Southeast Wyoming Healthcare Coalition Pediatric Annex

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**Purpose**

Theoutlines the plans, processes, and resources that support member collaboration during the response phase of emergencies, natural disasters, and other crises that are specific to a surge including pediatric patients. It is our intent to integrate our pediatric response and address the unique needs of children as a part of and not separate from our HCC Response Plan. We recognize that much of pediatric healthcare has developed as a separate and parallel healthcare system. As a result, there are certain special considerations that need to be identified and addressed during an event in order to best support children.It is understood that this document is part of the overallSoutheast Wyoming Healthcare Response Plan.

**Logistics**

*Space*

As requested by ESF-8/health and medical branch or an HCC member organization, the Southeast Wyoming HCC can educate and support facilities in identifying and securing additional space conducive to pediatric care. Space should adhere to all regulatory requirements or to the Wyoming Crisis Standards of Care when activated.

Spaces can be categorized as follows:

* *Conventional Spaces:* Areas where such care is normally provided (e.g., treatment space inside a hospital or physician’s office space).
* *Contingency spaces:* Areas where care could be provided at a level functionally equivalent to usual care (e.g., adult rooms used as pediatric units, closed units).
* *Crisis Spaces:* Areas where sufficient care could be provided when usual resources are overwhelmed (this might involve non-pediatric providers and/or ambulatory care pediatric providers supervising inpatient care, temporary intensive care/ventilator support for patients who cannot be moved, or alternative space).

*Staff*

As requested by ESF-8/health and medical branch or an HCC member organization, the Southeast Wyoming HCC can help educate and support facilities in coordinating strategies for increasing/maintaining pediatric staffing levels.

Strategies can include:

* Assigning pediatric trained staff to larger numbers of patients, younger patients (e.g., age <8), or the more injured/ill to closely monitor fluids, medications, and other specific care.
* Non pediatric nursing and other staff would take over patients that require less precise management
* Implement just-in-time training when needed to expand pediatric expertise when the response time frame allows.
* Use of telemedicine as an adjunct for in-person staff.

Actions to augment or increase pediatric staffing should be aligned with existing hospital/facility policies or Wyoming Crisis Standards of Care.

*Supplies*

The Southeast Wyoming HCCdoes not currently have coalition level equipment expectations of member healthcare organizations. As regional and state pediatric disaster planning evolves, we expect to include guidelines for hospitals developed in coordination with Emergency Medical Services for Children, The Wyoming Dept. of Public Health and Environment, and the Wyoming Pediatric Disaster Coalition.

As requested by ESF-8/health and medical branch or an HCC member organization, the Healthcare Coalition will support local and regional strategies for providing medical countermeasures for children to help ensure appropriate pharmaceutical formulations, delivery devices, and age- or size- based dosing instructions.

**Additional Considerations**

*Behavioral Health*

As requested by ESF-8/health and medical branch or an HCC member organization, The HCC will work through existing protocols and procedures to identify pediatric behavioral health needs and request behavioral health resources for children, caregivers and providers.

*Decontamination*

As requested by ESF-8/health and medical branch or an HCC member organization the Southeast Wyoming HCC will assist in coordinating pediatric decontamination resources and supplies. To help ensure that hospitals are adequately prepared to provide appropriate decontamination to children the HCC will provide guidance found in **Appendix 1.3 Pediatric Decontamination**.

*Evacuation*

As requested by ESF-8/health and medical branch or an HCC member organization, the Southeast Wyoming HCC will assist in coordinating pediatric patient movement and identifying appropriate receiving facilities both inside and outside of the region, as requested during an evacuation. This will include Pediatric/Neonatal Intensive Care units.

*Special Pathogens*

The Southeast Wyoming HCCwill support ESF-8/health and medical branches in the management and care (including behavioral health) of children exposed or potentially exposed to a highly infectious disease (and minimize exposure to others, including caregivers). All activities will be coordinated with local and state highly infectious disease plans (where available) and with identified epidemiologists. For transportation resources, please refer to the **Transportation** section.

*Security*

As requested by ESF-8/health and medical branch or an HCC member organization, the Southeast Wyoming HCC will assist in identifying additional security resources as requested to support pediatric safe areas, family reunification sites, and the incident scene.

The HCC will encourage member agencies and organizations to ensure that adequate plans exist at all facilities for keeping children with caregivers as much as possible. In addition, the HCC will encourage members to have detailed security plans for protecting children against kidnapping and predation that include the childproofing of areas not intended for pediatrics.

**Medical Operations**

*Triage*

Triage and transportation protocols often fall under State and regional EMS and trauma regulations, guidance, and protocols.

As requested by the ESF-8/health and medical branch, the Healthcare Coalition can support the identification and coordination of resources to help manage the patient load on emergency departments. This support can include:

* Identifying and coordinating activation of alternative care sites.
* Identifying and coordinating pediatric equipment and supplies to alternative care sites.
* Work with hospitals to identify how and when to send/receive pediatric staff between facilities/locations to best serve the greatest numbers of pediatric patients.
* Identifying and coordinating EMS transportation and treatment personnel and assets.

*Treatment*

The treatment of pediatric patients even during a mass casualty or surge event is the responsibility of the hospital and treating practitioners. The Southeast Wyoming HCCencourages member hospitals to develop and exercise a pediatric surge plan that addresses how it will maintain the best possible care when the demand for pediatric services and/or transport exceeds supply. This includes, but is not limited to: how information on patients will be shared between facilities; how patients will be prioritized for transfer to specialty care; transfer agreements with a hospital providing definitive pediatric specialty care; and agreements that allow access to pediatric specialty consultation through telemedicine or other means.

As requested by the ESF-8/health and medical branch and/or coalition members , the Healthcare Coalition can support the treatment of pediatric patients. This support can include:

* Working with State ESF-8 lead/health and medical branch to disseminate information from pediatric subject matter experts regarding the care and treatment of children with hospitals, community clinicians, and others to aid in caring for children throughout the affected area.
* Requesting activation of “Crisis Standards of Care” through ESF-8 Lead(s).
* Requesting activation of Mountain States Pediatric Disaster Coalition for interstate transfer of patients.
* Supporting the evacuation of pediatric patients, pediatric hospital or Neonatal Intensive Care Unit.
* Assisting in identifying transportation resources for repatriating children transferred to other areas.
* Helping identify and match available EMS transportation and treatment capabilities to patient needs.

*Pediatric Centers*

Colorado

Children’s Hospital Colorado – Regional Pediatric Trauma Center-(Level I Pediatric) 720-777-1350

Denver Health Pediatric Emergency Care Center – Level I Pediatric Emergency Department

Rocky Mountain Hospital for Children Presbyterian/St. Luke’s – Level IV Pediatric Emergency Department

Mountain States Pediatric Disaster Coalition

Utah

Primary Children’s Hospital – Level IV Pediatric Emergency Department

Montana

St. Vincent Healthcare – Level III Pediatric Emergency Department

**Transportation**

Sending and receiving hospitals work together to prioritize specialty patient transfers. When possible, the state ESF-8 Lead will provide a subject matter expert to help hospitals identify the appropriate pediatric center to receive a specific patient.

Requests for inter-facility transport of a specialty pediatric patient can come from either the sending or receiving facility. However, each EMS Agency is responsible for coordinating and prioritizing patient transfers based upon state and regional regulations and protocols and the availability of resources.

When requested by ESF-8/health and medical branch and/or an EMS agency, the Healthcare Coalition can assist in tracking and coordinating pediatric transportation resources (e.g. coordinating with the local EMS agency or an EMS Multi-agency Coordinating Center [MACC]).

**Displaced/unaccompanied Children and Family Reunification**

Wyoming does not have a statewide system for tracking and identifying displaced/unaccompanied children and identification of parent/guardian. Through collaboration with local partners and the ESF-8 lead(s), the Southeast Wyoming HCCwill support the state, county and/or local efforts to reunify pediatric patients and/or missing children of adult patients within and outside the coalition, for both pediatrics surge events where children can be separated from parent/guardian and in the event of a healthcare facility evacuation.

Support activities will include:

* Supporting local plans for identifying and locating missing family members (include a description of local plans & protocols such as using 211.)
* Supporting the use of the National Center for Missing and Exploited Children Unaccompanied Minor Registry <https://umr.missingkids.org/umr/reportUMR?execution=e1s1> by all healthcare providers during a disaster or emergency to report unaccompanied minors in their care. (This does not supersede or replace other protocols such as reporting the child to police/sheriff and child welfare.)
* Supporting the use of the National Center for Missing and Exploited Children <http://www.missingkids.com/> by all healthcare providers for reporting missing children of adult patients.
* Supporting the establishment of Family Assistance Center(s) within the jurisdiction.
* Coordinating with other agencies (such as public schools and the American Red Cross) involved in family reunification

**Just-in-Time Training**

The Southeast Wyoming HCCwill work with HCC members and local ESF-8 Lead(s) to identify knowledge gaps and training needs to support the pediatric surge response. The HCC will work with local ESF-8 Lead(s) to request and coordinate Just-in-Time training from subject matter experts. Training resources may be requested from the State ESF-8 Lead by the local ESF-8 Lead(s) if local or regional resources are not available.

**Training and Exercise**

The Southeast Wyoming HCC *will* participate in a standardized tabletop exercise designed to test this Pediatric Surge Annex by June 15, 2020. During the after-action evaluation the HCC will identify at least one training need to include in the After-Action Report.

The HCC will work to include a pediatric component in all exercises it leads.

**Appendix 1.1 – Transfer Agreements**

**Appendix 1.2**

Access & Functional Needs Guidance for Pediatric Surge Events

Delivering healthcare to children and maintaining children’s healthy functioning during disasters often relies on the involvement and functioning of parents and other caregivers. Children and their caregivers also have intersectional identities and lived experiences that inform what they need to access or function while receiving effective, equitable healthcare. The C-MIST framework organizes access & functional needs into five big areas that affect community members’ functioning and access to services. Consider these examples and other needs that you identify in these 5 functional areas as they affect children, their families/caregivers and the healthcare system’s ability to provide services to children. Integrate these needs into your HCC’s planning and resource management.

*Note: Not all access & functional needs can be addressed by just healthcare partners. By building situational awareness about a community’s access & functional needs, it becomes clear what other partners an HCC will need to collaborate with.*

*C – Communication*

Communication is crucial to delivering healthcare and maintaining the dignity and consent of patients while delivering services. Functional services and practices that support communication must be planned for as critical staff and infrastructure in healthcare systems.

* Developmentally, children have lower literacy, vocabulary, and comprehension skills to understand their safety and what’s happening during a disaster, but they still need communication to involve them and help them function.
* Children and their caregivers/communities may need communication in alternate language or formats, or need access to assistive technology devices. Consider pediatric demographics and whole household/community demographics within the HCC that affect communication needs. What language service resources - interpretation, translation, culturally-informed staff or community brokers – need to be identified or maintained in disasters?
* Resource for community demographics and resource partners: <http://www.cohealthmaps.dphe.state.co.us/colorado_community_inclusion/>

*M – Maintaining Health*

* Consider limits on specialty pediatric health services or equipment in the HCC – how many children could be supported at the same time? How many kids use those services regularly? If that capacity is exceeded or surged, how will those needs be addressed? Include services for:
  + children with serious mental health or emotional disturbance needs
  + children using durable medical equipment or medical services (home health, transportation)
  + other known groups of children or youth with special healthcare needs
* Additional resource for community/regional information about pediatric healthcare needs: HCP program contacts: <https://docs.google.com/spreadsheets/d/1rdzcjr3E-gZxPcGNwloKuc4W5W8l8Tag1vmlzc8W0kY/edit#gid=1218008202>
* Resource available: [**Questions to Ask for Identifying Communication and Accommodation Needs**](http://www.jik.com/pubs/VerifyingNeeds.doc)

*I - Independence*

Children and their family members/caregivers may maintain their independence through devices, services, practices and other environmental accommodations. Independence needs must be considered in delivering healthcare but not misunderstood as evidence of medical need or limited agency and competence. In a disaster, someone with power dependence or non-medical care services does not need to be brought to healthcare settings unless there are other health concerns. Equipment and services that allow people to maintain their independence should be integrated in healthcare settings to support equal access to services in the least restrictive and most integrated environment.

* Involve community partners that address children’s independence and functioning in HCC planning.
* Consider transfer, examination equipment for pediatric patients, including pediatric patients with disabilities or other physical functioning supports
* Resource available: [**Questions to Ask for Identifying Communication and Accommodation Needs**](http://www.jik.com/pubs/VerifyingNeeds.doc)

*S - Safety/Services/Supports*

This functional need area can capture other resources or practices that help to preserve children’s safety and other services or supports they rely on for their well-being and functioning.

* Consider protocols for family notification and reunification used by HCC members and how they might be supported by the whole coalition. Key questions to HCC agency partners:
  + How is patient tracking or family notification/reunification built into the services or agreements set with your patients/clients?
  + How do you address family notification/reunification in preparedness planning with your patients/clients?
  + What agency practices do you currently have in place for patient tracking and family notification/reunification?
  + If a patient/client is displaced from where they were originally receiving services, how are families or social supports made aware?
  + What coordination or assistance for family reunification would be helpful from the HCC or fellow HCC agencies?
  + What barriers or difficulties can you imagine having with family reunification at your agency?
* Consider where child-friendly spaces might be needed and maintained

*T - Transportation*

* Children are generally reliant on adults to be transported to different places and may need physical support to be transported safely. Information on specialty agencies or resources for pediatric transportation should be identified if available.
* Single parent households, or households with no vehicle access may experience barriers to accessing healthcare in disasters. [CICOmaps](http://www.cohealthmaps.dphe.state.co.us/colorado_community_inclusion/general_indicators/) include these demographics.
* Transportation resources from schools and other providers that serve children may be sought for other transportation needs – including health care - during disasters and may need to be deconflicted.
* Wyoming recognized that some early childcare facilities (i.e. summer camps) are licensed to serve large numbers of children but do not always have enough transportation resources to move them if evacuation is necessary.

In addition to the five areas identified in C-MIST, access & functional needs are influenced by the following factors:

* **Trust** and past experiences with the various partners involved in disasters (healthcare, first responders, government, etc.) will affect whether community members seek information and services from those partners during disasters.
* **Economic** barriers or constraints for community members affect which access & functional needs they can help to address or prepare for with their own resources.
* **Isolation** (whether geographic, social or cultural) will affect people’s ability to access resources that support their needs. They may be unavailable nearby or difficult to acquire because of lack of understanding or familiarity. Some resources may be ineffective or withheld because of social stigma or lack of cultural awareness.
* **Capacity** – having a resource to address an access or functional need may have limited effectiveness if there is not enough of the resource to serve the number of people or amount of need in the community.
* **Housing** – stable access to housing or shelter affects a person’s ability to stabilize and protect resources for each of the C-MIST functional areas.

Demographics and resources related to some of these influencing areas are also available in the [CICOmaps](http://www.cohealthmaps.dphe.state.co.us/colorado_community_inclusion)

**Appendix 1.3 Decontamination**

Decontamination of Children Retrieved from <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Decontamination.aspx>

Patient Decontamination in a Mass Chemical Exposure Incident: National Planning Guidance for Communities

The US Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR) and the US Department of Homeland Security (DHS) Office of Health Affairs published the nation’s first evidence-based guidance for mass decontamination. The guidance, titled “[Patient Decontamination in a Mass Chemical Exposure Incident: National Planning Guidance for Communities](http://www.phe.gov/Preparedness/responders/Documents/patient-decon-natl-plng-guide.pdf)”, informs planning and response for a wide variety of situations, from local chemical plant accidents to terrorism incidents, and covers mass casualties, chemical release, external contamination, and decontamination of people. Certain details related to children are included. HHS and DHS have started developing a companion guidance document focused on decontaminating pediatric patients.

**Decontamination of Children**

Whether as a result of an accidental release at a chemical plant, a transportation accident, or an intentional terrorist action, the threat of exposure of the public to hazardous chemicals is real. Children are particularly vulnerable to aerosolized biologic or chemical agentsbecause they normally breathe more times per minute than adults, and they would be exposed to larger doses than adults in the same period of time. Children are also more vulnerable to agents that act on or through the skin because their skin is thinner and they have a larger skin surface-to-body mass ratio than adults. Children will require different advanced planning and supplies for decontamination. For example, children, especially young children, are more at risk of hypothermia and therefore require heated water or decontamination conducted in a site more protected from cold environments. Each hospital must have its own system or plan for decontamination, with protocols specific to children.

**Need for Decontamination**

Decontamination is the removal or reduction of harmful substances from a patient's body. The goal of decontamination is to ensure that a toxic substance, whether chemical, biological, or radiological, is no longer in direct contact with the patient. This prevents further absorption by the patient and will decrease the possibility of transfer of the toxic substance to health care workers.

**Important Processes for Decontaminating Children**

The following are tips and suggestions for decontaminating children:

* Staff helping with decontamination should receive training on the vulnerabilities of children and how to address these.
* Children should be prioritized before adults within the same decontamination priority group.
* Unless strictly contraindicated due to medical needs, families should undergo decontamination together. Children and parents may become upset if separated from family members during decontamination. Keeping children with their parents or caregivers may reduce psychological stress for all family members and decrease the need for additional assistance from responders or health care personnel.
* Children will take more time to disrobe and prepare (emotionally) for the decontamination. Parents may fear that the privacy, safety, and welfare of their children are not protected if they are cared for by responders of the opposite gender. Children of certain ages may become more anxious when asked to disrobe, and it is recommended to have both male and female personnel to assist children. A [study​](http://www.hhs.gov/about/news/2016/05/10/hhs-sponsored-study-shows-disrobing-vital-decontamination-method.html) sponsored by the HHS revealed that 99% of chemical contamination can be eliminated by carefully removing clothes and wiping skin with a paper towel or dry wipe.
* The risk of adverse consequences of water-based decontamination may be greater in children; warming measures will be necessary. The water temperature should be 98◦ to 110◦ F out of tap, and foil/metallic blankets should be used post decontamination for ease of use and disposal.
* Hospital personnel should take care to ensure each child's airway remains open and protected during decontamination.
* Low pressure shower systems should be used to decontaminate children.
* Infants and young children can be slippery when wet and will require a system to ensure their safety (eg, hand spraying while on a stretcher, in a bassinet, or laundry basket with holes).

**Psychological Support**

* When children are exposed to circumstances that are beyond the usual scope of human experience, they may have difficulty understanding and coping with the events and may need support from adults. See additional information on [Promoting Adjustment and Helping Children Cope](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Promoting-Adjustment-and-Helping-Children-Cope.aspx).
* For unaccompanied minors, psychosocial support should be provided in a pre-designated child safe area with age appropriate activities.
* When appropriate, self -care decontamination (actions that a patient can perform for him/herself) can have a positive impact on children following a chemical exposure. Consider developing standard protocols and kits to support self-care decontamination.

To ensure that the unique physical and emotional needs of children are met during times of disaster, the pediatrician should be involved in community preparedness planning in advance of a disaster. Clinicians can talk to parents about the need to develop a family disaster plan and encourage them to talk to their children about what to do in various emergency situations. See the [Family Readiness Kit](https://www.aap.org/en-us/Documents/disasters_family_readiness_kit.pdf). See additional information from the [Pediatric Preparedness Resource Kit](https://www.aap.org/disasters/resourcekit) or [The Youngest Victims: Disaster Preparedness to Meet Children's Needs](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Documents/Youngest-Victims-Final.pdf).

**Resources**

[Biological Terrorism and Agents](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Biological-Terrorism-and-Agents.aspx) (AAP)

[Chemical Terrorism and Agents](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Chemical-Terrorism-and-Agents.aspx) (AAP)

[Decontamination of Children](https://www.youtube.com/watch?v=ctt6RJGMV9Y)(HHS)

[Decontamination of Poisoned Children](http://www.uptodate.com/contents/decontamination-of-poisoned-children) (UpToDate)

[Domain 4 of the EMSC Pediatric Disaster Checklist for Hospitals](https://emscimprovement.center/media/emsc/files/pdf/emsc_resources/checklist_ped_domains/Checklist_HospitalDisasterPrepared2125.pdf?la=en)(EMSC)

[Dropbox of Pediatric Decontamination Resources](https://www.dropbox.com/sh/ti5wnkxj6uybczh/AABZgEScq_I_9dmEBplEIliXa?dl=0)

[Essential Pediatric Domains and Considerations for Every Hospital's Disaster Preparedness Policies - Domain 4](https://emscimprovement.center/resources/publications/checklist-essential-for-every-hospitals-disaster-preparedness-policies/) (EMSC)

[Hospitals](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Hospitals.aspx) (AAP)

[Principles of Pediatric Decontamination Article](http://www.ny2aap.org/pdf/Disaster/186.pdf) (Clinical Pediatric Emergency Medicine)

[Radiologic or Nuclear Terrorism and Agents](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Radiologic-or-Nuclear-Terrorism-and-Agents.aspx)(AAP)

[Talking to Children About Disasters](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Talking-to-Children-About-Disasters.aspx) (AAP)  
  
[Decontamination Decoded: Disrobing, Dry Wiping Removes 99% of Chemical Contaminants (ASPR Blog)​​​](https://www.phe.gov/ASPRBlog/pages/BlogArticlePage.aspx?PostID=306)