SOUTHEAST REGIONAL HEALTHCARE COALITION

TENNESSEE DEPARTMENT OF HEALTH

PEDIATRIC DISASTER PLAN ANNEX

June 2020

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Record of Revisions

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1.0 Health Care Coalition South East Regional Health Care Coalition

The Southeast Regional Healthcare Coalition has members from across the region that includes: hospitals, mental health facilities, dialysis clinics, long term care facilities, rehabilitation facilities, police, EMS, TEMA, RMCC, and Air Medical. The coalition covers the following counties known as Region 3: Hamilton, Rhea, Sequatchie, Bledsoe, Franklin, Grundy, Meigs, McMinn, Bradley, Polk, and Marion.

Within Region 3, there are 16 hospitals. Erlanger Health System is comprised of six campuses: Children's Hospital at Erlanger, Erlanger East, Erlanger North, Erlanger Bledsoe and Erlanger Sequatchie E.D. Parkridge Health Center has 4 campuses: Parkridge Medical Center, Parkridge East Hospital, Parkridge West ED/ Valley Psychiatric, and Parkridge North E.D. Memorial Health System has 2 campuses: Memorial Glenwood campus, and Memorial Hixson Campus. Other hospitals in Region 3 are: Rhea Medical, Tennova Bradley County, Southern Tennessee, Sewanee, which is part of the Southern Tennessee system, Athens and Etowah which are part of Star Regional Medical Center

Children's Hospital at Erlanger is one of four Comprehensive Regional Pediatric Centers in Tennessee. The center provides services all of the counties above as well as Georgia, Alabama and North Carolina facilities that are geographically close.

Other medical facilities include: 13 dialysis centers, 19 skilled care facilities some of which accept patients for rehabilitation, 1 acute long term care facility, and 2 major rehabilitation facilities. Children's Hospital at Erlanger maintains a transfer agreement with Shepherd's in Atlanta for pediatrics less than 15 years of age requiring physical rehabilitation.

1.1 Access & Functional Needs

In SERHC's 11 counties, there are (per the 2019 estimated census) approximately 688,040 people and 144,142 children under the age of 18. Of the pediatric population, 1 in 5 has some type of disability which means there are approximately 28,000 children with a disability living in the healthcare service area. These numbers cover the entire spectrum of pediatric issues from severe disabilities such as ventilator dependent patients in the home to learning

disabilities. Hospitals work with multiple agencies to identify and make sure that this population has the services that they need. If the child is a medically fragile such as ventilator dependent, the CRPC sends information home with the families which identifies who they need to notify regarding their unique circumstances such as their local hospitals, EMS, electric power, etc. At time of hospital discharge, families or other care givers are educated on the type of items they should have in an emergency "go bag" should they need to leave their home quickly. Our regional health care coalition periodically discusses things that can be done to mitigate issues with our special populations and that include the pediatric patients as well as those adults with special needs.

Another major issue is with children with serious emotional issues. One of the things that are so important in the SERHC is to provide educational information to the membership that gives them information as to how to deal with this population of patients from an EMS and hospital perspective. For example, the child with Autism needs a quieter environment and can become overwhelmed very quickly; this patient can then escalate into a major issue with EMS and hospitals. The CRPC Education staff trains EMS to ask the appropriate questions of the parents in how to deal with their child's needs to mitigate some of those issues. In the hospital environment those patients should be placed in the quietest area with as much decreased stimulation as possible. Some facilities have noise cancelling headsets that can be placed on the patient and others use small DVD players for distraction. The main objective is to care for these children so that responders do not escalate their symptoms. Tennessee Department of Health launched "The Emergency Alert Decals" a set of resources available for families who have children and youth with special healthcare needs

Children's hospital at Erlanger does not have major cardiac surgeries or transplant for the pediatric patient, should those needs arise there are transfer agreements that can be activated to transfer those patients to the appropriate facility for care. Interpreters and a language line are available to assist with language barriers. The hospital has a communication board for the deaf as well as on call persons for signing for the deaf community. Assistive devices are available for the patient that is blind.

It is the desire of the HCC to make sure that all facilities and EMS understand that the best plan for these patients is to keep them with someone that is familiar to them; in the event that this is impossible it may be necessary to have one staff member be assigned to those patients for continuity of care. The plan then would be reunification as soon as possible.

This plan complies with the Americans with Disabilities Act. It addresses the provision of appropriate auxiliary aids and services to ensure effective communication with individuals with disabilities; ensure individuals with disabilities are not separated from service animals and assistive devices, and can receive disability-related assistance throughout emergencies; and comply with the law's architectural and other requirements.

Effective communication with individuals with limited English proficiency (LEP), including children and caretakers, is an essential component of emergency planning and response.

It addresses the following, but not limited to:

- No water, electricity, telephone, heat, air conditioning, or refrigeration
- No local access to prescription refills or health products
- Separation from family members
- Inability to leave your home or need for evacuation
- Limited health care access and emergency rescue services
- A lack of transportation
- No access to augmentative communications devices or other assistive technologies
- No access to dialysis or other life-sustaining treatment
- The need for assistive technology devices for mobility such as canes, walkers, wheelchairs, etc.
- Patients with sensory processing disorders and/or developmental delays

2. Concept of Operations

2.1 Activation

General: A variety of situations may prompt the need to activate portions of this Annex. Our pediatric facility works closely with our regional facilities and has MOU's with four of our adult focused facilities to assist with decompression of our pediatric hospital to be able to care for the most critical when surge occurs. We would notify our regional hospital coordinator that we were above our capabilities to care for patients, or any of the issues below. We would activate our hospital command center to assist with decompression and mobilization of any needed resources per our pediatric plan.

Some examples include the following:

- Overwhelming influx or surge of pediatric and neonatal patients; this would be if our PICU, NICU or inpatient beds were full. The first line would be to discharge or transfer any patients that were ready for discharge/transfer. We can also board patients in our ED if there is not an influx of patients in our emergency department. If the surge involves our emergency department we would then start the process of identifying our regional facilities that were able to assist with seeing pediatric patients to decrease the surge in our emergency department. In the event that there were critical patients and we were above our admission resources we would still accept the transfer and stabilize the patient and then transfer if needed to another tertiary care facility capable of caring for the patient.
- Inadequate hospital resources for pediatric (i.e. inpatient monitored beds, ventilators, isolation beds);
- Damage or threats to hospital(s);
- Staffing limitations (i.e., lack of qualified and trained staff to care for pediatric or neonatal patients);
- Activation of hospital disaster plans when surge capacity for pediatric patients has been exceeded; of pediatric patients.
- System decompression processes outlined in this Annex

2.2 Notifications

Depending on the nature and scope of the surge, notification requirements may vary. In general, the following entities are identified as key players, and as such, would be subject to call:

- TEMA
- Regional EMS Consultant (Nita Jernigan)
- Regional Hospital Coordinators (Jenny Wolverton and Ken Tarter)
- Regional Emergency Response Coordinators (ERC)
- Regional Medical Communications Center (RMCC)
- Transportation Agencies (as needed)
- Department of Health Strategic National Stockpile (SNS)/CHEMPACK Coordinator

This list is not all-inclusive, but these notifications should trigger additional notifications as may be appropriate for the nature of the surge.

Generally, the primary method of communicating alerts to hospitals and other key entities will be accomplished through the Healthcare Resource Tracking System (Attachment 6.1 contains the HRTS Activation Policy) and the TN Health Alert Network (TNHAN) or its equivalent. Additional means of communication may be used depending on the nature of the incident. These may include email, cell phone, land line, HAM, VHF, UHF, 800 or 900 megahertz radio systems. Should any of these methods be unavailable, multiple options exist. TNHAN (or its equivalent replacement) alerts provide a built-in mechanism for acknowledgement of receipt, ensuring that the alert is not only sent, but that its reception can be confirmed and tracked.

2.3 Roles and Responsibilities

2.3.1 Hospitals

Tennessee is unique in its provision of emergency care to the pediatric population in terms of its geography and its designation of pediatric care facilities. Emergent medical care of individual children within the state is served by a four-tiered classification of emergency departments. These include:

- **Comprehensive Regional Pediatric Centers** have all the capabilities of the three lower classifications, plus a dedicated Pediatric Intensive Care Unit (PICU) and/or Neonatal Intensive Care Unit (NICU).

- **General Pediatric Facilities with a PICU** have the capabilities of the two lower classifications, plus a defined and separate pediatric inpatient service, a department of pediatrics within the medical staff structure, and a dedicated Pediatric Intensive Care Unit (PICU). These facilities may accept appropriate transfers from lower tiered facilities when no CRPC is available.

- **General Pediatric Facilities** have the capabilities of the two lower classifications, plus a defined and separate pediatric inpatient service and a department of pediatrics within the medical staff structure.

- **Primary Pediatric Facilities** provide same services as basic, have limited capabilities for the management of minor pediatric inpatient problems, and may accept appropriate transfers when no CRPC is available.

- **Basic Pediatric Centers** have the capability of identify those pediatric patients who are critically ill or injured, stabilize them, and provide for an appropriate transfer to a definitive care facility.

Each designation reflects the pediatric capability of each facility's Emergency Department. Each of the Emergency Departments in the lower three tiers is linked to one of four Comprehensive Regional Pediatric Centers within the State according to its transfer and educational agreements.

The four Comprehensive Regional Pediatric Centers (CRPCs) are almost equidistantly spread across the State. These are located at:

- Chattanooga
- Knoxville
- Memphis
- Nashville

In addition, Tennessee is bordered by eight states that often transfer children across the border.

The CRPCs are located in each of the four major metropolitan areas. The majority of critical pediatric care in the state occurs within or near these densely populated areas. The lack of dispersed pediatric practices with hospital care creates clear challenges during times of disaster. While this referral system is highly functional during ordinary conditions, the daily occupancy rates at the four CRPCs will dictate that a surge of pediatric patients in a pandemic or mass casualty event will quickly overwhelm the system. TEMA, WebEOC, and TDH websites will allow access to real-time data during a disaster event to assist in maintaining a common operating picture.

Number of Tennessee hospitals with PICU beds and their availability, is shown in the Hospital Resource Tracking System for current availability.] HRTS Activation Policy is in Attachment 6.1 and the State Patient Tracking Policy is Attachment 6.2.

(https://www.tn.gov/health/cedep/cedep-emergency-preparedness/temarr.html)

CRPC

- Monroe Carrell, Jr. Children's Hospital at Vanderbilt (Nashville)
- East TN Children's (Knoxville)
- Children's at Erlanger (Chattanooga)
- Le Bonheur Children's (Memphis)

Non-CRPC Hospitals

- Centennial (Nashville)
- Baptist Children's Hospital (Memphis)
- Niswonger Children's Hospital (Johnson City)
- St. Jude (Memphis)
- Holston Valley Medical Center (Kingsport)
- University of Tennessee Medical Center (Knoxville)

Patients can be initially triaged and/or stabilized at any facility, and may be transferred to a facility with increased care capabilities as needed. Primary and Basic level facilities have limited capability to treat pediatric patients, and generally do not admit pediatric patients. General level facilities provide intermediate care and can provide some pediatric inpatient care. Statewide utilized HRTS database is available to access specific number of beds at each facility. The local RHC and EMS consultant is contacted prior to moving patients once the Emergency Operation Center (EOC) is opened and a disaster is declared. Contact information for them can be found in HRTS.

Children's hospital at Erlanger has 32 emergency room beds with 4 designated trauma bays, 50 inpatient beds, 56 neonatal beds with an additional 10 NICU beds at Erlanger East. We also have 14 pediatric intensive care beds with 3 of those beds that are capable of negative or positive pressure isolation. We currently have no state designation for pediatric trauma so our facility operates at the highest level of pediatric trauma care as a CRPC.

Children's will not divert any unstable and/or potentially unstable pediatric patient coming from the pre-hospital environment. When this situation occurs, the ED will stabilize the patient, and if no ICU bed is available, then the patient may be transferred to another tertiary care facility.

Children's hospital also has transfer agreements with Children's hospital of Atlanta, Emory, Joseph Still Burn Center, Shriners Burn Center, Shepherds rehabilitation center in Atlanta as well as the CRPC facilities to include East Tennessee Children's and Monroe Carell Children's Hospital. This list is not exhaustive as there is a MOU with the Southeastern states: Alabama, Georgia, Florida, Mississippi and North Carolina.

The SERHC in cooperation with the Knox/East Tennessee Coalition has a MOU between the two Health Care Coalitions.

2.3.2 Non-Hospitals

Currently, there are no MOU's with non-hospitals with the exception of MOU's for additional supplies that is maintained by Erlanger's Central Dispatch department. The supervisor of this area will attempt to provide needed supplies from these vendors should our routine routes be unavailable.

2.3.3 EMS Agencies

Children's hospital has the capability of sending Air Medical to another facility should they need to transfer critical patients. Life Force air medical has 6 strategically located helicopters located throughout the region as well as in Georgia and North Carolina to transfer these critical patients in a timely manner. These health care professionals are all critical care certified and maintain the highest level of pediatric education for their crews. In the event that weather does not permit the helicopters to fly they have in place the ability to send the critical care response vehicle and equipment to that facility to assist that facility with stabilization. The local ground transport EMS agency would then transfer the patient to Children's hospital at Erlanger. If assistance is needed on transport, Life Force crew is available to assist the local EMS agency by accompanying them on the transport. The CRPC utilizes Puckett EMS for critical care ground transport of pediatric patients as well as neonatal transport. Children's Hospital at Erlanger has a dedicated NICU transport team available to dispatch to the transferring facility. Life force can transport staff to the facility to initialize stabilization while

the ground critical care ambulance is in route. Once that neonate is stabilized then Puckett will transport the patient and team back to Children's at Erlanger.

There are educational agreements between the CRPC and the regional EMS agencies to assist them in maintaining pediatric education. Pediatric transports are low volume therefore high risk; as a general rule less than 20% of EMS transports involve children. Children's at Erlanger continues to work with other three CRPC counterparts to develop and offer education and simulation to EMS agencies.

2.4 Logistics

During a disaster or other extended surge event, the Healthcare Resource Tracking System (HRTS) is activated by the Regional Medical Communication Center (RMCC). The Regional Hospital Coordinators (RHC) and a representative from the RMCC report to the county Emergency Operations Center (EOC). Public Health's Emergency Response Coordinator may report to the EOC depending on the type of disaster or surge event. The EMS Consultant reports to the scene, or to the RMCC. Initial communication is established with ESF-8 at the State Emergency Operations Center (SEOC) using WebEOC. The RHCs also establishes communication with the State Health Operations Center (SHOC) through HRTS. The RHC uses HRTS, email, Tennessee Health Alert Network and telephone calls as appropriate for further communications with the healthcare systems.

2.4.1 Space

Each acute care hospital in Region 3 have established internal plans for expanding space for patient care during an ED surge, and for inpatient beds. During a pediatric surge event, the CRPC has a designated location near the ED entrance to erect tents for the purpose of triage. The CRPC has also established an area located in an adjoining building near the ED to accommodate families/friends waiting to hear about their pediatric family member/friend.

2.4.2 Staff

The CRPC has access to Pastoral care to meet the needs of the patients and or family. Hamilton County EOC has access to a team of counselors who can be activated 24/7. Both Pastoral Care and the Counselors can be made available to the staff following the event. In addition, Tennessee has a Disaster Mental Health Strike Team which can be activated through ESF-8 at the SEOC.

Hospitals in Region 3 including the CRPC have internal plans for expanding staff. The CRPC can move ED staff from the adult unit to the adjoining Pediatric unit, patient/Nurse rations can be expanded, and work scheduled can be extended. In a declared disaster by the Governor, waivers can be activated to allow for specific licensed personnel to work outside their scope with appropriate oversight.

2.4.3 Supplies and Equipment

The CRPC has access to the SERHC's medical equipment and supply cache by notifying the Regional Hospitals. When additional supplies/equipment from other local hospitals begins to run low, the Regional Hospital Coordinators can activate the MOU between the SERHC and the Knox East Tennessee Healthcare Coalition (KETHCC). Resources can also be requested through ESF-8 at the SEOC.

2.5 Special Considerations

When a Disaster or surge event occurs, the RMCC activates HRTS for all impacted counties. Other RMCCs, RHCs, and EMS Consultants across the state are notified through HRTS. Hospitals in the impacted counties are requested to update their bed availability to include number of GREEN, YELLOW, and RED incoming injured they can accommodate.

All supplies borrowed from another facility are expected to be replaced as soon as possible at the conclusion of the event. Any equipment borrowed from the SERHC's cache or from another hospital is expected to be returned in good condition and fully operational. Damaged equipment is expected to be repaired or replaced as outlined in the MOU between local hospitals, and the MOU between the Southeast and the Knox/East Healthcare Coalitions.

2.5.1 Behavioral Health

Tennessee uses PsySTART (Psychological Simple Triage and Rapid Treatment) to Triage mental health needs and assess and manage behavioral health impact. PsySTART Tennessee can be found at:

https://www.tn.gov/health/cedep/cedep-emergency-preparedness/temarr.html

The Tennessee Department of Health, in collaboration with the Tennessee Department of Mental Health and Substance Abuse Services, established a Tennessee Disaster Mental Health Strike Team through the Tennessee Federation of Fire Chaplains (TFFC). The TFFC provides training and management of the Strike Team which includes a State-Wide deployment-capable cadre of trained Chaplain, Mental Health, and Emergency Service Peer Professionals. The Tennessee Department of Health may activate and deploy the team for service during disasters. The Strike Team provides timely initial referral to Licensed Mental Health Care Professionals — including immediate emergency referrals when appropriate.

2.5.2 Decontamination

The highest level of PPE available to staff members will always be utilized. This level of protection will remain in place until advised otherwise by the Incident Commander (House Supervisor). The staff will follow the appropriate donning and doffing PPE policies per facility.

Stretchers/wheelchairs will be positioned within the cold zone ready to receive decontaminated casualties. Once a team member or piece of equipment has entered the warm zone (it) they cannot return to the cold zone until it has been decontaminated. At the end of decontamination process all persons wearing PPE must be evaluated for needed decontamination before being allowed to leave the hot/warm zone. All personnel who have been wearing PPE in a contaminated zone or who have handled contaminated casualties MUST undergo a full medical examination and be observed for the development of any symptoms in compliance with OSHA regulations.

In regards to pediatric patients all attempts will be made to decontaminate pediatric patients using only warm water. Warm blankets will be obtained from the Children's emergency department as needed and will be used to re-warm these patients immediately once the decontamination process has been completed. Warming lights and warm air blankets will be obtained and used as needed to insure proper re-warming of decontaminated patients. When possible, room and hallway temperatures will be increased to aid in the prevention of hypothermia.

2.5.3 Evacuation

Patients who are closest to danger will be moved first. Wheelchair and non-ambulatory patients will be moved via wheel chairs, stretchers, NICU evacuation trays with capabilities to take oxygen with them. They also have the vests to move several patients at the same time. They will move these patients either vertically or horizontally depending on what type of disaster is occurring and or determined by the command center.

Charge Nurse will prepare a list of patient names, room number, and medical records.

Pediatric Attending physicians & residents, as well as nurse practitioners will follow evacuated patients to designated area and triage for possible discharge/transfer, if appropriate. Nursing staff will stay with assigned patients throughout this process. The regional hospital coordinator will be contacted as soon as the disaster is called along with all of the entities listed in the document for a called disaster.

.2.5.4 Infection Control

All staff will adhere to the hospital policy for infection control. The hospital will abide by the CDC's recommendation in regards to precautions for the different types of patients that could present a risk to other patient's or to the staff. Our health care coalition partners will be kept up to date via HERTZ, and the command center if activated, if the command center is not activated information will be disseminated by our Regional hospital coordinators.

2.5.5 Security

Security is made aware of any changes in children's hospital status. The head of security or his/her designee will maintain facility safety by watching the flow and addressing any needs in the event of a disaster. If the event is community wide, like a tornado, they will be updated on a regular basis by the command center so that they will know how to mitigate any issues that might occur. One of the major issues that occur with a mass casualty is an influx of people that might know the patients which could overwhelm our emergency department area. We have put in place a plan to only allow only the parent/guardian of the patient to be in the emergency area. Our security team will direct the rest of the people to a pre-determined area to wait. This area will be manned by non-essential personnel and security. The hospitals' command centers will be in contact with security and also the Regional hospital coordinators to keep them up to date as well as frequent communication with the effective county's EOC.

2.6 Operations Medical Care

2.6.1 Triage

The state standard triage system utilized throughout the state uses SMART TAGS through Simple Triage and Rapid Treatment (START Triage). Healthcare coalitions provide training and logistical support for hospitals and pre-hospital services.

2.6.2 Treatment

Standard of Pediatric Care is followed by the standards approved by the State Board of EMS and Board of Licensing Healthcare Facilities outlined by CoPEC guidelines. Local protocols may vary from region to region based on local medical direction.

https://cecatn.org/what-we-do/resource-center/

2.7 Transportation

All ambulances and licensed EMS personnel operating within the State of Tennessee must meet certain pediatric standards set by the State Board of EMS.

There are also several specialized pediatric transport teams, primarily housed at CRPCs, as well as, several air ambulance services. Specialized EMS transport resources are accessed through the EMS Consultants, working with the Regional Medical Communications Centers, and when required, the RHCs. As noted earlier in this document we have critical care transport with Life Force air medical and Puckett EMS. They are all up to date with their pediatric education and also have critical care credentials.

2.8 Tracking

The Tennessee Department of Health Global Emergency Response (GER) patient tracking model (HC Standard) is integrated into the national system for patient tracking. This system is used to provide situational awareness, family reunification and re-patriation for emergency evacuees, quickly register, record assessment, triage and document patient treatment. The system is scalable and can be deployed for mass casualties, healthcare facility evacuations and medical assistance in shelter operations.

2.9 Reunification

Joint reunification planning with county emergency management was interrupted by response to two (2) disasters in early 2020: COVID-19 and a tornado affecting several counties in the region. Response to COVID-19 is ongoing; joint planning will resume at an undetermined date.

Patients may arrive from many different areas during a disaster event; this makes having a plan for reunification even more important. Lessons learned from other regions that have had issues with getting children back to their families resulted in implementing a few additional measures at Children's Hospital at Erlanger to address these issues. The first thing we do of course is to get verification of who the family is looking for, we then ask them to send us a photo to the charge nurses phone so that we can identify if we have that patient in our ED. The next thing we have done is use our local schools to assist us in who the legal guardians are and also to help identify children when there is a mass casualty event involving a particular school. We have asked for all triage tags to stay with the patient and to put the sending hospital on the tag so that we will

know where each patient arrived from, and if we have to send this patient out we also add that they were in our facility so that we have a document on the patient that lets the receiving hospital know where the patient came from initially and subsequently. If we transfer a child, that goes into the chart that stays with us and we take a Polaroid photo and place with the record, that way we can identify those patients for reunification purposes. In the event that the patient was brought from the scene by EMS we put on the triage tag what area this patient originated from, this assist us as well with reunification. We will continue to use our partnerships with the organizations that assist with reunification such as the American Red Cross, TBI Find, School Board of Education and FBI. This list is not all inclusive as we will utilize any organization that is available to assist us in reuniting families.

2.10 Deactivation and Recovery

When activated, this Annex functions within the existing ESF-8 systems and structures. All communication and coordination activities within ESF-8, including lead and supporting agencies, remain unchanged. In addition, recovery activities are managed as part of the overall recovery from the disaster.

3.0 Training

There are a variety of training options that are designed to enhance the effectiveness in managing disasters involving pediatric populations. Such training is available for clinical practitioners and others who may be involved in the medical or psychological aspects of care for pediatric patients, as well as for those involved in sheltering or other related operations. Associated topics include the following:

- Clinical aspects of pediatric care for licensed providers, including standards and best practices based upon continuing research data. (Tennessee Department of Health, Office of Emergency Medical Services requires specific numbers of hours for EMTs and Paramedics who choose to renew licensure by submitting continuing education credits.)

- Psychological aspects of managing pediatric patients
- Sheltering considerations for pediatric patients
- Resource management/logistics for securing supplies for pediatric populations
- Other emergency preparedness training for families, responders, and providers
- Numerous online and instructor-led courses are identified on the Children's Emergency Care Alliance Website: www.cecatn.org
- FEMA course: Pediatric Disaster Response and Emergency Preparedness MGT-439
- START Triage Training

SERHC's CRPC has educational agreements with all of the adult focused hospitals; in Region 3. CRPC staff will provide pediatric education to their staff and assist them with site visit preparation. The CRPC has the same agreements with EMS providers. Examples of the training are: PALS, NRP, Stable, and PEPP, as well as specific educational request, things such as assessment, critical care red flags, and others. CRPC educators also do simulation in the form of mock codes for acute care hospitals and EMS. The SERHC provided Children's Hospital at Erlanger with a high definition simulator that is used for these trainings.

4.0 Pediatric Referral Resource

A network of participants in FEMA Region IV is available to communicate and coordinate response efforts and resources: This list may be useful to coordinate an Emergency Management Assistance Compact (EMAC) with TEMA to coordinate assistance across the region.

- Children's of Alabama (Huntsville, Birmingham, Tuscaloosa, AL)
- Children's Healthcare of Atlanta (Atlanta, GA)
- Le Bonheur Children's Hospital (Memphis, TN)

- Mississippi State Department of Health (State)
- Monroe Carell Jr. Children's Hospital at Vanderbilt (Nashville, TN)
- Sacred Heart Health System (Pensacola, FL)
- East Tennessee Children's Hospital (Knoxville, TN)
- St. Joseph's Children's Hospital (Tampa, FL)
- Children's Hospital of Erlanger (Chattanooga, TN)
- Children's Healthcare of Mississippi (Jackson, MS)
- Alabama Department of Public Health (State)
- Florida Association of Children's Hospitals (State)

5.0 Appendices