KNOXVILLE/EAST TENNESSEE HEALTHCARE COALITION PEDIATRIC DISASTER PLAN

APPENDIX TO TENNESSEE PEDIATRIC ANNEX

APPENDIX TO KNOXVILLE/EAST TENNESSEE HEALTHCARE COALITION PREPAREDNESS AND RESPONSE PLANS

August 2020

With Collaboration From:

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Knox East TN Healthcare Coalition
KETHC
Plan Train Coordinate

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1.0 Knox East Tennessee Healthcare Coalition (KETHC)

Mission

The Knox/East Tennessee Healthcare Coalition (KET HC) will assist the health care community and other emergency response agencies to jointly prepare for, respond to and recover from disaster events by supporting collaborative planning and information sharing among a broad range of healthcare partners in order to protect, promote, and improve the health and prosperity of the people in Tennessee.

Purpose

The purpose of The Knox/East Tennessee Healthcare Coalition is to support the development of cooperative partnerships in order to promote and enhance the well-being of the community's healthcare system through coordinated disaster preparedness, education, public information, response/ recovery activities, and sharing of resources.

Coalition Boundaries

The KET HC primary boundaries include the following counties: Scott, Campbell, Claiborne, Hamblen, Grainger, Union, Morgan, Anderson, Jefferson, Cocke, Knox, Roane, Loudon, Blount, Sevier, and Monroe.

KET HC participates in an active network of healthcare coalitions across Tennessee as well, through the Regional Hospital Coordinators (RHCs) and Regional Medical Communications Centers, which permits planning, response, and recovery activities to also occur outside of our geographical boundaries.

Membership

Coalition Membership is open to all healthcare organizations and jurisdictions and emergency management related organizations within the coalition's geographic area as outlined in the KET HC Bylaws.

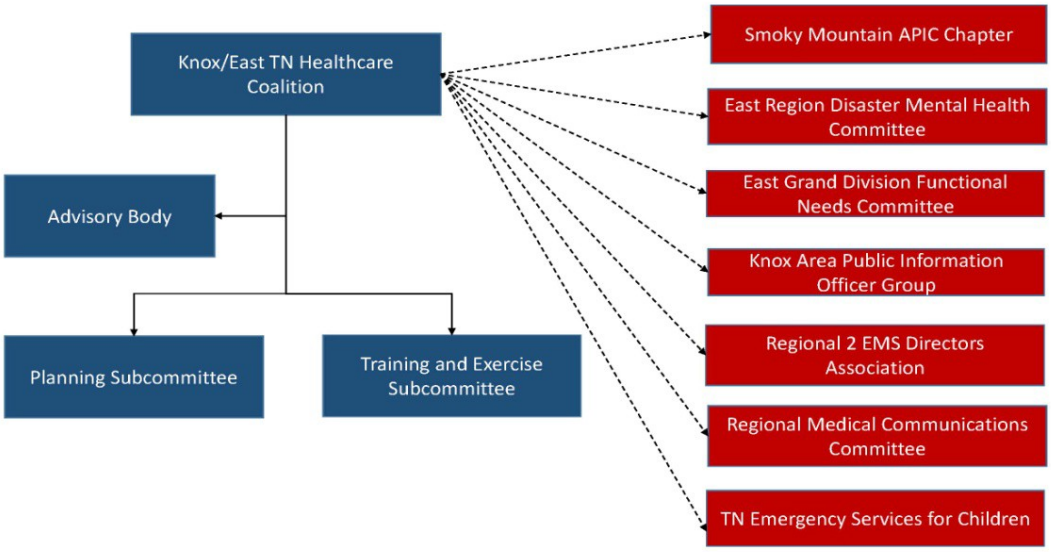
Membership details can be found in the KET HC Bylaws and in the KET HC Memorandum of Understanding.

Organizational Structure and Governance

In an effort to meet all required Healthcare Preparedness Program capabilities and d eliverables, the KET HC must maintain an internal structure to support coalition activities and operations. Specific roles and responsibilities by membership type are described in the KET HC Bylaws to include member guidelines for participation and engagement as well as policies and procedures for making changes and delegation of authority.

Participating organization executives formally endorse their organization's participation in the KET HC through signing our KET HC Memorandum of Understanding. KET HC newsletters are developed to engage healthcare and governmental executives and other stakeholders. Executives are encouraged to participate in KET HC meetings or send feedback through their KET HC organizational representative. Furthermore, most participating organizations incorporate KET HC activities into their internal emergency preparedness/response meetings and structure, which includes executive input and oversight.

KET HC integration with existing state, local, and member-specific incident management structures is described in the KET HC Response/Coordination Plan, along with ESF 8 integration details.



1.1 Regional Pediatric Population

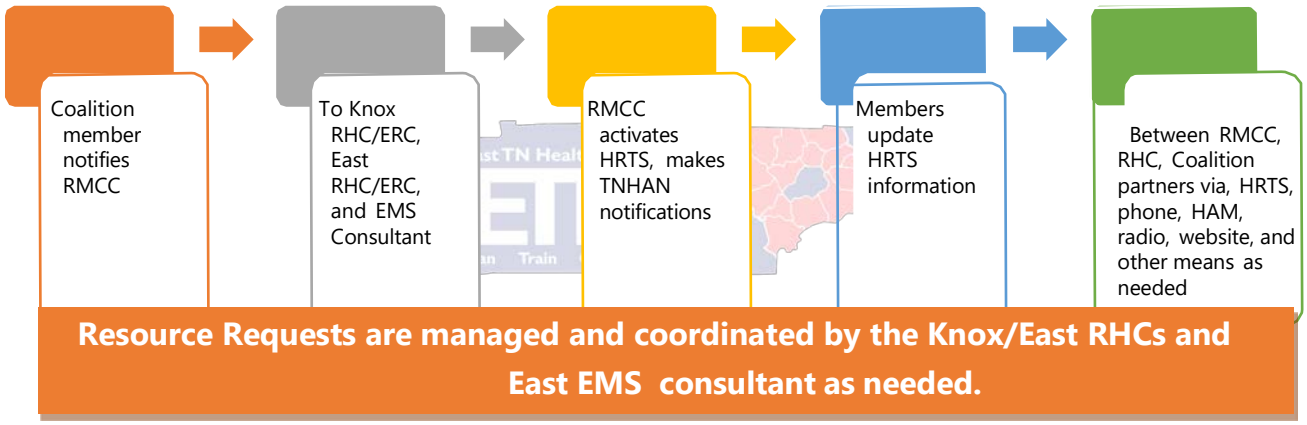
Population estimates for 2019 according to the US Census Bureau:

County	Total Population	Percent Population < 18	Population <18
Anderson	76978	21.2	3631
Blount	133088	19.9	6688
Campbell	39842	20.3	1963
Claiborne	31959	19.1	1673
Cocke	36004	20.2	1782
Grainger	23320	20.0	1166
Hamblen	64934	23.0	2823
Jefferson	54495	19.2	2838
Knox	470313	20.9	22503
Loudon	54068	19.1	2831
Monroe	46545	20.9	2227
Morgan	21403	18.9	1132
Roane	53382	18.6	2870
Scott	22068	24.1	916
Sevier	98250	20.4	4816
Union	19972	21.5	929
Estimated Total Pediatric Population			60789

2.0 Concept of Operations

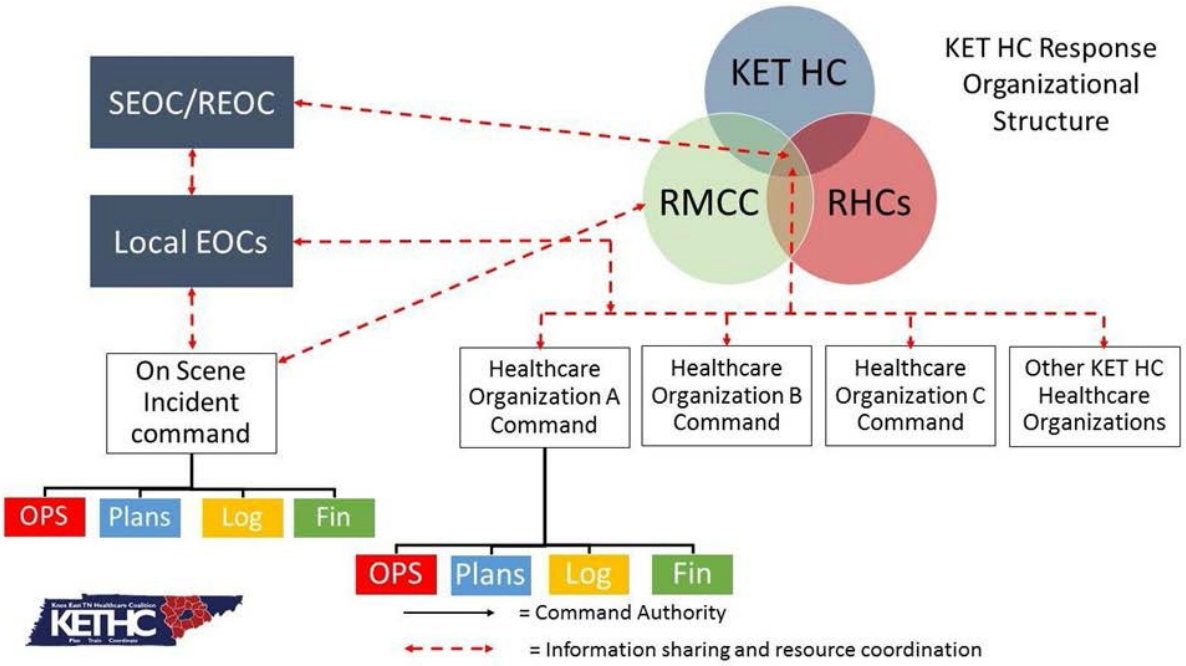
2.1 Activation

In some cases, at our smallest hospitals even one critical pediatric patient could overwhelm immediate local resources. During a surge incident recognition, overwhelmed providers should contact public health (Emergency Response Coordinators (ERCs), RHCs, and EMS Consultants) will coordinate to determine the level of activation required. This can vary from monitoring to a fully staffed response with public health representatives deploying to the local or regional EOC, RHCs to the Regional Medical Communications Center (RMCC), and EMS Consultants to a scene (when applicable). The public health partners work with the RMCC who activates the regional response.



Following this activation, the below may occur:

- RMCC will activate the Healthcare Resource Tracking System (HRTS) (the statewide system that help can track the availability of hospital resources, EMS, and long-term care partners) to alert regional hospitals and partners of the event.
- Placing HRTS in disaster mode triggers hospitals & health care system partners to evaluate the level of response required and enhances situational awareness.
- Availability of facilities to receive patients will be monitored through HRTS by the RMCC, RHC, and the EMS Consultant.
- Resources coordination will be managed via the Regional Hospital Coordinators, Emergency Response Coordinators, EMS Consultant, and local and state Emergency Management utilizing HRTS and WebEOC (for emergency management).



2.2 Notifications and Information/Essential Elements to be Shared During Events

Notification to KET HC members will be made via Tennessee Health Alert Network (TNHAN), HRTS, and the KET HC website membership management tool. KET HC essential information elements to be shared include:

- Bed Availability (HRTS)
- Resource Capabilities (HRTS)
- Organization and Service Capabilities (HRTS)
- Facility Status Form which will be uploaded as needed on the KET Coalition website. This allows KET HC and RHCs to quickly identify member status of mission critical systems such as electricity, water, and medical gases.

2.3 Roles and Responsibilities

2.3.1 Hospitals

Tennessee State Rules and Regulations guide the designation of pediatric readiness for each emergency care facility. It is the responsibility of each emergency care facility to maintain the standards of designation. See appendix A for current pediatric designations.

All KETHC emergency care facilities have in place a transport and education agreement with the local Comprehensive Regional Pediatric Center (East Tennessee Children's Hospital) per state rules and regulations. Subject Matter Experts (SMEs) will be available as needed for pediatric disasters.

The KET HC has a regional memorandum of understanding (MOU) regarding staff and supplies with all member facilities that is updated as needed. Each hospital has an emergency response plan to address internal plan activation, emergency staffing, on loading and off-loading of patients, isolation patient management, acquisition of additional supplies/equipment/pharmaceuticals, emergency evacuation, business continuity, shelter-in-place, fatality management, and coordination with their local office of emergency management and other hospitals in the region. Hospital Emergency Departments have been supplied with pediatric supplies and coalition-wide exercises have been conducted to assess current readiness to manage pediatric surge events.

Crisis standards of care procedures are consistent across the state per state guidance found in the document titled *Guidance for Ethical Allocation of Scarce Resources During a Community-Wide Public Health Emergency as Declared by the Governor of Tennessee.(version 1.6 July 16 revises 2020)*

2.3.2 Non-Hospitals

The KET HCC has worked with several governmental and non-governmental agencies in a grassroots effort since 2010 to assist childcare providers in developing emergency response plans. This effort has helped families and childcare facilities in the East Tennessee Region prepare for and recover from disasters in a way that ensures that infants, toddlers and older children stay safe and secure. These partners have been integrated into the ESF 6 and ESF 8 response structure.

2.3.3 EMS Agencies

The Emergency Medical Services (EMS) in the KETHC region is comprised of the following

elements:

- 21 publicly operated service providers
- 238 Advanced Life Support units
- 40 Basic Life Support units
- 2 AmbuBus
- 1 State EMS Coordinator

In addition to ground transportation, the region has access to air transports provided by UT LIFESTAR. UT LIFESTAR has 5 rotor wing aircraft based in Sevierville TN, Morristown TN, Jacksboro TN, Rockwood TN and Sweetwater TN. UT LIFESTAR is in the process of starting back up their neonatal transport services by rotor wing, with the assistance of the University of Tennessee Medical Center, which should be available before December 31, 2020.

EMS will follow state and local protocols for pediatric disaster management, utilizing JumpSTART triage guidance. The State EMS coordinator provides guidance and subject matter expertise as needed.

2.4 Logistics

Resources coordination will be managed via the Regional Hospital Coordinators, Emergency Response Coordinators, EMS Consultant, and local and state Emergency Management utilizing HRTS and WebEOC (for emergency management).

2.4.1 Space

The University of Tennessee Hospital (UTMC) and East Tennessee Children's Hospital (ETCH) have the following **pediatric beds** as listed in HRTS:

Facility	Floor Beds	NICU 3	PICU
UTMC	0	67	2
ETCH	78	60	14

Identification of alternate care sites are the responsibility of the individual facilities. Alternate care sites will be activated as needed to accommodate the space needs during a disaster.

Pre-established alternative care sites can be activated through coordination with the local Emergency Management Agency. Spaces should offer adequate heating and cooling as needed for environmental considerations.

2.4.2 Staff

Regional Memorandum of Understandings (MOUs) between KET HC facilities allow for the sharing of staff during a disaster event. Requests for staffing needs should be escalated according to the KET HC response plan.

MOUs with neighboring coalitions provide for the sharing of staffing resources when necessary.

2.4.3 Supplies and Equipment

Each KET HC emergency care facility has available a disaster cart specific to pediatric needs during a pediatric surge and/or disaster. Additional supplies and resources can be mobilized through the activation through public health. These supplies include but are not limited to diapers, clothing and bedding.

MOUs with neighboring coalitions provide for the sharing of resources when necessary.

Pediatric supply needs will be reviewed through KET HC on an annual basis.

2.5 Special Considerations

2.5.1 Behavioral Health

A disaster can have long-term effects on the mental and emotional health of all children. Coping with a disaster can be particularly difficult for children with disabilities. Children who have serious emotional and behavioral problems are at high risk for severe stress after a disaster or traumatic event.

The KETHC works directly with the Knoxville/East Tennessee Disaster Mental Health Team, led by the American Red Cross and in the event of need will be activated by the KET HCC .

Tennessee uses Psychological First Aid through the Red Cross as well as PsySTART (Psychological Simple Triage and Rapid Treatment) to triage mental health needs and to assess and manage the behavioral health impact during a disaster.

PsySTART Tennessee can be found at:https://www.tn.gov/health/cedep/cedep-emergency-preparedness/temarr.html

The Tennessee Department of Health, in collaboration with the Tennessee Department of Mental Health and Substance Abuse Services, has established a Tennessee Disaster Mental Health Strike Team through the Tennessee Federation of Fire Chaplains (TFFC). The TFFC provides training and management of the Strike Team which includes a diverse cadre of Chaplain, Mental Health, and Emergency Service Peer Professionals capable of statewide

deployments. The Tennessee Department of Health or the KET HCC may request the team for service during disasters. The Strike Team provides timely initial referral to Licensed Mental Health Care Professionals — including immediate emergency referrals when appropriate.

2.5.2 Decontamination

Children, as compared to adults, will require different planning and supplies for decontamination. They are more vulnerable to hazardous substances because they have lower body weights, are typically shorter (closer to the ground), and breathe more times per minute than adults thus typically exposing them to larger doses than adults. In addition, their skin is thinner, and they have a larger skin surface-to-body mass ratio than adults.

Children, especially young children, are more at risk of hypothermia and therefore may require additional heated water for decontamination and more protection from becoming cold versus adults. Each hospital must have its own system or plan for decontamination, with protocols specific to children. Because of their unique anatomical, physiological and developmental characteristics, here are some issues to consider:

- Warm water (between 98°F - 110°F or 36.6° C - 43.3° C) to prevent hypothermia
- Low pressure/high volume
- Only soap and water
- Soft bristle brushes
- Safe method of transport through the decon shower without being carried (in a bassinet or laundry basket with holes)
- Process to keep families together
- A safe heating system for the environment

Pediatric Decontamination Checklist is provided to all KET HC emergency care facilities to help guide supply acquisition. A Checklist can be found in Appendix A.

2.5.3 Evacuation

For evacuations the Healthcare Resource Tracking System (HRTS) will be utilized by hospital, EMS, long term care, and RMCC's to assess bed and transport availability. Patient transfers will be coordinated through the Regional Hospital Coordinators (RHCs).

KET HC will utilize the TDH Patient Tracking System located on the Tennessee Emergency Medical Awareness, Response and Resources (TEMARR) website at: https://www.tn.gov/health/cedep/cedep-emergency-preparedness/temarr.html. RHCs will provide training and access for the patient tracking system to KET HC partners. Also, RHCs will notify KET HC partners of patient tracking system activation during events through HRTS, TNHAN, and/or the KET HC website.

2.5.4 Infection Control

Individual facilities should have mechanisms for screening patients of all ages for possible or suspected exposure to highly infectious disease. All hospitals in the KET HC have the capacity to maintain patients who are suspected case of a highly communicable disease in Negative Pressure Isolation (NPI).

University of Tennessee Medical Center of Knoxville (UTMCK) has been designated as the regional highly infectious disease assessment facility. Suspected exposures that cannot be managed at outlying regional hospitals (i.e. Ebola) shall be transferred to UTMCK according to regional/state procedures.

2.5.5 Security

KET HC facilities shall have plans and provisions in place to maintain security measures within their facilities. Facilities should also have plans developed to obtain additional support as needed during disaster events. Considerations when planning should include:

- Infant/Child abduction prevention
- Procedures in place to verify children are released to an appropriate caregiver
- Adequate staff to ensure there are always 2 adults present
- Background checks according to hospital policies and/or procedures
- Established lockdown procedures

2.6 Medical Care

2.6.1 Triage and Transfers

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

During a disaster, pediatric patients will be triaged and disbursed to regional emergency care facilities. The most critically ill/injured, youngest and/or medically complex children will generally have priority for transport to the regional children's facility. Priorities may be different depending on the scale of the event, type of event, ages and severity of patients affected.

Emergency care facilities should be prepared to provide continued care of complex pediatric patients until stabilization of the scene has been achieved and the regional pediatric facility is available to accept patients from outside facilities.

2.6.2 Treatment

Standard of Pediatric Care is followed by the standards approved by the State Board of EMS and Board of Licensing Healthcare Facilities and as outlined by the Tennessee Committee on Pediatric Emergency Care (CoPEC) guidelines. CoPEC works closely with the Children's Emergency Care Alliance of Tennessee to establish and support pediatric care standards. Board of Licensing standards can be found here: https://cecatn.org/what-we-do/resource-center/

During a disaster, providers at outside facilities seeking pediatric expertise for complex pediatric patients will coordinate communications through the Regional Hospital Coordinators (RHCs). Mass communication from the pediatric SME to outside providers will be communication by the RHCs through HRTS.

2.7 Transportation

All ambulances and licensed EMS personnel operating within the State of Tennessee must meet certain pediatric standards set by the State Board of EMS. There are also several specialized pediatric transport teams, primarily housed at regional pediatric facilities, as well as, several air ambulance services. Specialized EMS transport resources are accessed through the EMS Consultants, working with the Regional Medical Communications Centers, and when required, the RHCs.

The regional pediatric facility will coordinate with the regional EMS consultant and RHCs to arrange and prioritize interfacility transportation of pediatric patients.

2.8 Patient Tracking

The Tennessee Department of Health Global Emergency Response (GER) patient tracking model (HC Standard) is integrated into the national system for patient tracking. This system is used to provide situational awareness, family reunification and re-patriation for emergency evacuees, quickly register, record assessment, triage and document patient treatment. The system is scalable and can be deployed for mass casualties, healthcare facility evacuations and medical assistance in shelter operations. The TDH Patient Tracking Policy is located at: https://files.asprtracie.hhs.gov/documents/tdh-pt.-tracking-policy-6-13-2018-v-1.2.pdf

2.9 Reunification

During both small and large events (50 or more victims) responders will need to activate various sites and resources as needed to meet reunification and family assistance needs. Even after the initial response is over, families will still need services. The coalition is key in establishing and maintaining relationships with non-profit organizations – such as the Red Cross, Salvation Army, schools, TFFC and local faith-based groups to meet the needs of the community during emergency situations.

Assumptions[1]:

- Expect a minimum of eight to ten family members or loved ones to arrive or need assistance for each victim.
- After an incident, family members may immediately call or self- report to the hospital they believe their loved one may have been taken.
- Coordination among responding agencies about family members, missing persons, and patient tracking will be necessary.
- An FRC will be necessary to provide a safe place for families to convene until a Family Assistance Center (FAC) or shelter is activated.
- Families will have high expectations regarding:
- Identification of the deceased,
- The return of loved ones and their belongings,
- Accurate and timely information and updates.
- Victim identification may take multiple days, weeks, months or even years.
- Not all families will grieve or process information in the same manner.
- Ethnic and cultural traditions will be important factors in the way families grieve or process information.
- Both Behavioral Health and Spiritual Care resources should be available.
- Responding to a mass casualty or mass fatality incident can be overwhelming and lead to traumatic stress. Support for staff will be essential.
- A specific safe zone must be established for unaccompanied minors to ensure appropriate release to a custodial adult.

Actions (as needed):

- Establish an on-scene secure location to protect uninjured children
- Establish a protocol to release children to family
- Provide public service messaging through various communication channels
- Establish a call center to answer questions, report missing persons (separate number may be required) and direct assistance
- Coordinate response to social media trending
- Establish and implement information release guidelines
- Utilize HRTS to coordinate messaging and resources among healthcare facilities

See Appendix B for pediatric reunification checklist

1- Seattle and King County Healthcare Coalition's Family Reception Services Guidelines for Hospitals. April 2012.

2.10 Deactivation and Recovery

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

Each coalition member organization should complete an internal recovery plan utilizing guidance in the National Disaster Recovery Framework. As with response, the KET HC will continue to play a role in information sharing and resource coordination through the recovery period by sharing recovery related resources, planning, and activities by local, state, and federal levels with coalition members. KET HC will remain flexible in planning recovery operations and tactics, so that specific event-based needs may be addressed, ensuring a coordinated transition from response to recovery. The RHCs and other KET

HC member organizations will strive to integrate with pre-incident recovery planning efforts in their communities identify critical infrastructure dependencies, and meet workforce needs to ensure the healthcare system remains operational following a disaster.

2.10.1 Deactivation

When it is determined that the situation is contained, through the local EMA or the on scene IC / UC, the RMCC will communicate to health care agencies via HRTS, phone, radio, website and/or other communication methods that the disaster or situation has been contained and the region has returned to a normal state of operation.

2.10.2 Facility Re-Entry Authorization

If a facility has been evacuated as a result of an event, Hospital Administration, and/or health care agencies in conjunction with lead local, state and/or federal agencies, will authorize re-entry to the facility in accordance with their internal reentry guidelines.

2.10.3 Additional Potential Coalition Recovery Support Roles

- Facilitate data use agreements and data collection and analysis to identify priorities in the reconstruction and delivery of community health care services at the outset of an emergency.
- Collaborate with federal infrastructure assessment teams to enhance

knowledge of disaster impacts on physical infrastructure and inform future risk mitigation strategies.

- Implement emergency management organizations' disaster impact assessments to assess post-disaster community health concerns.
- Facilitate family reunification in partnership with law enforcement and the American Red Cross as appropriate.
- Facilitate patient repatriation and system operations restoration.
- Support mental health need requests for responding agencies and support community efforts where appropriate.
- Assist KETHC members by linking them to resources and information to support processes for reimbursement, reconstitution, and resupply in concert with emergency management activities.
- Utilize current communications practices to identify long-term health care and community health recovery gaps and assist in community-wide efforts to develop potential strategies to address them when possible.
- Develop and communicate short and long-term priorities to the jurisdiction's government and emergency management functions related to healthcare operations.
- Develop after action reports and improvement plans with emergency management organizations and government officials to identify opportunities for future mitigation strategies or initiatives to enhance resilience of the physical healthcare infrastructure.

3.0 Training

The coalition has hosted the FEMA *MGT-439 Pediatric Disaster Response and Emergency Preparedness,* Neonatal Resuscitation Program and Advanced Burn Life Support.

KET Coalition-wide training of all healthcare system stakeholders will ensure effective use of this pediatric annex. Additional training needs will be identified by the Knox/East Tennessee Healthcare Coalition through gap analysis.

4.0 Pediatric Referral Resources

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

- Children's Hospital of Erlanger (Chattanooga, TN)
- Nisownger Children's Hospital (Johnson City, TN)

- Monroe Carell Jr. Children's Hospital at Vanderbilt (Nashville, TN)
- Cincinnati Children's Hospital (Cincinnati, OH)
- Children's of Alabama (Huntsville, Birmingham, Tuscaloosa, AL)
- Children's Healthcare of Atlanta (Atlanta, GA)
- Shriner's Hospital Cincinnati (Cincinnati, OH)
- Kentucky Children's Hospital (Lexington, KY)
- JM Still Burn Center (Augusta, GA)
- Brenner Children's Hospital (Winston-Salem, NC)

4.1 Appendices

Appendix A: Pediatric Decontamination Checklist

PURPOSE: This checklist is designed to assist with decontamination planning and response to ensure the needs of children are met prior to, during and after undergoing decontamination.

ITEM #	Pediatric Decontamination Component	Agency/Organization Process To Integrate Component	Completed Y/N
	PRIOR TO DECON		
1.	Identification and tracking process for children, especially unaccompanied minors		
2.	Process to provide privacy		
3.	Process to provide space for families to disrobe		
	DURING DECON		
4.	Access to warm water (98˚-110˚ F)		
5.	Method to monitor water temperature during decon		
6.	Access to low pressure/high volume water (≤ 60 psi)		
7.	Handheld nozzles		
8.	Anti-slip surfaces		
9.	Mild soap		
10.	Soft bristle brushes, sponges or wash cloths		
11.	Method to transport infants and younger children through shower		
12.	Method to transport non ambulatory, CSHCN/CFAN** through shower		
13.	Process to allow families to stay together during decon		
14.	Process to handle medical and assistive devices		
15.	Process to decon service animals		

16.	Communication boards and other processes		
POST DECON			
17.	Warming devices		
18.	Age/size appropriate gowns/coverings post decon		
19.	Process to evaluate for psychological trauma after incident and decon procedures		
DECON TRAINING, DRILLS, AND EXERCISES			
20.	Inclusion of children of all ages in every decon training, drill and exercise (infants, toddlers, school age, adolescents)		
21.	Inclusion of CSHCN/CFAN** in every decon training, drill and exercise		

** Children with Special Health Care Needs/Children with Functional Access Needs (CSHCN/CFAN)

State of Illinois EMSC June 2017

Appendix B: Unaccompanied Minor Reunification Checklist

PURPOSE: This checklist is designed to assist with identification, tracking and reunification of unaccompanied minors during a disaster.

ITEM #	Reunification Component	Agency/Organization Process To Integrate Component	Completed Y/N
	Identification and Tracking		
1.	Process to identify unaccompanied minors	Click here to enter text.	
2.	Staff that will be responsible for tracking unaccompanied minors	Click here to enter text.	
3.	Banding/tagging/ identification process	Click here to enter text.	
4.	Camera with printer	Click here to enter text.	
5.	Process to photograph all unaccompanied minors	Click here to enter text.	
6.	Process to include an identifier (tracking number or other child specific identifier) in the picture	Click here to enter text.	
7.	Method to track all children (e.g. pediatric patients, non-injured children, child visitors, shelter occupants), especially unaccompanied minors	Click here to enter text.	
8.	Implementation of tracking forms, including the ability to attach the picture of the child	Click here to enter text.	
9.	Communication process with Incident Command	Click here to enter text.	
10.	Communication process with outside agencies to assist with tracking and reunification	Click here to enter text.	
	Ensuring the Safety of Unaccompanied Minors		
11.	Potential locations for a Child Safe Area before an incident	Click here to enter text.	
12.	Potential locations for the Family Information and Support Center that is in a separate/different location than the Child Safe Area	Click here to enter text.	
13.	Child Safe Area Checklist that can assist staff with setting up an area for unaccompanied minors during an incident	Click here to enter text.	
14.	Job Action Sheets for both the Child Safe Area and the Hospital Family Information Center/Family Assistance Center to assist staff with their role during an incident	Click here to enter text.	

15.	Staffing requirements for child safe area (e.g. staffing ratios)	Click here to enter text.	
16.	Staff that will care for children in child safe area	Click here to enter text.	
17.	Type of staff that will be needed in the Hospital Family Information Center/Family Assistance Center (e.g. translators, mental health providers)	Click here to enter text.	
18.	Supplies for the Child Safe Area and the Hospital Family Information Center/Family Assistance Center and how these supplies will be obtained.	Click here to enter text.	.
	Reunification		
19.	Specific process/steps for reunification	Click here to enter text.	
20.	Job Action Sheets that outline the specific steps in the reunification process to assist staff and ensure consistency	Click here to enter text.	

Illinois EMSC June 2019 Unaccompanied Minor Reunification Checklist

ITEM #	Reunification Component	Agency/Organization Process To Integrate Component	Completed Y/N
21.	Information to obtain from family	Click here to enter text.	
22.	How information will be shared with family	Click here to enter text.	
23.	Staff that will be responsible for reunification process	Click here to enter text.	
24.	External agencies that can assist with the process (e.g. schools, childcare agencies, American Red Cross)	Click here to enter text.	
25.	Establishment of MOUs with external agencies that can assist with process as applicable	Click here to enter text.	
26.	Process/plan integrates statewide reunification/ tracking systems (e.g. EMTrack, National Center for Missing Children, American Red Cross Safe & Well)	Click here to enter text.	
	Verification of Relationship to Child		
27.	Job Action Sheet to outline the steps staff should take to verify relationship	Click here to enter text.	
28.	Staff that will be responsible for the verification of relationship process	Click here to enter text.	
29.	Specific steps staff should take to match the child to their family	Click here to enter text.	
30.	List of documents or other information family must provide to assist with process	Click here to enter text.	

31.	Photocopy all documents provided	Click here to enter text.	
32.	Process to bring child to family once identified	Click here to enter text.	
33.	Process if family does not have required documentation or relationship cannot be verified	Click here to enter text.	
34.	Steps to take to address custodial issues and other potential issues during verification process	Click here to enter text.	
35.	Process to document the verification of relationship procedures	Click here to enter text.	
Release of Unaccompanied Minor			
36.	Job Action Sheet to outline the steps staff should take to release the child	Click here to enter text.	
37.	Staff that will be responsible for releasing the child to family after reunification process	Click here to enter text.	
38.	Process to photograph family member that the child will be released to	Click here to enter text.	
39.	Process to obtain vehicle information and contact information of family member that the child will be released to	Click here to enter text.	
40.	Steps to take if no family arrives for child	Click here to enter text.	
41.	Identification of external resources to assist in placing child if no family arrives for child	Click here to enter text.	
42.	Process to document the release of unaccompanied minors	Click here to enter text.	