ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ESF-8 PLAN:

PEDIATRIC AND NEONATAL SURGE ANNEX

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ACRONYMS/DEFINITIONS

ACS	Alternate Care Site
APA	American Pharmaceutical Association
APLS	Advanced Pediatric Life Support
APN	Advanced Practice Nurse
ARC	American Red Cross
ATS	Alternate Treatment Site
CCRRA	Child Care Resources and Referral Agencies
CEMP	Comprehensive Emergency Management Program
CFAN	Children with Functional and Access Needs
CHUG	Collaborative Healthcare Urgency Group
CSHCN	Children with Special Health Care Needs
DCFS	Illinois Department of Children and Family Services
DPR	Division of Disaster Planning and Readiness
DSCC	Division of Specialized Care for Children
ED	Emergency Department
EDAP	Emergency Department Approved for Pediatrics
EMAC	Emergency Medical Assistance Compact
EMResource	Commercial electronic resource management/communication tool
EMS	Emergency Medical Services
EMSC	Emergency Medical Services for Children
EMTrack	Commercial electronic multi-functional tracking system
ENPC	Emergency Nursing Pediatric Course
EOC	Emergency Operations Center
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FAN	Functional and Access Needs
FEMA	Federal Emergency Management Agency
FGM	Fiscal and Grants Management
HAM	Amateur radio
GLHPP	Great Lakes Healthcare Partnership Program
HAv-BED	Hospital Available Beds for Emergencies and Disasters
HBPPC	Indiana State Department of Health, Hospital Bioterrorism Preparedness Planning Committee
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
IA	Iowa
IAACCT	Illinois Association of Air and Critical Care Transport
IAFP	Illinois Academy of Family Physicians
ICAAP	Illinois Chapter of American Academy of Pediatrics
ICAHN	Illinois Critical Access Hospital Network
ICEP	Illinois College of Emergency Physicians

ID	Identification
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
Illinois ENA	Illinois Emergency Nurses Association
Illinois HELPS	Illinois ESAR-VHP Program
IMERT	Illinois Medical Emergency Response Team
IMT	Incident Management Team
IN	Indiana
INCCRRA	Illinois Network of Child Care Resource and Referral Agencies
IPA	Illinois Pharmacists Association
ISBE	Illinois State Board of Education
ISMS	Illinois State Medical Society
KY	Kentucky
KYEM	Kentucky Emergency Management
LEO	Law Enforcement Officer
LHD	Local health department
LTC	Long-term Care
LTC for U-22	Long-term Care for Under 22 Years of Age
MACS	Multiple Agency Command System
MCI	Mass Casualty Incident
MDHSS ERC	Missouri Dept. of Health & Senior Services Emergency Response Center
MO	Missouri
MOU	Memorandum of Understanding
NCMEC	National Center for Missing and Exploited Children
NICU	Neonatal Intensive Care Unit
NIMS	National Incident Management System
NRP	Neonatal Resuscitation Program
OPR	Office of Preparedness and Response
PA	Physician Assistant
PALS	Pediatric Advanced Life Support
PCCC	Pediatric Critical Care Center
PCMS	Pediatric Care Medical Specialist
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health and Emergency Preparedness
PHMSRR	Public Health and Medical Services Response Regions
PICU	Pediatric Intensive Care Unit
POD	Point of Distribution
REMSC	Regional Emergency Medical Services Coordinator
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SEDP	Standby Emergency Department Approved for Pediatrics
SEOC	State Emergency Operations Center
SIREN	State of Illinois Rapid Electronic Notification
SMOC	St. Louis Medical Operation Center
SNS	Strategic National Stockpile
T and E	Training and Exercise

TMTS	Temporary Medical Treatment Stations
WHEPP	Wisconsin Hospital Emergency Preparedness Program
WI	Wisconsin

RECORD OF REVISIONS

DATE OF CHANGE	SECTION(S) UPDATED	DATE POSTED
January 2015	Original document finalized	January 2015
August 2015	1. Removed Attachment 6: Indiana HBPPC District Lead Contact Information and Attachment 9: WHEPP Regional Manager Contact Information Map 2. 1.2.4: Added Request for Medical Resource (RFMR) Process language 3. 2.2.3: Added language to clarify communication process versus RFMR process 4. 2.2.3: Revised process of contacting Indiana and Wisconsin 5. 2.4.4: Revised process of contacting Indiana and Wisconsin 6. 2.4.3: Clarified when to use JumpSTART Triage during field triage and the Pediatric Triage Guidelines found in the Annex 7. 3.2.2: Added role of EMS for Children is to maintain the Resource Allocation Strategies for the Pediatric Population document	August 2015
March 2017	1. Record of Revisions section added to annex 2. 2.1.4 & 2.1.4.1: Redefined the types of events and circumstances of incidents that would lead to the activation of the Annex to be consistent with more common disaster terminology. 3. 2.2.3: This language and information was added to the Annex for clarification and consistency with the planned revisions to the IDPH ESF-8 Plan to separate the process to request medical and non-medical resources. 4. 2.4.2.1c: Clarified how the tracking numbers will be assigned to patients during a disaster 5. 2.4.3 2: Clarified how the Pediatric/ Neonatal Medical Incident Report Form to request transfers of pediatric patients during a disaster when the Annex is activated. 6. 3.2.4 2-3.2.6 2: Clarified the role of all hospitals in providing education to families within their facilities on the process of transferring pediatric patients as outlined in the Annex 7. New additions to the Annex: a. Attachment 1: Overview of the Pediatric and Neonatal Surge Annex b. Attachment 9: IDPH and PCMS Communication Process	March 2017

	8. Additional changes: a. Attachment 4: Pediatric and Neonatal Surge Annex Activation Pathway (reformatted) b. Attachment 5: Pediatric and Neonatal Medical Incident Report Form (activation type, triage categories and placement/transfer information) c. Attachment 6: Pediatric/Neonatal Communication Pathway (reformatted) d. Attachment 10: Pediatric Triage Guidelines (renamed triage categories to use plain language) e. Attachment 11: Pediatric Patient Tracking Log (tracking number information, mode and type of transport services added)	
July 2020	1. Date of document updated to July 2020. 2. Table of contents modified to reflect annex changes. 3. Additional organizations/terms added to acronyms/definitions list. 4. Added "Local Health Departments" to support agencies and organizations; minor organization name modifications 5. 1.5.5 Verbiage modified to reflect IDPH ESF-8 plan. 6. 2.2.3 GLHPP order of participants alphabetized; City of Chicago added 7. 2.3.1 2. Referenced sections updated 8. 2.3.2 "Regional ESF-8 Plan" changed to "Regional Health Care Coalition Preparedness Plan" 9. 2.3.4 a. GLHPP order of participants alphabetized, City of Chicago added 10. 2.3.4 e. Wisconsin: modified verbiage to reflect use of EMResource instead of WI-TRAC. 11. 2.4.2 3a: American Red Cross—Patient Connection Program removed; added Safe & Well program and new resources 12. 2.4.2 3b: NCMEC weblink updated 13. 2.4.4 Illinois Association of Air and Critical Care Transport (IAACCT) resources removed; resource page no longer functional 14. 2.4.6 Weblink to access system decompression information was updated 15. 2.4.7 Modified verbiage to identify two annexes that contain pediatric resource allocation strategies – Functional and Access Needs (FAN) Annex and the Catastrophic Incident Response (CIR) Annex. 16. 3.2 Order of organizations listed modified to reflect order of supporting agencies/organizations the beginning of this annex	

	17. 3.2.2 Modified verbiage to identify two annexes that contain pediatric resource allocation strategies – Functional and Access Needs (FAN) Annex and the Catastrophic Incident Response (CIR) Annex. 18. 3.2.3 Identified the responsibility of each RHCC to annually review their self-assigned decompression category; "ESF-8 Plan" changed to "Regional Health Care Coalition Preparedness Plan" 19. 3.2.4 Identified the responsibility of each Resource Hospital to annually review their self-assigned decompression category; "ESF-8 Plan" changed to "Regional Health Care Coalition Preparedness Plan" 20. 3.2.5 Identified the responsibility of all hospitals to annually review their self-assigned decompression categories; "ESF-8 Plan" changed to "Regional Health Care Coalition Preparedness Plan" 21. 3.2.6 Added the Illinois Critical Access Hospital Network and their responsibilities 22. 3.2.8.5 Modified verbiage to reflect use of EMResource instead of WI-TRAC 23. 3.2.9 Provided more specific detail regarding IMERT responsibilities; removed Pediatric Care Medical Specialist as a separated item and added as sub-bullet to IMERT 24. 3.2.11.4 Added an emergency contact phone number for CHUG 25. 3.2.12 Added the Illinois College of Emergency Physicians (ICEP) and their responsibilities 26. 3.2.13 Added the Illinois Emergency Nurses Association (ENA) and their responsibilities 27. 3.2.16 Removed inactive phone number; modified verbiage for role of DCFS related to unaccompanied minors 28. 3.2.17 Provided more specific detail regarding IDHS responsibilities related to child care programs and maintaining the Illinois Statewide Child Care Emergency Preparedness and Response Plan	

PRIMARY AGENCY

Illinois Department of Public Health

SUPPORT AGENCIES AND ORGANIZATIONS

Illinois Emergency Management Agency
Illinois Emergency Medical Services for Children
Regional Hospital Coordinating Centers
EMS Resource Hospitals
All other hospitals
Illinois Critical Access Hospital Network
Local Health Departments
Border States (GLHPP, Iowa, Kentucky, Missouri, Wisconsin)
Illinois Medical Emergency Response Team

- Pediatric Care Medical Specialists

Long-term Care Facilities for Under Age 22 Years
Illinois Chapter of American Academy of Pediatrics
Illinois College of Emergency Physicians
Illinois Emergency Nurses Association
Illinois HELPS
Division of Specialized Care for Children
Illinois Department of Children and Family Services
Illinois Department of Human Services

1.0 INTRODUCTION

1.1 PURPOSE

The purpose of this Pediatric and Neonatal Surge Annex is to support the Illinois Department of Public Health (IDPH) ESF-8 Plan, by providing a functional annex for all stakeholders involved in an emergency response within the state of Illinois and/or adjacent states in order to protect children and to provide appropriate pediatric medical care during a disaster. This annex guides the state level response and provides local medical services guidance on the care of children, including patient movement, system decompression, recommendations for care, and resource allocation during a surge of pediatric patients that overwhelms the local health care system. This annex is intended to support, not replace, any agencies' existing policies or plans by providing coordinated response actions in the case of pediatric emergency. The *Overview of the Pediatric and Neonatal Surge Annex* (Attachment 1) provides an algorithm reference for the overall components and processes outlined in this Annex.

1.2 ASSUMPTIONS

1.2.1 The IDPH ESF-8 Plan has been activated, either partially or fully, at the discretion of the IDPH director.

1.2.2 The Public Health and Medical Services Response Regions (see Attachment 2) serve as the primary regional geographical organizational structure for the IDPH ESF-8 Plan and the Pediatric and Neonatal Surge Annex response.

1.2.3 The local and/or regional health care system has exhausted its capacity to care for pediatric patients and has implemented and exhausted any mutual aid agreements, therefore, requiring assistance from the other regions and/or the state.

1.2.4 Requests for assistance with medical consultation, system decompression, and coordination of pediatric patient movement will be considered once a Request for Medical Resources (RFMR) has been made as outlined in the IDPH ESF-8 Plan.

1.2.5 In the initial stages of a mass casualty event that includes large numbers of ill and/or injured children, all health care facilities may have to provide care to pediatric patients until adequate resources become available to allow for transport to pediatric tertiary care centers/specialty care centers.

1.2.6 The age range for children that meet the definition of a pediatric patient in this annex is birth through 15 years of age. Since children within this age range comprise approximately a quarter of the population within Illinois, it should be assumed children may comprise approximately a quarter of the victims during a disaster.

1.3 SCOPE

The Pediatric and Neonatal Surge Annex is designed to provide the command structure, communication protocols, RFMR process, and the procedure for inter-regional and interstate transfer as related to pediatric patients. The Pediatric and Neonatal Surge Annex is designed to:

1. Enable safe pediatric transfer decision making
2. Implement standardized care guidelines as needed
3. Ensure associated communications processes are in place
4. Support the tracking of pediatric patients throughout the incident
5. Assist with the coordination of transferring acutely ill/injured pediatric patients to pediatric tertiary care centers/specialty care centers
6. Assist with the decompression from pediatric tertiary care centers/specialty care centers in order to make additional critical care beds available for acutely ill/injured pediatric patients

The Hospital Preparedness Program (HPP) and Public Health and Emergency Preparedness (PHEP) domains addressed in this annex include, but are not limited to:

1. Community Resilience
2. Strengthen Incident Management
3. Information Management
4. Countermeasure and Mitigation
5. Surge Management

1.4 SITUATION

The IDPH ESF-8 Plan and its corresponding annexes are activated when the State Emergency Operations Center (SEOC) is activated and/or at the discretion of the IDPH director when circumstances dictate and when the Public Health Emergency Operations

Center (PHEOC) is activated. It can be partially or fully implemented in the context of a threat, in anticipation of a significant event or in response to an incident. Scalable implementation allows for appropriate levels of coordination.

1.5 AUTHORITIES

1.5.1 Within Illinois, the overall authority for direction and control of the response to an emergency medical incident rests with the governor. Article V, Section 6, of the Illinois Constitution of 1970 and the Governor Succession Act (15 ILCS 5/1) identify the officers next in line of succession in the following order: the lieutenant governor, the elected attorney general, the elected secretary of state, the elected comptroller, the elected treasurer, the president of the senate, and the speaker of the House of Representatives. The governor is assisted in the exercise of direction and control activities by his/her staff and in the coordination of the activities by Illinois Emergency Management Agency (IEMA). The State Emergency Operation Center (SEOC) is the strategic direction and control point for Illinois response to an emergency medical incident (see Attachment 3).

1.5.2 IDPH is the lead agency for all public health and medical response operations in Illinois. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to local operations.

1.5.3 All requests for health and medical assistance with the care of children during emergency events will be routed through the State Emergency Operations Center (SEOC) and IEMA as indicated in Request for Medical Resources (RFMR) process in the IDPH ESF-8 Plan. The request will then be directed by the SEOC manager to the IDPH SEOC liaison. IDPH will determine the best resources from the health and medical standpoint to deploy in order to fulfill the request.

1.5.4 The overall authority for direction and control of IDPH's resources to respond to an emergency medical incident is the Department's director. The line of succession at IDPH extends from the director to the assistant director, forward to the appropriate deputy directors of the IDPH offices.

1.5.5 The RHCC and/or regional HCC shall have authority to coordinate supply/equipment caches and services (other than EMS licensed providers and personnel) as outlined in the IDPH approved regional disaster preparedness plan and within the scope of the IDPH HPP program.

2.0 CONCEPT OF OPERATIONS

2.1 GENERAL

2.1.1 Throughout the response and recovery periods, the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex will provide the framework to evaluate and to analyze information regarding medical and public health assistance requests for response; develop and update assessments of medical and public health status in the impact area; and provide contingency planning to meet anticipated demands as they relate to children.

2.1.2 When an incident affects large numbers of children, subject matter expertise will be provided to advise and/or to direct operations as it pertains to pediatric patient movement, system decompression, care guidelines, and resource allocation within the context of the Incident Command System structure. Pediatric subject matter experts throughout the state and surrounding border states will be utilized.

2.1.3 Incidents that could prompt the activation of the Pediatric and Neonatal Surge Annex include, but are not limited to:

1. Activation of the IDPH ESF-8 Plan
2. Overwhelming influx or surge of pediatric and neonatal patients
3. Inadequate pediatric health care facility resources (e.g., inpatient monitored beds, ventilators, isolation beds)
4. Damage or threats to health care facility(ies)
5. Staffing limitations (e.g., qualified and trained staff to care for pediatric or neonatal patients)
6. Activation of health care facility(ies) disaster plan when surge capacity for pediatric patients has been exceeded
7. Requests from border states to assist with a surge of pediatric patients

2.1.4 This annex can be partially or fully activated during Type 3, Type 2, or Type 1 Health and Medical Emergency Events that involve pediatric casualties and leads to the exhaustion of pediatric resources to care for these casualties at the local, regional or state level. See Attachment 4 for the Pediatric and Neonatal Surge Annex Activation Pathway. The circumstances of the incident that leads to the activation of the annex can range from a large, unexpected, potentially life-threatening incident involving the pediatric population (e.g., earthquake) to a slow, gradually building or preplanned incident (e.g., epidemic, pandemic, partial or full planned evacuation).

2.1.4.1 While appropriate and established communication and/or notification processes during an incident are important, providing emergency medical care to pediatric patients initially takes priority over any external bed authorization, communication, and/or notification processes. Once the incident and patients become more stabilized, health care facilities must communicate with IDPH to relay what processes (e.g., increased bed capacity beyond licensure) occurred as indicated in the IDPH ESF-8 Plan. For those incidents that build more gradually or are preplanned incidents, the established external authorization and communication processes must occur as indicated in this annex and the IDPH ESF-8 Plan.

2.1.5 Regardless of the pathway to activate the Annex, the health care entities involved with the incident function independently and may activate the necessary internal resources and policies to successfully respond to the needs of the pediatric patient (e.g., early or expedited inpatient discharge).

2.1.6 Within the IDPH ESF-8 Plan, multiple annexes exist that address the needs of specialty populations (i.e., pediatric and neonatal patients, burn patients). Depending on the scope of the disaster, multiple annexes or components of each may need to be activated simultaneously in order to thoroughly address the specific needs of the victims (e.g., pediatric burn patients). Efforts have been made to ensure consistency between annexes that address the needs of specialty populations. It is the recommendation that the experts for the specialty populations involved in the mass casualty incident (MCI) work together to address any conflicts that may occur.

2.2. NOTIFICATION

2.2.1 Upon the activation of the Pediatric and Neonatal Surge Annex, the *Pediatric/Neonatal Medical Incident Report Form* (See Attachment 5) will be utilized to communicate necessary information about the annex activation with affected entities and those entities that may be called upon to assist during the incident. See Section 2.2.3 for a listing of possible stakeholders that should be notified during the activation of the Pediatric and Neonatal Surge Annex. This form may be sent and received via any available communication method (e.g., SIREN, e-mail, fax). When the *Pediatric/Neonatal Medical Incident Report Form* is utilized during an event, the communication method that will be utilized for stakeholders to reply will be indicated on the form in the "Reply/Action Required" section.

2.2.2 Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information internally and externally from their facility. Information should be shared in the preferred and most expected method (i.e., SIREN). However, depending on the type of incident, the typical alert and messaging systems may or may not be available and alternate methods will be utilized to communicate. Some of the possible established methods for communication that can be used include:

1. Telephone (landline)
2. Telephone (cellular)
3. Facsimile
4. Radio systems (StarCom, HAM/Amateur, MERCI, telemetry)
5. E-mail
6. Electronic emergency management systems
7. SIREN
8. HAv-BED Tracking System in each state
9. WebEOC®
10. Social media
11. Comprehensive Emergency Management Program (CEMP) (For information sharing, including access to documents and resources)

2.2.3 Communication during an incident that involves large numbers of children is vital and information sharing needs to occur with health care facilities/agencies and non-health care entities where children are typically located. The *Pediatric/Neonatal Medical Incident Report Form* should be utilized by all stakeholders to assist with ensuring consistent communication between stakeholders and to provide a mechanism to request pediatric patient transfer resources and identify availability of resources at a health care facility. For pediatric care equipment resource needs/requests, complete the ICS 213RR form and submit it through the RFMR Process as outlined in the IDPH ESF-8 Plan. Listed below are facilities/agencies/entities that either play a role in caring for children or are part of the incident response and should be notified and receive

ongoing communication from the time the Pediatric and Neonatal Surge Annex is activated until normal operations resume. The *Pediatric/Neonatal Communication Pathway* (Attachment 6) outlines which stakeholders will typically communicate and share information with each other when the annex is activated. This communication process is similar to daily communication processes and other types of disaster. The communication pathway is different from the RFMR process, although there is some overlap. The following list is not inclusive, nor are entities listed in any priority order. Depending on the type of incident that has occurred, additional stakeholders should be included in the information sharing process as needed and appropriate.

1. Health care facilities
    a. Acute care hospitals
    b. Pediatric specialty hospitals
    c. Psychiatric hospitals
    d. Rehabilitation hospitals
2. Regional Hospital Coordinating Centers (RHCC)
3. County Emergency Management Agencies (EMA)
4. Local health departments (LHD)
5. Local Emergency Medical Services (EMS) agencies
6. IDPH Regional Emergency Medical Services Coordinator (REMSC)
7. Illinois Department of Public Health (IDPH)
8. Illinois Emergency Management Agency (IEMA)
9. Professional medical organizations
    a. Illinois Chapter of American Academy of Pediatrics (ICAAP)
    b. Illinois College of Emergency Physicians (ICEP)
    c. Illinois State Medical Society (ISMS)
    d. Illinois Academy of Family Physicians (IAFP)
    e. American Pharmaceutical Association (APA)
    f. Illinois Pharmacists Association (IPA)
    g. Illinois Emergency Nurses Association (ENA)
10. Illinois Critical Access Hospital Network
11. Division of Specialized Care for Children (DSCC)
12. Long-term Care Facilities for Under Age 22 Years (U-22)
13. Collaborative Healthcare Urgency Group (CHUG)
14. Border state agencies (Refer to Section 2.3.4 for specific notification details)
    a. Great Lakes Healthcare Partnership Program (GLHPP) through the Minnesota Department of Health, Office of Emergency Preparedness (for the City of Chicago, Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin)
    b. Iowa - Iowa Department of Public Health duty officer
    c. Kentucky - Duty officer in the Commonwealth Emergency Operations Center (See Attachment 7)
    d. Missouri - Missouri – Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) as Missouri ESF-8 Lead

i. For incidents that occur in Illinois counties served by the St. Louis Medical Operations Center (SMOC) (specifically Madison, Monroe, and St Clair counties), the SMOC should secondarily be contacted (See Attachment 8).

15. Illinois State Board of Education (ISBE), Regional Offices of Education
16. Health care coalitions
17. Any alternate treatment sites, alternate care sites, and/or temporary medical treatment stations that have been established during the incident

2.3. ORGANIZATION

2.3.1 Health Care Facility Response Structure

1. During a MCI with significant number of pediatric casualties, resources at health care facilities with pediatric critical care capabilities will quickly become exhausted. Therefore, developing a system that outlines how all health care facilities can assist with providing care to children is crucial to the response. Dividing the health care facilities into categories based on their pre-event pediatric and neonatal capabilities can assist with decompressing pediatric and neonatal specialty care centers during an event to ensure children are treated at the best possible health care facility. See Section 2.4: *Pediatric Patient Care and Movement* and Section 2.4.6. *System Decompression* for more information on this coordination of care.
2. When this annex is activated, all health care facilities within Illinois will fall into one of the following four categories to assist with the coordination of care during a pediatric mass casualty incident. See Sections 3.2.4, 3.2.5 and 3.2.6 for hospital responsibilities. See Section 2.4.6 for additional information on the following categorization:
   a. Category 1: Pediatric specialty centers (pediatric intensive care unit {PICU} and/or neonatal intensive care unit {NICU})
   b. Category 2: Community hospitals with some pediatric services
   c. Category 3: Community hospitals with no pediatric/neonatal services
   d. Category 4: Community hospitals with Level I, II, and/or II-E (II+) nurseries, but no other pediatric services

2.3.2 Regional Response Structure

Each region will respond as indicated within its Regional Health Care Coalition Preparedness Plan.

2.3.3 State Response Structure

1. State emergency management officials will activate the SEOC to coordinate state and/or federal support to local jurisdictions. The public health emergency operations center (PHEOC) will be activated by IDPH. Requests for Medical Resources (RFMR) will be processed in accordance with the IDPH ESF-8 Plan.
2. Upon receiving requests for pediatric medical resources, the SEOC manager will notify the IDPH SEOC liaison. The IDPH SEOC liaison will notify the IDPH duty officer, who will request from IEMA that the Illinois Medical Emergency Response Team (IMERT) be activated to deploy the Pediatric Care Medical Specialists (PCMS). The Emergency Medical Services for

Children (EMSC) manager (or designees) will be activated to assist with the Pediatric Care Medical Specialist role and the coordination and notification of stakeholders. See *Attachment 9: IDPH and PCMS Communication Process*.

3. During an activation of the SEOC in the event of a large number of pediatric casualties, pediatric subject matter experts from the IMERT Pediatric Care Medical Specialist Team will be integrated into the incident command structure to fill the Pediatric Care Medical Specialist role and will allow for an appropriate, coordinated and timely response to the needs of children during the incident. This may be accomplished via updates from the IDPH SEOC Liaison or IMERT directly through the IMERT PCMS Pediatric Team Leader.
4. When this annex is activated, the request for pediatric specific medical resources by multiple health care facilities, health care facility or regionally based alternate care site (ACS), health care facility or regionally based alternate treatment site (ATS), and/or state temporary medical treatment station (TMTS) will follow the same pathway as the request for other medical resources as outlined in the IDPH ESF-8 Plan. These pediatric resources can include, but are not limited to:
   a. Pediatric equipment, supplies, and medications
   b. Medical consultation
   c. Placement of pediatric patients in pediatric tertiary care centers/specialty care centers or health care facilities with pediatric services
   d. System decompression processes outlined in this annex

   (See the *IDPH ESF-8 Request for Medical Resources Process*).
5. The IDPH Regional EMS Coordinators (REMSC) will assist with the communication between IDPH and the RHCCs. The REMSC(s) should be involved in the situational awareness briefings throughout the event during which the PCMS will provide updates on interactions/communication with health care facilities and their medical consultation and transfer coordination requests. The REMSC should then relay this information to their RHCC to assure loop closure and awareness of the response activities within their region.
6. IDPH, in conjunction with support agencies, develops and maintains this annex and accompanying operational guidelines that govern response actions related to large scale events involving children. However, support agencies may develop and maintain their own operational guidelines for internal use, which must be compatible with and in support of this annex.

2.3.4 Multi-State Response Structure

1. The incident may require accessing pediatric resources that exist outside Illinois. The PHEOC, in collaboration with the SEOC, may consider requesting out-of-state resources through normal request patterns, methods indicated within this annex and the IDPH ESF-8 Plan, and/or interstate mutual aid agreements, including Emergency Medical Assistance Compact (EMAC). Border states will be contacted as indicated below to identify pediatric resource availability, send information about the event and to assist with the coordination of transfers.
   a. Great Lakes Healthcare Partnership Program (GLHPP)

The GLHPP is a consortium of jurisdictions, including the City of Chicago, Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin, located within the Federal Emergency Management Agency (FEMA) Region V that can provide communication and resource assistance in the first 24-72 hours of a significant incident in the region when other resources are being activated through conventional channels. To access the Great Lakes Healthcare Partnership Program resources, call the Minnesota Department of Health, Office of Emergency Preparedness at XXX-XXX-XXXX and specifically ask for the Great Lakes Healthcare Partnership Program (GLHPP). More information on this process can be found in the GLHPP Alerting/ Communication Annex.

b. Iowa
The Iowa Department of Public Health Duty Officer will serve as the primary contact for Iowa at XXX-XXX-XXX or XXXX@idph.iowa.gov. Once contacted, the duty officer will serve as the point of contact to identify pediatric resource availability (health care facilities, transport and EMS) and assist with communication with Iowa health care facilities/agencies.

c. Kentucky
The on-call Kentucky Emergency Management (KYEM) duty officer in the Commonwealth Emergency Operations Center will serve as the primary contact for Kentucky at XXX-XXX-XXXX. Once contacted, the KYEM duty officer will notify the KYEM Manager on call, one of the ESF-8 Public Health/Kentucky Health Association Partners and the Kentucky Board of EMS based on the requested needs to assist with patient placement and transportation (See Attachment 7).

d. Missouri
The Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) will serve as the primary contact for Missouri. Contact the ERC at XXX-XXX-XXXX and inform the duty officer of requested action. The duty officer will contact the appropriate personnel for response and coordination including contact with the St. Louis Medical Operations Center (SMOC) as appropriate, sending information to Missouri health care facilities and assisting with coordination of pediatric resources and pediatric transport. However, it is recommended that during pediatric surge incidents impacting the Illinois counties of Madison, Monroe and St. Clair, Illinois also contact the SMOC as the secondary contact for Missouri, at the Central County Emergency 911 Communications Center at XXX-XXX-XXXX and request the SMOC duty officer be contacted (See Attachment 8).

e. Wisconsin
In addition to communicating with Wisconsin via GLHPP, selected IDPH and organizational roles have permission to view EMResource to identify bed and selected non-bed resource availability and capacity counts at health care facilities in Wisconsin. These individuals can also access contact information for Wisconsin health care facilities that border Illinois

to identify pediatric resource availability. If existing tracking categories do not fully meet situational needs, the two states can quickly define temporary categories for collecting additional count information, either separately or as part of a joint effort.

2.3.5 Federal Response Structure

When response to a disaster or emergency incident exceeds the resources and capabilities of Illinois to manage, IEMA will notify officials at FEMA Region V of the governor's forthcoming request for federal assistance and a presidential disaster declaration. FEMA authorities will deploy a FEMA liaison officer to the SEOC when a presidential disaster declaration appears imminent.

2.4. PEDIATRIC PATIENT CARE AND MOVEMENT

The Pediatric and Neonatal Surge Annex is designed to help coordinate the following components of care as related to children during an incident:

2.4.1 IMERT Pediatric Care Medical Specialist (PCMS)

1. Definition

   Pediatric experts from Illinois and its border states who volunteer pre-event as part of the IMERT Pediatric Care Medical Specialist Team to be called upon by IDPH during a large scale event in which there are numerous pediatric casualties leading to the activation of this annex. These volunteers will function as subject matter experts for the state by providing guidance on the coordination of care and medical consultation for pediatric patients.

2. Types

   There are three types of Pediatric Care Medical Specialists.

   a. Group 1 Specialists: Includes pediatric intensivists, pediatric emergency physicians, and/or pediatric physicians with transport expertise who will be called upon during all events in which the annex is activated to assist with patient triage, coordination of transfers and system decompression.
   b. Group 2 Specialists: Includes pediatric specialty physicians, primary care physicians, and neonatal subspecialists who will be activated to serve in a medical consultation role based on the specific needs of the event and the affected population.
   c. Group 3 Specialists: Includes pediatric specialty advanced practice providers (e.g., nurse practitioners) and support resources (e.g., child life specialists, pediatric Pharm D/pharmacists) that will be activated to serve in a consultation role based on the specific needs of the event and the affected population.

3. Roles and Responsibilities

   a. Triage pediatric patients to pediatric specialty health care facilities utilizing the information submitted by non-pediatric specialty health care facilities based on the *Pediatric Triage Guidelines* (Attachment 10).
   b. Assist with system decompression as requested from pediatric tertiary care centers/specialty centers.
   c. Address requests for medical consultation from health care facilities.
   d. Assist with coordination of pediatric transport needs.

e. Document all coordinated pediatric patient transfers in the *Pediatric Patient Tracking Log* (see Attachment 11)

2.4.2 Pediatric Patient Tracking

As pediatric patient movement occurs throughout Illinois and its border states, both for the acutely ill/injured being transported to pediatric tertiary care centers/specialty care centers and for those patients being decompressed from pediatric tertiary care centers/specialty care centers, tracking the location of the pediatric patient is crucial in aiding in the reunification of these children with their families. Electronic patient tracking may be available (e.g. EMTrack). Manual tracking of patient movement through the methods listed below will be necessary if the electronic system is unavailable or can be used in conjunction with the electronic system.

1. *Patient Identification Tracking Form*: (See Attachment 12)
   a. Purpose: To assist in identifying, tracking, and reunification of pediatric patients during a disaster.
   b. Responsibility: The primary physician and/or nurse at every health care facility.
   c. Instructions: This form will be completed to the best of the ability given the information/resources available on ALL pediatric patients who arrive at a health care treatment facility (hospital, clinic, ACS, ATS, TMTS), regardless if they are accompanied by a parent/guardian. This form records a patient tracking number (assigned by initial health care facility), demographic information, description of the child, a place to attach a photo of the child, patient tracking log, accompanied and unaccompanied child information, medical history, and disposition. The form should be copied. The original form will accompany the patient if/when the patient is transferred to another facility and a copy should be kept as part of the facility's medical record. Each receiving facility will add their facility's information in the Patient Tracking Log section. **NOTE: All attempts should be made to keep patient identification (ID) bands from previous facilities and triage tags from EMS on the patient.** If ID bands need to be removed, attach the removed band to this form under the Patient Tracking Log section. If triage tags are removed, ensure all information on the tag is incorporated into the patient's medical record or, if possible, place a photo copy of the tag in the patient's medical record.
2. *Pediatric Patient Tracking Log:* (See Attachment 11)
   a. Purpose: To assist with tracking pediatric patients during a disaster.
   b. Responsibility: Pediatric subject matter expert (i.e. PCMS or other IDPH pediatric representative) who is assisting with the coordination of patient movement.
   c. Instructions: This form will be completed by the PCMS or other IDPH pediatric representative when they assist with transfer coordination of pediatric patients between health care facilities. Any issued tracking number (assigned by initial health care facility), name, gender, date of birth and age shall be recorded on all patients, and each health care

facility's name, location and the arrival/departure date from each health care facility. This document will be forwarded to IDPH at the PHEOC at the end of each operational period by the PCMS and stored in the same manner as other incident related command documents after the PHEOC closes.

3. Additional Pediatric Patient Tracking Resources:
   a. American Red Cross (ARC) Safe & Well Program
      The ARC Safe & Well Program is available for use during a large scale event and can assist individuals, families, and organizations with communication. This free online tool is always available, open to the public, and available in Spanish. It allows individuals to register and post messages to indicate that they are safe, or to search for loved ones. The ARC can also provide resources to families and hospital staff. Reunification teams can be deployed to hospitals depending on the nature of the incident. Assistance from the ARC can be obtained by contacting the ARC Dispatch at XXX-XXX-XXXX. For minors, the ARC works with DCFS, NCMEC, and Law Enforcement Officers (LEO).
   b. National Center for Missing and Exploited Children (NCMEC) Unaccompanied Minor Registry
      The Unaccompanied Minors Registry is a tool that will enable NCMEC to provide assistance to local law enforcement and to assist in the reunification of displaced children with their parents or legal guardians. The registry may be available to assist providers with unaccompanied minors. The program also allows the public to report information related to children who have been separated from their parents or legal guardians as a result of a disaster. For more information or to enter information on an unaccompanied minor:
      https://umr.missingkids.org/umr/reportUMR?execution=e1s1

2.4.3 Pediatric Patient Triaging and Transfer Coordination

During MCIs with significant numbers of pediatric casualties, resources at health care facilities with pediatric critical care capabilities will quickly become exhausted. JumpSTART Triage is used in Illinois for the pediatric patient during field (EMS) triage and upon initial arrival to a hospital during a surge event. The *Pediatric Triage Guidelines* were developed to assist with statewide triage during a disaster when the Annex is activated to identify the type of pediatric specialty resources needed so pediatric patients will be transferred to the most appropriate health care facility, based on their pre-event capabilities (through the self-assigned decompression categories), to receive proper pediatric care. These Guidelines would be used after a patient has arrived and received care at a health care facility to assist with interfacility transfers. These Guidelines would not be used for field (EMS) triage.

1. *Pediatric Triage Guidelines* (See Attachment 10)
   a. Purpose: To provide guidance to the transferring facility and the PCMS during statewide triage of patients by identifying the most appropriate facility to receive transferred pediatric patients.

b. Responsibility: The physician responsible for the care of the pediatric patient at the originating health care facility, and who has identified that a higher level of care is needed than what can be provided at the current location.
c. Instructions: The transferring facility will use these guidelines to triage their pediatric patients based on the criteria (includes interventions, conditions, and perinatal considerations) listed in the *Pediatric Triage Guidelines*. The criteria list within the guidelines is not inclusive and does not replace clinical judgment. Once the transferring provider has determined what triage category the pediatric patient(s) are, this information should be communicated to the PCMS via the *Pediatric/Neonatal Medical Incident Report Form* (Attachment 5). This form should be sent to the PCMS via the mechanism identified in the "Reply/Action Required" section. The initials of the patient, any assigned tracking number, age, triage category, and diagnosis should all be listed on the form to help guide the PCMS in identifying the most appropriate facility.

2. Upon receiving the *Pediatric/Neonatal Medical Incident Report Form*, the PCMS will identify bed placement based on the triage categories identified for each patient. The PCMS should consider using existing bed reporting systems and direct communication with the hospitals. The EMSC Pediatric Regional Resource Directory may assist with identifying the most appropriate hospital to accept the patient through each hospital's Decompression Category, perinatal level, and as applicable, the trauma center level, and Pediatric Facility Recognition Program designation. Once the receiving health care facility has been identified, the PCMS will send the receiving health care facility name, physician, and any additional transfer information back to the transferring facility via the *Pediatric/Neonatal Medical Incident Report Form*.
3. *Pediatric Patient Transfer Form* (see Attachment 13)
   a. Purpose: To provide a method of communicating medical and treatment information on pediatric patients during a disaster when the patients are being transferred to pediatric tertiary care centers/specialty care centers. This information will be shared with the physician at the receiving health care facility (e.g. pediatric tertiary care centers/specialty care centers), and assist with ensuring continuity of care for pediatric patients when they arrive at the receiving facility. This form may also be used by the PCMS to assist with triage decision making for patients who may need special consideration during the triage process.
   b. Responsibility: The physician responsible for the pediatric patient at the transferring health care facility, and who has identified that a higher level of care is needed than what can be provided at the current location.
   c. Instructions: This form will be completed at the transferring health care facility and sent with the patient to the receiving health care facility This form provides the receiving providers with the patient tracking number (assigned by initial health care facility), basic demographic information, past medical history, clinical assessment and treatments, request for

services at pediatric tertiary care centers/specialty care centers, transport needs and any telemedicine management recommendations received and performed.

2.4.4 Pediatric Transport

The transportation needs during a large-scale incident involving children may be quite extensive. The transferring physician and staff, the PCMS, or other IDPH pediatric representative and receiving physician will work together to identify the resources needed to transport the pediatric patient(s) in the most efficient and safe manner available at the time. The PCMS, other IDPH pediatric representatives and pediatric tertiary care centers can assist health care facilities in identifying known transport companies that have pediatric capabilities, and available alternative methods for transporting pediatric patients.

2.4.5 Pediatric and Neonatal Care Guidelines

During a large-scale incident, normal inter-facility transfer patterns may be disrupted. Health care facilities that typically transfer their acutely ill/injured pediatric patients or children with special health care needs to pediatric tertiary care centers/specialty care centers may need to care for these patients for longer periods of time until they are able to transfer these patients to a higher level of care. The PCMS or other IDPH pediatric representatives can be accessed for medical consultation. In addition, *Pediatric and Neonatal Care Guidelines* are available as an adjunct to this annex for common pediatric medical issues, such as respiratory; shock; burn injury; trauma and blast injury; pandemic; newborn care; premature newborn care; obstetrical (OB) care; radiation exposure; and inpatient treatment and monitoring interventions. These documents provide support and guidance to those practitioners caring for children during the initial 96 hours following an incident.

1. Purpose: To provide guidance to practitioners caring for pediatric patients during a disaster.
2. Responsibility: These guidelines are not meant to be all inclusive, replace an existing policy and procedure at a health care facility or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.
3. Instructions: Practitioners may use the *Guidelines* as a reference and to assist with care of pediatric and neonatal patients during a disaster. The *Guidelines* will be updated and maintained by Illinois EMSC.

2.4.6 System Decompression

In a large scale incident that leads to a significant number of ill or injured children, the need for pediatric and neonatal critical care resources may exceed what is available. If this or any other trigger occurs as listed in Section 2.1, pediatric and/or neonatal tertiary care centers/specialty care centers will need to decompress their less critically ill/injured pediatric/neonatal patients to other health care facilities that have the capabilities to care for them in order to have space to accept and treat more acutely ill or injured children. Ideally, facilities should decompress to a similar or higher level of care facility. However, in a large scale disaster, this may not be possible. If there is a need to decompress to another

health care facility, the following categories for health care facilities that outline pediatric/neonatal capabilities should be considered:

1. Category 1: Specialty Centers (pediatric intensive care unit {PICU} and/or neonatal intensive care unit {NICU}) (includes Pediatric Critical Care Centers {PCCC}) able to provide complex pediatric care to ages 0 through 15 years.
2. Category 2: Community Hospitals with Some Pediatric Services (includes Emergency Departments Approved for Pediatrics {EDAP}) and accepts 0-12 year-old patients.
3. Category 3: Community Hospitals with no Pediatric/Neonatal Services (can include Standby Emergency Departments Approved for Pediatrics {SEDP}) and accepts 12 years of age or older.
4. Category 4: Community Hospitals with Level I, II, and/or II-E (II+) nurseries, but no other pediatric services (can include Standby Emergency Departments Approved for Pediatrics {SEDP}) and accepts 0-1 year old patients.

Whenever decompressing to a facility, phone consultation between the transferring physician and/or the PCMS or other IDPH pediatric representative within the PHEOC with the practitioners receiving the patient will need to take place. The self-assigned Decompression Category for every Illinois health care facility can be found in the Regional Pediatric Resource Directory through the Illinois EMSC website at https://www.luriechildrens.org/emsc

2.4.7 Resource Allocation

In a large scale event involving significant numbers of pediatric casualties, resources (e.g., equipment, medications, trained staff and available space) needed to care for pediatric patients may quickly be depleted. This could lead to health care providers having to adapt normal standards of care and to implement resource allocation strategies or crisis standards of care for those seeking or currently receiving care at their facility. The IDPH Functional and Access Needs (FAN) Annex to the State ESF-8 Plan outlines potential needs/issues that vulnerable/at-risk populations may encounter during a disaster as well as strategies/tactics for addressing those needs (including pediatric specific strategies). In addition, the Catastrophic Incident Response (CIR) Annex includes an attachment outlining crisis care and resource allocation tactics for the pediatric and neonatal populations during catastrophic incidents. This information can assist health care providers, health care facilities, regions, IDPH, and the PCMS with identifying possible strategies to assist with this task.

3.0 ROLES, RESPONSIBILITIES AND RESOURCE REQUIREMENTS

3.1 PRIMARY AGENCY

3.1.1 ILLINOIS DEPARTMENT OF PUBLIC HEALTH

1. Provide leadership in directing, coordinating, and integrating overall state efforts to provide public health and medical assistance to affected areas and the pediatric populations within those areas.

2. Coordinate and direct the activation and deployment of this Pediatric and Neonatal Surge Annex as part of the IDPH ESF-8 Plan either partially or in its entirety as indicated by the pediatric needs following an incident.
3. Assist with the communication between stakeholders (e.g., health care facilities, LHDs, border states, GLHPP) during an incident.
4. Collaborate with IEMA on the RFMRs for pediatric specific resources from health care facilities, public health departments, alternate care sites, alternate treatment sites, and temporary medical treatment stations.

3.2 SUPPORT AGENCIES/FACILITIES/ORGANIZATIONS

3.2.1 ILLINOIS EMERGENCY MANAGEMENT AGENCY

1. Coordinate collection, receipt, compilation, and development of situational reports on damage impacts to services, facilities, sites and programs at the federal, state and local levels.
2. Collaborate with IDPH on the requests for pediatric specific resources.
3. Collaborate with IDPH to coordinate the activation of medical mobile support teams including activating IMERT and their PCMS team.
4. Request disaster declaration (state and federal) as indicated.
5. Facilitate EMAC requests as indicated.

3.2.2 ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN (EMSC)

1. Assist with the notification of stakeholders listed in the Pediatric and Neonatal Surge Annex during the activation of the annex.
2. Assist with revising and maintaining the Pediatric and Neonatal Surge Annex in accordance with timelines defined by IDPH.
3. Assist in maintaining the PCMS database.
4. Maintain and update the *Pediatric and Neonatal Care Guidelines* associated with this annex to ensure compliance with current treatment recommendations.
5. Maintain and update the pediatric components located within the IDPH FAN Annex and the IDPH CIR Annex.
6. Continue to develop materials to assist in the education of health care providers regarding the care of pediatric patients.

3.2.3 REGIONAL HOSPITAL COORDINATING CENTER (RHCC)

1. Provide care for neonatal and pediatric patients and children with special health care needs that arrive at their health care facility to the best of the facility and practitioners' ability.
2. Provide patient families at their facility with information about the event and education about components of the response that may involve their child's care (e.g., system decompression, coordination of care statewide, and transfer processes).
3. Provide necessary situational awareness communications to/from the affected and/or assisting health care facility(s) within the region and to/from IDPH.
4. Inform IDPH, as appropriate, when Regional Health Care Coalition Preparedness Plan has been activated.

5. Inform IDPH, as appropriate, when regional pediatric resources have been depleted.
6. Assist with the communication and RFMR for pediatric specific resources as indicated in this annex (see Attachment 6).
7. Assist health care facilities with accessing Illinois HELPS (See Section 3.2.14)
8. Review their self-assigned pediatric decompression category at least annually. Notify EMSC if any changes are needed.
9. Function as a liaison between IDPH and IEMA with health care facilities and EMS providers within their region.

3.2.4 EMS RESOURCE HOSPITALS

1. Provide care for neonatal and pediatric patients and children with special health care needs that arrive at their facility to the best of the facility and practitioners' ability.
2. Provide patient families at their facility with information about the event and education about components of the response that may involve their child's care (e.g., system decompression, coordination of care statewide, and transfer processes).
3. Assist with the communication and RFMRs for pediatric specific resources as indicated in the Regional Health Care Coalition Preparedness Plan, the IDPH ESF-8 Plan, and in this annex (see Attachment 6).
4. Function as a liaison between the EMS associate and participating health care facilities within their system, and the RHCC.
5. Assist with the communication with EMS providers within their EMS system.
6. Review their self-assigned pediatric decompression category at least annually. Notify EMSC if any changes are needed.

3.2.5 ALL OTHER HOSPITALS

1. Provide care for neonatal and pediatric patients and children with special health care needs that arrive at their facility to the best of the facility and practitioners' ability.
2. Provide patients' families at the facility with information about the event and education about components of the response that may involve their child's care (e.g., system decompression, coordination of care statewide, and transfer processes).
3. Communicate and submit RFMR for pediatric resources as necessary as indicated in the Regional Health Care Coalition Preparedness Plan, the IDPH ESF-8 Plan, and in this annex (see Attachment 6).
4. Review their self-assigned pediatric decompression category at least annually. Notify EMSC if any changes are needed.

3.2.6 ILLINOIS CRITICAL ACCESS HOSPITAL NETWORK

1. Act as a key contact for critical access hospitals to identify pediatric needs within their organization.
2. Act as a liaison between critical access hospitals and pediatric resources such as the IMERT PCMS team.

3.2.7 LOCAL HEALTH DEPARTMENTS

1. Assist health care facilities in obtaining supplies from the Strategic National Stockpile (SNS), specific to pediatrics, as requested, through the processes that are currently identified and incorporated into their existing plans and the RFMR process outlined in the IDPH ESF-8 Plan.
2. Maintain communication and provide situational awareness updates, specific to pediatrics, to health care facilities and to IDPH, as indicated.

3.2.8 BORDER STATES

1. Great Lakes Healthcare Partnership Program (GLHPP)
   The PCMS or other IDPH pediatric representative will notify the Minnesota Department of Health, Office of Emergency Preparedness at XXX-XXX-XXXX and ask for the Great Lakes Healthcare Partnership Program contact that can then assist with the communication and resource assistance in the first 24-72 hours of an incident involving a large number of pediatric casualties.
2. Iowa
   The PCMS or other IDPH pediatric representative will notify the on call Iowa Department of Public Health duty officer at XXX-XXX-XXXX and/or XXXX@idph.iowa.gov, regarding the situation and pediatric resource needs. The duty officer can then assist with the identification of pediatric resource availability in health care facilities, transport services and EMS, and assist with communication with Iowa health care facilities/agencies.
3. Kentucky
   The PCMS or other IDPH pediatric representative will notify the on call KYEM duty officer in the Commonwealth Emergency Operations Center at XXX-XXX-XXXX regarding the situation and pediatric resource needs. The KYEM duty officer can then assist with the identification and coordination of available pediatric resources (health care facility and transport) (See Attachment 7).
4. Missouri
   Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) will serve as the primary contact for Missouri. Contact the ERC at XXX-XXX-XXXX and inform the duty officer of requested action. The duty officer will contact the appropriate personnel for response and coordination including contact with the St. Louis Medical Operations Center (SMOC) as appropriate, sending information to Missouri health care facilities and assisting with coordination of pediatric resources and pediatric transport. However, it is recommended that during pediatric surge incidents impacting the Illinois counties of Madison, Monroe, and St. Clair, Illinois also contact the SMOC as the secondary contact for Missouri, at the Central County Emergency 911 Communications Center at XXX-XXX-XXXX and request the SMOC duty officer be contacted (See Attachment 8).
5. Wisconsin
   In addition to communicating with Wisconsin via GLHPP, the PCMS or

other IDPH pediatric representative may access EMResource to identify bed and non-bed resource availability and capacity counts at Wisconsin health care facilities. Contact information for health care facilities in Wisconsin can also be obtained.

3.2.9 ILLINOIS MEDICAL EMERGENCY RESPONSE TEAM (IMERT)

1. Maintain a PCMS team of pediatric experts that can be activated and serve in a consultative role as pediatric subject matter experts/resources when this annex is activated
2. Facilitate communications between the PCMS team, IMERT leadership, and IDPH liaison(s)
3. PEDIATRIC CARE MEDICAL SPECIALISTS
   a. Role
      1. Function as subject matter experts to the state of Illinois (IDPH and/or IEMA) as members of IMERT's PCMS team by providing guidance on triaging pediatric and neonatal patients to pediatric tertiary care centers/specialty care centers when the Pediatric and Neonatal Surge Annex is activated during a multiregional or statewide disaster.
      2. Provide medical consultation to those health care facilities caring for pediatric and neonatal patients waiting to be transferred to pediatric tertiary care centers/specialty care centers, as members of IMERT's PCMS team.
      3. Assist with the coordination of system decompression as members of IMERT's Pediatric Care Medical Specialist Team.
   b. Responsibility
      1. Serve as a consultant to provide advice in the areas of pediatric emergency, surgical, medical, psychological, neonatal, and transport care per their training, qualifications, and within their scope of practice.
      2. Be an active member in compliance with IMERT requirements.

3.2.10 LONG-TERM CARE FACILITIES for Under Age 22 Years (U-22)

1. Illinois has skilled pediatric long-term care facilities that have the capabilities to provide extensive medical care to children under the age of 22 with chronic medical and behavioral conditions. Two agencies within Illinois oversee and regulate these types of facilities: IDPH Office of Health Care Regulation and the Illinois Department of Children and Family Services (DCFS). During a large scale incident in which the annex is activated, these facilities can assist health care facilities with system decompression and early discharge for children who are less acutely ill or injured, but still require medical care.
2. To access facilities regulated by the IDPH, Office of Health care Regulation, the IDPH duty officer will contact the Long-term Care (LTC) bureau chief who can assist with sharing information about the event with facilities and identifying facilities able to assist with system decompression. After the initial contact with the Long-term Care bureau

chief by the duty officer, the PCMS will work closely with IDPH through the EMSC designee on the coordination of patient transfers.

3. To access facilities associated with the DCFS, the PCMS or other IDPH pediatric representative can contact DCFS to obtain a list of facilities with capacity to assist with system decompression.
4. Collaborative Health Care Urgency Group (CHUG)
   Some LTC for U-22 with pediatric capabilities are members of CHUG. CHUG may be utilized to help provide information to its members and possibly coordinate patient movement during the system decompression process. CHUG can be contacted at XXX-XXX-XXXX. For immediate assistance, CHUG can be contacted at XXX-XXX-XXXX.

3.2.11 ILLINOIS CHAPTER OF AMERICAN ACADEMY OF PEDIATRICS (ICAAP)

1. Assist with the pre-activation recruitment of PCMS Specialists, including, but not limited to:
   a. pediatric intensivists
   b. emergency physicians with pediatric expertise
   c. pediatric surgeons
   d. neonatologists
   e. pediatric psychologists/psychiatrists
   f. pediatric physicians with transport experience
2. Provide a method to communicate information with its members about the incident and recommendations for care and action.

3.2.12 ILLINOIS COLLEGE OF EMERGENCY PHYSICIANS (ICEP)

1. Assist with the pre-activation recruitment of PCMS Specialists, including, but not limited to:
   a. emergency physicians with pediatric expertise
   b. pediatric physicians with transport experience
2. Provide a method to communicate information with its members about the incident and recommendations for care and action.

3.2.13 ILLINOIS EMERGENCY NURSES ASSOCIATION (ENA)

1. Assist with the pre-activation recruitment of PCMS Specialists, including, but not limited to:
   a. advanced practice nurses (APNs) with pediatric expertise
2. Provide a method to communicate information with its members about the incident and recommendations for care and action.

3.2.14 ILLINOIS HELPS

1. The Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) system for Illinois (Illinois HELPS) supports the pre-registration, management, and mobilization of clinical and non-clinical volunteers to help in responding to all types of disasters. The volunteer management system is part of a nationwide effort to ensure that volunteer professionals can be quickly identified and their credentials checked so that they can be properly utilized in response to a disaster.

2. Provide a method to track credentials, qualifications, certifications, contact information, and training of pre-registered volunteers throughout the state.

3.2.15 DIVISION OF SPECIALIZED CARE FOR CHILDREN (DSCC)

Provide a method to communicate information to CSHCN, their families, and its members about the incident and recommendations for care and action.

3.2.16 DEPARTMENT OF CHILDREN AND FAMILY SERVICES (DCFS)

1. Provide assistance to health care facilities, health care facility or regionally based ACS, health care facility or regionally based ATS, and/or state TMTS:
   a. Secure placement for non-injured/ill children who have been unable to be reunited with their families.
   b. Provide consent for treatment for those children in need of medical care who are youth in care of the state.
   c. Provide consent for patient transfer during the decompression process for those children who are youth in care of the state.
   d. Assume legal responsibility for unaccompanied minors within its geographic jurisdiction.
      a. Ensure unaccompanied minors receive the full range of assistance, care, and services to which a child in the State is entitled
      b. Designate a legal authority to act in place of the child's unavailable parent(s)
2. Report any missing children/youth whom DCFS is legally responsible for to the local law enforcement agency, the child's case manager and the Child Intake and Recovery Unit (XXX-XXX-XXXX).
3. The Child Intake Recovery Unit provides child specific information and advocacy intervention services to law enforcement officials, the National Center for Missing and Exploited Children, child care workers and supervisors, and assistance to any child for whom the department has legal responsibility.
4. Health care facilities, health care facility or regionally based ACS, health care facility or regionally based ATS, and/or state TMTS can contact the DCFS Hotline (XXX-XXX-XXXX) for questions and/or concerns about unaccompanied minors and children who are youth in care of the State and/or to report suspected abuse or neglect.

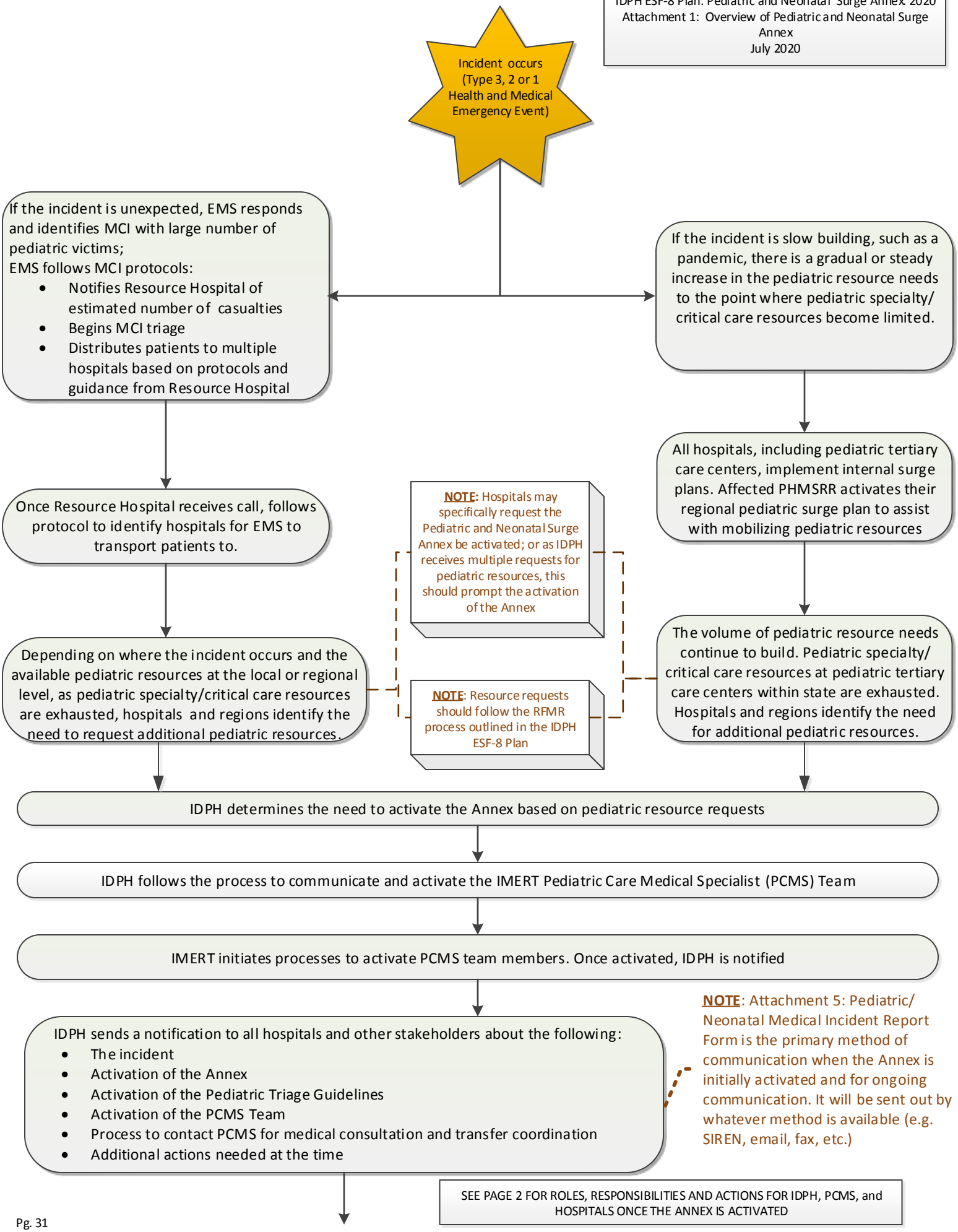
3.2.17 ILLINOIS DEPARTMENT OF HUMAN SERVICES (DHS)

1. Assist IDPH in their communications with child care programs via the Illinois Network of Child Care Resources and Referral Agencies (INCCRRA) local Child Care Resource and Referral agencies, and other communication avenues.
2. Provide guidance to child care providers, parents, and stakeholders on preparedness, response and recovery activities related to child care subsidy and child care licensing in the event of a significant emergency situation.

3. Maintain and update the Illinois Statewide Child Care Emergency Preparedness and Response Plan

4.0 RECOVERY

The recovery process following a pediatric surge incident may require a significant amount of time and should follow the continuity and recovery processes (COOP) outlined in the IDPH ESF-8 Plan. Recovery components specific to children should include working with primary care providers, social services, community partners, public health, and/or other health services to provide services including screening, primary prevention, and treatment for the medical and behavioral health needs of children and children with special health care needs/children with functional access needs.



SEE PAGE 2 FOR ROLES, RESPONSIBILITIES AND ACTIONS FOR IDPH, PCMS, and HOSPITALS ONCE THE ANNEX IS ACTIVATED

ROLES, RESPONSIBILITIES AND ACTIONS FOR IDPH, PCMS and HOSPITALS ONCE ANNEX IS ACTIVATED

Incident occurs; Pediatric and Neonatal Surge Annex is activated

IDPH

- Lead agency when Annex is activated
- Assist with pediatric medical resource requests (supplies)
- Communicate with PCMS Team
- Communicate with stakeholders as indicated in *Attachment 6: Pediatric/ Neonatal Communication Pathway*

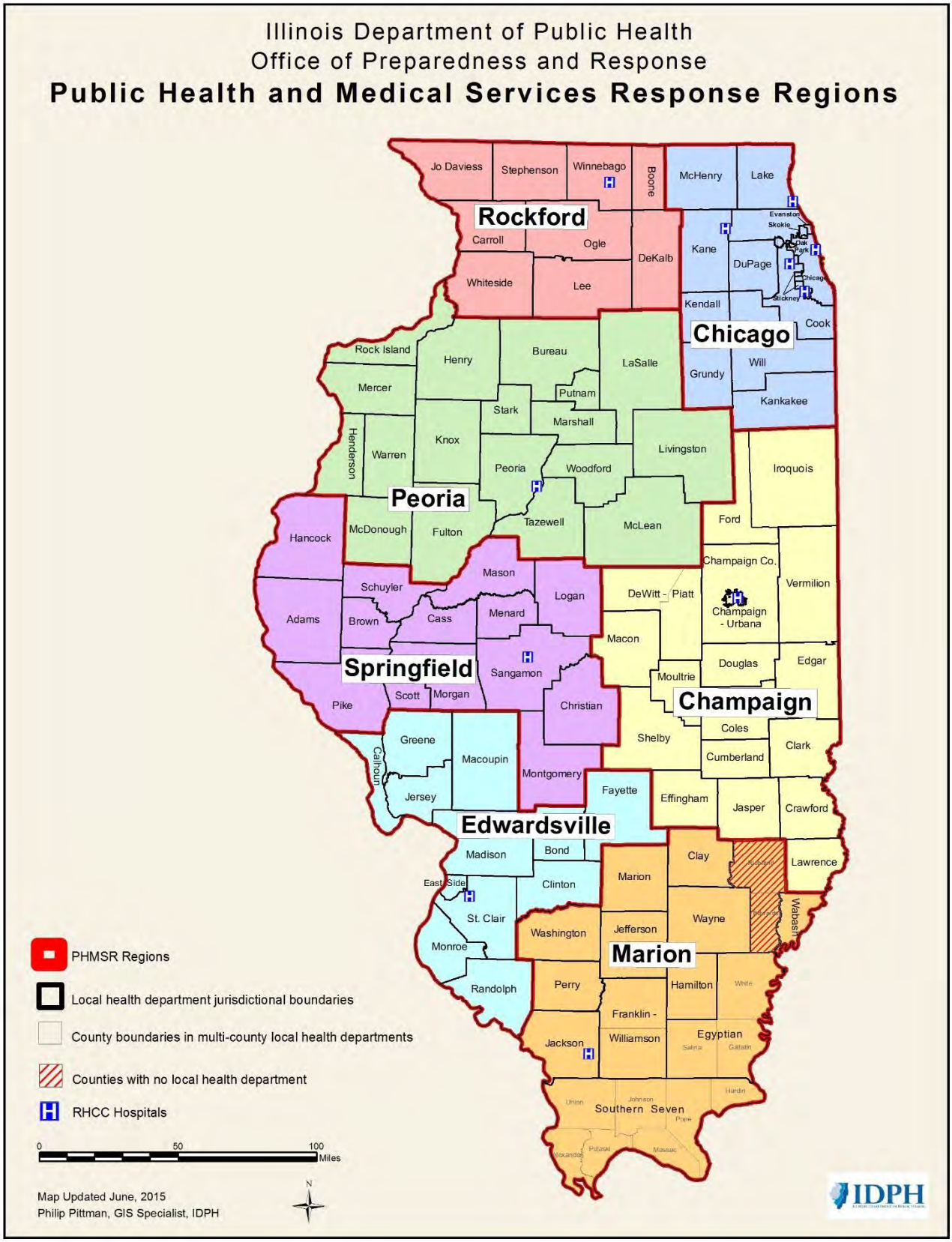
IMERT Pediatric Care Medical Specialist Team

- Activate pediatric specialist team members as applicable to assist with statewide triage and medical/nursing consultation
- Communicate with IDPH as outlined in *Attachment 9: IDPH and PCMS Communication Process*
- Utilize *Attachment 10: Pediatric Triage Guidelines*, EMResource, and the EMSC Pediatric Regional Resource Directory to identify the most appropriate hospitals for interfacility transfer of pediatric patients based on transfer requests
- Complete and maintain *Attachment 11: Pediatric Patient Tracking Log*
- Provide medical and nursing consultation to healthcare facilities with limited pediatric capabilities, as requested

Hospitals

- Care for patients as they arrive at their hospital and use available pediatric patient care resources to assist:
  - *Pediatric and Neonatal Care Guidelines*
  - Contact the PCMS for remote medical consultation/guidance
- Utilize *Attachment 10: Pediatric Triage Guidelines* to triage patients at their hospital that need to be transferred to another facility
- Request transfer coordination assistance by completing the *Attachment 5: Pediatric/Neonatal Medical Incident Report Form* and submitting it to the PCMS. Once received by the PCMS and a receiving hospital is identified, this form will be sent back to the local hospital with transfer information
- Once receiving hospital is identified:
  - Complete *Attachment 13: Pediatric Patient Transfer Form*. Send this form with patient when transported to the receiving hospital
  - Complete *Attachment 12: Patient Identification Tracking Form*. Send this form with patient when transported to receiving hospital
  - Coordinate available and most appropriate transport resources to move the patient from the transferring hospital to receiving hospital
- Admit and care for pediatric patients based on the Decompression Category for your hospital if unable to transfer to another facility or to assist tertiary care centers with decompressing their facilities.
  - Category 1: Pediatric specialty centers with NICU and/or PICU services
  - Category 2: Community hospital with some pediatric services
  - Category 3: Community hospital with no pediatric/neonatal services
  - Category 4: Community hospital with Level I, II, or II-E (II+) nursery but no other pediatric services

ATTACHMENT 2: PUBLIC HEALTH AND MEDICAL SERVICE RESPONSE REGIONS MAP



ATTACHMENT 3: IDPH OPR IMT ORGANIZATIONAL CHART

Chart of IDPH Office of Preparedness and Response Incident Management Team (IMT)

Command Staff

Incident Commander
Title
OPR Deputy Director
EMS Chief
FGM Chief

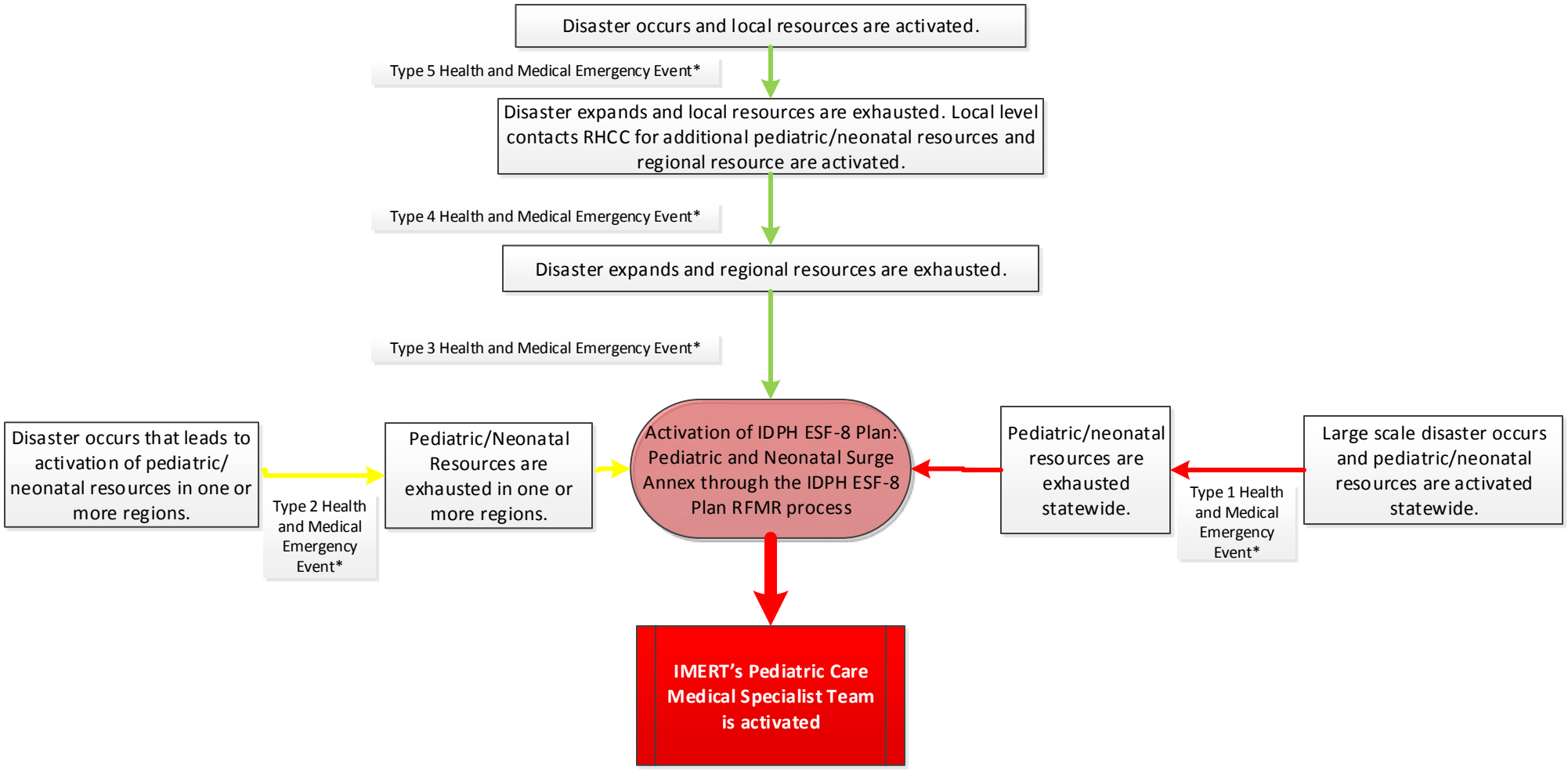
Safety Officer	Liaison Officer	Public Information Officer	State ESF-8 Lead State Emergency Operations Center (SEOC)
Title	Title	Title	Title
T & E Safety Officer	OPR Administrative Assistant	Communications Manager	DPR Chief
EMS Special Programs Coordinator	DPR Administrative Assistant	Communications Manager	All-Hazards Planning Section Chief
	EMS Administrative Assistant		

General Staff

Operations Section	Planning Section	Logistics Section	Finance and Administration Section
Title	Title	Title	Title
EMS Chief	All-Hazards Planning Section Chief	PHEOC Coordinator	FGM Chief
ERC Regional Supervisor	Evaluation Coordinator	Accounting Technician	HPP Grants Manager
HPP Program Manager			PHEP Grants Manager

IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex 2020
Attachment 4: Pediatric and Neonatal Surge Annex Activation Pathway

Purpose: Outline the types of incidents that prompt the activation of the Pediatric and Neonatal Surge Annex
Instructions: All stakeholders should use this pathway as a reference guide for the different avenues and types of Health and Medical Emergency Events that can trigger the activation of the Annex



* = See IDPH ESF-8 Plan for definitions of each type of Health and Medical Emergency Event

ATTACHMENT 5: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

Purpose: Assist with ensuring consistent communication between stakeholders and provide a mechanism to request pediatric medical resources and identify availability of resources at a health care facility.

Instructions: When the annex is activated, this form will be utilized by **all** stakeholders (e.g., health care facilities, LHDs, IDPH, PCMS) to communicate necessary information about the incident, annex activation, and pediatric patient transfer resource needs/requests. For pediatric care equipment needs/requests, complete the ICS 213RR form and submit it through the Request for Medical Resources Process as outlined in the IDPH ESF-8 Plan.

INCIDENT NAME:			
DATE/TIME PREPARED	**DATE/TIME RECEIVED**	**OPERATIONAL PERIOD**	**RECEIVED VIA** □ Phone □ Radio □ Fax □ Other
FROM (SENDER)	**TO (RECEIVER)**	**REPLY/ACTION REQUIRED?** □ YES □ NO If YES, *include detailed sending information* below **REPLY TO: □ Phone □ Radio □ Fax □ Other** **(List number)**	
PRIORITY: □ Urgent/High □ Non-urgent/Medium □ Informational/Low			

DATE/TIME PHEOC ACTIVATED	**REASON FOR PHEOC ACTIVATION**
DATE/TIME ANNEX ACTIVATED	**REASON FOR ANNEX ACTIVATION**
ACTIVATION LEVEL □ Local □ Regional □ State	
DATE/TIME PEDIATRIC CARE MEDICAL SPECIALISTS (PCMS) ACTIVATED	**REASON FOR PEDIATRIC CARE MEDICAL SPECIALISTS (PCMS) ACTIVATION**
CURRENT INCIDENT INFORMATION	

CURRENT NUMBER OF PEDIATRIC/NEONATAL BED NEEDS

(The purpose of this section is to identify the number of pediatric/neonatal patients and what type of health care facility is needed for their care when the annex is activated. These categories are for interfacility transfers only, not EMS scene transports. Enter the total number of patients for each triage category in the corresponding boxes below. In the *Pediatric Patient Placement Information* section on page 2 of this form, provide more specific information about the individual patients (tracking number, gender, and age). For more information, see Pediatric and Neonatal Surge Annex, Attachment 10: Pediatric Triage Guidelines.

	TRIAGE CATEGORY					
	CRITICAL CARE (PICU/NICU)	**INTERMEDIATE CARE (Pediatric/Neonatal Intermediate Care)**		**GENERAL CARE (Pediatric/neonatal general medical care)**		
	CATEGORY 1 HOSPITALS	**CATEGORY 2 HOSPITALS**	**CATEGORY 4 HOSPITALS**	**CATEGORY 2 HOSPITALS**	**CATEGORY 3 HOSPITALS**	**CATEGORY 4 HOSPITALS**
NUMBER OF PATIENTS						

Definitions:

- Category 1: Specialty centers (pediatric intensive care unit {PICU} and/or neonatal intensive care unit {NICU}) able to provide complex pediatric care to ages 0 through 15 years (includes Pediatric Critical Care Centers {PCCC}).
- Category 2: Community hospitals with some pediatric services (includes Emergency Departments Approved for Pediatrics {EDAP}) and accepts 0-12-year-old patients.
- Category 3: Community hospitals with no pediatric/neonatal services (can include Standby Emergency Departments Approved for Pediatrics {SEDP}) and accepts 12 years old and older patients.
- Category 4: Community hospitals with Level I, II and/or II-E (II+) nurseries, but no other pediatric services and accepts 0-1-year-old patients (can include Standby Emergency Departments Approved for Pediatrics {SEDP}).

ATTACHMENT 5: PEDIATRIC/NEONATAL MEDICAL INCIDENT REPORT FORM

REQUIRED/REQUESTED ACTIONS AT THIS TIME

PEDIATRIC/NEONATAL PATIENT PLACEMENT INFORMATION

The transferring health care facilities should complete this section for each patient who requires transfer/placement at another health care facility when submitting a request to the PCMS. Do not include detailed information about the patient's medical condition or treatment. Once a receiving facility has been identified, the PCMS will complete the last column and send this information back to the transferring facility.

To be Completed by the Transferring Health Care Facility				To be Completed by the PCMS
Patient Tracking Number (assigned by initial health care facility)	**Triage Category**	**Gender**	**Age**	**Receiving Health Care Facility Name** **Receiving Health Care Facility Address**

SEND REPLY TO: □ **Phone** □ **Radio** □ **Fax** □ **Other**
(List number):

PREPARED BY

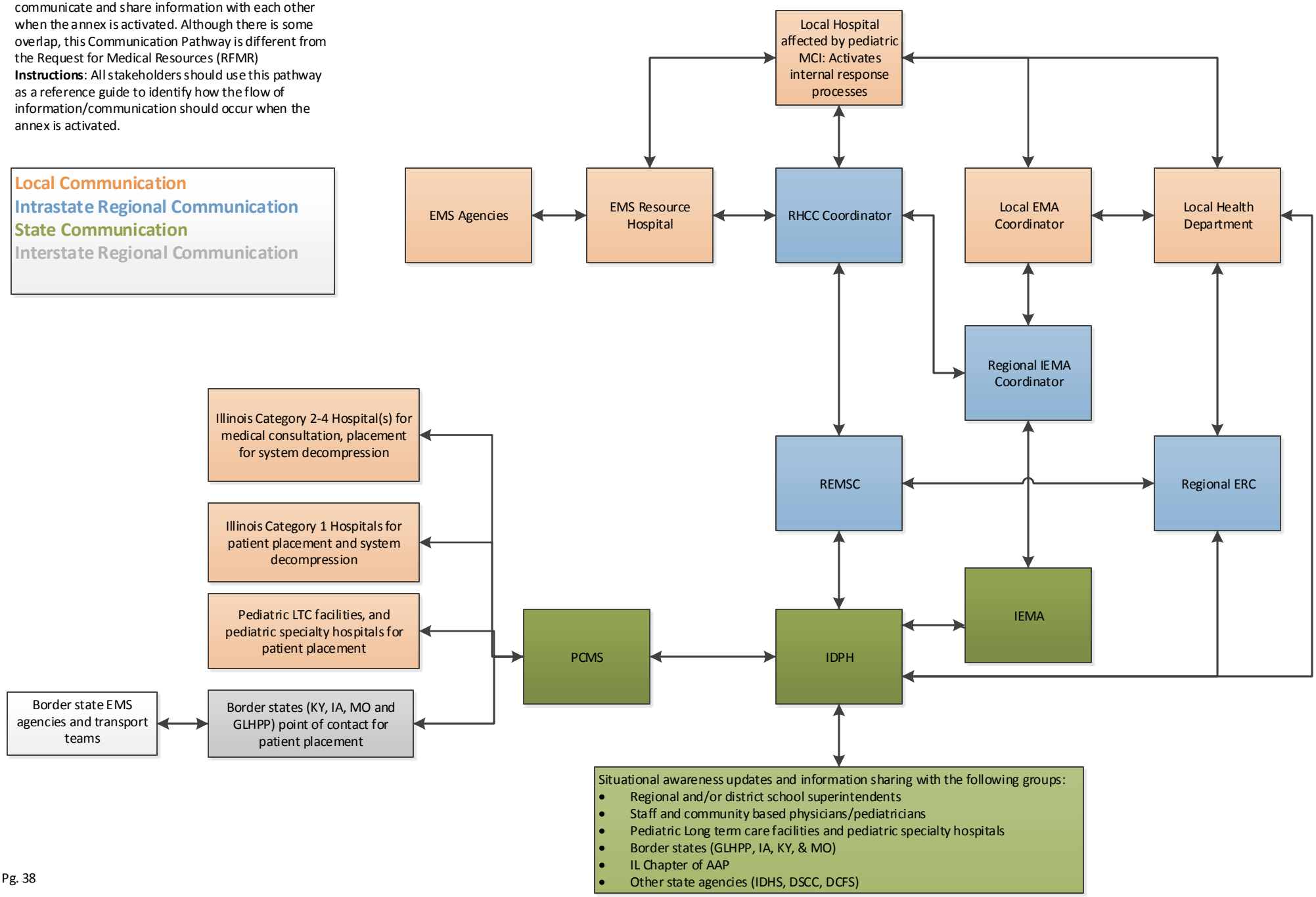
RECEIVED BY	**TIME RECEIVED**	**FORWARD TO**

COMMENTS

FACILITY NAME/LOCATION

IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex 2020
Attachment 6: Pediatric/Neonatal Communication Pathway
July 2020

Purpose: Outline which stakeholders will typically communicate and share information with each other when the annex is activated. Although there is some overlap, this Communication Pathway is different from the Request for Medical Resources (RFMR)
Instructions: All stakeholders should use this pathway as a reference guide to identify how the flow of information/communication should occur when the annex is activated.



Attachment 7: Kentucky Resource Request Process
July 2020

Purpose: Outline the process to contact border states in order to facilitate communication and request resources during a disaster
Instructions: When the annex is activated, this process will be utilized by IDPH and PCMS to communicate necessary information about the incident, annex activation and resource needs/requests to Kentucky

Pediatric Care Medical Specialist/IDPH contacts the KYEM duty officer in the Commonwealth Emergency Operations Center (CEOC) at XXX-XXX-XXXX.

↓

Information will be provided to the duty officer about pediatric resource needs.

↓

KYEM duty officer will notify the manager on call and e-mail ESF-8 distribution list with request.

↓

KYEM manager on call will contact one of the ESF-8 public health/Kentucky Hospital Association partners to verify request for bed availability has been received and is being addressed.

↓

ESF-8 public health/Kentucky Hospital Association will identify bed availability and report information directly to PCMS/IDPH.

↓

The Kentucky Board of EMS will be notified if EMS transportation assistance is needed.

↓

ESF-8 public health/Kentucky Hospital Association will confirm with the manager on call or to the CEOC duty officer via email that request was addressed and provide them the information given to Illinois.

↓

Manager on call and ESF-8 lead will determine if the need exists to elevate CEOC status or open the SHOC (State Health Operations Center) based on the size of the event and requested needs.

↓

If communication has been compromised with Illinois, the manager on call will activate the amateur radio operations to report to the CEOC to establish communications with Illinois state EOC and the areas from which the patients will originate from.

↓

The CEOC will assist the SHOC as needed with:
- notifying hospitals of inbound patients and
- resource allocation and other needs

ATTACHMENT 8: MISSOURI RESOURCE REQUEST PROCESS

Purpose: Outline the process to contact border states in order to facilitate communication and request resources during a disaster

Instructions: When the annex is activated, this process will be utilized by IDPH and PCMS to communicate necessary information about the incident, annex activation and resource needs/requests to **Missouri**.

State of Missouri:

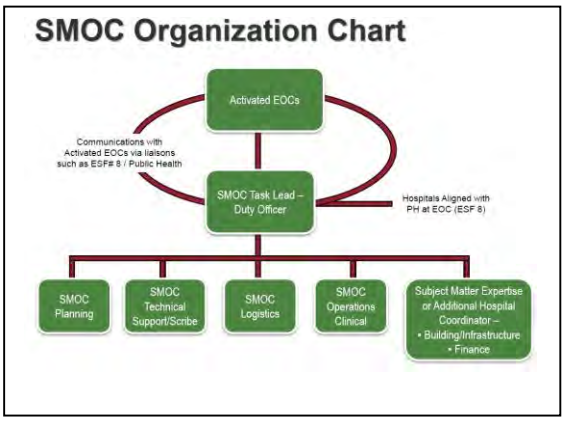
Missouri Department of Health and Senior Services' Emergency Response Center (MDHSS ERC) will serve as the primary contact for Missouri. Contact their ERC at XXX-XXX-XXXX and inform the duty officer of requested action. The duty officer will contact the appropriate personnel for response and coordination including contact with the St. Louis Medical Operations Center (SMOC) as appropriate, sending information to Missouri hospitals and assisting with coordination of pediatric resources and pediatric transport. However, it is recommended that during pediatric surge incidents impacting the Illinois counties of Madison, Monroe and St. Clair, Illinois also contact the SMOC as the secondary contact for Missouri.

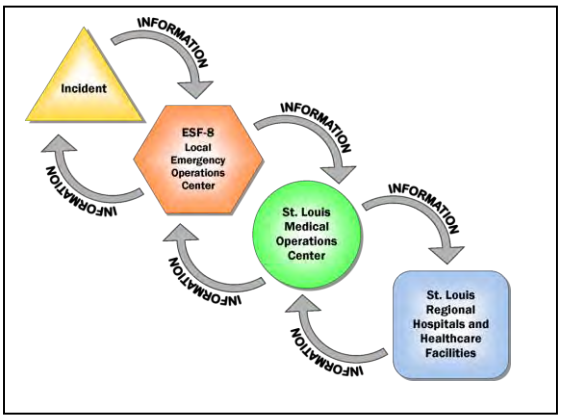
St. Louis Medical Operations Center (SMOC)

- Regional coordination entity supported and staffed by health care organizations to help coordinate decision making for hospitals when hospitals need assistance beyond their walls.
- Supported by volunteers from the medical community (administrative, clinical, non-clinical.
- During an emergency:
    - Serves as central point of contact among healthcare facilities, state and local emergency management agencies, and other governmental and non-governmental agencies as needed.
    - Collects and disseminates current situational information about incident and facility status.
    - Accesses health care resources and needs (e.g., equipment, bed capacity, personnel, supplies, etc.).
    - Develops priority allocations.
    - Tracks disbursement of resources.
    - Manages relevant health care response and communication.
    - Serves as advisors to other emergency support functions (ESF's) within the EOC.

Process for Communication:

- PCMS/IDPH contacts the Central County 911 Center at XXX-XXX-XXXX and requests SMOC duty officer be contacted.
- The duty officer will then serve as the liaison to identify pediatric resource availability, send information to Missouri hospitals and assist with the coordination of transfers.





ATTACHMENT 9: IDPH and PCMS Communication Process

Purpose: Outline the process for what, when, and how information should be shared between the IDPH and the PCMS Team in order to facilitate communication and request resources during a disaster.

Instructions: When the annex is activated, this process will be utilized by IDPH and PCMS to communicate necessary information about the incident, annex activation, and resource needs/requests to each other.

Event Initiation

- The Pediatric and Neonatal Surge Annex can be activated based on two types of incidents -- an immediate incident such as an earthquake that leads to a significant number of pediatric victims in a short period of time and a controlled incident that leads to a gradual or steady increase in the pediatric resource needs (e.g., pandemic flu). With either type of incident, pediatric resources become exhausted.

- If the affected hospital(s) needs additional resources to handle the volume of pediatric patients, they will contact the local Resource Hospital/RHCC. If the needs requested cannot be met at the regional level, the affected hospital should follow the Request for Medical Resources (RFMR) process as outlined in the IDPH ESF-8 Plan by contacting the local health department (LHD) and requesting assistance using the ICS 213RR form. The LHD will contact the emergency management agency (EMA) having jurisdiction.

- If the request cannot be handled by the local EMA, the request will continue to follow the RFMR process up to the state level where the event and the request for resources will be evaluated.

- IDPH will notify IEMA, IMERT, and the Illinois EMS for Children Program that the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex is being activated and request IMERT activate their Pediatric Care Medical Specialist (PCMS) team while providing a situational awareness update and their contact information.

Initial Notifications

IMERT PCMS Team

1. The PCMS Pediatric Team Leader will notify IDPH when the PCMS team is operational.
2. IMERT will notify IEMA when the PCMS team is operational through the IDPH SEOC liaison.
3. IMERT will notify IDPH of contact information to distribute to stakeholders (e.g., phone number for medical consultation; phone/fax/email for transfer requests) for the current PCMS via the Pediatric/Neonatal Medical Incident Report Form (Attachment 5).

IDPH

1. IDPH will notify stakeholders of the following, utilizing the Pediatric/Neonatal Medical Incident Report Form:
   a. the incident;
   b. activation of the Pediatric/Neonatal Surge Annex, including the Pediatric Triage Guidelines (Attachment 11;
   c. activation of the IMERT PCMS team;
   d. process to contact the current PCMS for medical consultation and transfer coordination requests; and

   e. request hospitals (especially the Category 1 hospitals {pediatric tertiary/specialty care hospitals}) update the electronic bed tracking system with bed availability.
2. IDPH will notify the Great Lakes Healthcare Partnership Program (GLHPP), as outlined in the Pediatric and Neonatal Surge Annex of the incident and the activation of the PCMS team, informing them that the PCMS may be contacting them directly for transfer coordination assistance.
3. IDPH will notify Iowa, Kentucky, and Missouri as outlined in the Pediatric and Neonatal Surge Annex of the incident and activation of the PCMS team, informing them that the PCMS may be contacting them directly for transfer coordination assistance.

Ongoing Notifications

1. IDPH, through the Incident Management Team (IMT) Hospital Unit Lead, will provide situational awareness updates to the PCMS Team based on the defined Operational Periods unless otherwise requested. The updates will be provided using the Pediatric/Neonatal Medical Incident Report Form or verbally, and will contain the following:
   a. General incident information as determined pertinent by the Public Health Emergency Operations Center (PHEOC) Incident Commander.
   b. Follow up on issues requiring IDPH assistance.

2. IDPH, through the IDPH SEOC Liaison, will provide situational awareness updates to IEMA based on the defined Operational Period unless otherwise requested. The updates will be provided using the Pediatric/Neonatal Medical Incident Report Form or verbally, and will contain the following:
   a. Update on the current situation.
   b. Number of pediatric patients and their acuity level.
   c. Any issues and their resolution.

3. The PCMS Team, through the Pediatric Team Leader, will provide Situational Awareness updates to IDPH based on the Operational Periods determined by IDPH. The updates will be provided using the Pediatric/Neonatal Medical Incident Report Form either verbally during conference calls, or via other means of communication and will also contain the following:
   1. The number of available PICU and NICU beds available in the state.
   2. Pediatric Patient Tracking Log (Attachment 9), which will provide information on:
      a. number of pediatric patients transferred to another health care facility,
      b. what health care facility(ies) patients were transferred to and from, and
      c. number of pediatric patients still needing interfacility transfer.
   3. The number of medical consultations provided (using the IMERT Patient Communication Form), maintained by the PCMS Team.
   4. Issues requiring IDPH assistance.

4. IDPH, through the Incident Management Team Hospital Unit Lead, will provide updates to the GLHPP, and the states of Iowa, Kentucky, and Missouri as to pediatric victims handled within the state; the numbers transferred out of state and to which state; and expected additional pediatric victims. The PCMS Team Pediatric Team Leader will provide the Hospital Unit Lead with this information.

Shift Change for the PCMS

The PCMS' shifts will vary from 4 hours to 12 hours. At the end of each shift, the PCMS Pediatric Team Leader will notify the Hospital Unit Lead with the information for the new PCMS, including the process to contact the new PCMS for medical consultation and transfer coordination requests. This information will be sent utilizing the Pediatric/Neonatal Medical Incident Report Form. IDPH will notify stakeholders of this information utilizing the Pediatric/Neonatal Medical Incident Report Form.

ATTACHMENT 10: PEDIATRIC TRIAGE GUIDELINES

Purpose: Provide guidance to the transferring facility and the Pediatric Care Medical Specialist (PCMS) during statewide triage of patients to identify the most appropriate facility to receive transferred pediatric patients.

Instructions: Transferring physician should use these guidelines to determine which category hospital the pediatric patient needs. The triage category assigned to each patient by the transferring physician should be sent to the PCMS using the Pediatric/Neonatal Medical Incident Report Form (Attachment 5)

TRIAGE CATEGORY	POSSIBLE CRITERIA*		
	PEDIATRIC INTERVENTIONS	PEDIATRIC CONDITIONS	PERINATAL CRITERIA
CRITICAL CARE (Pediatric/Neonatal Intensive Care/ Category 1 Hospitals)	• Invasive monitoring (either present or needed) (e.g., A-line, CVP, ICP) • Continuous cardiac, NIBP, and/or pulse oximetry monitoring • Immediate/emergent dialysis for acute or chronic renal failure • IV drips ≥ 2 (e.g., insulin, inotropes, TPN, etc.) • Highly specialized equipment needs (HFOV-high frequency oscillator ventilators, ECMO) • Conventional ventilator/BiPAP/CPAP/Hi flow oxygen (unstable) • Continuous nebulizer treatments (not responding adequately to treatments) • Externally paced • Other highly specialized services needed • Other specialized equipment (e.g., LVADs)	• Active seizures/status epilepticus • Post cardiopulmonary arrest patients • Dehydration, electrolyte imbalances, and/or metabolic disturbances (unstable) • Shock responding inadequately to treatment (refractory) • Respiratory distress (responding inadequately to treatment) • Unstable vital signs • Unstable cardiac rhythm disturbances • Trauma (unstable): Spinal cord injuries; major pelvic fractures; blunt injury to chest or abdomen; significant penetrating wounds to head, neck, thorax, abdomen, or pelvis • Trauma: Head injury with any of the following: cerebrospinal fluid leaks, open head injuries (excluding simple scalp injuries), depressed skull fractures, decreased level of consciousness • Trauma: Amputation proximal to the wrist or ankle • Trauma (unstable): Fractures and deep penetrating wounds to an extremity with neurovascular or compartment injury • Burns ≥ 20% TBSA, burns to genitalia, circumferential burns (Request hospital with burn capabilities) • Other condition(s) requiring pediatric critical care specialty	Level III Perinatal Center Criteria • Post cardio-pulmonary failure/arrest • Eclampsia • Active hemorrhage/heavy bleeding • Fetal parts or foreign bodies protruding from vagina • Diabetic coma/DKA • Altered level of consciousness • Multiple gestations (greater than twins) in active labor • Active labor in mothers < 30 weeks gestation • Preterm rupture of membranes < 30 weeks gestation • Laboring mother with known antenatal fetus defect (e.g., cardiac, pediatric surgery) • Pre-eclampsia or Hemolysis, Elevated Liver Enzymes, and Low Platelets (HELLP) syndrome • Other life-threatening conditions to mother or fetus Pregnant women with > 10% TBSA burns (Request hospital with burn capabilities)
INTERMEDIATE CARE (Pediatric/Neonatal Intermediate Care/ Category 2 & 4 Hospitals)	• IV drip x 1 (e.g., insulin, inotropes, TPN) • Central lines (IJ, Subclavian, Femoral) • Intermittent cardiac, NIBP and/or pulse oximetry monitoring • Continuous nebulizer treatments (responding adequately to treatment) • Conventional ventilator, CPAP/BiPAP/Hi flow oxygen (stable) • Non-emergent hemodialysis for chronic renal failure	• Shock, responding adequately to treatment (compensated) • Stable cardiac rhythm disturbances • Dehydration, electrolyte imbalances, and/or metabolic disturbances (stable) • Respiratory distress (responding adequately to treatment) • Trauma (stable): Head injury, pelvic fractures, spinal cord injuries, blunt injury to chest or abdomen • Trauma (stable): Fractures and deep penetrating wounds to an extremity with neurovascular or compartment injury • Trauma: Patient with chest tube, hemovac (stable) • Burns ≥10% but < 20% TBSA • Other urgent condition(s) requiring care	Level II-E Perinatal Center Criteria • Active labor in mothers > 30 and < 35 weeks gestation • Multiple gestations (no more than twins) in active labor • Decreased fetal movement • Abdominal pain • Preterm rupture of membranes > 30 and < 35 weeks gestation Pregnant women with ≤ 10% TBSA burns
GENERAL CARE (Pediatric/Neonatal General Medical Care/ Category 2, 3 & 4 Hospitals)	• Intermittent monitoring (e.g., pulse oximetry) • Maintenance IV fluids or saline lock • Low flow oxygen (up to 4L) • Nebulizer treatments q 4 hrs or greater • PO/IV meds	• Pediatric burns < 10% • Fever (Stable) • Inpatient psychiatric resources • Other minor condition(s) requiring care	Level I or II Perinatal Center Criteria • Active labor in mothers > 35 gestation • Stable gestational hypertension • Premature rupture of membranes > 35 weeks gestation • Rule out rupture of membranes (ROM)

* This list is not meant to be all inclusive and is to be used ONLY during disasters

ATTACHMENT 11: PEDIATRIC PATIENT TRACKING LOG

Purpose: Assist with tracking of pediatric patients during disasters.

Instructions: The Pediatric Care Medical Specialist (PCMS) or designee will complete this form on all patients the PCMS assists with transfer coordination between two health care facilities. This form will be used as a reference for the PCMS and IDPH to assist with reunification of patients with their families. At the end of each operational period (or other agreed upon designated time frame), the PCMS will forward this completed form to IDPH IMT at the PHEOC, who will store it in the same manner as other incident related command documents.

Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

.

Incident name	Date	Time	Prepared by:

Tracking Number (assigned by initial health care facility)	Patient Name (Last, First)	DOB	GENDER	Chief complaint/ condition	Intubated?	Triage Category	Method of Transport (Ground, Air) / Type of Transport (BLS, ALS, Critical Care)	Transferring Facility: Name / Point of Contact / Address	Receiving Facility: Name / Point of Contact / Address	Initial transfer? Y/N	Transfer Complete (Time)
					Y N					Y N	
					Y N					Y N	
					Y N					Y N	
					Y N					Y N	
					Y N					Y N	
					Y N					Y N	

ATTACHMENT 11: PEDIATRIC PATIENT TRACKING LOG

Incident name	Date	Time	Prepared by:

Tracking Number (assigned by initial health care facility)	Patient Name (Last, First)	DOB	GENDER	Chief complaint/ condition	Intubated?	Triage Category	Method of Transport (Ground, Air) / Type of Transport (BLS, ALS, Critical Care)	Transferring Facility: Name / Point of Contact / Address	Receiving Facility: Name / Point of Contact / Address	Initial transfer? Y/N	Transfer Complete (Time)
					Y N					Y N	
					Y N					Y N	
					Y N					Y N	
					Y N					Y N	
					Y N					Y N	

ATTACHMENT 12: PATIENT IDENTIFICATION TRACKING FORM

Purpose: Assist in identifying, tracking, and reunifying patients during a disaster.

Instructions: This form should be completed to the best of the ability given the information available on all patients, especially pediatric patients, who arrive at a health care facility regardless if accompanied by family/parent/guardian. Send the original form with the patient if transferred to another facility and keep a copy of the form on file with the patient's medical record at the transferring health care facility.

Note: Information contained within this form is confidential and should not be shared, except with those assisting in the care of the patient.

Date of Arrival	Time of Arrival AM/PM	Incident Name
Tracking Number (assigned by initial health care facility)		
Patient's Name (Last, First)		Patient's Phone
Patient's Full Home Address		
(For Minors) Parent/Guardians' Names		Presented with patient? □ Yes □ No
Patient's DOB □ Unknown	Age Years Months □ Estimated	Gender □ Male □ Female
Race/ethnicity, if known □ White non-Hispanic □ Black/African American, non-Hispanic □ Asian or Pacific Islander □ Hispanic □ Asian Indian □ American Indian or Alaska Native □ Unknown □ Other _____		Language □ English □ Spanish □ Nonverbal □ Other _____

□ Accompanied □ Unaccompanied How patient arrived at hospital (list name if available) □ EMS_____ □ Private medical transport service (ambulance/flight)_____ _____ □ Law enforcement _____ _____ □ Private vehicle □ Walk-in □ Other_____	Describe where patient was found. Be as specific as possible, including neighborhood/street address.	Items worn by or with patient when found (describe color, pattern, type) □ Pants_____ □ Shirt_____ □ Dress _____ □ Shoes _____ □ Socks _____ □ Coat/jacket _____ □ Jewelry_____ □ Glasses_____ □ Medical devices_____ □ Other _____ □ Other _____

DESCRIPTION OF THE PATIENT

Skin color_____	Attach photo here
Hair Color □ Blonde □ Brown □ Black □ Bald □ Red □ Grey □ White □ Other_____	
Eye Color □ Brown □ Blue □ Green □ Other_____	
Height □Estimated	
Weight □Estimated	
Other markings □ Scars_____ □ Moles_____ □ Birthmarks _____ □ Tattoos_____ □ Missing teeth_____ □ Braces_____ □ Other_____ □ Other_____	

PATIENT TRACKING LOG

Hospital/Facility Name	Phone Number	Arrival Date	ID Band #/ ID Band
Location (city, state)	Fax Number	Departure Date	*(If patient has ID bands from other facilities and they need to be removed to provide care, attach ID band in this area)*

MEDICAL HISTORY AND TREATMENT WHILE AT THIS FACILITY
Does the patient have any pre-existing medical conditions, medical problems, previous surgeries, special needs? □ No □ Unknown □ Yes (list)
Is the patient on any medications? □ No □ Unknown □ Yes (list)
Does the patient have any allergies? □ No □ Unknown □ Yes (list)
Did the patient receive medical care for an injury/illness while at this facility? □ No □ Yes (list)

COMPLETE FOR MINORS: CHILD ACCOMPANIED BY PARENT/GUARDIAN	
Name of person accompanying child	□ Adult □ Child/Minor
Relationship to child □ Parent □ Guardian □ Sibling □ Grandparent □ Aunt/Uncle/Cousin □ Unknown □ Other _____	Attach Copy of ID
ID Checked? □ Yes □ No Form of ID (list)_____	
If accompanied by adult, was child living with this adult prior to the emergency? □ Yes □ No Does this adult have proof of legal guardianship or relationship? □ Yes □ No If yes, make copy and attach to this form.	
If child and adult were separated after arrival at current facility, where is accompanying adult now?	
If accompanied by someone other than parent/guardian, what is known about the parent/guardian's current whereabouts? □ Nothing at this time □ Their current location is:	
Is it known if there are orders of protection or other custody issues? □ No known custody/protection issues □ Issue(s) identified	

COMPLETE FOR MINORS: CHILD UNACCOMPANIED BY PARENT/GUARDIAN	
Are the whereabouts of the parent/guardian currently known? □ No □ Yes Is information about parent/guardian known? □ No □ Yes Name Location E-mail address	Phone
Where and when was the parent/guardian last seen	
Has the parent/guardian been contacted □ No □ Yes Contacted by_____ Date Time _____	
Plans for reuniting child with parent/guardian	
Agencies used to assist with reunification (Date/Person contacted) □ American Red Cross _____ □ Illinois Department of Children and Family Services_____ □ Law enforcement_____ □ National Center for Missing and Exploited Children _____ □ Other_____	Additional steps to verify guardianship if reunited at hospital □ Does parent/guardian describe child accurately? □ Does parent/guardian pick correct child out from a group of pictures? □ Does parent/guardian have a picture of them with the child? □ Does the child respond appropriately when reunited with parent/guardian?

DISPOSITION
□ Admitted to_____ □ Discharged □ Expired □ Patient was released to an individual □ Parent □ Guardian □ Other_____ Name Phone License Plate Number Address □ Permanent □ Temporary Was consent obtained from parent/guardian if released to another adult? □ Yes □ No (explain)_____
□ Patient was transferred to another facility/agency (Name)_____ Address Phone Contact name Transported by

Signature of patient/individual patient released to	Date: Time	Name of person completing form
		Signature of person completing form

ATTACHMENT 13: PEDIATRIC PATIENT TRANSFER FORM

Purpose: Provide a method of communicating medical and treatment information during a disaster when pediatric patients are being transferred to another health care facility (e.g., pediatric specialty care centers).

Instructions: This form should be completed to the best of the provider's ability given the care that has been provided on every patient transferred to another health care facility. This form should be completed prior to transfer. The original form will accompany the patient while a copy of the form should remain with the patient's medical record at the transferring health care facility.

Note: All information within this form is confidential and should not be shared except with those assisting in the care of the patient.

Incident Name		Date	Time
Form completed by	Title		
Patient Name (last, first)	DOB		Sex
Tracking Number (assigned by initial health care facility)	Age Years Months □ Estimated		□ Male □ Female
Parent/guardian present □ No □ Yes If yes, provide the following information: Name Phone Custody/legal status Documentation provided □ No □ Yes	Is information about parent/guardian known? □ No □ Yes If yes, provide the following information: Name Phone Are the whereabouts of the parent/guardian currently known? □ No □ Yes Efforts to contact		
Interpreter needed? □ No □ Yes Language_____	Primary care provider notified? □ No □ Yes Phone_____		

INITIAL STATUS

Transferring health care facility Unit at hospital Full address	Transferring physician
	Transferring physician specialty □ ED □ Pediatrician □ Family Practice □ Neonatologist □ Obstetrician □ Other (list) _____
Phone	Transferring physician/facility contact's phone
Preliminary diagnosis	Reason for transfer

Acuity Level □ Stable/Non-emergent □ Stable/Emergent □ Unstable/Emergent

Requested services/specialty □ ED □ Trauma □ PICU □ NICU □ Burn □ In-patient services □ Other specialty services (list):
_____

PATIENT HISTORY

Weight	**Allergies (list)**	**Home medications (list)**
_____kg □ actual □ estimated	□ NKDA □ Unknown	□ None □ Unknown □ See attached medication reconciliation form

Relevant Medical/Surgical History (list) □ See attached

CLINICAL ASSESSMENT AND TREATMENTS

Vital signs (time)	T	HR	RR	BP	SaO2
(initial)					
(most recent)					

Intake/Output (time)	INTAKE	OUTPUT

Vascular access □ Arterial □ IO □ PICC □ PIV □ UVC
□ Indwelling venous catheter □ Central venous line
Site _____
Fluid type_____ Rate_____
Bolus? □ No □ Yes: Type_____
Total volume _____ Time given _____

Physical Findings

FORM CONTINUES ON PAGE 2

ATTACHMENT 13: PEDIATRIC PATIENT TRANSFER FORM

Current Medications □ See attached

X-Ray/CT/MRI/Ultrasound Results □ See attached

Blood Gas □ See attached

Time	Site	pH	pCO_2	pO_2	HCO_3	BD/BE

Labs □ See attached

Other (include critical lab values):

Airway

Intubated □ No □ Yes
ETT/TR Size_____ Depth_____
Vent settings
CXR □ No □ Yes

O_2 Mask □ No □ Yes
Nasal cannula □ No □ Yes
O_2 Liters/Min_____
Bi-PAP/CPAP □ No □ Yes
Settings _____

	+	-	Pending	Isolation
Flu				
RSV				
MRSA				
Cough				

Other Treatments

Treatment Summary

TRANSPORT NEEDS

Type of transport service needed □ BLS □ ALS □ Critical care □ Ground □ Air □ Other_____

Type of transport service available at transferring hospital? □ No □ Yes

Name of transport provider used to transport patient

Phone number of transport provider

Equipment needed for transport □ oxygen □ ventilator □ C-PAP □ cardiac monitor □ IV pump □ invasive monitoring □ spine immobilization □ restraints □ isolette □ car seat □ Other (list)_____

MEDICAL MANAGEMENT PROVIDED BY PCMS

Management discussion/Recommendations □ Telemedicine capabilities used

RECEIVING HOSPITAL INFORMATION

Receiving hospital
Address

Bed assignment_____
Phone _____

Receiving physician

Specialty □ ED □ Pediatrician □ Family Practice □ Neonatologist □ Obstetrician □ Other (list)
_____

Receiving physician phone

Assignment Date	Assignment Time	Person contacted at transferring hospital

ADDITIONAL NOTES