital/region.

Emergency Medical Services (EMS)

Pre-hospital providers will utilize the Pediatric MCI Field Triage system to assist with treatment, triage and transfer from the scene of an event. In hospital evacuations, they will assist by executing contracts

Healthcare Coalition (HCC) Regional Coordinators

Hospital Coordinators – communicate the situation and share information with other hospitals and coalition members. Request resources through local, regional and state channels when necessary. Assist with identification of bed availability.

EMS Coordinators

EMS Coordinators communicate to response partners that the emerging situation exceeds local response capabilities. Serves as a coordinator to task units when state and federal surge contracts are activated.

Pediatric Coordinators

The Pediatric Coordinator assists with communication and identification of resources between hospitals as well as public health partners when needed. See Attachment for the Pediatric Coordinator Position Description.

Louisiana Emergency Response Network (LERN)

To better understand LERN's MCI Response – see Attachment *LERN MCI Patient Distribution Guidelines*

LERN has a Tactical Operations Center (TOC) which during large-scale events, such as hurricanes in which medical institutions from the coast must be evacuated, assists the state with the command and control of contracted surge units. The *EMS Surge Ambulance Plan* outlines details the role of the LERN and the functions of the TOC.

LDH - Office of Public Health (OPH)

Infectious Disease and Epidemiology department will assist with tracking cases and issuing HAN alerts for clinicians as they pertain to infectious disease outbreaks among populations, including pediatrics. Regional Public Health officials will work with local public health offices, practitioners and school systems to disseminate information and conduct vaccine campaigns if warranted.

The State's *Infectious Disease Annex* identifies the specific roles and responsibilities of various LDH-OPH offices.

Schools & Childcare Centers

During MCI incidents, schools and childcare centers may play a critical role in assisting healthcare facilities with identification of students and family reunification activities

Schools and Childcare Centers may be called upon to exercise with local partners and engage in planning efforts

ACTIVATION AND NOTIFICATION

Protocols for activating any portion of the pediatric disaster plan will begin at the local level. The notification process along with details of the roles of the healthcare coalition(s) and the tiered response structure is detailed in the Louisiana ESF8 Emergency Response Network Coalition Plan.

- Healthcare coalitions will notify coalition members of the event through the ESF8 Portal notification system.
- EMS providers may receive notification through 911, the LERN call center or the EMS DRC when additional support is needed.
- Pediatric Regional Coordinators in large scale or quickly unfolding events may provide support to the ESF8 regional and state incident command with identifying resources and solutions for the impacted facilities.

COMMUNICATION AND INFORMATION SHARING

Communication and information sharing procedures will vary depending on the type of event taking place. The LERN Call center is operated 24 hours and is the primary method of disseminating communication during MCIs. They may also provide support with sending ESF8 Portal messages to hospitals, EMS providers and other ESF8 coalition partners via text, email and phone calls. Hospitals and EMS providers should have radios programmed to regional channels as a means of redundant communications.

The ESF8 Portal Resource Management platform can be used in real-time to provide information on bed availability, ED specialty services and other resources needed. The MSTAT application of the ESF8 Portal can also provide real-time operations status updates during longer duration events in which power

failure and service interruption is likely and ongoing. These two systems provide regional coordinators and state partners with essential elements of information for response.

The State maintains the At Risk Registry (ARR), a patient tracking system that can be used by hospitals to track patients being evacuated as well as patients received into a hospital during an MCI incident. A key feature of this system when enabled, allows the public to search for patients involved in an emergency.

CONCEPT OF OPERATIONS

The overall concept of operations for the State ESF-8 entities is detailed in the Louisiana ESF-8 Preparedness and Response Network Coalition Plan. This Annex outlines some general medical considerations and contains assumptions and concept of operations for four specific pediatric disaster scenarios namely 1) mass casualty, 2) evacuation of a single hospital, 3) evacuation of multiple facilities and 4) Infectious disease outbreak.

GENERAL CONSIDERATIONS

Field Triage & Transport (Pre-Hospital)

- JumpSTART Triage Protocol is used for infants and children See Attachment
- START Triage protocol may be used for older, larger adolescents See Attachment

Transport

- Patient distribution to EDs/hospitals (with/without inpatient pediatric services, tertiary pediatric care hospitals, adult specialty hospitals, stand-alone EDs...) NOTE: Refer to hospital transport destination protocol for burns, when applicable
- Local EMS awareness of pediatric surge capabilities so as not to overwhelm a single hospital
- Patient movement from the field—ground vs. air
- Availability of pediatric equipped units and/or pediatric trained EMS first responders
- Transportation distance to reach specialized facilities with available bed capacity.
- Consider “Alternate Care” facilities (e.g. urgent cares, specialty surgical centers). Keep the (pediatric) hospitals available for the sickest and most injured

Scenario 1: Mass Casualty Incident (MCI)

MCI Description: This can include school bus accidents, school shooting or mass shooting at location with high density of children, explosion or hazardous materials exposure

Assumptions

- 1) Patients may be pre-triaged and routed to most appropriate facilities from scene by the Louisiana Emergency Response Network (LERN) call center, through the normal MCI triage and transport protocols.
- 2) Hospitals may receive patients from scene via personal vehicles, therefore facilities with limited or no pediatric ED capabilities may receive patients.

Concept of Operations

Patients will be routed from the scene by LERN through the call center. LERN will be in communication with EMS providers on the scene to understand the severity of casualties and appropriately route to nearest capable hospital based on triage information.

Those patients arriving from a scene by personal vehicle “drive-ups” to facilities not equipped for the severity of injury or illness will be stabilized as best as possible. LERN can be contacted to help arrange transport for critical patients.

- Facilities should maintain a minimum package of pediatric supplies for an MCI event response in which “drive-ups” are likely
- Hospitals are encouraged to have facility transfer agreements in place should pediatric patients arrive in “drive-up” scenario

Patient Tracking Protocol

- DRC/LERN to use the At-Risk Registry (ARR) to track patients
- Hospitals to use the ARR to inform the DRC/LERN of patients received from the MCI event

Re-unification Protocol

- In school related events, i.e. bus accidents, events occurring on school campuses or during school sponsored trips, the school will be the primary interface with family notification
- OPH/Regional ESF8 will provide appropriate information (name and location) of child to the school.
- At-Risk Registry has a public-facing component where name and DOB can be used to identify location of patient.

Resources and Considerations

- LERN Call Center: 1-866-320-8293
- Hospital Plan that includes pediatric supplies, equipment and baseline pediatric training
- Hospital transfer agreements

Scenario 2: Single Facility Evacuation

Description: This can include severe weather affecting a facility, facility fire, water damage, or any other event that requires the patients to be evacuated to another location.

Assumptions

- 1) The disruption of services will be short duration; the return of patients and full operations would resume within hours to a few days.
- 2) This will likely be a no-notice event
- 3) The evacuating facility will engage the regional Hospital DRC to assist with placement of patients

Concept of Operations

The sending facility will attempt to discharge any patients that are medically ready. The evacuating hospital will determine the appropriate level of care needed for each patient and will use existing transfer agreements to place patients. If there are not adequate beds within the region, or if the facility requires additional assistance finding beds, the DRC will request a statewide bed poll and assist with placement at the request of the sending hospital. The EMS DRC will assist with securing appropriate and timely transportation assets.

Patient Tracking Protocol

- DRC/LERN to use the At-Risk Registry (ARR) to track patients
- Hospitals to use the ARR to inform the DRC/LERN of patients received from the sending hospital It will be the responsibility of the hospital to inform family members of the pediatric patient transfer location
- At-Risk Registry has a public-facing component where name and DOB can be used to identify location of patient should the evacuating hospital choose to use this feature.

Resources and Considerations

- Hospital Plan that includes pediatric supplies, equipment and baseline pediatric training
- Hospital transfer agreements
- Joint Commission guidance for transfers and staffing during emergencies

Scenario 3: Multi-Facility Evacuation

Description: This would be a catastrophic scenario affecting one or more regions in the state caused by direct hit by a major hurricane, a massive flooding, prolonged disruption to the electrical grid, etc.

Assumptions

- 1) Multiple hospitals are affected within a region or across regions
- 2) Normal transfer agreements cannot be honored
- 3) Surge capability is compromised regionally or statewide
- 4) State and Federal resources may be requested
- 5) Affected facilities will not be operational for months to years
- 6) Woman's Hospital in Baton Rouge will function as the "control tower" for movement of NICU patients in catastrophic events

Concept of Operations

Evacuating facilities requiring assistance will work with their regional Healthcare Coalition (HCC) partners, LERN and State ESF-8 to determine the best course of action to safely evacuate their facility. The regional DRC will work with the State ESF8 to maintain situational awareness, and to identify necessary supplies and transportation resources. The State ESF8 will obtain/supply transport resources beyond what is available in the region. Please refer to the Medical Institution Evacuation Plan (MIEP) and NICU ConOps for additional information on state and federal capabilities.

Patient Tracking Protocol

- DRC/LERN to use the At-Risk Registry (ARR) to track patients
- Hospitals to use the ARR to inform the DRC/LERN of patients received from the sending hospital It will be the responsibility of the hospital to inform family members of the pediatric patient transfer location
- At-Risk Registry has a public-facing component where name and DOB can be used to identify location of patient should the evacuating hospital choose to use this feature.

Resources and Considerations

- Hospital Plan that includes pediatric supplies, equipment and baseline pediatric training

- Joint Commission guidance for staffing during emergencies
- MIEP and NICU ConOps

Scenario 4: Infectious Disease Outbreak

Description: This scenario involves a disease outbreak affecting the pediatric population e.g. measles, influenza or any other infectious disease requiring negative pressure and isolation of infected/suspected patients. Unlike the other scenarios this doesn't involve large numbers of patient transfers

Assumptions

- 1) Multiple hospitals are affected within a region or across regions
- 2) Patients will require isolation
- 3) Surge capability is compromised regionally/statewide and or nationally
- 4) State and Federal resources may be requested
- 5) The outbreak may trigger implementation of crisis standards of care plans

Concept of Operations

Facilities requiring assistance will work with their regional Healthcare Coalition (HCC) partners and the State ESF-8 to determine the best course of action to safely care for patients presenting at their facilities. The regional DRC will work with the State ESF8 to maintain situational awareness, and to identify necessary supplies and transportation resources. All hospitals will isolate suspected cases, identify the pathogen and inform State Infectious Disease Epidemiology.

Resources and Considerations

- Hospital Plan that includes pediatric supplies, equipment and baseline pediatric training
- Joint Commission guidance for staffing during emergencies
- Crisis Standards of Care: A Guideline for Louisiana's Acute Care Hospitals
- LHD Infectious Disease Epidemiology Section Surveillance and Epidemiological Investigation Plan
- LDH Hospital Pandemic Influenza Annex

Authorities and References

1. Health Standards: Emergency Preparedness for Providers <http://ldh.la.gov/index.cfm/page/297>
 - [Hospital Emergency Preparedness](#)
 - [CMS Rule - Emergency Preparedness for Medicare and Medicaid Providers](#)
 - Developing an All Hazards Risk Assessment and Emergency Plan
2. Louisiana Medicaid: Hospital Emergency Preparedness (<http://www.ldh.la.gov/index.cfm/page/294>)
3. Hospitals
 - EMTALA--Medicare participating hospitals must meet the Emergency Medical Treatment and Labor Act (EMTALA) statute codified at §1867 of the Social Security Act, (the Act) the accompanying regulations in 42 CFR §489.24 and the related requirements at 42 CFR 489.20(l), (m), (q), and (r).
 - HIPAA
 - Telehealth: Louisiana RS 40: 1223.1-1223.5. Part VII. Louisiana Telehealth Access ACT
 - LAC (Louisiana Administrative Code) Title 48, Subchapter B, §9327 Emergency Services
4. Personnel
 - LA Administrative Code, Title 48 Part 1 Subpart 3 Subchapter B Hospital Organization and Services §9327 Emergency Services- outlines requirements and qualifications of professionals providing hospital emergency services
 - Title 48 Part 1 Subpart 3 Subchapter T further details, facility specifications, staff qualification for facilities treating pediatric patients
5. Emergency Medical Services
 - EMS Education: <http://www.ldh.la.gov/index.cfm/page/1858>
 - EMS Licensing: <http://www.ldh.la.gov/index.cfm/page/759>
 - Louisiana RS 40:1135.2 A.2 Qualifications to Operate EMS Response Vehicles
 - Louisiana RS 40:1135.6. Advanced Emergency Medical Technicians
4. Emergency Medical Services for Children (EMS-C)
 - [LA Rev Stat § 40:1075.4 \(2018\)](#)-- Emergency Medical Services for Children

Attachment 1 Louisiana Regional Healthcare Coalition Map



Attachment 2 Pediatric Response Capability by Scenario

The ESF8 Portal Resource Management Application provides a real-time snapshot of hospital bed availability and service availability. LERN, the DRC network and EMS services who utilize the portal can ascertain resource availability to meet the needs of pediatric patients given the disaster scenario.

Pediatric Facility Disaster Criteria based on services and bed availability:

Peds 1 Facilities

- Trauma hospital that can stabilize patients of any age with trauma
- Have in-patient pediatric ICU (PICU) capabilities and medical surge capabilities
- Separate pediatric emergency departments
- Pediatric tertiary care & Pediatric Trauma Centers (*future*)

Peds 2 Facilities

- Have in-patient pediatric medical surge capabilities
- Have an adult ward, capable of accepting pediatric patients
- Sees pediatric patients in the ED and can transfer internally

Peds 3 Facilities

- Sees pediatric patients in the ED, can transfer externally via contract
- Does not have any in-patient pediatric capability

Attachment 3 Pediatric Bed Capacity by Region identifies hospitals with PICU, pediatric medical surge and neonatal intensive care unit (NICU) capability. The snapshot of regional bed availability allows regional and state planners to understand risks to these regions along with surge, transfer and evacuation limitations.

The table below outlines the type of support offered by different hospitals during the four identified types of medical surge incidents in which pediatric patients may be involved. It is important to note, that pediatric patients may not be the only patient type impacted by these events.

Scenarios	Peds 1	Peds 2	Peds 3
Large-scale MCI <ul style="list-style-type: none"> - School bus accident - Mass shooting 	Receives Red patients; Manages patients needing specialty services	Receives Yellow Patients; May surge adult units to accept/off-load patients; works with LERN to transfer POV Red patients; May share resources – medical supplies, staff, etc. to support severely injured	Receives Green patients; Any POV Red or Yellow patients that cannot be managed, work with LERN to transfer
Infectious Disease Outbreak <ul style="list-style-type: none"> - Measles - Influenza - Pertussis 	Accepts critical and vulnerable patients; capability to isolate; expanded lab testing capabilities; can share resources with Peds 2 and 3 facilities overwhelmed	Some isolation capabilities but may need to do altered standards of care; transfer critically ill to a Peds 1 facility	Minimal isolation capabilities; minimal lab and resource capabilities to care for ill for extended periods of time; establish transfer arrangement
Single-facility evacuation <ul style="list-style-type: none"> - Utility failure - Fire 	Accepts critical patients and those needing specialized care (surgery, ortho, etc.)	Accepts the non-critical patients and can accept general med surge patients	(not applicable)
Regional/Multi-facility evacuation <ul style="list-style-type: none"> - Hurricane - Flood 	Accepts PICU patients and those needing specialized care; Sending facility to provide staff and resources when possible	Expands in-patient units' capacity for both pediatric beds and adult beds when necessary. Consider placement of older children in adult units.	(not applicable)
Refer to state's <i>Medical Institution Evacuation Plan (MIEP)</i>	<i>NICU Plan (In Progress)</i>		

Attachment 3 Pediatric Bed Capacity by Region

Region	PICU Capacity	Pediatric Med Surge Capacity	NICU Capacity
1	62 Children's Hospital 33 Ochsner Medical Center 29	152 Children's 108 Ochsner Medical Center 44	183 Children's 32 EJGH 13 Ochsner Baptist 57 Ochsner Westbank 12 Ochsner Kenner 5 Touro 26 Tulane Lakeside 28 West Jefferson Medical Center 10
2	14 Our Lady of the Lake Regional Medical Center (OLOL) 14	76 BR General Medical Center (BB) 4 OLOL 72	110 Ochsner – BR 8 BR General Medical Center (BB) 18 Woman's Hospital 84
3	0	12 Leonard Chabert Medical Center 6 Teche Regional Medical Center 6	14 Terrebonne General Med Center 8 Thibodaux Regional Med Center 6
4	11 Lourdes Women's and Children's 11	59 Abbeville General 2 Acadia General – American Legion 2 Acadian Medical Center 6 Iberia Medical Center 4 Lafayette General Medical Center 6 Mercy Regional 2 Opelousas General 9 Lourdes Women's and Children's 28	86 Lafayette General Med Center 31 Lourdes Women's and Children's 55
5	10 Lake Charles Memorial 10	22 Allen Parish Hospital 2 Beauregard Health System 4 CHRISTUS Ochsner Lake Area 2 CHRISTUS Ochsner St. Patrick 2 Lake Charles Memorial 12	30 CHRISTUS Ochsner Lake Area 7 Lake Charles Mem for Women 23
6	6 Rapides Regional Med Center 6	41 Bunkie General 4 Christus St. Frances Cabrini 18 Rapides Regional Medical Center 19	49 Christus St. Frances Cabrini 15 Rapides Regional Med Center 34
7	14 Ochsner LSU Health Shreveport 8 Willis-Knighton South 6	118 Christus Coushatta 1 Natchitoches Regional Med Center 2 Ochsner LSU Health Shreveport 23 Willis-Knighton Bossier 5 Willis-Knighton Pierremont 18 Willis-Knighton South 24 Shriner's Hospital for Children 45	80 CHRISTUS Highland Med Center 10 Ochsner LSU Health Shreveport 30 Willis-Knighton South 40
8	4 St. Francis Medical Center 4	63 Glenwood Regional Med Center 12 Madison Parish Hospital 7 Northern LA Medical Center 4 Ochsner LSU Health – Monroe 4 St. Francis Medical Center 10 Reeves Memorial Medical Center 15 P&S Surgical (Tier 2) 11	66 Glenwood Regional Med Center 8 Northern LA Medical Center 5 Ochsner LSU Health – Monroe 13 St. Francis Medical Center 40
9	4 St. Tammany Parish Hospital 4	31 Lakeview Regional 9 North Oaks 7 Ochsner – Northshore 10 St. Tammany Parish Hospital 5	56 Lakeview Regional 12 North Oaks 14 Slidell Memorial 14 St. Tammany Parish Hospital 16
STATE TOTAL	125 10 Hospitals	574 40 Hospitals	674 30 Hospitals

Attachment 4 Pediatric Preparedness Coordinator Position Description

PEDIATRIC PREPAREDNESS & RESPONSE SUBCOMMITTEE PEDIATRIC REGIONAL COORDINATOR (PRC) ROLES and RESPONSIBILITIES

Objective: To facilitate and develop a network of regional coordinators with pediatric clinical expertise that coincides with the existing emergency preparedness and response network for healthcare coalitions. This network of Pediatric Regional Coordinators (PRCs) will work closely with Administrative and Hospital-based Designated Regional Coordinators, EMS and Public Health representatives to ensure pediatric considerations are being incorporated into regional and state-level plans. The PRC may be requested to engage groups of pediatric clinicians in the region to assist with socializing plans, engaging other key partners, coordination during disasters in which a pediatric population has been impacted and identification of gaps upon the conclusion of exercises or real events. PRCs may also be requested to solicit input in the development of policies or execution of deliverables for pediatric and emergency focused programs such as the Hospital Preparedness Program, the American Academy of Pediatrics Louisiana Chapter, the EMS for Children Program and the Louisiana Emergency Response Network (LERN).

Qualifications

- Pediatric Physician, Nurse Practitioner or Registered Nurse with Hospital, Emergency Department or Critical Care experience
- Completion of National Incident Management Systems (NIMS) IS 100, IS 200 & IS 700
- Recommended Hospital Incident Command System (HICS) training, and NIMS ICS 300 and 400
- Outreach and facilitation skills to engage appropriate partners with emergency preparedness activities

Essential Functions

Preparedness

- 1) Assist with educating hospital personnel on incorporating pediatric preparedness into Emergency Operations Plans (EOPs) – this includes all hospitals with EDs regardless of their day-to-day ability to care for pediatric patients
- 2) Provide guidance to Healthcare Coalition (HCC) leads on the development of a Regional Pediatric Annex to the HCC Preparedness and Response Plan(s)
- 3) Participate in exercise development for state, regional and local exercises to ensure pediatric elements are being addressed
- 4) Support planning efforts by socializing HCC level Preparedness and Response Plans with key pediatric stakeholders in the region
- 5) Maintain a list of pediatric “champions” who may be able to give feedback to plans, participate in exercises and engage with non-hospital and non-healthcare partners to align disaster planning initiatives – i.e., physician offices, schools, daycare centers

Response

- 1) Assist with identification and coordination of resource needs specific to pediatrics during real-world disaster event response
- 2) Serve as a regional point of contact for information sharing between regional/state partners and local stakeholders as necessary
- 3) Provide guidance on alternative care mechanisms and processes to be used during medical surge response

Attachment 5 LERN MCI Distribution Guidelines

LERN will use the following guidelines for MCI patient distribution. NOTE: Levels are defined considering size and severity of incident, number of patients, amounts of resources needed, amount of regional resources available, and possibility of interregional involvement.

Levels are as follows:

- **MCI Level 1** – Incident will require local resources and responding agencies. Incident may require additional resources within the region.
 - Size – 5 to 10 patients
 - Hospitals – notification to local hospitals in area near location of incident
 - Triage - patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines and primary injury/service needed (*LERN may be able to direct patients to specific area emergency departments with appropriate resources in small scale event*)
 - Communications – primary: phone; secondary: radio

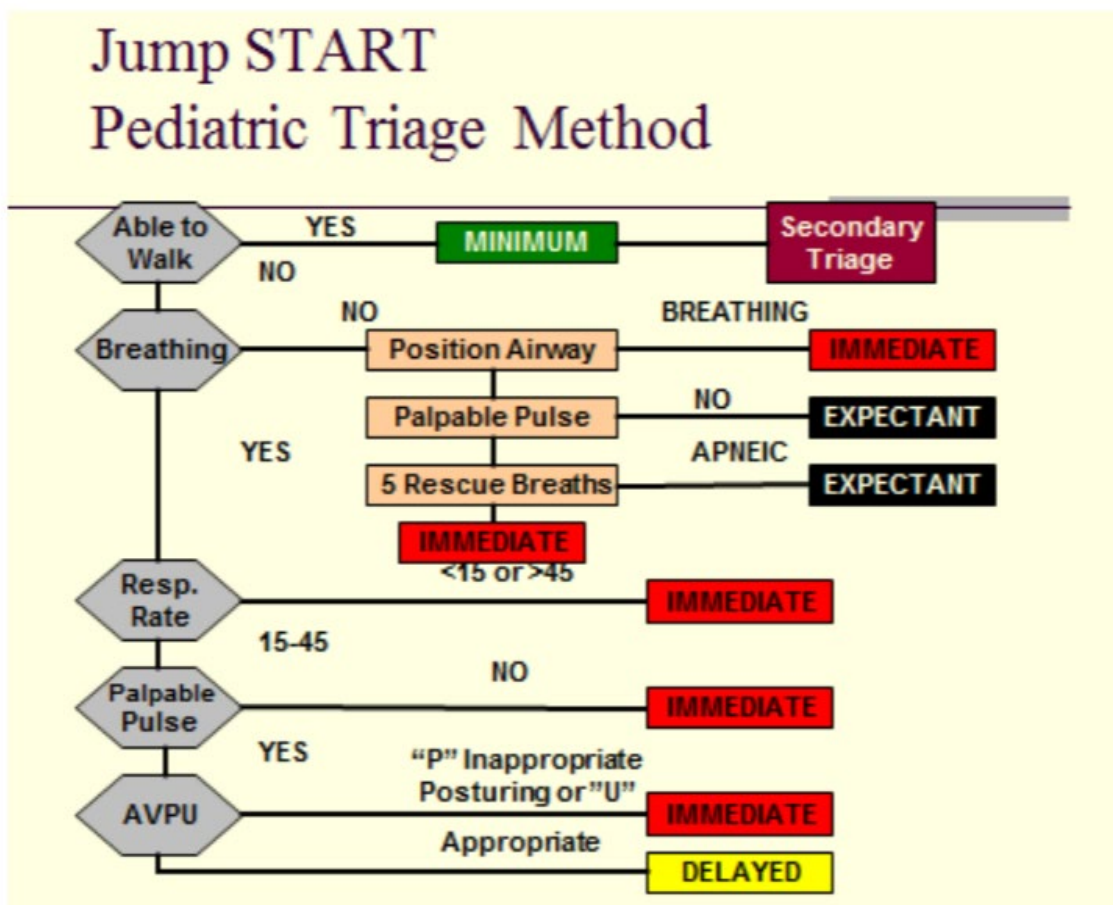
- **MCI Level 2** – Incident will require local resources and responding agencies. Incident may require additional resources within the region.
 - Size – 10 to 20 patients
 - Hospitals – notification to local hospitals in area near location of incident and/or adjacent city or parishes
 - Triage - patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines and primary injury/service needed (*LERN may be able to direct patients to specific area emergency departments with appropriate resources in small scale event*)
 - Communications – primary: phone; secondary: radio

- **MCI Level 3** – Incident will require multiple regional resources and responding agencies. Incident may require additional resources in adjacent regions.
 - Size – 20 to 100 patients
 - Hospitals – initial notification to all regional hospitals and/or adjacent regions
 - Triage - patients identified as **RED**, **YELLOW**, **GREEN** START Triage guidelines
 - Communications – Phone and radio communications. Incident command, operational officers, and area hospitals should monitor HRSA __ during incident.

- **MCI Level 4** – Incident will require multiple regional resources and responding agencies. Incident may require additional resources in adjacent and/or multiple regions.
 - Size – 100 to 1000 patients or casualties
 - Hospitals – initial notification to all hospitals statewide
 - Triage – patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines
 - Communications – Phone and radio communications. Incident command, operational officers, and area hospitals should monitor HRSA __ during incident.

- **MCI Level 5** – Incident will require statewide resources.
 - Size – greater than 1000 patients
 - Hospitals – initial notification to all hospitals statewide
 - Triage – patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines
 - Communications – Phone and radio communications. Incident command, operational officers, and area hospitals should monitor HRSA __ during incident.

Attachment 6 Jump START Pediatric Triage Method



START TRIAGE

(Simple Triage and Rapid Treatment)

