Knox/East Tennessee Healthcare Coalition

Integrated Surge Annexes

Medical / Trauma Surge | Burn | Chemical | Pediatric | Radiological | Infectious Disease

Updated 2026 Coalition Review Draft

Prepared for coalition review, specialty subject matter expert validation, and formal approval.

Document field	Entry
Document owner	Knox/East Tennessee Healthcare Coalition (KETHC)
Operational owner	Regional Healthcare Coordinators, Emergency Response Coordinators, RMCC, EMS Consultant, and coalition leadership
Effective date	Pending coalition approval
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Distribution	Coalition members and response partners; restricted operational appendices distributed by need-to-know only
Supersedes	KETHC Combined Surge Annexes 2026 draft package

Document Control and Approval

This integrated surge annex package establishes a common coalition framework for coordinating healthcare preparedness, response, and recovery across the Knox/East Tennessee region. It is intended to complement, not replace, member organization emergency operations plans, clinical protocols, EMS protocols, public health plans, emergency management plans, or legal authorities.

The Coalition is a coordination and information-sharing body. Each member organization retains responsibility for internal incident command, clinical operations, credentialing, legal compliance, facility security, and patient care decisions. The Coalition supports a shared operating picture, resource coordination, patient movement coordination, subject matter expert access, and common messaging.

Date	Section/pages revised	Revision	Entered by
07/2026	All sections	Full rewrite; structure consolidated into base plan plus specialty annexes; tracked-change issues removed; outdated language refreshed; data quality, contact verification, and restricted appendix controls added.	KETHC review draft

Date	Section/pages revised	Revision	Entered by
Future	As approved	Record formal coalition approval, SME review, and annual maintenance updates.	KETHC

Approval

Formal approval should be documented below or in the Coalition meeting minutes. Electronic approval records may be attached or referenced in the final publication copy.

Approving body / role	Name	Signature or approval record	Date
KETHC Coalition membership	KETHC Members		
Regional Healthcare Coordinator - Knox County	John Brinkley		
Regional Healthcare Coordinator - East TN Region	Wanda Roberts		
Regional Medical Communications Center representative	Tim Taylor		
EMS Consultant	Jonathan Beaty		
Public Health Emergency Response Coordinator Knox County	Steve Hanby		
Public Health Emergency Response Coordinator East TN Region	Chase Watts		

Role / resource	Current entry	Verification / use note
RMCC - MED LINK 2 Dispatch	UHF Med 10, 865-305-8500; 800-792-1033 Tim Taylor - jtaylor@utmck.edu	24/7 coordination point
RHC - Knox County	John Brinkley - John.Brinkley@knoxcounty.org; 865-216-6280 cell; 865-215-5456 office	
RHC - East TN Region	Wanda Roberts - ETRHC.Health@tn.gov; 865-202-9800 cell; 865-549-5294 office	
Vulnerable Population Coordinator - East TN Region	Brenan Mitchell - Brenan.Mitchell@tn.gov; 865-850-2884	
EMS Consultant	Jonathan Beaty - Jonathan.Beaty@tn.gov; 865-235-6360 cell	
ERC - Knox County	Steve Hamby - Steve.Hamby@knoxcounty.org; 865-215-5161cell: 865-755-1490 office	
ERC - East TN Region	Chase Watts - Chase.Watts@tn.gov; 865-549-5291office; 865-2742477 cell	

How to use this document

- **Start with the Base Medical / Trauma Surge Plan.** It applies to all surge events and describes activation, communications, resource coordination, patient movement, tracking, recovery, and improvement planning.
- **Use specialty annexes when the event requires unique capabilities.** Burn, chemical, pediatric, radiological, and infectious disease incidents require targeted subject matter expertise and may require special triage, decontamination, isolation, countermeasure, or transfer pathways.
- **Use HRTS, TNHAN, and ReadyOp for current operational information.** Static tables in this plan support preparedness; real-time bed, staffing, transport, and resource decisions must be based on incident-specific reporting and direct coordination.
- **Maintain restricted operational appendices separately.** Detailed cache locations, controlled substance custody procedures, law enforcement routing, responder contact trees, and facility-specific SOPs should be kept in a controlled appendix with access limited to authorized personnel.
- **Validate clinical content with SMEs before final approval.** Clinical reference material should be verified against current specialty guidance and local medical control requirements before publication.

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Coalition Overview

The Knox/East Tennessee Healthcare Coalition is a multi-agency coordinating group that supports the healthcare community and response partners as they prepare for, respond to, recover from, and mitigate disasters and public health emergencies. The Coalition promotes coordinated disaster preparedness, education, public information, response, recovery, and resource sharing across the region.

The Coalition includes hospitals, emergency medical services, emergency management, communications/dispatch, public health, long-term care, dialysis, behavioral health, rehabilitation, home health, hospice, outpatient clinics, law enforcement, fire service, air medical partners, state agencies, and other public and private partners. Membership and participation should be refreshed annually and after major partner changes.

Regional Profile

KETHC covers the 16 counties of Tennessee Region 2: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union. The region includes urban, suburban, rural, and remote areas; major interstate and rail corridors; tourism destinations; industrial and research facilities; behavioral health resources; critical access and acute care hospitals; and specialty trauma and pediatric capabilities.

Planning factor	Current planning statement
Geography	16 counties; approximately 6,565 square miles; bordered by Kentucky, North Carolina, Northeast TN, Southeast TN, and Mid-Cumberland regions.
Population	Approximately 1.25 million residents based on the prior annex.
Primary coordination channels	RMCC, RHCs, ERCs, EMS Consultant, HRTS, TNHAN, ReadyOp, WebEOC, phone, radio, and direct liaisons.
Regional risks	Mass casualty trauma, severe weather, wildfire, transportation incidents, hazardous materials, chemical exposure, radiological/nuclear events, infectious disease outbreaks, pediatric surge, burn incidents, facility evacuation, infrastructure interruption, and behavioral health impacts.

Member Hospitals and Specialty Facilities

Facility	Planning role / type
Big South Fork Medical Center	Critical access / acute care
Center for Behavioral Health	Behavioral health
Claiborne Medical Center	Acute care
Dolly Parton Children's Hospital	Comprehensive Regional Pediatric Center
East Tennessee Behavioral Health Hospital	Behavioral health
Fort Loudoun Medical Center	Acute care
Fort Sanders Regional Medical Center	Acute care
Jefferson Memorial Hospital	Acute care
LaFollette Medical Center	Acute care
LeConte Medical Center	Acute care
Methodist Medical Center of Oak Ridge	Acute care
Morristown-Hamblen Healthcare System	Acute care
Newport Medical Center	Acute care
North Knoxville Medical Center	Acute care
Parkwest Medical Center	Acute care
Peninsula Psychiatric Hospital	Behavioral health
Prisma Health Blount Memorial Hospital	Acute care
Ridgeview Behavioral Health Hospital	Behavioral health
Roane Medical Center	Acute care
Select Specialty Hospitals	Long-term acute care / ventilator-capable specialty hospital
Sweetwater Hospital Association	Acute care
Tennova Turkey Creek Medical Center	Level III Trauma Center
University of Tennessee Medical Center	Level I Trauma Center

EMS and Transport Resources

EMS / transport partner	Planning role / type
AMR - Knox County	ALS - Ground
AMR - Blount County	ALS - Ground
Anderson County EMS	ALS - Ground
Campbell County EMS	ALS - Ground

EMS / transport partner	Planning role / type
Claiborne EMS LLC	ALS - Ground
Covenant Health EMS	Air medical / transport partner
Dolly Parton Children's Hospital Lifeline	Specialty pediatric transport
Gatlinburg Fire Department	ALS - Ground
Grainger County Ambulance Authority	ALS - Ground
Jefferson County EMS	ALS - Ground
Lifeguard Ambulance Service, LLC - Knox County	BLS - Ground
Lifeline Ambulance - Knox	BLS - Ground
Lifeline Ambulance - Claiborne	BLS - Ground
Monroe County Ambulance Service	ALS - Ground
Morgan County Ambulance Service	ALS - Ground
Morristown-Hamblen EMS	ALS - Ground
Oak Ridge National Laboratory Fire Department	ALS - Ground
Prestige Patient Transport LLC - Knox County	BLS - Ground
Priority Ambulance - Blount	BLS - Ground
Priority Ambulance - Knox	BLS - Ground
Priority Ambulance - Loudon	ALS - Ground
Roane County Office of Emergency Services	ALS - Ground
Scott County Ambulance Service	ALS - Ground
Sevier County EMS	ALS - Ground
Shoals Ambulance dba Priority Ambulance	ALS - Ground
Union County EMS	ALS - Ground
UT LIFESTAR	Air medical
Vital Medical Transport - Knox	BLS - Ground
Y-12 Fire Department	ALS - Ground

Base Medical / Trauma Surge Response Plan

Purpose

This base plan establishes the coalition-level framework for coordinating medical surge and trauma mass casualty response across KETHC. It applies to sudden-onset events, sustained operational disruptions, planned event surges, and specialty incidents that require activation of one or more annexes.

Desired Outcome

The desired outcome is a coordinated regional healthcare response that moves the right patients to the right level of care, sustains healthcare delivery, protects staff and patients, supports public health and emergency management objectives, and accelerates recovery.

Scope

This plan applies to hospitals, EMS, public health, emergency management, behavioral health, long-term care, dialysis, home health, hospice, outpatient clinics, rehabilitation facilities, specialty transport, law enforcement, fire service, state partners, and other coalition members. It does not override facility incident command, local jurisdictional authority, EMS medical direction, TDH authority, TEMA authority, or state/federal law.

Planning Assumptions

- No single facility or jurisdiction can independently manage every large-scale healthcare surge event.
- Coalition coordination is most effective when information is timely, structured, and consistently reported through HRTS, TNHAN, ReadyOp, WebEOC, and direct RMCC/RHC/ERC/EMS Consultant communication.
- Hospitals and EMS agencies may receive patients before a formal coalition activation has occurred.
- Specialty populations and hazard-specific events may require external subject matter experts, state-level coordination, interstate transfer, or federal support.
- Federal assets may not arrive during the first operational period; coalition members should plan for immediate self-sufficiency and mutual aid.
- Patient movement decisions must balance patient acuity, specialty needs, transport availability, receiving facility capability, family reunification, and systemwide capacity.
- Crisis standards of care must follow state guidance, legal authority, and facility policy.

Activation Triggers

- Mass casualty incident with significant numbers of injured or ill patients.
- Actual or anticipated ED, inpatient, critical care, EMS, or specialty-care capacity strain.
- A facility evacuation, closure, infrastructure failure, cyber disruption, staffing shortage, supply shortage, or patient transfer problem requiring regional coordination.
- Burn, chemical, pediatric, radiological, infectious disease, or other specialty event requiring annex-specific coordination.
- Request for coalition assistance from a member organization, EMS, fire, law enforcement, EMA, public health, RMCC, RHC, ERC, or EMS Consultant.
- Planned event or forecast hazard expected to affect healthcare demand or continuity of operations.

Activation Levels

Activation level	Use when	Communication posture	Primary coalition actions
Level 1 - Routine monitoring	No active surge; routine planning and readiness.	Normal HRTS updates as required; routine coalition communications.	RHC/ERC/RMCC monitor threats; members maintain readiness and accuracy.
Level 2 - Enhanced monitoring	Potential threat or localized issue with possible healthcare impact.	Situation update through RMCC/RHC/ERC as needed; targeted HRTS/ReadyOp update may be requested.	Collect initial EEIs; identify affected partners; verify contacts and specialty resources.
Level 3 - Partial activation	Active incident affecting one or more facilities, counties, or specialty resources.	HRTS event page activated or enhanced; TNHAN/ReadyOp notice; operational updates at least every 2-4 hours or as needed.	Activate emergency management group; coordinate bed/resource reporting, transport constraints, and unmet needs.
Level 4 - Full regional activation	Regional surge, specialty surge, multi-county incident, or significant resource scarcity.	HRTS/ReadyOp/WebEOC coordination; scheduled situation calls; JIC coordination if activated; reporting cadence set by incident command/ESF-8.	Coordinate patient distribution, resource requests, mutual aid, subject matter experts, and state/federal escalation.
Level 5 - Recovery / demobilization	Immediate threat contained; system is stabilizing but recovery tasks continue.	Final HRTS/ReadyOp updates; deactivation notice; AAR/IP communications.	Repatriate patients as appropriate; replenish caches; restore operations; document costs and improvement actions.

Initial Coordination Sequence

1. Recognize the incident and initiate local facility or field incident command.
2. Notify the RMCC and appropriate RHC/ERC/EMS Consultant as soon as coalition coordination may be needed.
3. Open or update the HRTS event page when regional situational awareness, bed status, transport status, or resource reporting is required.
4. Send initial TNHAN, ReadyOp, phone, radio, or email notifications to affected members and supporting partners.
5. Collect essential elements of information and establish an update cadence.

6. Assist with coordinating patient movement, resource needs, subject matter expertise, and external support requests.
7. Document decisions, requests, approvals, unmet needs, and operational impacts for reimbursement, AAR/IP, and continuity purposes.

Essential Elements of Information

EEI category	Minimum information requested
Incident description	What happened, where, when, current threat, expected evolution, counties/facilities affected.
Patient estimate and acuity	Known and projected counts by triage category, age group, specialty need, contamination/isolation status, transport priority.
Facility status	ED status, inpatient capacity, ICU, OR, pediatric, behavioral health, dialysis, isolation, ventilators, staffing, utilities, security, decontamination status.
EMS / transport status	Available ambulances, air medical status, specialty teams, offload delays, staging, access routes, patient movement constraints.
Resource needs	Supplies, equipment, medications, PPE, antidotes, blood, dialysis, oxygen, staff, behavioral health, security, interpreter, family reunification.
Specialty resources	Burn center, pediatric, trauma, toxicology, REAC/TS, RITN, special pathogen, infection prevention, public health, laboratory, HAZMAT, radiation safety, law enforcement, fatality management.
Public information	Risk communication needs, media issues, worried well, family assistance, misinformation, language access, community reception center needs.
Recovery needs	Repatriation, resupply, staff support, continuity of operations, facility remediation, documentation, reimbursement, AAR/IP.

Communications and Common Operating Picture

KETHC will use layered communications. No single system should be treated as the only method during an incident. HRTS should be used for healthcare resource and facility status reporting. TNHAN supports public health notifications. ReadyOp supports targeted communications, facility status forms, acknowledgements, and patient/resource tracking as configured. WebEOC supports emergency management coordination. Phone, radio, email, and direct liaisons should be used when time-sensitive coordination is required or when electronic systems are degraded.

Tool / channel	Primary use	Planning notes
RMCC	24/7 notification, EMS-hospital coordination, patient distribution support, escalation to coalition leadership.	Use as the initial coalition notification point unless incident-specific instructions direct otherwise.
HRTS	Facility status, bed availability, event activation, resource status, healthcare situational awareness.	Facilities should update promptly and at the requested cadence during an event.
TNHAN	Public health and healthcare alerts.	Use for urgent or official public health notifications and regional alerting.

Tool / channel	Primary use	Planning notes
ReadyOp	Acknowledgement, Facility status forms, patient/resource tracking, targeted messaging.	Use consistent form names and avoid duplicate data entry when possible.
WebEOC	Emergency management resource requests and situational awareness.	Use through local EMA/TEMA pathways.
Phone/radio/direct liaison	Time-sensitive coordination and redundancy.	Document key decisions and resource requests after verbal coordination.

Resource Request Pathway

Coalition members should use normal internal supply, staffing, and mutual aid processes before escalating requests. When local resources are insufficient, requests should be communicated through the RMCC/RHC/ERC/EMS Consultant and local EMA as appropriate. Requests for state, interstate, or federal resources should follow local and state emergency management processes.

Request type	Initial coordination point	Escalation pathway
Bed / destination coordination	RMCC, receiving facilities, RHC/ERC, EMS Consultant	Adjacent HCCs, TDH, TEMA, EMAC, federal assets as needed.
EMS / patient transport	EMS agency command, RMCC, EMS Consultant	Local EMA, mutual aid EMS, state EMS, ambulance strike teams, EMAC/federal transport.
Clinical specialty consult	Facility clinical leadership and RMCC/RHC	Burn centers, pediatric center, poison center, REAC/TS, Radiation Injury Treatment Network (RITN), infection prevention, TDH SMEs.
Medical supplies/equipment/PPE	Facility logistics and coalition emergency management group	HRTS, Local EMA/WebEOC, TDH, TEMA, SNS/MCM pathways.
Staffing	Facility labor pool and mutual aid contacts	Coalition MOU, adjacent coalitions, Medical Reserve Corps, state/federal staffing resources.
Public information / family assistance	Facility PIO and local jurisdiction PIO	Joint Information Center, public health, EMA, behavioral health, Red Cross and partner agencies.

Patient Movement and Transfer Prioritization

Patient movement should be coordinated through facility transfer processes, EMS/transport partners, RMCC, RHC/ERC, and EMS Consultant support. Transfers should be prioritized by life-saving specialty need, available destination capability, patient stability for transport, and system sustainability. When definitive specialty care is unavailable immediately, receiving facilities should stabilize, consult specialty SMEs, document care, and prepare for delayed transfer.

- Use START for adult MCI triage and JumpSTART for pediatric triage unless local protocols specify otherwise.
- Track patients from scene or presenting facility through transfer, discharge, repatriation, or death using facility policy and coalition patient tracking tools when activated.

- Prioritize unaccompanied minors, vulnerable adults, and patients with access and functional needs for enhanced identification and reunification support.
- Do not delay emergency stabilization for administrative transfer coordination.

Recovery, Deactivation, and Improvement Planning

The Coalition will support recovery by communicating deactivation status, facilitating patient repatriation, sharing recovery resources, supporting cache replenishment, coordinating behavioral health resources, documenting unmet needs, and collecting lessons learned. The RHC/ERC/RMCC/EMS Consultant group should develop or support an after-action report and improvement plan for any significant activation or exercise.

Training and Exercise Program

Readiness area	Recommended training / exercise focus
Base surge operations	HRTS event reporting, RMCC notifications, resource requests, patient distribution, AAR/IP documentation, BDLS and ADLS Course.
Trauma/MCI	START/JumpSTART, HICS, family reunification, patient tracking, fatality management, behavioral health.
Burn	Advanced Burn Life Support, TBSA estimation, burn consultation, delayed transfer care.
Chemical	HAZMAT awareness, first receiver operations, PRISM decontamination, CHEMPACK request pathway.
Pediatric	Pediatric readiness, pediatric decon, neonatal/pediatric transport, unaccompanied minor reunification.
Radiological	Exposure vs contamination, PPE, survey instruments, patient decontamination, REAC/TS consultation.
Infectious disease	PPE donning/doffing, isolation, special pathogen assessment, testing, vaccination/MCM operations, LTC and outpatient coordination.

Annex A - Burn Surge

Purpose and Scope

This annex guides coalition coordination when the number or severity of burn patients exceeds, or is expected to exceed, the capability of local hospitals, EMS, and regional specialty resources. It supports scene triage, initial stabilization, specialty consultation, patient distribution, delayed transfer care, tracking, recovery, and rehabilitation coordination.

The Knox/East Tennessee region does not have a burn center. Burn patients may initially present to or be transported to local emergency departments, the regional trauma center, the regional pediatric center, or other coalition hospitals for stabilization before definitive burn-center transfer. Transfer decisions should be informed by burn center consultation, transport resources, patient condition, incident scale, and real-time capacity.

Activation Triggers

- Multiple burn patients from a fire, explosion, wildfire, industrial event, transportation incident, mass gathering, residential setting, or combined hazard event.
- One or more facilities exceed or anticipate exceeding burn stabilization, critical care, operating room, pain management, dressing, fluid, or staff capacity.
- Need for burn SME consultation, regional patient distribution, burn-center bed matching, interfacility transfer prioritization, or external burn coordination.
- Burn patients with concurrent trauma, inhalation injury, chemical exposure, radiation exposure, or pediatric specialty needs.

Local Risk Profile

Higher likelihood / higher consequence	Moderate planning concern	Lower likelihood but high consequence
Fire/explosion at mass gathering; wildfire affecting populated areas; industrial or chemical fire/explosion; transportation fire/explosion.	Railway or pipeline fire/explosion; high-density residential fire; nightclub/venue fire; radiological event with thermal injuries.	Earthquake with fires; large regional infrastructure failure with secondary fires; intentional mass casualty burn event.

Burn Surge Objectives

1. Support safe scene triage, treatment, and destination decisions according to EMS protocols and medical direction.
2. Ensure all receiving hospitals can provide airway management, initial burn stabilization, pain control, hypothermia prevention, fluid resuscitation, wound coverage, and transfer preparation.
3. Engage burn, trauma, pediatric, and transport SMEs early.
4. Coordinate patient movement so patients with the greatest need for burn-center care are prioritized without overwhelming any single facility.
5. Maintain patient tracking and family assistance center information.
6. Support delayed transfer care for 24-72 hours when burn-center capacity or transport is limited.
7. Plan rehabilitation, outpatient follow-up, behavioral health support, and repatriation from the beginning of the incident.

Burn EEIs

EEI	Details needed
Incident and scene status	Location, fire/explosion status, hazards, access constraints, weather, number of patients, contamination concerns.
Patient count by acuity	Immediate, delayed, minor, expectant; adult/pediatric; ambulatory/non-ambulatory; inhalation injury suspected.
Burn severity	Estimated TBSA, depth, face/hands/feet/genital/perineal/major joint involvement, circumferential burns, electrical/chemical/burn-trauma combination.
Critical care needs	Airway/intubation, ventilator, fluid resuscitation, shock, analgesia/sedation, OR need, blood product need, dialysis, comorbidities.
Facility status	ED, ICU, OR, ventilators, burn dressings, fluids, staffing, pediatric capability, transfer capacity.
Destination / transfer	Burn center capacity, trauma center status, pediatric center status, ground/air critical care transport availability, transfer sequencing.
Support needs	Burn consult line, family assistance, behavioral health, morgue/fatality management, public information, rehabilitation resources.

Initial Response Actions

Timeframe	Coalition / RMCC / RHC / ERC / EMS Consultant actions	Hospital / EMS actions
0-30 minutes	Confirm incident, notify emergency management group, activate HRTS/ReadyOp if needed, request bed and resource updates, identify burn/pediatric/trauma SMEs.	Activate EOP/HICS/MCI plans, prepare ED and decon if needed, estimate capacity, begin patient tracking, request consultation early.
30-120 minutes	Support patient distribution, burn-center contact, critical care transport prioritization, resource requests, and public information coordination.	Stabilize patients, estimate TBSA, protect airway, prevent hypothermia, initiate fluids, pain control, wound coverage, tetanus, transfer documentation.
2-12 hours	Reassess regional capacity, coordinate delayed transfer plan, engage adjacent coalitions/state/federal resources as needed, track transfers.	Continue resuscitation and monitoring, update HRTS/ReadyOp, prepare critical care transport, support families, rotate staff.
12-72 hours	Coordinate prolonged holding, rehabilitation planning, repatriation, resource replenishment, AAR data collection.	Provide burn SME-guided care, manage complications, maintain documentation, coordinate discharge/transfer/repatriation.

Triage and Referral Guidance

Primary triage occurs at the scene by EMS. Secondary triage occurs at the first receiving facility and may be repeated as burn SME input, patient condition, and resource availability change. Use START for adults and JumpSTART for children unless current EMS protocols require otherwise. Burn-center consultation should occur early for patients who meet burn referral criteria or whose needs exceed the receiving facility's capability.

Burn referral considerations include deep partial-thickness or full-thickness burns, partial-thickness burns above the current ABA referral threshold, burns involving the face, hands, feet, genitalia, perineum, or major joints, inhalation injury, electrical or chemical burns, significant comorbidities, pediatric patients at hospitals without pediatric burn capability, and burn injuries with concomitant trauma. Use the current American Burn Association referral guidance and clinical judgment for final decisions.

Care Priorities for Non-Burn Centers

- Stop the burning process and remove smoldering clothing or jewelry when safe.
- Prioritize airway, breathing, circulation, disability, exposure, and hypothermia prevention.
- Estimate TBSA using an age-appropriate method; avoid counting superficial first-degree burns in TBSA calculations.
- Assess for inhalation injury, associated trauma, blast injury, chemical exposure, electrical injury, and radiological exposure as applicable.
- Initiate fluid resuscitation for significant burns according to current facility protocol, burn-center recommendations, and medical direction; monitor urine output when appropriate.
- Provide analgesia, anxiolysis, tetanus prophylaxis, and wound coverage with clean/dry or antimicrobial dressings per protocol and consultation.
- Avoid hypothermia. Warm the room, warm fluids when feasible, cover patients, and minimize unnecessary exposure.
- Document serial exams, intake/output, dressings, medications, photos if policy permits, and transfer information.

Roles and Responsibilities

Partner	Primary roles	Support roles
Fire / EMS / incident command	Rescue, scene safety, triage, initial treatment, destination coordination, transport.	Coordinate with RMCC, HAZMAT, law enforcement, EMA, and air/ground transport.
RMCC / RHC / ERC / EMS Consultant	Activate notification pathways, collect HRTS data, coordinate patient distribution and transfer prioritization.	Engage burn SMEs, adjacent coalitions, TDH/TEMA, EMAC/federal assets as needed.
Trauma centers / hospitals	Initial stabilization, HICS activation, delayed transfer care, patient tracking, family support.	Decompress census, share resources, support regional bed matching.
Dolly Parton Children's Hospital	Pediatric consultation, pediatric stabilization/transfer coordination as capacity allows.	Support pediatric-specific guidance and family-centered care considerations.
Burn centers / burn SMEs	Consultation, transfer acceptance, specialty triage, treatment recommendations.	Support regional or out-of-state burn coordination when in-state capacity is constrained.
TDH / TEMA / EMA	State-level coordination and resource request support.	Support declarations, EMAC, NDMS/DMAT/SNS requests, public information, fatality and behavioral health resources.

Rehabilitation, Outpatient Follow-up, and Recovery

Rehabilitation begins on day one and may continue for months or years. The receiving burn center should coordinate burn rehabilitation, scar management, occupational and physical therapy, psychosocial support, pain management, reconstructive needs, and outpatient follow-up. KETHC may support patient repatriation, family assistance, behavioral health referral, and coordination with local outpatient resources after specialty discharge.

Training and Exercise Priorities

- Advanced Burn Life Support or equivalent burn stabilization education for ED, ICU, EMS, and emergency management partners.
- TBSA estimation practice, burn-center consultation drills, and delayed transfer scenarios.
- Combined burn/trauma, burn/chemical, burn/radiation, and pediatric burn scenarios.
- Patient tracking, family assistance, and behavioral health integration.

Burn Annex Maintenance Notes

- Verify burn center names, consultation numbers, capacity assumptions, and referral guidance annually.
- Do not publish outdated burn bed counts as operational capacity. Use HRTS and direct burn-center contact during incidents.
- Maintain a controlled contact appendix for burn consultation and transfer coordination numbers.

Annex B - Chemical Surge

Purpose and Scope

This annex guides healthcare coordination during a chemical emergency that produces exposed, contaminated, or potentially exposed patients and challenges local EMS, hospital, public health, HAZMAT, or decontamination capability. It applies to accidental, transportation, industrial, intentional, agricultural, laboratory, or mixed-hazard chemical events.

Core Response Principles

- Life safety is the first priority. Responders should not become victims.
- Decontamination is an emergency medical intervention when contamination threatens the patient, responders, facilities, or the public.
- Scene HAZMAT operations remain under the appropriate incident command/ESF-10 structure. Healthcare coordination aligns with ESF-8.
- Hospitals must prepare for self-presenting patients who bypass scene decontamination.
- Early toxicology consultation improves triage, antidote use, PPE decisions, and risk communication.
- Detailed CHEMPACK cache locations, transport routing, custody records, and law enforcement procedures should remain in a restricted operational appendix.

Activation Triggers

- Known or suspected chemical release with multiple exposed or symptomatic patients.
- Unknown exposure with clustering of toxidrome symptoms.
- Request for decontamination support, CHEMPACK, antidotes, PPE, HAZMAT support, or poison center/toxicology consultation.
- Hospital contamination risk from self-presenting patients.
- Need for community reception center, mass screening, or extended public health monitoring.

Preparedness Actions

Preparedness area	Coalition expectation
Partner engagement	Include hospitals, EMS, fire/HAZMAT, EMA, public health, law enforcement, poison center, industrial partners, transportation hubs, and laboratories in planning and exercises.
Training	Maintain HAZMAT awareness, hospital first receiver, PPE, decontamination, PRISM, antidote, and patient tracking training.
Resource visibility	Maintain current HRTS/ReadyOp information on decon capability, PPE, antidotes, shower setup, warm water, waste handling, and specialty services.
Reference tools	Ensure access to ERG, CHEMM, poison center consultation, SDS information, and incident-specific public health guidance.
Restricted appendices	Maintain current CHEMPACK and controlled asset activation procedures under need-to-know distribution.

Initial Response Actions

Timeframe	Field / EMS / HAZMAT	Healthcare coalition / hospitals
0-30 minutes	Recognize incident, isolate hot zone, protect responders, establish command, request HAZMAT, begin lifesaving rescue and emergency decon if safe.	Notify RMCC/RHC/ERC/EMS Consultant, activate HRTS/TNHAN/ReadyOp as needed, prepare first receiver decon and facility security, alert ED/ICU/pharmacy.
30-120 minutes	Identify agent if possible, establish hot/warm/cold zones, use PRISM-informed decon, triage and distribute patients, communicate contaminant status.	Collect EEIs, consult Poison Control/CHEMTREC/CHEMM, determine antidote/PPE needs, coordinate patient distribution and contamination control.
2-12 hours	Support ongoing decon, transport, scene safety, environmental monitoring, and responder rehab.	Coordinate antidote/countermeasure requests, community reception center support, waste guidance, patient tracking, family/public messaging.
12+ hours	Transition to remediation, evidence preservation, demobilization, and responder monitoring.	Support follow-up care, occupational health, cache replenishment, environmental/waste coordination, AAR/IP.

Chemical EEIs

EEI	Details needed
Agent / hazard	Known or suspected chemical, SDS/placard/UN number, physical state, concentration, quantity, route of exposure, ongoing release status.
Patient effects	Toxidrome signs, onset time, severity, number symptomatic/asymptomatic, adult/pediatric, pregnancy, comorbidities.
Contamination status	Gross contamination, decon performed, clothing removed, secondary contamination risk, runoff/waste issues.
Responder safety	PPE level, hot/warm/cold zones, casualties among responders, hospital first receiver risk.
Antidotes / MCM	Need for atropine, pralidoxime, benzodiazepines, cyanide kits, hydroxocobalamin, naloxone, bronchodilators, or other agent-specific treatment per medical direction.
Facilities	Decon capacity, ED capacity, ICU/ventilator status, pharmacy inventory, security, isolation/contamination control, wastewater/waste holding.
Public health	Shelter-in-place/evacuation, community reception center needs, public messaging, environmental monitoring, poison center call volume.

PRISM-Informed Decontamination - https://medicalcountermeasures.gov/barda/cbrn/prism

PRISM (Primary Response Incident Scene Management) supports rapid, evidence-informed casualty management during chemical incidents. KETHC partners should use current PRISM, CHEMM, ERG, HAZMAT, and medical direction guidance. In broad terms, chemical decontamination may include evacuation from the hazard, disrobing, emergency dry decontamination, gross decontamination, active drying, and technical decontamination when indicated.

Decon step	Operational planning note
Evacuate / isolate	Move patients away from the hazard, uphill/upwind when possible; establish control zones and facility entry control.
Disrobe	Removal of clothing can substantially reduce contamination; protect privacy, warmth, evidence, and patient dignity.
Emergency dry decon	Use absorbent materials when water is unavailable, delayed, or contraindicated; avoid spreading contamination.
Gross decon	Use water and mild soap when indicated; prevent hypothermia and manage runoff according to incident guidance.
Active drying / warming	Dry and warm patients quickly, especially children, older adults, and medically fragile patients.
Technical decon	Use for responders, equipment, or patients when incident-specific contamination control requires it.

CHEMPACK and Antidote Coordination

CHEMPACK assets may be requested for a suspected or confirmed nerve agent or organophosphate-type mass exposure when local antidote supplies are inadequate. The RMCC should serve as the initial regional coordination point, with state and local emergency management, TDH, EMS, law enforcement, pharmacy, and receiving entities engaged according to the controlled CHEMPACK procedure.

- Do not delay lifesaving antidote administration while waiting for confirmation when clinical presentation and medical direction support treatment.
- Collect the estimated number of casualties, severity, suspected agent, requested delivery point, receiving point of contact, security needs, and transport constraints before requesting assets when time permits.
- Treat CHEMPACK pharmaceuticals as federal assets and controlled substances when applicable; maintain chain-of-custody documentation.
- Return, inventory, and replenish unused assets according to TDH/CDC requirements after demobilization.

Roles and Responsibilities

Partner	Primary roles	Support roles
Incident command / Fire / HAZMAT	Scene safety, hazard identification, control zones, rescue, decon, environmental monitoring.	Coordinate with EMS, law enforcement, EMA, public health, and healthcare.
EMS	Triage, treatment, decon coordination, transport, responder safety, hospital notification.	Use medical direction and toxicology input for antidotes and destination decisions.
Hospitals	First receiver decon, patient stabilization, antidote administration, facility protection, tracking.	Report capacity, contamination status, resource needs, and patient disposition.

Partner	Primary roles	Support roles
RMCC / RHC / ERC / EMS Consultant	Notifications, HRTS/TNHAN/ReadyOp coordination, patient distribution, resource escalation.	Support CHEMPACK request pathway, poison center/toxicology coordination, community reception center planning.
Poison Control / toxicology SMEs	Clinical toxicology guidance, antidote recommendations, symptom monitoring.	Support public health messaging and provider education.
EMA / TDH / TEMA / TDEC	Emergency management, public health, environmental health, state resource coordination.	Support public protective actions, waste guidance, state/federal requests, SNS/MCM coordination.

Recovery and Demobilization

- Confirm no additional patients, contamination risk, or resource requests remain active before deactivation.
- Coordinate contaminated waste, wastewater, PPE, and equipment disposition with HAZMAT, TDEC, EPA, local utilities, and facility safety officers as appropriate.
- Complete patient follow-up, occupational health monitoring, responder exposure documentation, and family assistance.
- Replenish antidotes, PPE, decon supplies, CHEMPACK assets, and other caches.
- Complete an AAR/IP that addresses notification, decon throughput, antidote access, hospital protection, risk communication, and patient tracking.

Annex C - Pediatric Surge

Purpose and Scope

This annex guides coalition coordination when pediatric patients exceed routine emergency, inpatient, critical care, transport, or specialty capacity. It applies to all hazards, including trauma, burn, chemical, radiological, infectious disease, severe weather, evacuation, family separation, mass fatality, and prolonged community disruption incidents.

Children have distinct physiology, developmental, psychosocial, equipment, medication, communication, reunification, and legal needs. Pediatric readiness must be integrated into every coalition surge operation, not treated as a separate optional activity.

Regional Pediatric Capabilities

Dolly Parton Children's Hospital in Knoxville is the region's state-certified Comprehensive Regional Pediatric Center. Pediatric-capable hospitals, EMS agencies, pediatric transport teams, and adjacent pediatric referral centers support the regional continuum of care. Real-time capability should be verified through HRTS, direct facility communication, RMCC/RHC coordination, and established transfer agreements.

Pediatric planning factor	Coalition expectation
Primary pediatric specialty anchor	Dolly Parton Children's Hospital, Knoxville; formerly East Tennessee Children's Hospital.
Adjacent referral resources	Children's Hospital at Erlanger, Niswonger Children's Hospital, Monroe Carell Jr. Children's Hospital at Vanderbilt, Kentucky Children's Hospital, Children's of Alabama, Children's Healthcare of Atlanta, Brenner Children's Hospital, and burn centers as applicable.
Transport	Use pediatric and neonatal specialty transport when available; otherwise apply current EMS pediatric protocols and medical direction.
Pediatric equipment	All receiving hospitals should maintain age/weight-appropriate airway, vascular access, medication dosing, warming, decon, and family support supplies.
Reunification	Every pediatric surge must include identification, tracking, unaccompanied minor protection, caregiver verification, and family assistance.

Pediatric Population Planning Table

County	Total population	Percent under 18	Estimated population under 18
Anderson	76,978	21.2%	16,319
Blount	133,088	19.9%	26,485
Campbell	39,842	20.3%	8,088
Claiborne	31,959	19.1%	6,104
Cocke	36,004	20.2%	7,273
Grainger	23,320	20.0%	4,664

County	Total population	Percent under 18	Estimated population under 18
Hamblen	64,934	23.0%	14,935
Jefferson	54,495	19.2%	10,463
Knox	470,313	20.9%	98,295
Loudon	54,068	19.1%	10,327
Monroe	46,545	20.9%	9,728
Morgan	21,403	18.9%	4,045
Roane	53,382	18.6%	9,929
Scott	22,068	24.1%	5,318
Sevier	98,250	20.4%	20,043
Union	19,972	21.5%	4,294
Total	1,246,621		256,310

Activation Triggers

- Multiple pediatric casualties or a pediatric-heavy incident.
- Pediatric ED, inpatient, PICU, NICU, behavioral health, decon, or transport resources are strained or unavailable.
- Need for pediatric specialty consultation, pediatric transfer prioritization, family reunification, or unaccompanied minor coordination.
- A school, childcare, bus, event venue, shelter, or pediatric long-term care incident affects children.
- An adult-focused incident includes pediatric patients requiring age-appropriate care.

Pediatric EEIs

EEI	Details needed
Patient count and age bands	Neonate, infant, toddler, school-age, adolescent; estimated weights if available; unaccompanied minors.
Acuity and specialty needs	Immediate/delayed/minor; trauma, burn, respiratory, infectious, behavioral health, decon, dialysis, technology dependence.
Transport needs	Pediatric/neonatal team availability, ventilator/isolette needs, car seat/restraint needs, caregiver transport, air/ground constraints.
Facility capability	Pediatric ED beds, inpatient beds, PICU/NICU, isolation, pediatric surgical/anesthesia, pediatric pharmacy, behavioral health, decon supplies.
Family reunification	Identification method, caregiver verification, safe area for unaccompanied minors, call center/family reception center needs.
Access and functional needs	Medical devices, communication support, language access, disability needs, medications, formula, diapers, mobility support.

Pediatric Triage, Treatment, and Transfer

- Use JumpSTART for pediatric MCI triage unless current EMS protocols specify otherwise.
- The most critically ill, youngest, medically complex, or specialty-dependent pediatric patients generally have priority for pediatric specialty transfer, subject to incident scale and receiving capability.
- All hospitals should be prepared to stabilize pediatric patients until transfer is available. This includes age-appropriate airway equipment, medication dosing, vascular access, warming, fluids, pain control, behavioral support, and caregiver communication.
- Adult hospitals may need to hold stable pediatric patients when the pediatric center is saturated; pediatric SMEs should provide guidance through RMCC/RHC channels when possible.
- Pediatric patients should not be separated from caregivers unless safety, treatment, or legal requirements make separation unavoidable; document all separations and reunifications.

Pediatric Decontamination Considerations

- Prevent hypothermia: use warm water when possible, warm rooms, rapid drying, blankets, and warmed transport areas.
- Use low-pressure/high-volume water and mild soap unless incident-specific guidance says otherwise.
- Provide privacy and family-centered flow through decon whenever safe.
- Use safe devices to move infants, non-ambulatory children, and children with access and functional needs through decon without requiring responders to carry slippery children.
- Plan for diapers, formula, clothing, footwear, blankets, communication boards, comfort items, and medication continuity.
- Account for service animals and assistive devices.

Pediatric Roles and Responsibilities

Partner	Primary roles	Support roles
Dolly Parton Children's Hospital	Pediatric specialty consultation, transfer support, pediatric surge guidance, pediatric/critical care expertise.	Support pediatric education, transport coordination, and pediatric-specific resource planning.
General hospitals	Initial stabilization, pediatric-safe holding, family support, decon, tracking.	Coordinate with pediatric SMEs and decompress adult capacity when needed.
EMS / transport	JumpSTART triage, age-appropriate treatment and transport, pediatric/neonatal transfer coordination.	Use pediatric restraint, dosing, warming, and caregiver processes.
RHC / ERC / RMCC / EMS Consultant	Regional coordination, HRTS/ReadyOp reporting, patient distribution, pediatric resource requests.	Engage adjacent pediatric centers and state resources as needed.
Public health / EMA / schools / childcare partners	Support family assistance, shelters, reunification, risk communication, and community recovery.	Coordinate child care, schools, behavioral health, and access/functional needs support.

Family Reception and Unaccompanied Minors

Expect multiple family members to call or self-present for each pediatric victim. Hospitals and local jurisdictions should be prepared to establish a family reception area and coordinate with a family assistance

center if activated. Unaccompanied minors require a secure, supervised, child-friendly location; identification and tracking; caregiver verification; and documentation of release.

Training and Exercise Priorities

- Pediatric disaster response and emergency preparedness.
- Neonatal resuscitation and pediatric stabilization skills appropriate to facility role.
- Pediatric decontamination and pediatric access/functional needs.
- Unaccompanied minor reunification and family reception center operations.
- Pediatric components in every MCI, burn, chemical, radiological, infectious disease, evacuation, and sheltering exercise.

Tennessee Committee on Pediatric Emergency Care (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/

Annex D - Radiological Surge

Purpose and Scope

This annex guides healthcare coordination during radiological or nuclear incidents affecting KETHC. It addresses exposure-only events, external contamination, internal contamination, radiological dispersal devices, radiological exposure devices, improvised nuclear device consequences, transportation incidents, industrial/research incidents, and regional impacts from nuclear power plant or Department of Energy-related events.

Regional Risk Context

The KETHC region includes the Department of Energy Oak Ridge Reservation and multiple healthcare, academic, industrial, and transportation settings where radioactive materials may be present. Adjacent regions include Tennessee Valley Authority nuclear power plants that could generate healthcare impacts depending on plume direction, protective action decisions, public concern, and population movement. Most radiological healthcare responses will involve risk communication, patient screening, contamination control, and management of concurrent trauma or burns.

Key concepts

Concept	Operational meaning
Exposure / irradiation	The patient was exposed to radiation but is not necessarily contaminated. Exposed patients are not radioactive and do not pose contamination risk solely because of exposure.
External contamination	Radioactive material is on skin, hair, clothing, or belongings. Remove clothing and decontaminate while providing medical care.
Internal contamination	Radioactive material is inhaled, ingested, absorbed, or in wounds. Requires SME consultation for assessment and possible decorporation/countermeasures.
Medical care first	Immediate lifesaving care should not be delayed for radiological decontamination. Standard precautions plus contamination control are generally adequate for early care.
Time, distance, shielding	Minimize time near the source, maximize distance, and use practical shielding; do not compromise critical care.
Worried well	Large numbers of concerned but low-risk individuals may seek screening, information, and reassurance. Community reception centers may be needed.

Activation Triggers

- Known or suspected radiological/nuclear incident with exposed, contaminated, or potentially contaminated persons.
- Multiple patients requiring screening, decontamination, biodosimetry, countermeasure consultation, or specialty transfer.
- Facility or EMS uncertainty regarding radiation safety, PPE, contamination control, or patient disposition.
- Potential acute radiation syndrome, combined trauma/burn/radiation injury, or need for REAC/TS/RITN consultation.
- Public concern or worried well surge that threatens ED operations.

Radiological EEIs

EEI	Details needed
Incident type	RDD, RED, IND, transportation, power plant, industrial, medical source, unknown; location and time.
Exposure/contamination	External/internal/none/unknown; survey readings if available; isotope/source information; decon performed.
Clinical status	Trauma, burns, vomiting time, neurologic symptoms, skin injury, wounds, pregnancy, pediatric status, comorbidities.
Safety	Dose rates, control zones, PPE, dosimetry, survey instruments, staff monitoring, waste/runoff handling.
Capacity	ED, decon, isolation/holding, ICU, hematology/oncology, lab capacity for CBC with differential, blood products, mental health.
SME / resources	REAC/TS, radiation safety officer, medical physicist, TDEC, DOE RAP, RITN, poison/toxicology if mixed event.
Public health	Population monitoring, community reception center, registry/follow-up, risk communication, shelter/evacuation, KI decisions.

Initial Response Actions

Timeframe	Coalition / healthcare coordination	Facility / EMS actions
0-30 minutes	Notify RMCC/RHC/ERC/EMS Consultant and appropriate radiation/public health SMEs; open HRTS/ReadyOp as needed.	Provide lifesaving care, use appropriate PPE, control entry/exit, remove clothing if contaminated, prevent spread, preserve patient dignity.
30-120 minutes	Engage REAC/TS or other radiation SMEs; collect survey/capacity data; coordinate patient distribution and public information.	Survey patients/staff/equipment, decon as needed, obtain baseline labs, document times/symptoms/readings, manage trauma/burns.
2-12 hours	Support community reception center planning, countermeasure consultation, registry, waste guidance, and interfacility transfer.	Continue medical management, repeat CBCs as indicated, consult hematology/radiation SMEs, track exposure/contamination status.
12+ hours	Coordinate follow-up, repatriation, behavioral health, staff monitoring, resupply, and AAR/IP.	Prepare discharge instructions, long-term follow-up, documentation, and staff exposure records.

Subject Matter Expertise

- REAC/TS provides 24/7 medical radiation incident expertise and should be engaged early for uncertain or significant events.
- Radiation safety officers, medical physicists, radiologists, radiation oncologists, hematology/oncology specialists, and laboratory leaders may be needed locally.
- RITN supports acute radiation syndrome and marrow toxic injury consultation and referral pathways.
- TDEC, DOE RAP, EPA, local utilities, and local/state emergency management may be required for environmental monitoring and contaminated waste issues.

Triage and Patient Care

- Immediate lifesaving interventions take precedence over decontamination.
- Remove outer clothing and bag/labeled belongings when external contamination is suspected; this may remove most external contamination.
- Survey wounds before and after irrigation when feasible; cover contaminated wounds after decon to limit spread.
- Use serial CBC with differential and time-to-emesis information when assessing possible acute radiation syndrome under SME guidance.
- Consult radiation SMEs before isotope-specific decorporation therapy or potassium iodide distribution unless standing public health orders apply.
- Coordinate population monitoring and worried well screening away from acute care facilities when possible.

Roles and Responsibilities

Partner	Primary roles	Support roles
Hospitals / EMS	Lifesaving care, contamination control, survey/decon, tracking, initial labs, staff safety.	Consult radiation SMEs and report facility capacity/resource needs.
RMCC / RHC / ERC / EMS Consultant	Notifications, HRTS/ReadyOp coordination, patient distribution, specialty consultation support.	Coordinate adjacent coalition/state/federal resource requests.
REAC/TS / radiation SMEs	Medical radiation consultation, biodosimetry guidance, patient management recommendations.	Support just-in-time training and responder/provider reassurance.
TDEC / TDH / TEMA / DOE RAP	Public health, environmental monitoring, protective actions, state/federal resource coordination.	Support population monitoring, waste guidance, KI/MCM decisions, public messaging.
Public information / behavioral health partners	Risk communication, rumor control, worried well messaging, staff/community support.	Coordinate with JIC and family assistance resources.

Pediatric and At-Risk Populations

Children, pregnant patients, older adults, people with disabilities, individuals with limited English proficiency, incarcerated persons, people experiencing homelessness, and technology-dependent patients may require tailored screening, decontamination, transport, sheltering, medication, and follow-up processes. Pediatric patients with medical concerns should be coordinated with Dolly Parton Children's Hospital when appropriate; pediatric trauma should follow trauma destination protocols and medical direction.

Recovery and Long-Term Follow-up

- Maintain patient registry and follow-up instructions for those screened, treated, decontaminated, exposed, or internally contaminated.

- Coordinate outpatient monitoring, serial labs, biodosimetry, hematology/oncology, dermatology, mental health, and rehabilitation as needed.
- Document staff monitoring and address worker confidence through clear dose/contamination information.
- Replenish PPE, dosimetry, decon supplies, survey instruments, and lab materials.
- Complete AAR/IP with emphasis on risk communication, survey/decon flow, staff safety, population monitoring, and SME integration.

The Radiation Emergency Assistance Center/Training Site (REAC/TS) at the Oak Ridge Institute for Science and Education (ORISE), has the capability to provide 24/7 advice, consultation, and subject matter expertise: Radiation Emergency Assistance Center/Training Site (REAC/TS) (orau.gov). Additionally, the Radiation Injury Treatment Network (RITN), a national network of medical centers with expertise in caring for marrow toxic injuries, can aid in managing patients with acute radiation syndrome (ARS) and its health-related consequences: Radiation Injury Treatment Network (RITN).

REAC/TS Just-in-Time Training Video Series (orau.gov)

Internal Contamination Countermeasures

Examples that may help limit uptake, incorporation, or organ injury - with KI dosing reference

Countermeasure overview

Countermeasure	Used for	How it helps / key notes
Prussian Blue (Radiogardase®)	Cesium or thallium	Taken orally; helps remove these elements from the body.
Diethylenetriamine-pentaacetic acid (DTPA) **Calcium-DTPA / Zinc-DTPA**	Plutonium, americium, or curium Off-label: other transuranics	FDA-approved chelating agent that limits incorporation. May be given intravenously, intramuscularly, by inhalation, or used to irrigate contaminated wounds. Calcium-DTPA has greater chelation ability but a greater likelihood of depleting essential minerals; it is usually preferred for the first dose when given soon after internalization. The Strategic National Stockpile contains Zinc-DTPA.
Sodium Bicarbonate	Uranium	Alkalinizes the urine to reduce the risk of renal damage.
Calcium or Aluminum Phosphate	Strontium or radium	Mitigates absorption through competitive inhibition.
Potassium Iodide (KI)	Radioactive iodine	Blocks thyroid deposition and is most effective when administered soon after an incident. It may be stockpiled near higher-risk sites (e.g., within 10 miles of nuclear power plants). FDA age-based dosing is shown at right.

Potassium Iodide (KI) dosing

Purpose: blocks thyroid deposition of radioactive iodine.
Timing: most effective when given soon after an incident, when directed by medical or public health authorities.

FDA-recommended dose (as supplied)

Risk Group	KI Dose (mg)	Number of 130 mg tablets	Oral Solution (mL)
Over 40 Years	130	1	2
18-40 years	130	1	2
12-18 years*	65	0.5	1
3-12 years	65	0.5	1
1 month-3 years	32	Use oral solution	0.5
Birth-1 month	16	Use oral solution	0.25

* Adolescents approaching adult size (>150 lb) should receive the full adult dose. For adults over 40, give only if the thyroid dose is >5 Gy.

Operational note: KI dosing is prioritized by age. Confirm current agency guidance and incident-specific direction before use.

Prepared from the supplied text and KI dosing table. Confirm current guidance before clinical or operational use.

Annex E – High Consequence Infectious Disease (HCID) Surge

Purpose and Scope

This annex supports coalition coordination during infectious disease incidents that affect healthcare demand, staffing, isolation capacity, EMS transport, public health operations, medical countermeasures, or continuity of care. It applies to special pathogens, high-consequence infectious diseases, pandemic or novel respiratory viruses, vaccine-preventable disease outbreaks, multidrug-resistant organisms, gastrointestinal outbreaks, healthcare-associated outbreaks, and sustained community transmission events.

Response Objectives

1. Detect and communicate healthcare impacts early.
2. Protect healthcare workers, patients, visitors, EMS, and community partners through appropriate infection prevention and control.
3. Maintain emergency, inpatient, outpatient, long-term care, EMS, dialysis, behavioral health, and home-based care continuity.
4. Coordinate isolation capacity, testing, MCM, vaccines, PPE, staffing, transport, and public information.
5. Support equitable access for vulnerable populations and facilities with limited resources.
6. Transition from response to recovery while incorporating lessons learned.

Activation Triggers

- Suspected or confirmed high-consequence infectious disease or special pathogen requiring notification, assessment, isolation, or specialized transport.
- Outbreak causing ED surge, inpatient surge, ICU surge, staffing shortage, PPE shortage, testing constraints, or EMS offload delays.
- Public health requests healthcare coalition support for surveillance, testing, MCM, vaccine, public messaging, or facility coordination.
- Multiple long-term care, dialysis, behavioral health, congregate care, school, childcare, or shelter outbreaks affecting healthcare demand.
- Need for crisis standards, regulatory waivers, alternate care, telehealth expansion, or external staffing.

Infectious Disease EEIs

EEI	Details needed
Disease / agent	Known/suspected pathogen, case definition, transmission mode, severity, infectious period, testing criteria, public health status.
Healthcare impact	ED volume, admissions, ICU, ventilators, isolation rooms, airborne infection isolation rooms, staffing, EMS offload, outpatient demand.
Facility status	PPE, testing supplies, lab throughput, pharmacy/MCM, environmental services, waste, morgue capacity, security, visitation.
Population impact	LTC, dialysis, behavioral health, schools/childcare, shelters, corrections, access/functional needs, language access.
Public health actions	Surveillance, contact tracing, isolation/quarantine, vaccination, prophylaxis, community mitigation, public messaging.

EEI	Details needed
Transport	EMS PPE, transport protocol, destination facility, ambulance decon, interfacility transfer constraints.
Recovery	Backlog of care, staff fatigue, supply replenishment, vaccination catch-up, AAR/IP, policy revision.

Initial Response Actions

Timeframe	Coalition / public health coordination	Facility / EMS actions
0-30 minutes	Confirm notification pathway; notify RHC/ERC/RMCC/EMS Consultant and TDH/public health as appropriate; open HRTS/ReadyOp if needed.	Screen, isolate, use appropriate PPE, notify infection prevention and leadership, protect staff, report suspected special pathogen per protocol.
30-120 minutes	Collect EEIs, establish reporting cadence, distribute current guidance, identify isolation/PPE/testing constraints, support transport/destination decisions.	Activate HICS/EOP, update HRTS, evaluate PPE burn rate, test criteria, staffing, visitor controls, and patient cohorting.
2-12 hours	Coordinate across hospitals, LTC, EMS, public health, labs, and EMA; plan MCM/testing/vaccination/community mitigation support.	Expand isolation/cohorting, telehealth, staffing contingencies, environmental cleaning, staff monitoring, and communication to patients/families.
12+ hours	Support sustained operations, data reporting, regulatory waiver requests, resource requests, community messaging, recovery planning.	Maintain continuity of care, manage workforce impacts, replenish supplies, document costs, participate in AAR/IP.

Infection Prevention and Control Framework

- Use current CDC, TDH, and facility infection prevention guidance for the specific pathogen and setting.
- Implement screening, source control, respiratory hygiene, hand hygiene, appropriate PPE, isolation/cohorting, cleaning/disinfection, ventilation considerations, and healthcare worker monitoring according to incident guidance.
- Ensure fit testing, donning/doffing competency, observer support for high-risk PPE, and just-in-time training.
- Protect EMS and transport teams through pre-transport notification, PPE, patient masking/source control when appropriate, and ambulance decontamination procedures.
- Use telehealth, alternate triage, drive-through/remote testing, or outpatient treatment pathways to reduce unnecessary ED crowding when appropriate.
- Coordinate with long-term care, dialysis, behavioral health, home health, hospice, and congregate settings because outbreaks in those settings can rapidly affect hospitals and EMS.

Special Pathogen / HCID coordination

For suspected high-consequence infectious disease, facilities should immediately implement isolation, notify infection prevention and public health through established channels, and avoid unnecessary movement. Specialized transport and assessment hospital pathways should be activated through

TDH/RHC/RMCC/EMS Consultant coordination. Detailed special pathogen contact trees and facility-specific assessment/treatment protocols should be maintained in a restricted operational appendix and validated at least annually.

Special pathogen function	Planning expectation
Recognition	Maintain screening questions, travel/exposure prompts, triage isolation triggers, and staff education.
Isolation	Identify initial isolation location, PPE access, negative pressure capability if available, and staff entry/exit control.
Notification	Notify facility leadership, infection prevention, public health, RHC/ERC/RMCC/EMS Consultant, and receiving/transport partners as indicated.
Transport	Use dedicated or trained transport teams when required; coordinate destination and ambulance decontamination before movement.
Waste / lab	Follow current pathogen-specific packaging, shipping, waste, and laboratory guidance.
Staff support	Provide monitoring, occupational health follow-up, behavioral health support, and transparent risk communication.

Medical Countermeasures, Testing, and Vaccination

- Coordinate MCM requests through public health and emergency management pathways; document allocation priorities and distribution sites.
- Support mass vaccination, prophylaxis, treatment distribution, or points of dispensing if activated by public health.
- Ensure vaccinators and dispensing partners have appropriate authorization, training, documentation systems, cold chain, and safety procedures.
- Coordinate testing criteria, specimen collection, packaging/shipping, reporting, and laboratory surge across hospitals and public health.
- Use clear public messaging to direct the community to appropriate care, testing, vaccination, and information sources.

Staffing, Continuity, and Scarce Resources

Large infectious disease events can affect staff through illness, exposure, school/childcare disruption, fear, fatigue, and burnout. Facilities should activate staffing contingency plans, cross-training, labor pools, telework/telehealth, volunteer processes, return-to-work guidance, and behavioral health support. Coalition coordination should identify regional staffing gaps and support mutual aid or state/federal resource requests when available.

Crisis standards or scarce resource allocation may be considered only through the appropriate legal, ethical, facility, and state processes. KETHC should help distribute current state guidance and support consistent situational awareness, but facility-level implementation must follow approved governance and legal authority.

Roles and Responsibilities

Partner	Primary roles	Support roles
Public health / TDH	Disease surveillance, case investigation, contact tracing, guidance, isolation/quarantine authority, MCM/vaccine coordination.	Coordinate with CDC/ASPR and state leadership; support public information.
Hospitals / healthcare facilities	Screening, isolation, treatment, infection prevention, staffing, reporting, continuity of care.	Support testing, vaccination, MCM, patient tracking, and data reporting.
EMS / transport	Safe transport, PPE, destination coordination, ambulance decon, transport documentation.	Support special pathogen transport through established pathways.
RMCC / RHC / ERC / EMS Consultant	Healthcare situational awareness, HRTS/ReadyOp coordination, resource requests, regional calls.	Coordinate with EMA, TDH, adjacent coalitions, and specialty SMEs.
LTC / dialysis / behavioral health / outpatient partners	Continuity of care, outbreak reporting, infection prevention, patient/resident support.	Coordinate transport, hospital transfers, staffing, PPE, and public health guidance.
EMA / public information / behavioral health	Emergency management coordination, resource support, risk communication, community support.	Support shelters, access/functional needs, family assistance, and staff/community resilience.

Training and Exercise Priorities

- PPE donning/doffing, fit testing, and observer-led high-risk PPE procedures.
- Special pathogen recognition, notification, isolation, and transport drills.
- Respiratory virus surge, vaccination/MCM, community testing, and LTC outbreak coordination exercises.
- Healthcare worker monitoring, staffing contingency, behavioral health, and continuity of operations.
- After-action improvement tracking from real-world outbreaks and annual exercises.

Recovery and Demobilization

- Return to routine disease surveillance only after public health and healthcare operations agree that response-level coordination is no longer needed.
- Continue monitoring for subsequent waves, delayed complications, staff fatigue, supply shortages, and backlogs of deferred care.
- Replenish PPE, testing, vaccine, MCM, cleaning, and laboratory supplies.
- Review infection prevention, staffing, MCM, public information, and data reporting performance through AAR/IP.
- Update this annex after major changes in public health guidance, pathogen risk, special pathogen designation, or coalition capability.

Annex F - Medical / Trauma Surge Quick Reference

This quick reference summarizes the operational actions most likely to be needed during a general medical or trauma surge not covered by a more specific annex. It should be used with the Base Medical / Trauma Surge Response Plan.

Activation Triggers

- Trauma MCI, active assailant, transportation crash, severe weather casualties, building collapse, large public event incident, infrastructure disruption, evacuation, or no-notice surge.
- Hospital ED, ICU, OR, trauma, imaging, blood bank, or staffing capacity is strained.
- EMS unit availability, offload times, destination options, or specialty transport is constrained.
- More than one facility or county requires coordinated situational awareness or resource support.

Immediate Actions

Action	Responsible partners	Expected output
Activate local incident command and notify RMCC/RHC/ERC/EMS Consultant.	Impacted facility/EMS/EMA	Regional awareness and initial coordination.
Open HRTS event or request targeted updates.	RMCC/RHC/ERC	Shared bed, facility, and resource status.
Determine patient distribution strategy.	EMS command, RMCC, hospitals, EMS Consultant	Destination plan that protects specialty and total system capacity.
Request hospitals to report ED, ICU, OR, trauma, pediatric, behavioral health, and discharge capacity.	RMCC/RHC/ERC	Common operating picture for patient movement and decompression.
Coordinate transport assets and routes.	EMS, air medical, EMA, law enforcement, RMCC	Available transport plan and staging/retrieval priorities.
Prepare family assistance, patient tracking, and public information.	Hospitals, EMA, PIO/JIC, behavioral health partners	Reduced confusion, safer reunification, and consistent messaging.

Hospital Surge Strategies

- Activate HICS and establish operational periods, objectives, and a reporting cadence.
- Clear ED space by expedited admission, discharge, transfer, alternate triage, and outpatient redirection where safe.
- Assess ICU, OR, PACU, step-down, telemetry, medical-surgical, behavioral health, pediatric, isolation, and ventilator capacity.
- Cancel or delay elective procedures as directed by facility leadership when needed.
- Open internal alternate care, discharge lounge, family reception, staff support, and media staging areas according to facility plans.
- Track patients, staff, equipment, supplies, and costs from the beginning of the activation.
- Coordinate with local EMA and coalition partners for security, traffic control, fatality management, interpreters, behavioral health, and resource support.

EMS and Patient Distribution Strategies

- Use field triage and medical direction to distribute patients according to injury severity, specialty need, hospital capability, and current capacity.
- Avoid overloading the closest facility when multiple appropriate destinations are available.
- Use staging, transport officers, and RMCC coordination for large incidents.
- Coordinate air medical, specialty pediatric/neonatal, critical care, bariatric, ambulance bus, wheelchair, and non-emergency transport assets as appropriate.
- Communicate contamination, isolation, behavioral health, security, or access/functional needs before transport when known.

Recovery Priorities

- Reconcile patient tracking and family reunification records.
- Repatriate transferred patients when appropriate.
- Restore suspended services and address delayed care backlog.
- Restock blood products, medications, PPE, trauma supplies, decon supplies, and EMS assets.
- Support staff psychological first aid, peer support, and return-to-routine operations.
- Complete AAR/IP and assign corrective actions with owners and dates.

Appendix 1 - Master Contact and Resource Tables

The table below consolidates key coordination roles from the source document. Before final publication, KETHC should verify names, phone numbers, email addresses, after-hours coverage, and alternates. A controlled contact appendix should include additional sensitive contacts and call trees.

Role / resource	Current entry	Verification / use note
RMCC - MED LINK 2 Dispatch	UHF Med 10, 865-305-8500; 800-792-1033 Tim Taylor - jtaylor@utmck.edu	24/7 coordination point
RHC - Knox County	John Brinkley - John.Brinkley@knoxcounty.org; 865-216-6280 cell; 865-215-5456 office	
RHC - East TN Region	Wanda Roberts - ETRHC.Health@tn.gov; 865-202-9800 cell; 865-549-5294 office	
Vulnerable Population Coordinator - East TN Region	Brenan Mitchell - Brenan.Mitchell@tn.gov; 865-850-2884	
EMS Consultant	Jonathan Beaty - Jonathan.Beaty@tn.gov; 865-235-6360 cell	
ERC - Knox County	Steve Hamby - Steve.Hamby@knoxcounty.org; 865-215-5161cell: 865-755-1490 office	
ERC - East TN Region	Chase Watts - Chase.Watts@tn.gov; 865-549-5291office; 865-2742477 cell	
Poison Control	1-800-222-1222	Clinical toxicology consultation.

Role / resource	Current entry	Verification / use note
CHEMTREC emergency	1-800-424-9300	Chemical transportation / hazardous materials emergency information.
REAC/TS	General: 865-576-3131; After-hours: 865-576-1005	Radiation emergency medicine consultation; verify current numbers.
RITN	612-884-8276	Radiation injury / marrow toxic injury coordination; verify current number.

Appendix 2 - Essential Elements of Information Templates

Use the following templates to standardize reporting during a surge event. These fields may be built into HRTS, ReadyOp, WebEOC, or incident-specific forms.

Template	Fields
Initial incident report	Incident name; date/time; location; hazard; patient estimate; affected facilities; current actions; immediate life-safety issues; requested support; reporting point of contact.
Hospital status report	ED status; inpatient beds; ICU; OR; ventilators; isolation; pediatric; behavioral health; dialysis; decon; staffing; supplies; utilities; security; unmet needs.
EMS / transport report	Available ALS/BLS units; specialty transport; air status; offload delays; staging; routes; fuel; crew staffing; decon capability; unmet needs.
Patient movement report	Patient ID/tracking number; age group; triage category; diagnosis/injury; specialty need; contamination/isolation; sending facility; receiving facility; transport mode; departure/arrival; family notified.
Resource request	Requesting organization; resource type; quantity; priority; reason; delivery point; point of contact; duration; local attempts exhausted; approvals; status.
Recovery report	Patients remaining; transfers pending; repatriation; supply replenishment; staff support; cost documentation; regulatory issues; AAR/IP items.

Appendix 3 - Pediatric and Family Assistance Tools

Use these planning elements when children are involved. Facility and jurisdictional plans should provide detailed forms and release procedures.

Checklist item	Planning requirement
Identification	Assign a unique tracking identifier; photograph if policy permits; document clothing, belongings, caregiver information, and destination.
Safe area	Provide a secure, supervised, child-friendly location separate from media, crowds, and unverified adults.
Caregiver verification	Use facility policy and local law enforcement/child welfare support when identity or custody is uncertain.

Checklist item	Planning requirement
Communication	Use interpreters, communication boards, age-appropriate explanations, and regular updates.
Family reception	Coordinate call center/family reception center with local EMA, hospitals, schools, Red Cross, and behavioral health partners.
Release documentation	Record who released the child, to whom, time/date, identification verified, destination, and follow-up needs.

Appendix 4 - Decontamination Planning Checklist

Capability	Minimum planning elements
Activation	Clear trigger, authority, staffing, setup time, and safety officer involvement.
Zones and flow	Hot/warm/cold zones; entry control; privacy; gender/cultural considerations; pediatric/family flow; access/functional needs.
PPE	Role-based PPE; donning/doffing; trained observers; staff monitoring; heat/cold stress; responder rehab.
Water and temperature	Warm water when possible, low pressure/high volume for pediatric patients, runoff plan, hypothermia prevention.
Supplies	Modesty garments, blankets, towels, bags, labels, tags, soap, soft cloths, wheelchairs/stretchers, pediatric transport-through-decon devices.
Security and evidence	Access control, belongings chain-of-custody, law enforcement coordination for intentional events.
Waste	Contaminated clothing, PPE, runoff, equipment, and environmental cleaning coordinated with HAZMAT/TDEC/EPA/local utilities as indicated.
Documentation	Patient tracking, decon status, survey readings if radiological, clothing removed, belongings, medications, destination.

Appendix 5 – Acronyms

Acronym	Meaning
AAP	American Academy of Pediatrics
ABA	American Burn Association
ABLS	Advanced Burn Life Support
ACS	Alternate Care Site
AAR/IP	After-Action Report / Improvement Plan
ASPR	Administration for Strategic Preparedness and Response
BMCI	Burn Mass Casualty Incident

Acronym	Meaning
CBRN	Chemical, Biological, Radiological, Nuclear
CHEMM	Chemical Hazards Emergency Medical Management
COOP	Continuity of Operations
CRPC	Comprehensive Regional Pediatric Center
CSC	Crisis Standards of Care
DTPA	Diethylenetriaminepentaacetic acid
ED	Emergency Department
EEI	Essential Element of Information
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EOC	Emergency Operations Center
ERC	Emergency Response Coordinator
ESF-8	Emergency Support Function 8 - Public Health and Medical
HAZMAT	Hazardous Materials
HCC	Healthcare Coalition
HICS	Hospital Incident Command System
HID	Highly Infectious Disease
HPP	Hospital Preparedness Program
HRTS	Healthcare Resource Tracking System
IC/ICS	Incident Commander / Incident Command System
JIC	Joint Information Center
KI	Potassium Iodide
KETHC	Knox/East Tennessee Healthcare Coalition
LTC	Long-Term Care
MCI	Mass Casualty Incident
MCM	Medical Countermeasure
MOU	Memorandum of Understanding
NDMS	National Disaster Medical System
PPE	Personal Protective Equipment
PRISM	Primary Response Incident Scene Management

Acronym	Meaning
RAP	Radiological Assistance Program
RDD	Radiological Dispersal Device
REAC/TS	Radiation Emergency Assistance Center/Training Site
RED	Radiological Exposure Device
RHC	Regional Healthcare Coordinator
RITN	Radiation Injury Treatment Network
RMCC	Regional Medical Communications Center
SME	Subject Matter Expert
SNS	Strategic National Stockpile
START	Simple Triage and Rapid Treatment
TBSA	Total Body Surface Area
TDH	Tennessee Department of Health
TEMA	Tennessee Emergency Management Agency
TNHAN	Tennessee Health Alert Network

Appendix 6 - References and Authorities

Reference	URL / location
ASPR Hospital Preparedness Program	https://www.aspr.gov/readiness-response/healthcare-readiness/hpp
ASPR TRACIE Healthcare Coalition Resources	https://asprtracie.hhs.gov/hcc-resources
ASPR TRACIE Health Care Preparedness and Response Capabilities	https://asprtracie.hhs.gov/technical-resources/resource/3896/health-care-preparedness-and-response-capabilities-for-health-care-coalitions
Tennessee Department of Health Emergency Preparedness	https://www.tn.gov/health/prepare.html
Tennessee Health Alert Network	https://www.tn.gov/health/tnhan.html
KET Healthcare Coalition	https://www.ketcoalition.org/
Dolly Parton Children's Hospital	https://www.dollychildrens.org/
American Burn Association Burn Patient Referral Guidelines	https://www.ameriburn.org/burn-care-team/resources/guidelines-for-burn-patient-referral
Chemical Hazards Emergency Medical Management (CHEMM)	https://chemm.hhs.gov/
CHEMM Emergency Contacts	https://chemm.hhs.gov/emergencycontacts.htm

Reference	URL / location
PRISM: Primary Response Incident Scene Management	https://www.medicalcountermeasures.gov/barda/cbrn/prism
CDC Infection Control Guidance for Respiratory Viruses in Healthcare Settings	https://www.cdc.gov/infection-control/hcp/viral-respiratory-prevention/
CDC Radiation Emergencies - Resources for Clinicians	https://www.cdc.gov/radiation-emergencies/hcp/clinical-guidance/information-for-clinicians.html
Radiation Emergency Medical Management (REMM)	https://remm.hhs.gov/
REAC/TS Radiation Emergency Assistance Center/Training Site	https://orise.orau.gov/reacts/
Radiation Injury Treatment Network	https://ritn.net/
American Academy of Pediatrics Pediatric Disaster Preparedness Resources	https://www.aap.org/en/patient-care/disasters-and-children/professional-resources-for-disaster-preparedness/
U.S. Census Bureau Population Estimates APIs / data guidance	https://www.census.gov/data/developers/data-sets/popest-popproj/popest.html
Tennessee State Data Center Population Estimates	https://tnsdc.utk.edu/estimates-and-projections/population-estimates/
Tennessee Emergency Management Plan and applicable ESF-8 authorities	Maintain current version through TEMA/TDH channels.
Guidance for the Ethical Allocation of Scarce Resources During a Community-Wide Public Health Emergency as Declared by the Governor of Tennessee	Maintain current TDH-approved version through official channels.

Appendix 7 - Controlled Operational Appendices Index (insert Chempak Plan)

Appendix 8: 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 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)

Appendix 9: 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.	

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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 todocument 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.	