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# Family Reunification Following Disasters: *A Planning Tool for Health Care Facilities*

*Version 1: July 2018*

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## Executive Summary

Imagine if a disaster occurred in the middle of a workweek, when most children are either at school or in child care, or even while they are out on a school field trip. Or, perhaps a disaster caused many children to become separated from their lost, injured, or deceased caregivers. How would your hospital respond to the needs of both the injured children and the uninjured children who may be brought to your hospital without their parents/guardians? Because of the wide range of potential developmental, physiological, and psychological differences that children may have, safely reuniting them with their families can be an extremely challenging endeavor.

After a man-made or natural disaster, it is very common that family members will immediately contact, or come to, local hospitals to search for their loved ones — especially if there are reports of children injured in the event. Hospitals may also not be able to immediately identify all children if they are severely injured or if, developmentally, they cannot self-identify. Moreover, hospitals may have significant difficulties in determining who has the legal right to assume care for the injured or unaccompanied children if large numbers of children are present. Family members who are impatient with these delays may overwhelm staff and may therefore unintentionally impede care to other patients as they try to find their loved ones.

The American Academy of Pediatrics (AAP) *Family Reunification Following Disasters: A Planning Tool for Health Care Facilities* is meant to provide planning assistance for hospitals as they review and update their plans to provide information, support services, and safe reunification assistance to family members of patients who have experienced disasters. This tool provides instruction and examples of solutions to the following challenges:

### Challenges Present During Hospital Family Reunification Efforts

- Planning for the secure reception, tracking, and care of large numbers of children who may present to a hospital following a mass-casualty event
- Identifying injured and unaccompanied children in a disaster
- Providing information and other support to parents/legal guardians to expedite the reunification process
- Using available hospital manpower to meet the needs of children during disaster response
- Tracking the movement of children from arrival at the hospital until safe discharge
- Establishing partnerships and other relationships with child-serving organizations to understand their plans for related services (eg, transport of children who have critical injuries)
- What legal authority a hospital has to administer care to minors when the parent/guardian is unavailable to participate in the informed consent process
- Determining who within the community may also be able to support hospital efforts to identify, and safely reunify, children with their families



This guidance is meant to complement and integrate with the hospital’s emergency operations plan and is not meant to replace, duplicate, or conflict with the structures, roles, or guidance offered by that plan. It is possible that not all portions of this guidance will be appropriate for all hospitals. Hospitals are encouraged to review this document and adapt and incorporate those sections and tools they deem useful and appropriate to their needs. All sections of institutional plans that relate to applicable local, state, and federal laws relating to the care of children should be reviewed by hospital legal counsel as appropriate.

## Acknowledgments

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In creating this planning tool, the authors conducted an extensive literature review and reviewed hospital plans, policies, and procedures regarding family reunification following disaster events. The Coyote Crisis Collaborative family planning guide was used, in particular, as a reference for many of the specific tools and job action sheets in this tool. We gratefully acknowledge the outstanding hard work of many individuals who contributed time and energy to create the plans and resources from which several of this tool's components are adapted.

Much of this planning tool was created after consulting the following source documents:

1. *Coyote Crisis Collaborative Family Reunification Center Planning Guide, 2017*  
(<http://coyotecampaign.org/documents>)
2. *Western Region Homeland Security Advisory Council Family Reunification Plan Template, August 2017* (<http://wrhsac.org/projects-and-initiatives/family-reunification-plan-template>)
3. *Los Angeles County Operational Area Family Assistance Center Plan, Version 2, January 2014*  
([http://lacoa.org/PDF/HazardsandThreats/Annexes/LACo\\_FAC\\_Plan\\_May2014\\_Web.pdf](http://lacoa.org/PDF/HazardsandThreats/Annexes/LACo_FAC_Plan_May2014_Web.pdf))
4. *King County Healthcare Coalition Family Reception Services Guidelines for Hospitals, Version 2, April 2012* (<https://www.kingcounty.gov/depts/health/emergency-preparedness/professionals/preparedness-plans.aspx>)



## Handling Instructions

All questions and comments regarding this document and requests for copies can be directed to the AAP Disaster Preparedness Advisory Council and disaster preparedness and response initiatives staff at [DisasterReady@aap.org](mailto:DisasterReady@aap.org).



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## Introduction

If a bus accident, a tornado, a school shooting, or another major disaster event were to occur in a community, there is a substantial chance that at least some children affected would not be with their families and caregivers at the time of the incident. Every weekday in the United States, approximately 67 million children spend time away from their parents/guardians while they attend school or are supervised in child care facilities.<sup>1</sup> In addition, during disaster events, even those children who are initially with their caregivers can become unattended if those caregivers become lost, injured, or killed.

*During disasters, it is not uncommon for communities to face the challenge of needing to care for, and protect, some (or many) unattended children.*

*In 2005, Hurricanes Katrina and Rita separated >5,000 children from their families, and most responding agencies had no preexisting plans for family reunification. Consequently, following these historic events, it took >6 months for the final child to be reunited with her family.<sup>2</sup>*

Children who are separated from families are extremely vulnerable and are at risk for significant physical and mental trauma, neglect, abuse, and even exploitation. Therefore, it is important to return these children to the care of their custodial caregivers as quickly as possible. Unfortunately, however, safely reuniting children with their families can be particularly challenging given the wide range of potential developmental, physiological, and psychological differences that they may have. Moreover, too few hospitals have plans to generally care for children in disasters (a recent survey showed that >50% of US hospitals do not have disaster plans addressing children<sup>3</sup>), and even fewer have specific plans to care for unaccompanied children and support their family reunification following a disaster.

Understanding these challenges, the American Academy of Pediatrics (AAP) Disaster Preparedness Advisory Council gathered federal, state, and local subject matter experts to create a planning tool to help hospitals plan for family reunification and close this gap. This tool incorporates lessons learned from recent disaster events and provides best practices and examples of different regional/children's hospital family reunification plans. With further support from the AAP and Centers for Disease Control and Prevention cooperative agreement and an application process for state preparedness projects and the assistance of the Massachusetts General Hospital Center for Disaster Medicine, this family reunification planning tool was refined and vetted by stakeholder groups in Massachusetts and Missouri and was pilot tested in community hospitals.

Whether your hospital is just starting to think about planning for family reunification following a disaster or your hospital is looking to improve its plans, this planning tool is intended to be of use to expedite and improve your hospital family reunification plans.



## Assumptions and Principles

This planning tool has been designed with the following assumptions and principles in mind:

- After an incident, many family members and friends will immediately call or self-report to the hospital where they believe their loved ones may have been taken. Hospitals need to anticipate the arrival of large numbers of people looking for their relatives, even if there are few survivors from the event.
- Hospitals should not plan for family reunification in isolation. Hospital efforts and protocols should be well integrated with other critical partner organizations' plans and systems within the community.
- A specific Pediatric-Safe Area (PSA) must be established for unaccompanied minors to ensure appropriate safety precautions before release to an appropriate custodial adult.
- Children's behaviors may change after a disaster. Caregivers who care for children in the PSA can reduce long-term mental health impacts by understanding developmentally appropriate behaviors and identifying behaviors that need immediate interventions.
- Providing behavioral health and spiritual care resources to those affected by disaster events is essential following trauma.
- Families will expect hospitals to provide immediate identification of all individuals affected by disaster (both survivors and deceased people), access to accurate and timely information and real-time updates, and assistance to reunify with their loved ones and their belongings.
- Hospitals may not be able to meet the communication expectations of families because of challenges such as forensic issues and resource shortages.
- Sometimes, victim identification (especially of deceased people) may take multiple days, weeks, months, or even years. This is challenging for families to understand. When identification is delayed, it can be extremely difficult for families to grieve and cope.
- Staff should understand and appreciate that cultural traditions play an important role in how families grieve and process information.
- A Hospital Family Reunification Center will often be necessary to provide a safe place for families to convene until a regional Family Assistance Center or shelter is activated.
- Call centers or other means of handling the high volume of information may be necessary for effective coordination of information.
- Responding to a mass-casualty or mass-fatality incident can be overwhelming and can therefore lead to traumatic stress for responders and providers. Support for all involved hospital staff is essential.

## Scope

This planning tool focuses on providing guidance to hospitals that will help them create or update their plans to support family reunification after a disaster. This tool is scalable and is intended to be useful in smaller, more localized incidents (eg, shootings, motor-vehicle collisions) as well as in large-scale disasters (eg, terrorist attacks, natural disasters). This tool is meant to build on the plans that hospitals already have in place to care for unidentified patients and for children. While this tool is written in a manner that provides mostly high-level, quick-reference information, it includes enough background and operational-level detail to provide sufficient context to facilitate planning.

It is assumed that the systems, structures, and guidance recommended within this planning tool will always be used after the hospital's emergency operations plan (EOP) has been activated. Therefore, it is also assumed that the Hospital Incident Command System (HICS) will be used throughout the duration of the hospital's emergency response. Because each hospital will have its own unique HICS structure and EOP, this planning guidance does not replace or alter an institution's fundamental HICS structure but rather proposes to add additional specific functional components that may be utilized during emergency response. Whenever relevant, this planning guidance will show where a proposed function may fit within a general HICS structure.

## Using This Document

This planning tool is designed to assist hospitals as they review and update their plans to provide information, support services, and reunification assistance to family members of patients who present to the hospital following a disaster. The initial sections of this planning tool discuss how to convene a planning team within the hospital to address the anticipatable challenges as well as how to work with appropriate external stakeholders and partners. The next section (Essential Elements of a Hospital Family Reunification Plan) describes the family reunification planning process from start to finish. The final sections offer guidance on how to activate the plan when needed and on how to test the plan regularly to ensure ongoing effectiveness.

Supplementing the main guidance document are several appendixes that contain examples of planning documents and other tools to assist with family reunification planning and response operations. This supplementation includes job action sheets for essential roles and checklists for certain tasks.

While this planning tool is not a one-size-fits-all resource for hospitals, the resources included herein can serve as a strong foundation for any hospital's family reunification operations. The job action sheets, tools, checklists, and other resources in this tool can be easily adapted and incorporated into any hospital's plan. Any tools that are adapted should be read thoroughly and edited so they reflect the specifics of the individual hospital, the patient population, relevant/applicable laws and legal protocols, and the surrounding environment before the plans are used under emergency conditions.



## References:

1. Blake N, Stevenson K. Reunification: keeping families together in crisis. *J Trauma*. 2009;67(2) Suppl:S147–S151.
2. Broughton D, Allen E, Hannemann R, Petrikin JE. Getting 5000 families back together: reuniting fractured families after a disaster; the role of the National Center for Missing & Exploited Children. *Pediatrics*. 2006;117(5 Suppl 3):S442–S445.
3. American Academy of Pediatrics Disaster Preparedness Advisory Council and Committee on Pediatric Emergency Medicine. Ensuring the health of children in disasters. *Pediatrics*. 2015;136(5):e1407–e1417.



## Beginning the Planning Process

### Establishing a Common Operating Picture

In response to a mass-casualty or mass-fatality incident, it is anticipated that local jurisdictions will have plans and procedures in place to provide family assistance and to therefore support the reunification process. Disaster responders from other local, regional, state, and federal response partners may also have their own plans and procedures for reunification. To ensure that a hospital's efforts to support reunification are maximally effective and efficient, each hospital should reach out as early as possible in its planning process to its community partners. This outreach will help the hospital understand and leverage the community's capabilities and knowledge as it proceeds with its own internal planning process. Understanding which functions the community organizations will perform in a disaster will ensure that common expectations of reunification operations are understood by all involved.

### Needs Assessment

At the beginning of the planning process, hospitals should reflect on the patient populations and communities that they serve and should discuss how these factors may affect family reunification efforts. Hospitals should also be aware of unique groups in their area who may have specific religious or cultural customs, who may speak diverse languages, or who may have other (or a combination of) unique needs that may pose distinct challenges. Identifying these special considerations will help guide planning for the resources that may be needed to safely care for children and their families during reunification. It is worth special mention here that hospitals should *always* assume and plan that they will receive unaccompanied children in a disaster, even if they have no inpatient pediatric service or a larger pediatric hospital is nearby. In an emergency, children may be brought by bystanders or first responders to any hospital, and *all* hospitals should be prepared to respond to the challenges listed in this tool.

Hospitals should also examine the detailed layouts of the clinical care areas and other spaces within the institution that may be needed in the response. As described later in this tool, 2 essential components of planning for family reunification are the Hospital Family Reunification Center (HFRC) and the Pediatric-Safe Area (PSA). Both the HFRC and the PSA can have significant resource requirements of square footage, security, logistical support, and other needs, and the planning process may progress more smoothly if the planning team can assess all available space and logistical options. It is worth noting that some hospitals have arrangements with local hotels and other housing arrangements off-site to create the space required to accommodate large numbers of family members and others in this process.



## Assembling an Internal Planning Team

### Planning Team Membership

The most realistic and complete plans are usually prepared by a diverse planning team, one that includes representation from many different hospital departments, as well as with input and feedback from community agencies who are able to contribute critical perspectives or who have a role in executing the plan.

Therefore, adequate planning to support safe and effective reunification requires a significant multidisciplinary team and many months of work. At a minimum, the core team that creates or updates a hospital's reunification plan should include representatives from hospital services that possess the necessary expertise and understand the capabilities of the hospital. These departments may include (if available)...

#### Key Hospital Departments for Family Reunification Planning

- |                       |                        |
|-----------------------|------------------------|
| • Pediatrics          | • Nursing              |
| • Family Medicine     | • Social Work          |
| • Child Life Services | • Emergency Medicine   |
| • On-site Child Care  | • Emergency Management |
| • Security            | • Legal Counsel        |

Members from several other departments in the hospital may be useful and should also be strongly considered for inclusion on the planning team, either as core members or as ad hoc members, depending on the needs of the hospital and its potential constituents. These departments may include (if available)...

#### Adjunct Hospital Departments for Family Reunification Planning

- |                                    |   |
|------------------------------------|---|
| • Public Affairs / Media Relations | • Front Desk / Greeter Staff                |
| • Risk Management                  | • Nutrition / Food Services                 |
| • Psychiatry / Behavioral Health   | • Chaplaincy                                |
| • Telecommunications               | • Interpreter Services                      |
| • Health Information Management    | • Patient Relations / Family Advisory Group |



## Developing the Plan

Once the internal planning team members have been identified, the team should convene for a kick-off meeting. During the kick-off meeting, the project can be introduced. All team members should understand the rationale for developing a family reunification plan as well as the assumptions that will underlie the hospital's planning in the process. The scope of the project should be clearly defined, so team members know what topics are appropriate for inclusion in the plan and what topics are not appropriate.

The timeline for the planning process should also be defined, as should the vision of what content will ultimately be required in the final plan. After the internal planning team meets and reviews the kick-off items, the team can consider how it will reach out to other external stakeholders in the community to plan for reunification and how they anticipate best working together.





## External Stakeholder Involvement

### Planning With External Stakeholders for Reunification

Disaster events that involve reunifying large numbers of children with their families present considerations that extend beyond the hospital's walls. News media, schools, law enforcement, public health, emergency managers, and many others are likely to be involved in the response, depending on the specific nature of the incident. Because of this likelihood, it is essential that hospitals work with all their appropriate community stakeholders to harmonize their plans and to make the most efficient possible use of available resources.

### Emergency Management

Emergency management personnel will have a keen understanding about their capabilities to serve the community's needs and can be a valuable stakeholder in support of the hospital's planning process. Emergency managers can provide hospitals with an understanding of what organizations are currently outlined in local plans involving family reunification and can serve as a conduit to include those disciplines in planning efforts.

Following an incident, community emergency management personnel will coordinate the disaster response effort, interacting with local, regional, state, and federal response partners as necessary. Hospitals should ask to be notified of activation of any external or local Family Assistance Centers so appropriate measures can be taken to integrate response efforts. Further, community emergency management personnel may support resource requests by providing access to human or material support, as available, and have the ability to coordinate resource support from other communities, states, or the federal government, depending on the size of the incident.

### Schools / School Districts / Child Care Centers

Hospitals, and the health care coalitions they belong to, should strongly consider involving their local school and child care professionals in planning for their reunification planning processes. If an incident occurs during a school-related event, the school should have emergency plans in place and personnel who are specifically responsible for supervising the children. Unfortunately, the level of emergency planning is different from area to area, and reunification plans may differ significantly within school districts and from location to location, as there is no national standard.

In all cases, however, all school districts and child care facilities should have access to some level of information that may help hospitals and communities identify students and their parents/guardians. The Family Education Rights and Privacy Act (FERPA) is like the Health Insurance Portability and Accountability Act of 1996 and may restrict what information may be released, but it is important to note that it may be possible for some information to be released during certain emergency conditions. More information





regarding the application of FERPA in reunification and medical care settings is available at [www.hhs.gov/hipaa/for-professionals/faq/ferpa-and-hipaa](http://www.hhs.gov/hipaa/for-professionals/faq/ferpa-and-hipaa).

Nonetheless, schools may be able to help provide important information to hospitals during significant events that affect local populations involving children, even when those events are not school related. Hospitals should determine (a) whether there is a school reunification plan (and, if so, what are the roles, organizational structures, processes, capabilities to offer information, and other components within that plan) and (b) who are the essential contacts 24-7-365 in case of a disaster. (Emergency management personnel may assist in obtaining contact information for child care centers outside the local school system.)

### Additional Critical Stakeholders

In addition, the following list highlights additional critical partners that hospitals may wish to consider including in their planning efforts:

Discipline	Functions
Access and functional needs partners (eg, at-risk/vulnerable populations, individuals with disabilities)	<ul style="list-style-type: none"> <li>• Assist with effective and accessible communications methods.</li> <li>• Ensure integration of planning for individuals most at risk for adverse health outcomes during or following a disaster.</li> </ul>
Courts / judicial partners	<ul style="list-style-type: none"> <li>• Appoint <i>guardians ad litem</i> to unaccompanied minors to represent children’s interests.</li> <li>• Support the resolution of legal issues involving unaccompanied minors related to reunification.</li> </ul>
Emergency medical services	<ul style="list-style-type: none"> <li>• Provide medical treatment for unaccompanied and injured children.</li> <li>• Transport patients to area hospitals, distributing patients appropriately to minimize the risk of overwhelming individual medical facilities.</li> <li>• Aid in the collection of identification information.</li> </ul>
Health care coalition	<ul style="list-style-type: none"> <li>• Provide situational awareness and support information sharing among public health and health care entities.</li> <li>• Coordinate resource needs among public health and health care partners.</li> <li>• Coordinate access to human service needs in collaboration with municipal agencies.</li> </ul>
Hospitals	<ul style="list-style-type: none"> <li>• Provide appropriate medical care.</li> <li>• Manage capacity burden.</li> <li>• Participate in information sharing and situational awareness efforts.</li> </ul>



<p>Law enforcement</p>	<ul style="list-style-type: none"> <li>• Assist in identification, notification, protection, location, and reunification of children and their parents / legal guardians.</li> <li>• Provide direction and assistance regarding public safety and security.</li> <li>• Receive and direct inquiries regarding reunification efforts.</li> <li>• Work with local or state child welfare agencies to ensure children are safe and have temporary and supportive care.</li> <li>• Work with local child welfare agencies to investigate the incident.</li> <li>• Coordinate with the National Center for Missing &amp; Exploited Children, as needed.</li> <li>• Coordinate with other law enforcement agencies in conducting missing persons investigations and ensuring effective coordination between investigative efforts and survivor and family assistance efforts.</li> <li>• Coordinate as needed with coroner / medical examiner for communicating death notifications to families, as required.</li> </ul>
<p>Coroner / medical examiner</p>	<ul style="list-style-type: none"> <li>• Perform postmortem examination of bodies following a disaster.</li> <li>• Aid in the identification of deceased people, including children; that is, identify human remains by comparing postmortem and antemortem information.</li> <li>• Establish death notification procedures in coordination with mental health professionals and spiritual support providers.</li> <li>• Release deceased people to the legal next of kin.</li> </ul>
<p>Mental/behavioral health services</p>	<ul style="list-style-type: none"> <li>• Coordinate the disaster behavioral health, crisis counseling, emotional/spiritual support, and other mental health resources required during activation.</li> <li>• As needed, provide emotional support during interviews with families.</li> <li>• Provide informational handouts and referrals to local behavioral health resources.</li> <li>• As needed, assist in providing critical-incident stress debriefing to staff involved in response.</li> </ul>
<p>News media</p>	<ul style="list-style-type: none"> <li>• Aid in situational awareness and distribution of information regarding available resources to the public.</li> </ul>
<p>Nongovernmental organizations / volunteer organizations<sup>a</sup></p>	<ul style="list-style-type: none"> <li>• Assist with reunification, sheltering, feeding, health, and mental health support services to survivors.</li> <li>• Provide volunteers to help with crowd control and other necessities in a disaster.</li> </ul>
<p>Private sector</p>	<ul style="list-style-type: none"> <li>• Assist with logistical resources (eg, space, transportation) in support of reunification efforts.</li> </ul>



Public health / health and human services	<ul style="list-style-type: none"> <li>• Coordinate with appropriate agencies and organizations for the temporary care and shelter of unaccompanied children.</li> <li>• Coordinate with hospitals to develop centralized list of injured and missing individuals.</li> <li>• Aid in the identification and requesting of state, regional, or federal health and medical resources that may be needed to support the disaster response.</li> </ul>
Social services (hospital based or municipal)	<ul style="list-style-type: none"> <li>• Assist with the protection and temporary care of unaccompanied children.</li> <li>• Assist with custodial issues regarding legal guardianship of unaccompanied children.</li> <li>• Aid in coordinating access to municipal resources.</li> </ul>

Abbreviations: NGO, nongovernmental organization; VOAD, Voluntary Organizations Active in Disaster.

<sup>a</sup> National VOAD is the forum through which organizations share knowledge and resources to help disaster survivors and their communities. National VOAD may offer assistance to coordinate with NGOs and other voluntary organizations.

Other external partners that hospitals may wish to bring into their planning efforts may include

- Fire-and-rescue services
- Pediatric residential facility representatives
- Adoption or foster care agencies
- City or state child and family services departments
- Child care centers
- Universities and colleges
- Area military facility representatives
- Local transportation agencies and businesses
- 311 or similar types of community call centers
- Local and state American Red Cross representatives
- Foreign consulates and embassies
- Therapy-animal organizations or agencies



## Essential Elements of a Hospital Family Reunification Plan

### Essential Elements of a Hospital Family Reunification Plan

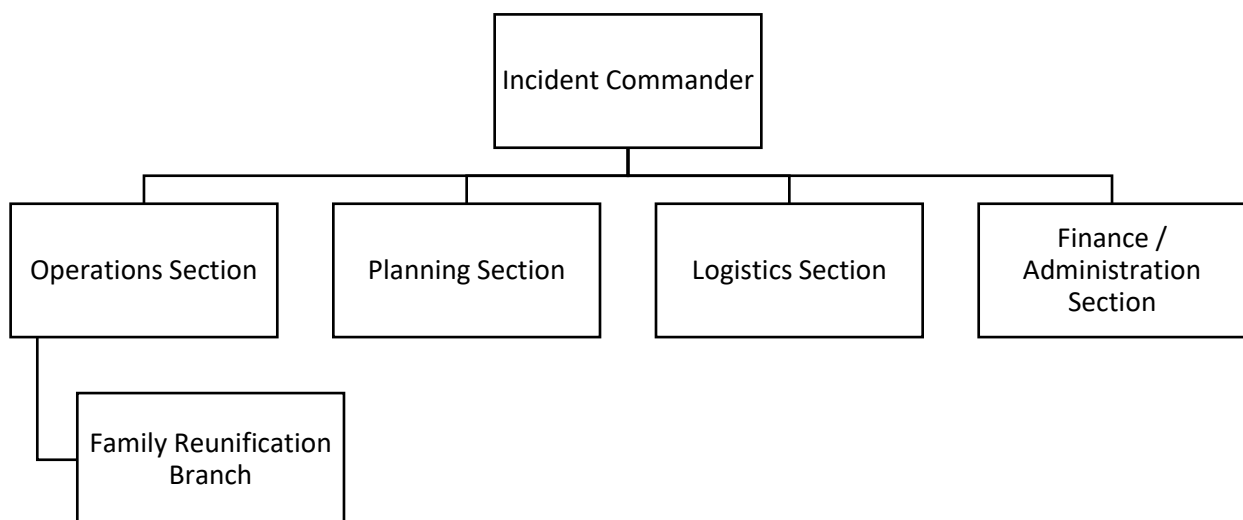
A comprehensive hospital family reunification plan has 7 essential elements.

1. Descriptions of the plan's leadership and organization of staff, including descriptions of how the plan's elements fit into the hospital's overall EOP and HICS structure
2. Processes defining how unaccompanied children will be registered and tracked and what information will be gathered from/about the child at initial intake
3. Processes defining how unaccompanied children will be definitively identified
4. Procedures to establish and operate an HFRC
5. Procedures to establish and operate a PSA
6. Procedures to establish a Family Reunification Site
7. Procedures that govern the sharing of relevant information with other hospitals, public health agencies, and other partners involved in the response, as legally permitted, to facilitate family reunification

Abbreviations: EOP, emergency operations plan; HFRC, Hospital Family Reunification Center; HICS, Hospital Incident Command System; PSA, Pediatric-Safe Area.

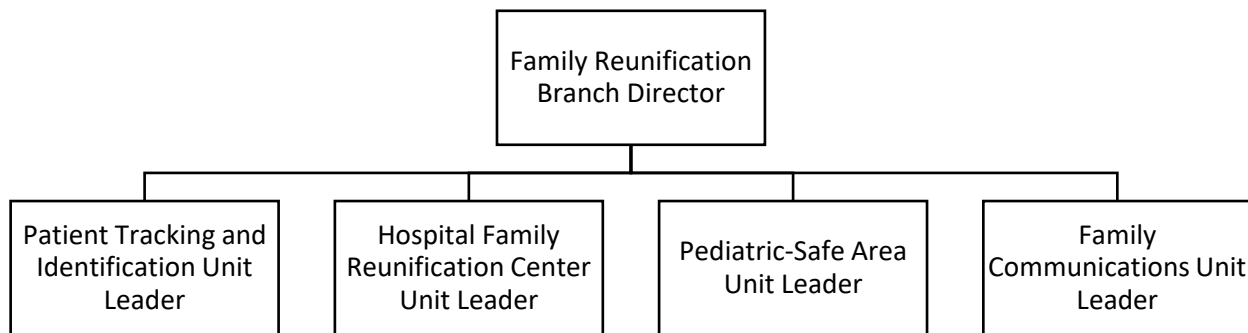
### Leadership and Organization

One member of the hospital staff must be assigned overall responsibility to lead the hospital's family reunification response when the plan is activated. This overall family reunification process is typically housed within the Operations Section of a facility's Hospital Incident Command System structure, often as a branch of the Operations Section. Therefore, if the hospital plan creates a Family Reunification Branch within the Operations Section, the title of the plan leader would be Family Reunification Branch Director.



To function effectively, the Family Reunification Branch Director (Reunification Leader) must be supported by other response leaders, including some or all of the following leaders:

- Patient Tracking and Identification Unit Leader
- Hospital Family Reunification Center Unit Leader
- Pediatric-Safe Area Unit Leader
- Family Communications Unit Leader



The branch operations should be supported internally by multidisciplinary hospital services, such as social work, security, child life (if available), interpreters, chaplains, and others. Staff from these services may be assigned specifically to the Family Reunification Branch and report to the Family Reunification Branch Director. Alternatively, these staff may report within their own departmental hierarchies but perform their job functions within the reunification areas.

The Family Reunification Branch Director may also need one or more liaison staff to work with outside agencies such as the regional health care coalition, public health, schools, American Red Cross, and others. These liaison staff may be housed within the Patient/Family Reunification Branch or be members of the command staff who assist with this process.

As with any activation of the hospital's emergency operations plan, a Safety Officer should be designated to monitor incident operations and advise the Incident Commander on all matters relating to health and safety of staff, patients, and families. The Safety Officer, or appropriate designee, should inspect all functional areas established as part of family reunification efforts to ensure compliance with life safety regulations.

## Registration, Intake, and Tracking of Unaccompanied Children

Registration of children (including documentation of identifying demographic and other data for unidentified children) into appropriate systems and tracking of those patients until they can be released to their custodial caregivers are essential elements that are needed to assure the timely and safe reunification of children with their families. Some larger cities and regions have now developed or acquired data systems that can capture patient data in the prehospital setting and synchronize it with data captured at the receiving hospitals in their area.



Alternatively, some larger hospitals have dedicated their own resources to create unique programs and systems to capture this kind of patient data within their existing electronic health record systems. However, for smaller hospitals this may not always be feasible. Whenever children are transferred between care sites, it is extremely important that whatever records are available be kept with or follow the child.

It is also important to clearly visually highlight the status of unaccompanied children, so they can be appropriately observed by the appropriate hospital staff. Many hospitals use brightly colored wristbands or other identifiers to help with this identification.

During a mass-casualty event, modified registration processes may be implemented to help expedite the triage and admitting processes. For example, patients may be registered using an anonymous patient registration process, as the priority will be to ensure all patients receive immediate life-sustaining care in the most efficient manner possible. As a result, a tiered process to capturing identifying patient data may be considered. As quickly as possible, staff should work with patients to attempt to gather and store information on as many of the data elements in the following list as possible to best support reunification efforts:

#### Data Elements to Support Reunification Efforts

1. Patient's full name
2. Parent/guardian name(s)
3. Nicknames for child and parent(s)/guardian(s)
4. Date of birth (or approximate age if unable to obtain)
5. Weight
6. Height
7. Race/ethnicity
8. Cultural, linguistic (languages spoken), and other special needs (eg, allergies, medical conditions, medications)
9. Hair color and length of hair
10. Eye color
11. Gender
12. Distinguishing marks on the body (may include tattoos, scars, and missing teeth)
13. Clothing worn at initial arrival, along with significant belongings (eg, stuffed animal)
14. Location and mechanism of arrival/presentation to the system
15. Photo (if system is capable)
16. Association with disaster event (to aid in reporting all patients associated with incident)

One example of sample tracking logs and tracking forms is available at the National Center for Missing & Exploited Children Web site ([www.missingkids.org/home](http://www.missingkids.org/home)).

## Definitive Patient Identification

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

- Release of a child to the wrong family
- Release of a child to an unauthorized noncustodial parent
- Delay of reunification with the child's actual family (This affects both the child and the family.)
- Failure to identify significant medical and other conditions important to the care of the child

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

- Confirm the identity of children/parents if
  - Person verbally identifies self or has identification.
  - Photographs, biometrics, or another identified person can be used to identify the child.
  - There is a match to answers for templated parent/child questions, such as favorite toy/blanket, name of teacher, school, name of pet, or family safe word.
- Use technology or other data to identify the child/parent if identity cannot be confirmed as above. Examples include
  - DNA samples of child-caregiver pair to address future concerns (Hospitals may already have such a system in place for collecting forensic samples.)
  - Palm printing, a newer technology that can trace the venous system of the hand, creating a unique image
  - Fingerprinting
  - Photograph of child-caregiver pair
  - Registration of child-caregiver pair with protective services

It is important to remember, however, that during disaster events, austere conditions may require special adaptations of the usual hospital policies because usual data and systems may be adversely affected. Such conditions may include

- Hospital computer or registration systems (or both) may not be functioning.
- No Internet access may be available.
- Presenting caregivers may not be able to produce legal identification.
- Presenting caregivers may not be able to produce photographs of the child.
- Governmental child services teams may be unavailable to assist, or could be overwhelmed.
- Local law enforcement may be unavailable to assist, or could be overwhelmed.



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

For children unable to be reunited with a parent / legal guardian, the state's child protective services should be notified to take emergency custody. Protective services will work with law enforcement personnel to continue the search for the legal custodians and will work with hospital personnel to arrange temporary placement for the child, as either a temporary social admission to the hospital or placement with a child's relatives or a foster family. The timeline for transferring unaccompanied minors to foster care or specialized care, when applicable, differs depending on specific state criteria and the particulars of the disaster. Service options could range from immediate transfer to foster care to delayed transfer following an extended period of time. To expedite the reunification process for children placed into foster care, courts may choose to issue an order stating that children may be immediately released from foster care and back to their parents / legal guardians once they are located and identification is confirmed. Health care facilities should take care to familiarize themselves with state laws regarding unaccompanied minors in advance of a disaster and adjust planning efforts accordingly.

## The Hospital Family Reunification Center

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

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





## HFRC Location

Here are some issues to consider when determining an HFRC location.

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

## HFRC Equipment, Supplies, and Resources

Some of the supplies that can help ensure the smooth functioning of the HFRC are listed here.

- Multiple computers with Internet access. (Paper backups of digital forms should, of course, be available as well.) Templates should permit families to input as much detail as possible regarding their loved ones, including information that would be used for parent/child verification.\*
- A mechanism to upload photos of the loved ones to assist with the reunification process.\*
- Sign-in–sign-out sheets for those presenting at the HFRC, with name, contact number, and time of sign-in–sign-out for tracking purposes.
- Access to appropriate support assistance and resources (eg, psychological or spiritual support).
- Phone chargers with multiple kinds of plugs.
- Posted contact information for any available community disaster resources and information.
- Toileting and sanitation, including diaper-changing area.
- The ability to acquire food and drink.
- Chairs and tables.
- Writing utensils/paper/clipboards.
- Language interpreters.

\*Privacy rules, including the Health Insurance Portability and Accountability Act of 1996, apply to information collected; consult the hospital’s Privacy Office or legal counsel regarding collection and storage of this information.



## The Pediatric-Safe Area

Even after medical clearance, unaccompanied pediatric patients cannot be discharged until an appropriate custodial parent/guardian (or an individual identified by the parent / legal guardian as a person to whom the child can be discharged) is present. Further, hospital beds should generally not be used for pediatric patients that do not have a clear medical need, to ensure that the medical response to the incident is not compromised. Children who have experienced a recent disaster will need qualified providers to distract, calm, and reassure them to help reduce long-term mental health effects. To ensure the pediatric patients' safety, as well as to help patients cope, a Pediatric-Safe Area (PSA) should be established in an appropriate area that allows children to play and move about safely. Therefore, the hospital should preplan for, and be able to securely operate, a PSA. The PSA is a controlled and supervised space where children can play and wait safely and securely while awaiting reunification with their families. This space should be located in an area separate from both the Emergency Department and the HFRC.

Children who are arriving to the PSA will be under a tremendous amount of stress and may have limited ability to process instructions or other information. The child's behavior may regress to an earlier developmental stage, or otherwise be different from the child's baseline behavior. It is important to understand that individual children will have different reactions to stress, and the staff of the PSA will need to recognize when pediatric patients need to be referred to mental health professionals. Sometimes, it may be helpful to consider asking older pediatric patients to assist younger pediatric patients if PSA staff determine that it is appropriate and helpful for the older pediatric patients. Pediatric patients may also develop new medical symptoms after the initial evaluation; therefore, staff must be available to clinically reassess children in the PSA as needed.

## PSA Location

Here are some issues to consider when determining a PSA location.

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



## PSA Equipment, Supplies, and Resources

Some of the supplies that can help ensure the smooth functioning of the PSA are listed here.

- Age-appropriate activities (eg, board and card games, books, movies, video games, art supplies)
- Diapers
- Formula (and any appropriate guidance for preparation and serving)
- Age-appropriate food (consider potential for allergies.)
- Hand sanitizer

A checklist that hospitals can use to evaluate the potential site and logistical decisions needed to create and support operation of a PSA is provided in the appendixes.

## The Family Reunification Site

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

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

## Staffing

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

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



## Information Sharing

In the aftermath of a disaster, people immediately try to seek information. The lack of timely information to the public about a disaster can result in more chaotic circumstances, such as increased crowds, increased call volume, and presence of anxious family members seeking their loved ones. Hospitals should establish close partnerships with other key response organizations, such as public health, emergency management, law enforcement, the American Red Cross, and others, so all response messaging efforts are consistent and coordinated. Consider the following guidance:

### Considerations for Information Sharing

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

Abbreviation: HIPAA, Health Insurance Portability and Accountability Act.

During events in which children are separated from their families and caregivers, these family members will be extremely anxious and eager for any information available and will require frequent updates to ensure that they do not feel forgotten about or marginalized. Hospital communications plans and plans for information sharing should ensure that the hospital gathers and disseminates the best possible internally and externally available, credible, and verified information to families and staff. Ensuring that all families have regular updates to their understanding of the incident status and the hospital response relevant to them will help minimize some of the potential psychological and security concerns that are generally associated with these incidents.

Hospitals must be able to manage the ways in which family members will utilize their existing public-facing infrastructure (such as an Information Desk, an Emergency Department Reception Area, or a Hospital Operator) as they inquire whether a loved one is present within the facility. If hospitals manage these points of contact effectively, they can support facilitation of rapid identification of survivors by family members whose presence is confirmed at the hospital. Internal sharing of information among response roles and centers is paramount to ensure a common operating picture for the facility. Hospitals should consider the following approaches to help maintain situational awareness among response roles:



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

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

### Social Media Considerations

Communications via social media have become increasingly common. While a valuable tool, communication via social media is virtually impossible to control and is prone to become a source for unfounded rumors and speculation. Hospitals should seek to minimize the potential harm of dissemination of misinformation via social media by

- Urging family members to refrain from disseminating information concerning children, hospital operations/conditions, or other sensitive information via social media
- Requesting family members to advise hospital staff if they discover inappropriate information concerning the HFRC, family members, or children via social media
- Advising hospital staff to be alert to rumors or speculation being disseminated via social media and informing the hospital Public Information Officer (PIO) of any occurrence
- Coordinating with the hospital PIO to respond to social media reports or inquiries, as appropriate

It is likely that children and adolescents, especially adolescents, will have access to social media, even in the wake of a disaster, via mobile devices such as smartphones and tablets. It is therefore critical to ensure that information sharing via social media by children and adolescents is limited or controlled to minimize the risk of inappropriate dissemination of information and to maintain patient privacy. Hospitals should closely monitor the phone and computer activities of children in their care to ensure that they are not posting pictures or information from the reunification sites in the hospital. Development of communication templates may help guide both patients and family members in the appropriate sharing of information.



## Security Concerns

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

## Legal Considerations

There are many legal issues that can influence reunification approaches or a hospital's specific plans. In each case, it is best to consult with your institution's Legal or Risk Management department. Issues that might vary by state or other locality include the process to discharge children to parents, legal guardians, or authorized caregivers/adults and how to verify an adult's authority to take custody before discharging the child into the adult's care. Caution around pediatric discharge to adults is recommended, even in a disaster. The following Web sites include information and should be reviewed for relevance:

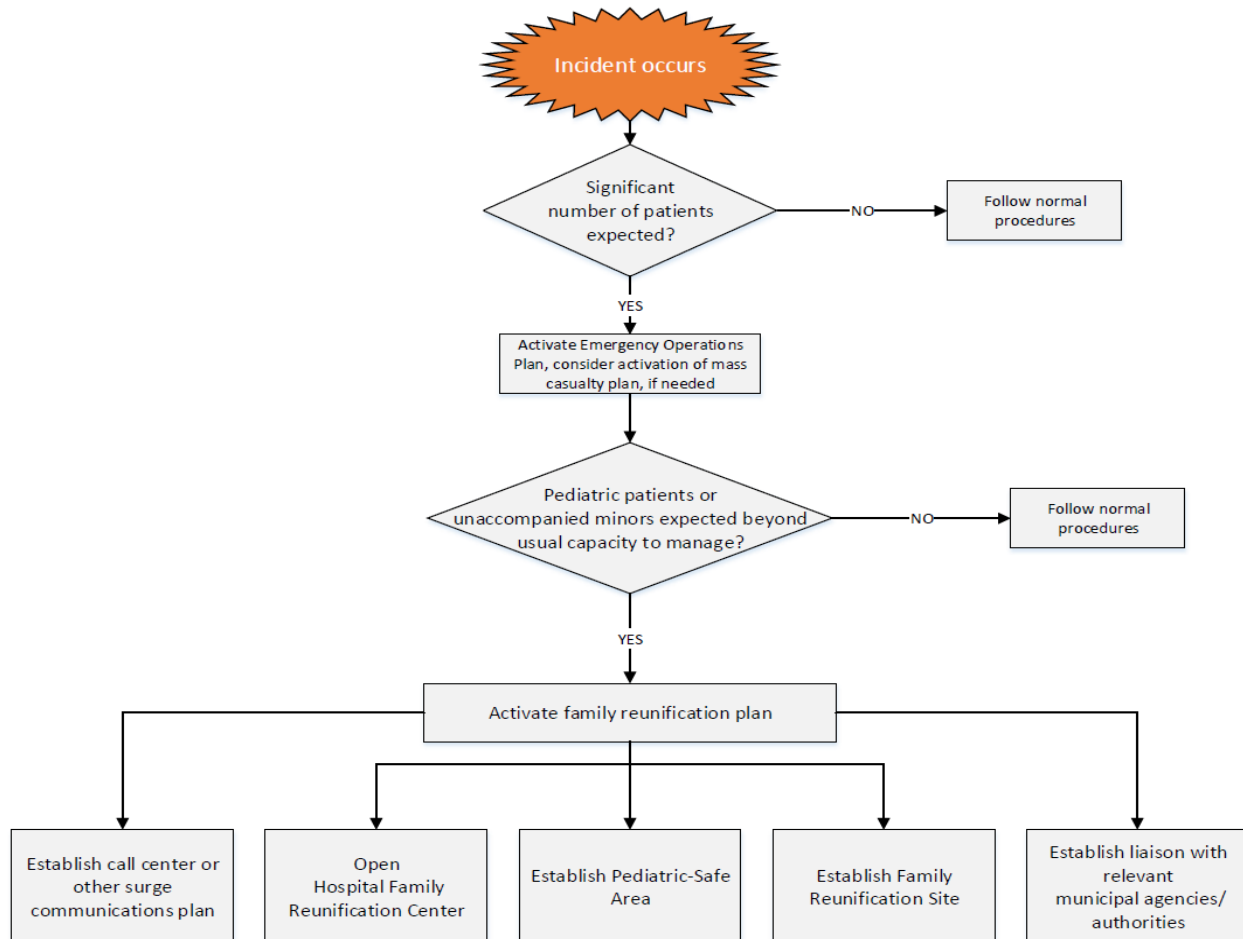
- Health Insurance Portability and Accountability Act of 1996: [www.hhs.gov/hipaa/index.html](http://www.hhs.gov/hipaa/index.html)
- Family Education Rights and Privacy Act: <https://studentprivacy.ed.gov/?src=fpc>

It is advisable to connect with social services and local law enforcement to see what protocols they typically follow, including when a hospital should contact these and other entities in regard to situations involving unaccompanied minors.

## Plan Activation

A hospital's decision to activate its family reunification plan generally depends on the magnitude of the incident and the demands the incident places on the hospital. As mentioned earlier, nearly all hospitals are already familiar with more-common small-scale emergency events during which children are brought directly to the hospital without their family or caregivers, and hospitals have existing protocols for how to manage these kinds of incidents. However, for larger events, when the hospital notices that the need for space, staffing, or materials to safely care for its unaccompanied pediatric patients outpaces its usual resources and response, the hospital should consider activating its family reunification plan. This decision is often made by the hospital's Incident Commander, with advice from the hospital's Operations Section Chief, the hospital's Security Advisor, and other expert staff. The planning process will help clarify the steps required to activate the plan.

Activation of the family reunification plan should be a part of the overall hospital's emergency operations plan, and generally it should not be completed separately from that plan. An activation checklist is provided in the appendixes. An example flowchart of the process is depicted here.





## Exercising Family Reunification Plans

As with any emergency response plan, hospital family reunification plans must be tested periodically to ensure that the assumptions, procedures, and choices within the plan make sense and to identify as many flaws or gaps in the plan as possible, before the plan is actually needed. When planned and executed properly, exercises that simulate response to major emergency situations can significantly help improve preparedness on 2 levels. At the individual level, exercises present an opportunity to educate staff members on disaster plans and procedures through hands-on practice. Exercises also help staff improve their performance through constructive critiques of their actions. On a system-wide level, well-designed exercises can reveal gaps in resources, uncover planning weaknesses, and clarify specific roles and responsibilities.

In general, there are 4 progressive levels of action in an effective exercise program.

### Types of Emergency Preparedness Training Exercises

**Tabletop exercises** are low-stress events designed to identify major gaps or conflicts in planning.

**Drills** test a single specified operation within a response plan. In contrast, exercises test multiple operations.

**Functional exercises** involve command-level decision-making, but they do not include the deployment of equipment and personnel.

**Full-scale exercises** involve deployment of physical resources as part of exercise play, and they most closely resemble real-world incident response.

A successful exercise depends on appropriate planning. The goals and scope of each exercise must be kept realistic with respect to what can be performed and tested. Exercises must also have sufficient controllers and evaluators every time they are conducted to ensure smooth exercise conduct and to ensure that adequate data is collected — that is, data that supports documentation of the challenges noted during the exercise. Controllers monitor the expected events and timeline of the exercise. Evaluators monitor the events of the exercise and offer objective measurements of how well exercise participants met the prespecified objectives. Adequate numbers of evaluators are vital since one of the most important products of an exercise is the independent assessment of the event.

### Tabletop Exercises

During a tabletop exercise, participants meet in person to discuss which actions they would take when faced with a given emergency, but no real resources are used. Suggestions for hospital family reunification tabletop exercises include





- Assessment of the overall assumptions and operations of the hospital family reunification plan
- Assessment of any one of the components of the hospital family reunification plan, including the operations of the Hospital Family Reunification Center (HFRC), the Pediatric-Safe Area (PSA), or the Family Reunification Site (or any combination of those locations)
- Assessment of the hospital family reunification plan's integration with community resources and partners (This requires significant external participation.)

## Drills

Drills test a single specified operation, such as activating a notification system or measuring response times. Suggestions for targeted family reunification drills include

- Test of notifications to staff who would operate the HFRC, the PSA, or the Family Reunification Site (or any combination of those locations) to see how quickly they can respond to the hospital at differing times on differing days
- Test of the physical setup of the HFRC, the PSA, or the Family Reunification Site (or any combination of those locations)
- Test of the setup of the call center to support the family reunification plan (if one is planned)

## Functional Exercises

Functional exercises are higher-stress events during which many participants simulate their actions within a Hospital Command Center (HCC) / an Emergency Operations Center (EOC) and must make immediate, specific decisions, but real field equipment and personnel are not deployed. Suggestions for hospital family reunification functional exercises include

- Measuring communications among the HCC/EOC and the HFRC, the PSA, and the Family Reunification Site
- Measuring communications among the hospital's HCC/EOC with the points of contact for other community resources and partners who are active in family reunification (This requires significant external participation.)

## Full-scale Exercises

Full-scale exercises are the most realistic and most complex during which personnel perform as many of their actual duties as possible in a simulated emergency to best assess the true capabilities of the response system and plans. Because of the high cost and effort associated with planning and conducting full-scale exercises, however, these are usually the exercises that are performed least often. Nonetheless, conduct of full-scale exercises is essential to test the plans and processes that depend highly on the appropriate utilization of physical space, as many components of the family reunification process do.



Full-scale exercises can be done with inanimate objects, such as boxes or mannequins, to simulate patients. Of course, live volunteers can be used in these exercises, but it is essential that additional safety and expert support staff be present to prevent safety or security concerns arising if children are used in an exercise. Volunteers should be paired with all child participants to monitor them for safety purposes. Extreme care should also be taken to ensure the exercise does not scare or traumatize the children as they participate.

Suggestions for hospital family reunification full-scale exercises include

- Assessment of the overall physical operations coordination of all components of the hospital family reunification plan
- Assessment of the physical operations of any one of the components of the hospital family reunification plan, including the operations of the HFRC, the PSA, or the Family Reunification Site (or any combination of those locations)
- Assessment of the physical operations of the hospital family reunification plan when integrated into an exercise with the operations of community resources and partners (This requires significant external participation and is, by far, the most complex exercise.)

## Measuring Performance

Every drill and exercise must have a structured evaluation and critique. Evaluators who observe an exercise should be armed with specific, measurable, prespecified objectives and should record those observations on preprepared forms. Evaluators should also be briefed, ahead of time, on the exercise scenario, timeline, and rules of play.

Following completion of the exercise, all participants should be given an opportunity to voice their observations and emotions in a group setting. This debriefing is often called a “hot wash” and should be performed immediately following the exercise, since its utility diminishes very rapidly, as emotions and immediate memories of events fade. A summary of the comments made by participants in the hot wash and the structured critiques from the evaluators should then be compiled into an After-Action Report (AAR). This comprehensive report analyzes each achievement and each problem that was noted in the exercise.

Last, an improvement plan contains specific steps that will be taken by the participants after the exercise to address the issues discussed in the AAR. The improvement plan should be circulated as widely as possible because the most important product that any exercise program can generate is visible, measurable, positive change. Participants may lose interest in the exercise program if they do not see it leading to specific improvements in preparedness afterward. Therefore, it is very important to publicize the changes and improvements that result from exercises and drills to sustain interest in the program and in the improvement process.



## Additional Resources

Note: Additional resources may also be available already in the local or regional community.

### Federal Resources

#### US Department of Health and Human Services Assistant Secretary for Preparedness and Response (ASPR)

- Technical Resources, Assistance Center, and Information Exchange (TRACIE) (<https://asprtracie.hhs.gov>)

ASPR TRACIE consists of 3 complementary domains.

- Technical Resources: a self-service collection of disaster medical, health care, and public health preparedness materials, searchable by keywords and functional areas
- Assistance Center: provides access to Technical Assistance Specialists for one-on-one support
- Information Exchange: a user-restricted, peer-to-peer discussion board that allows open discussion in near real time

#### Federal Emergency Management Agency (FEMA)

- “How do I find my family and friends?” Web page ([www.fema.gov/how-do-i-find-my-family](http://www.fema.gov/how-do-i-find-my-family))

Provides direction to reunification systems that may be available to the public during a disaster, including

- National Emergency Family Registry and Locator System
  - National Emergency Child Locator Center (National Center for Missing & Exploited Children)
  - Unaccompanied Minors Registry
  - American Red Cross Safe and Well system
- Homeland Security Exercise and Evaluation Program (HSEEP) (<https://preptoolkit.fema.gov/web/hseep-resources>)

HSEEP doctrine consists of fundamental principles that frame a common approach to emergency preparedness exercises.

#### Substance Abuse and Mental Health Services Administration (SAMHSA)

- Children and Youth Resource Collection ([www.samhsa.gov/dbhis-collections/children-and-youth-resource-collection](http://www.samhsa.gov/dbhis-collections/children-and-youth-resource-collection))

Focuses on the reactions and mental health needs of children and youths after a disaster. Topics covered include, but are not limited to,

- Ways that parents and other caregivers and health care professionals can help children cope



- with disasters
  - Planning and preparedness for child care providers, teachers, and schools
  - Issues in disasters for children with special needs
- SAMHSA Disaster Technical Assistance Center ([www.samhsa.gov/dtac](http://www.samhsa.gov/dtac))

Offers publications, tip sheets, and other resources for disaster behavioral health professionals

### US Department of Education

- Readiness and Emergency Management for Schools (REMS) Technical Assistance Center (<https://rems.ed.gov>)

REMS supports schools, school districts, and institutions of higher education, with their community partners, in the development of high-quality emergency operation plans and comprehensive emergency management

## National and Professional Society Resources

### American Academy of Child & Adolescent Psychiatry

- Disaster Resource Center ([www.aacap.org/aacap/Families\\_and\\_Youth/Resource\\_Centers/Disaster\\_Resource\\_Center/Home.aspx](http://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Disaster_Resource_Center/Home.aspx))  
Contains fact sheets to assist families in helping children during disasters

### American Psychological Association

- Disaster Resource Network ([www.apa.org/practice/programs/drn/index.aspx](http://www.apa.org/practice/programs/drn/index.aspx))  
A group of approximately 2,500 licensed psychologists in the United States and Canada who have expertise in the psychological impact of disasters on individuals, families, and communities
- *Children and Trauma: Update for Mental Health Professionals* ([www.apa.org/pi/families/resources/children-trauma-update.aspx](http://www.apa.org/pi/families/resources/children-trauma-update.aspx))  
Explains how children cope with disasters and what assistance mental health professionals can provide

### American Red Cross

- Helping Children Cope With Disaster ([www.redcross.org/images/MEDIA\\_CustomProductCatalog/m14740413\\_Helping\\_children\\_cope\\_with\\_disaster\\_-\\_English.pdf](http://www.redcross.org/images/MEDIA_CustomProductCatalog/m14740413_Helping_children_cope_with_disaster_-_English.pdf)) and “Disaster Safety” Web page ([www.redcross.org/get-help/how-to-prepare-for-emergencies/disaster-safety-for-children#Disaster-Safety](http://www.redcross.org/get-help/how-to-prepare-for-emergencies/disaster-safety-for-children#Disaster-Safety))



Offer parents, caregivers, and other adults suggestions on how to help children cope with the effects of disaster as well as on how to be prepared before a disaster strikes

## Bibliography:

- American Academy of Pediatrics Disaster Preparedness Advisory Council and Committee on Pediatric Emergency Medicine. Ensuring the health of children in disasters. *Pediatrics*. 2015;136(5):e1407–e1417.
- Blake N, Stevenson K. Reunification: keeping families together in crisis. *J Trauma*. 2009;67(2) Suppl:S147–S151.
- Broughton DD, Allen EE, Hannemann RE, Petrikin JE. Getting 5000 families back together: reuniting fractured families after a disaster: the role of the National Center for Missing & Exploited Children. *Pediatrics*. 2006;117(5 Suppl 3):S442–S445.
- Chung S, Blake N. Family reunification after disasters. *Clin Pediatr Emerg Med*. 2014;15(4):334–342.
- International Committee of the Red Cross. Unaccompanied and separated children in the tsunami-affected countries: guiding principles 2004. [https://www.unicef.org/protection/IAG\\_UASCs.pdf](https://www.unicef.org/protection/IAG_UASCs.pdf). Accessed August 7, 2018.
- Mason KE, Urbansky H, Crocker L, Connor M, Anderson MR, Kissoon N; Task Force for Pediatric Emergency Mass Critical Care. Pediatric emergency mass critical care: focus on family-centered care. *Pediatr Crit Care Med*. 2011;12(6) Suppl:S157–S162.
- Osofsky JD, Osofsky HJ, Harris WW. Katrina’s children: social policy considerations for children in disasters. *Soc Policy Rep*. 2007;21(1):3–19.
- Schonfeld DJ, Demaria T; American Academy of Pediatrics Disaster Preparedness Advisory Council and Committee on Psychosocial Aspects of Child and Family Health. Providing psychosocial support to children and families in the aftermath of disasters and crises. *Pediatrics*. 2015;136(4):e1120–e1130.



## Appendixes

1. HFRC Location Assessment Tool
2. HFRC Sample Site Diagrams
3. Sample HFRC Equipment and Supply List
4. PSA Location Assessment Tool
5. Sample HFRC Unit Leader Job Action Sheet
6. Parent/Guardian Vetting Form
7. Sample Communications Scripting
8. Hospital Family Reunification Planning Checklist



## HFRC Location Assessment Tool

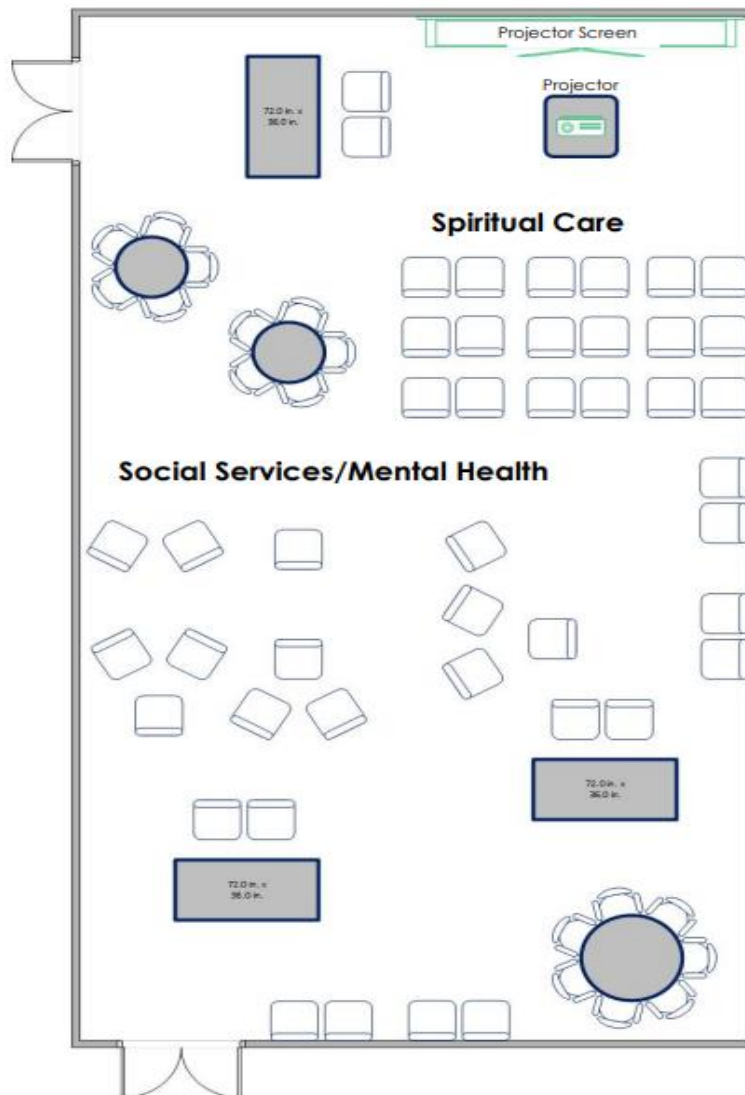
(Adapted from the Coyote Crisis Collaborative Family Reunification Center Planning Guide, 2017. Scottsdale, AZ: Coyote Crisis Collaborative; 2017. <http://coyotecampaign.org/documents>. Accessed June 21, 2018.)

- a. Site accessibility
  - Approval from facility owner or department representative
  - Easy access from major roads, freeways, or public transit
  - Proximity to individuals and clients affected by the incident
  - Adequate number of parking spaces
  - Availability on short notice
  
- b. Usable space and resource
  - Large indoor space to accommodate needs listed
  - Multiple exterior entry/departure points (preferably 2 distinct points)
  - Proximity to restrooms, water source, telephone, and security station
  - Controlled heating/air conditioning
  - Flow consideration for Hospital Family Reunification Center (HFRC) required areas to include
    - Reception / check-in
    - Credentialing
    - Reception lobby
    - Family interview/notification/counseling (individual rooms)
    - Pediatric-Safe Area (PSA)
    - Meal area (as appropriate)
    - Staff briefing area
    - Staff work area
    - Staff break room
    - Logistics/information technology area
  - Appropriate space for a PSA, including
    - Enclosed space with narrow entrance
    - Real walls (or solid partitions)
    - Unencumbered access to 2 means of ingress/egress
    - Food preparation or consumption, including any applicable cultural or religious considerations regarding the types of food permitted on the premises
  - Ability to support communications and technological infrastructure, including expected power load and data-transmission capability
  - Tables and chairs available on-site
  - Americans with Disabilities Act compliant or modifiable to be compliant
  
- c. Safety
  - Easily secured perimeter
  - Endorsement of local law enforcement

## HFRC Sample Site Diagrams

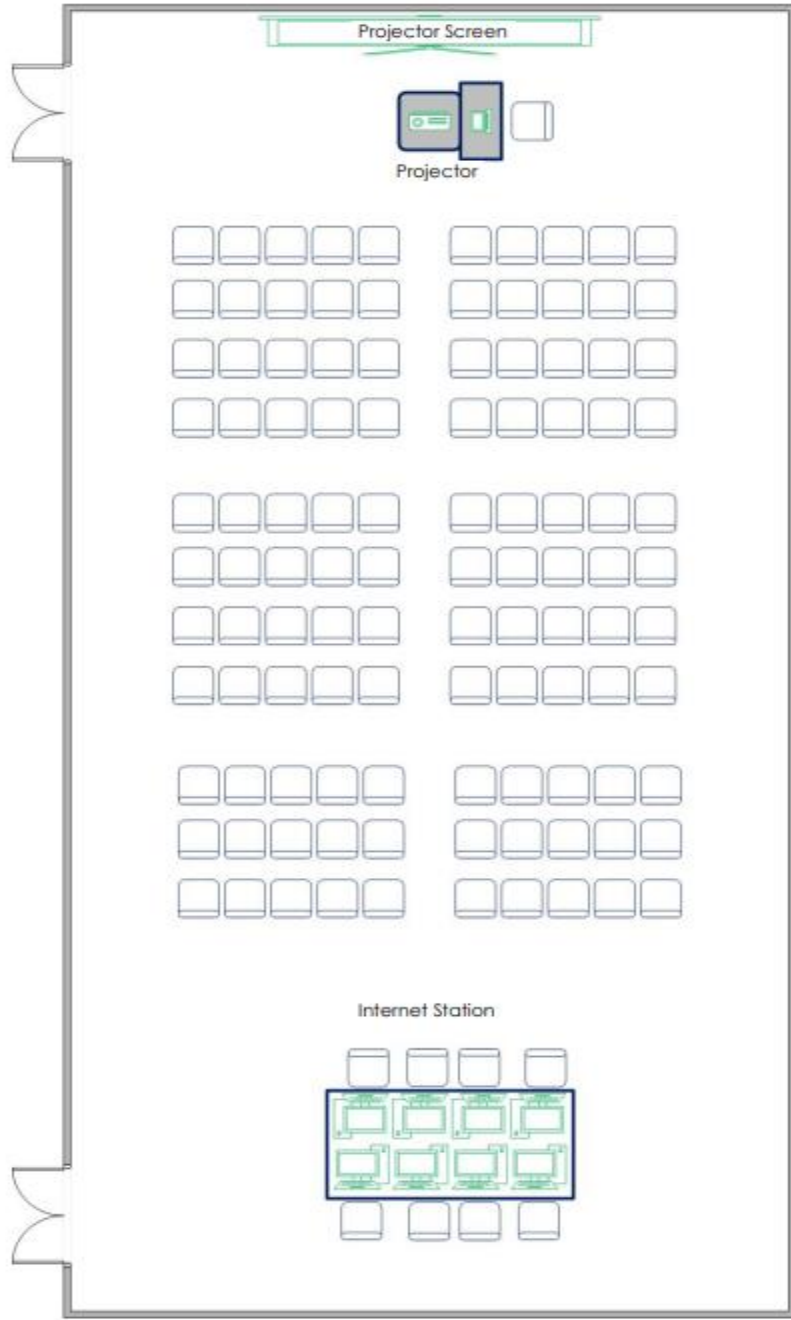
(Reproduced from Los Angeles County Operational Area Family Assistance Center Plan. Ver 2. Los Angeles, CA: Office of Emergency Management, Chief Executive Office, Los Angeles County Operational Area; 2014. [http://lacoa.org/PDF/HazardsandThreats/Annexes/LACo\\_FAC\\_Plan\\_May2014\\_Web.pdf](http://lacoa.org/PDF/HazardsandThreats/Annexes/LACo_FAC_Plan_May2014_Web.pdf). Accessed June 21, 2018.)

The following diagrams are sample layouts of various spaces in the Hospital Family Reunification Center (HFRC). Each health care facility should modify its layouts on the basis of its available spaces and services provided.

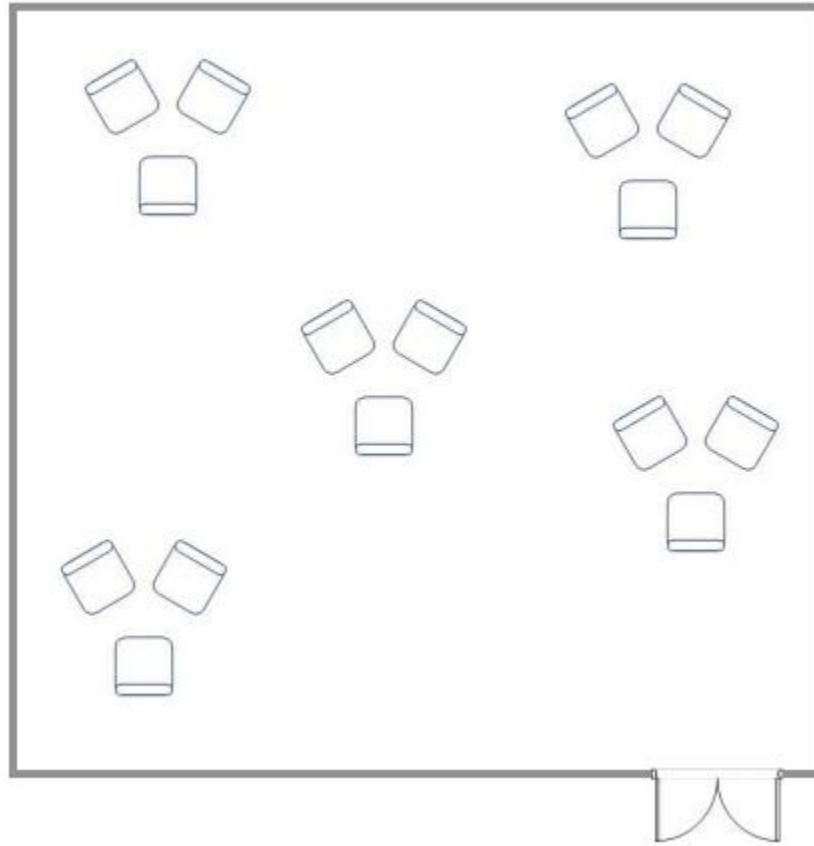


Sample Reception/Family Waiting Area





Sample Family Briefing/Assembly Area



Sample Interview/Notification/Counseling Room



## Sample HFRC Equipment and Supply List

(Adapted from the Coyote Crisis Collaborative Family Reunification Center Planning Guide, 2017. Scottsdale, AZ: Coyote Crisis Collaborative; 2017. <http://coyotecampaign.org/documents>. Accessed June 21, 2018.)

Resource	Scaling Guide	Quantity Required	Description/Comment
<b>Reception / Check-in</b>			
Administrative supplies	As needed		
Badging equipment	1 machine per 50 clients		
Signage	As needed		
Tables	1 per 2 filled positions		
Chairs	Number of tables × 2		
Telephones	1 per 2 filled positions		
Trash cans	As needed		
<b>Credentialing Area</b>			
Administrative supplies	As needed		
Badging equipment	1 machine per 50 staff		
Staff computers	1 per filled position		
Tables	1 per 2 filled positions		
Chairs	Number of tables × 2		
Telephones	1 per 2 filled positions		
Trash cans	As needed		
<b>Assembly Area</b>			
Chairs	Enough for all clients		
Communications boards	≥1 as needed		
Audiovisual equipment	Microphones, speakers, projector, and screen(s)		
Podium	1		
Signage	As needed		
Telephones	1 phone with speakerphone and conference call capabilities		
Tables	As needed		
Charging station	1 per 10 people		
Chargers	1 per 5 people		
Trash cans	As needed		
<b>Family Interview/Notification/Counseling Rooms (Behavioral Health and Spiritual Services)</b>			
Administrative supplies	As needed		
Chairs (per room)	6 for family, 1–2 for staff		
Signage	As needed		
Tables (per room)	1		
Telephones (per room)	1		
Tissues	As needed		
Trash cans	As needed		



<b>Pediatric-Safe Area</b>			
Age-appropriate toys	As appropriate		
Cribs/cots	1 per child		
Diaper-changing tables	1 minimum		
Diapers	As needed		
Digital camera	1		
First aid kit	1		
Folding partitions	As needed		
Linens/blankets/pillows	As needed		
Rest mats	As needed		
Small refrigerator	1 per child care area		
Trash cans	As needed		
<b>Meal Area (As Appropriate)</b>			
Food	3 meals a day throughout duration of operations		
Signage	As needed		
Tables and chairs	1 table per 6 clients and appropriate chairs per table		
Trash cans	As needed		
<b>Command Meeting Area</b>			
Incident command vests	1 per Hospital Incident Command System position		
Chairs	1 per staff member		
Tables	2 staff per table		
Trash cans	As needed		
Telephone	1		
<b>Staff Area</b>			
Administrative supplies	As needed		
Chairs	1 per staff		
Conference call phones	1		
Fax machine	1		
Photocopier and supplies	1		
Printer	1		
Radio	1 for each member of leadership staff		
Signage	1		
Tables	2 staff per table		
Telephones	3		
Trash cans	As needed		
<b>Other Supplies</b>			
AED	As required		
Fire extinguisher	As required		
Extension cords/power strips	As needed		



## PSA Location Assessment Tool

Area Reviewed: \_\_\_\_\_ Date Reviewed: \_\_\_\_\_ Reviewer: \_\_\_\_\_

Area of Concern	Finding		Follow-up Action Needed
	Yes	No	
1. Is access to the designated Pediatric-Safe Area (PSA) able to be controlled? Can children be contained and directly supervised in this area? (Consider stairwells, elevators, and doors.)			
2. Is there a plan for security of the unit?			
3. Have you conducted drills of the plans for this area with relevant departments?			
4. Do you have a plan to definitively identify the children?			
5. Do you have a plan for identifying the mental health needs of these children?			
6. If needed, can various age-groups be separated into different areas? (Consider whether older children pose a safety issue for the younger children.)			
7. Are enough staff members available to adequately supervise the children? (Consider that younger children need more staff to supervise.)			
8. Do you have a sign-in–sign-out sheet for all children and adults who enter the area?			
9. Are all children admitted to the area required to have appropriate identification bracelets?			
10. If children need to leave the area to use the bathrooms, are there appropriate methods to escort them?			
11. Is there a safe, stable area near a sink but away from eating areas that can be used for diapering?			
12. Are there appropriate facilities for handwashing?			
13. Does the area have fire and smoke alarms?			
14. Is there adequate egress in case of fire?			
15. Do the windows open? (Consider whether the windows would be used for egress in case of fire.)			
16. Are the windows appropriately protected? Do they have window guards?			
17. Is the area safe for children of varying ages? (Is the area free of blinds, drapes, or cords that could pose a strangulation hazard?)			
18. Are electrical outlets child safe / covered?			



Area of Concern	Finding		Follow-up Action Needed
	Yes	No	
19. Is the area free of any water basins/buckets/sinks that can pose a drowning hazard?			
20. Is the area free of fans, heaters, and generators that could pose a safety risk? If fans or heaters are used, are they sectioned off at a safe distance so they do not pose a risk for burns or amputation?			
21. If radiators or hot pipes run through the area, are they covered to prevent burn hazards?			
22. Are areas such as cupboards or under-sink areas appropriately locked?			
23. Is the area free of small toys and parts that would pose choking hazards?			
24. Are cabinets and tables free of items that might topple onto children? Is the area free of unstable, heavy items or carts that might topple onto children?			
25. If medical supplies are in the area, are medication carts and supply carts locked? Is access sufficiently controlled? Are medications and syringes secured and at least 48 in off the floor?			
26. Are there safe, adequate sleeping accommodations available (ie, foam mats on the floor) to avoid co-sleeping?			
27. Are infants placed in safe sleep areas on their backs to sleep to reduce the risk of sudden infant death syndrome?			
28. Are mattress surfaces firm and are soft pillows and toys removed from infant sleeping areas?			
29. Is the area smoke-free?			
30. Are there adequate age-appropriate games, videos, and toys to occupy the children?			
31. Are there nutritious, age-appropriate snacks available for the children, avoiding foods that comprise a choking hazard for younger children?			
32. Are there nearby child care centers or other experts who could be approached to help or advise, should it be necessary?			
33. Have staff/volunteers who will be working in this unit received security clearance (eg, no known child protection issues or criminal history)?			

*Adapted from Patricia Wilder, Administrative Project Director, PCS, LPCH, July 2011, New York City Department of Health and Mental Hygiene and its Centers for Bioterrorism Preparedness Planning.*



## Sample HFRC Unit Leader Job Action Sheet

(Adapted from the Coyote Crisis Collaborative Family Reunification Center Planning Guide, 2017. Scottsdale, AZ: Coyote Crisis Collaborative; 2017. <http://coyotecampaign.org/documents>. Accessed June 21, 2018.)

**Mission:** It is the mission of the Hospital Family Reunification Center (HFRC) Unit Leader to select the location of the HFRC and ensure that all staff are in place. The HFRC Unit Leader will report directly to the Family Reunification Branch Director unless that position is not established, at which time the HFRC Unit Leader will report directly to the Operations Section Chief.

The HFRC Unit Leader verifies that space, equipment, supplies, and staff are sufficient to handle the work assigned. This position monitors compliance to guidance and mediating and addresses any challenges that may influence service, efficiency, and productivity.

### Checklist for the HFRC Unit Leader

HFRC Unit Leader: \_\_\_\_\_

#### Situation Briefing

- Received situation update briefing from Incident Commander, Operations Section Chief, or Family Reunification Branch Director

#### Operational Period

- Received information related to the operational period

**Anticipated operational period:** \_\_\_\_\_

#### Additional Staffing Needs (Assign unit leaders for the following areas.)

- Credentialing
- Security
- Reception / Check-in
- Medical
- Behavioral Health Services
- Child Care
- Spiritual Services

#### Communications

- Establish with Family Reunification Branch Director, Operations Section Chief, or Incident Commander.
- Establish with HFRC.



- Establish with hospital Public Information Officer.
- Document all key activities, actions, and decisions.
- Notify and distribute job assignments, checklist information, maps, and other logistical information to all HFRC Unit Leaders and staff.
- Distribute contact information provided by the Family Reunification Branch Director.
- Instruct all HFRC Unit Leaders to periodically evaluate equipment, supply, and staff needs and report status; address those needs with appropriate HFRC staff, and report needs for additional staff or resources.
- Gain situational updates from HFRC Unit Leaders at scheduled intervals and provide that information to the Family Reunification Branch Director.
- Distribute information provided by the Family Reunification Branch Director to the appropriate HFRC Unit Leaders or entire HFRC team.

### Logistical Needs

- Electronic charging devices
- Food and water for staff
- Break-work cycle scheduling

### Additional Activities

- Distribute contact information provided by the Family Reunification Branch Director.
- Ensure physical wellness through proper nutrition, water intake, rest, and stress management techniques.
- Unit leaders should observe all staff and volunteers for signs of stress.
- Upon relief (eg, shift change), brief the replacement on the status of all ongoing operations, issues, and other relevant incident information.

### Demobilization

- As needs for the HFRC decrease, notify the Family Reunification Branch Director and demobilize when appropriate.
- Ensure the return/retrieval of equipment and supplies.
- Debrief staff on lessons learned and procedural/equipment changes needed.
- Provide formal evaluations of staff as required by the Family Reunification Branch Director.
- Upon deactivation of the position, brief the Family Reunification Branch Director on current problems, outstanding issues, and follow-up requirements.
- Upon deactivation of the position, ensure all documentation is submitted to the Family Reunification Branch Director.
- Submit written comments to the Family Reunification Branch Director for discussion and possible inclusion in the After-Action Report; topics include
  - Review of pertinent position descriptions and operational checklists
  - Recommendations for procedure changes
  - Section accomplishments and issues
- Participate in stress management and after-action debriefings.





## Parent/Guardian Vetting Form

Vetting Form: To be completed by each parent/guardian.

Each parent's name	
Contact number	
Family's address	
Child's name	
Child's medical record number	
Child's birth date	
Child's age	
Patient identifiers	
Hair color	
Eye color	
Clothing	
Shoes	
Jewelry	
Other	
Name of school / grade	
Each teacher's name	
Each pet's name and the type of animal(s)	

Vetting Form: To be completed by staff member interviewing child.

Name	
Medical record number	
Birth date	
Age (or approximate age)	
Parent 1's name	
Parent 2's name	
Sibling name(s) and age(s)	
Address (or street/town name)	
Name of school / grade	
Each teacher's name	
Each pet's name and the type of animal(s)	



## Sample Communications Scripting

Ensuring that all families have regular updates to their understanding of the incident status and the hospital response relevant to them will help minimize some of the potential psychological and security concerns that are associated with these incidents.

The following script examples may be used to maintain consistency and ensure family members seeking information receive the same correct information (when they have an appropriate right to know) whether they present in person or call to speak with a phone operator.

### Basic Scripting

Yes, I do show that we have a patient by that name here at [HOSPITAL NAME]. When you arrive, please check in at the [front desk in the Main Lobby or another arrival location] and we will direct you to your loved one's current location at that time.

OR

Unfortunately, I do not show any patients by that name here at [HOSPITAL NAME] right now. It takes some time for us to confirm patient identity; if you can call us back in one hour, we may have additional information available at that time.

### Additional Resources

Unfortunately, I do not show any patients by that name here at [HOSPITAL NAME] right now. Staff at the [Mayor's Hotline or another external resource] are also assisting with family reunification; if you dial [XXX/XXX-XXXX], you will be connected to additional resources.

Unfortunately, I do not show any patients by that name here at [HOSPITAL NAME] right now. The [city / county / state / nongovernmental organization] has set up a Family Support line and is a centralized resource with information from multiple hospitals; this is the best resource for you right now. The telephone number is [XXX/XXX-XXXX].

Unfortunately, I do not show any patients by that name here at [HOSPITAL NAME] right now. The [city / county / state / nongovernmental organization] has set up a Family Assistance Center at [LOCATION] with additional resources available to assist family members like yourself; this is the best resource for you right now. The address is [ADDRESS] / the telephone number is [XXX/XXX-XXXX].

### Callbacks

I apologize but because of the overwhelming number of requests, I am unable to provide callbacks at this time; we are trying to speak with as many callers as we can to reunite family members.



## Hospital Family Reunification Plan Planning Checklist

(Adapted from the Coyote Crisis Collaborative Family Reunification Center Planning Guide, 2017. Scottsdale, AZ: Coyote Crisis Collaborative; 2017. <http://coyotecampaign.org/documents>. Accessed June 21, 2018.)

Process	Notes	Complete	Next Step(s)
1. Existing policies			
a. Identifying children			
b. Identifying caregivers			
2. Processes in austere environment			
a. When Internet is down			
b. When electronic medical record is down			
c. When power is out			
d. When caregiver has no ID			
3. Confirming identity			
a. ID			
b. Photo			
c. DNA			
d. Biometrics			
e. Fingerprinting			



f. Verbal identification			
4. Partner agencies			
a. Child and family services			
b. Coroner/mortuary services			
c. Law enforcement			
d. American Red Cross			
e. United Way			
f. Local government			
g. Pediatricians			
h. Schools			



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