The Issues at Hand

PEDIATRIC REUNIFICATION:
NATIONAL CONSENSUS CONFERENCE
RECOMMENDATIONS

Pediatric Disaster
Resource and Training Center

ChildrensHospitalLosAngeles
International Leader in Pediatrics

The following recommendations are covered within this document. To directly view the results of each topic, please click on the topic's link.

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Summary of Reunification Conferences

Background on the Issue

After the Tsunami in 2004 separated a large number of children from their parents and families, the World Health Organization listed Guiding Principles for tracking and reunification of families.

These principles stated that unaccompanied and separated children should be provided with services aimed at reuniting them with their parents or caregivers. The principles also stated that, “Interim care should be consistent with the aim of family reunification and should ensure the children’s protection and well-being…Identifying, registering and documenting unaccompanied and separated children are priorities in any emergency and should be carried out as quickly as possible.”

The following list of Guiding Principles addresses critical disaster issues such as the prevention of separation, tracing and family reunification, and care arrangements.

- Registration activities should be conducted under the direction of government authorities and mandated agencies with prior experience and assigned responsibility for this task.

- The confidential nature of the information collected must be respected and systems deployed that ensure safe forwarding and storage of information. Information must only be shared among duly mandated agencies for the purposes of tracing, reunification and care.

- Tracing is the process of searching for family members or primary legal or customary caregivers. All those engaged in tracing should use the same approach, including standardized forms and mutually compatible systems.

- Relationships must be verified and the willingness of each child and family member to be reunited must be confirmed.

- No action should be taken that may hinder eventual family reunification such as adoption, change of name, or evacuation far from the family’s likely location until all tracing efforts have been exhausted.

Since the ’04 tsunami, several other disasters have separated families and complicated the process of reunifying parents and children. During Hurricane Katrina, the National Center for Missing and Exploited Children was designated by the government as the appropriate agency to assist in reunifying families. Yet, many families were separated because of the urgent nature of the final evacuations and the wide distances between evacuation sites. Victims were evacuated across state lines and parents were sent to one destination and their children to another. Since that time, some national efforts at

addressing reunification have occurred and other, private efforts have begun to look at this issue.

The most recent disasters in Texas with Hurricane Ike also resulted in a very large scale evacuation. A review of after action reports will provide data on the effectiveness of actions taken to track evacuated victims during these storms.

The Pediatric Disaster Resource and Training Center at Childrens Hospital Los Angeles

With support from the U.S. Department of Health and Human Services, and in collaboration with the Los Angeles Emergency Services Agency, Childrens Hospital Los Angeles (CHLA) received funding to create the *Pediatric Disaster Resource and Training Center (PDRTC).* The PDRTC is intended to investigate and address a range of issues surrounding pediatric disaster preparedness and training including family reunification. A key objective is the creation of a Family Reunification Plan, with evacuation and reunification protocols that can be utilized in a large scale disaster anywhere in the nation, and that can be replicated at the national level.

An Organized Approach to Creating Consensus

The PDRTC hosted two conferences in 2008 as a way to better understand the issue of family reunification from a national perspective and also gain input from pediatric disaster experts. The first conference was designed to brainstorm major reunification issues, while the second was intended to attract broader participation and finalize a set of national pediatric disaster reunification recommendations.

Conference # 1
Pediatric Reunification: Exploring the Issues at Hand
March 31 & April 1, 2008 – Los Angeles

This first conference brought together pediatric disaster experts from across the nation to discuss and debate six major themes including:

- Patient Movement/Transportation
- Technology/Tracking
- Clinical Issues
- Non-Medical Issues
- Communication/Regulatory Issues
- Pediatric Psychological Support for Aftermath

A total of 57 individuals participated in this two-day conference, with representatives from state and local emergency medical services and area hospitals, as well as experts from pediatric care organizations such at the National Center for Missing and Exploited Children, and the American Red Cross. After robust discussion sessions, each of the

six focus groups developed a set of recommendations for their particular theme, which were then presented to the larger group for review and discussion. Groups looked at how to reunify and also issues concerning the considerations for the children while waiting to reunify with the appropriate adult. The final set of draft recommendations became the basis for the discussion at the second reunification conference in June '08.

Participants:

Dr. Jeffrey Upperman – P.I. – Pediatric Disaster Resource and Training Center Grant
Conference Chairs – Nancy Blake, MN, RN and Kathleen Stevenson, BSN, RN
Conference Coordinators – Bridget Berg, MPH, Nellie Marie Nunez and Kelly Honecker

Workgroup Facilitators:

- Mike Robin – Communications/Information
- Inge Morton – Clinical Issues
- Judy Sherif/Annette Shaked – Transportation/Movement
- Sajaad Yacoob/David Davis - Technology
- Suzanne Taylor – Non-clinical/Non-Medical Issues
- Jeffrey Gold – Psychosocial Issues

Represented Associations:

- American Academy of Pediatrics
- Society of Pediatric Nurses

Also in attendance were experts from across the country.

Conference #2
Pediatric Reunification: Consensus Conference
June 24 & 25, 2008 – Los Angeles

The second reunification conference provided a forum to review, discuss and adopt the recommendations from the Spring conference. The June reunification conference attracted experts from area hospitals and emergency medical services, as well as representatives from the National Center for Disaster Preparedness at Columbia University, the Center for Bio Preparedness at Children's Hospital Boston, the National Center for Missing and Exploited Children, the Society of Pediatric Nurses and the American Association of Pediatrics.
Faculty at June Conference:

- Larry Bonney – Center for National and Exploited Children
- Nancy Blake – Pediatric Disaster Resource and Training Center
- David Markenson – Montefiore Children's Hospital
- Richard McGuire – Operation Safe Child – New York Department of Justice
- Mark Brandenberg – University of Oklahoma School of Medicine

This conference focused on gaining feedback on the reunification recommendations created during the first conference. After a period of discussion, an electronic audience polling system tracked participants' reactions to each recommendation and tabulated the percentage of participants supporting each recommendation. Results indicated that each of the 41 recommendations was approved by a majority of participants. The lowest approval rating was 70%.

The following are the broad recommendations resulting from the conference. In some cases the details for implementation still need to be developed.

Pediatric Reunification Recommendations

Transportation

- Perform a risk-based regional assessment of transportation resources that identifies available public and private resources including medical transport (air, ground, water) and non-medical transport (air, ground, water). (100% Approval)

- Establish Memo of Understanding (MOU) and protocols with identified transport resources.

- Develop and utilize a national pediatric disaster triage tool to prioritize the movement of children to appropriate receiving facilities.

- Establish formal categories of transportation type that includes:
    - Rescue – resources used to rescue people in life threatening situation
    - Medical – pediatric equipment and pediatric clinical expertise
    - Non-medical – ability to provide necessary level of supervision
    - Movement of deceased – a public health plan that addresses storing and transportation of deceased

- Capture and transfer the following known identification information throughout the transport continuum:
    - Minimum data would include pickup location;(i.e., cross streets, latitude & longitude, facility/school)
    - Gender and name (if possible)
    - Keep the primary caregiver with the patient, to the extent possible (i.e. parents, guardians, and foster parents)

- Establish formal categories of receiving facilities that can provide appropriate care and necessary level of supervision to ensure that special attention is paid to the safety concerns of children at these facilities. Suggested categories are:
    - Adult Only Hospitals
    - Adult/Pediatric Hospitals
    - Pediatric Specialty Care Hospitals
    - Mixed Population Shelters

- "Pediatric Safe" Shelters
- Evacuation "safety areas"
- Morgue Receiving facilities

- Develop standard formats for communicating the receiving facility's capacity and availability, and report centrally in order to maximize "match" with transportation receiving facility and also to minimize unnecessary movement.

- Develop a centralized non-medical dispatch system, which is based on the medical centralized dispatch model (MAC, CMED, etc.), and provides availability of non-medical holding sites, and also takes pediatric considerations into account when assigning resources (e.g. pediatric safe shelters).

Pediatric Psychosocial Support

- Adopt a standardized mental health triage model for hospitals that would screen for high risk/dose exposure. (100% approval)

- Adopt a set of standardized disaster mental health interventions for children, families and staff.

- Develop procedures for *e*Mental Health.

- Develop and adapt standardized educational protocols and procedures for pediatric disaster mental health.

- Require the inclusion of hospital mental health staff in the development and delivery of disaster communications.

- Ensure that hospitals have policies, procedures, plans and training in place to facilitate developmentally appropriate and culturally sensitive delivery of death notifications following a disaster.

- Require that hospitals include mental health staff and response scenarios in routine hospital disaster drills and exercises.

- Assign child ambassador/advocates to assist with hospital navigation and support for unaccompanied minors.

- Require that mental health brochures and pamphlets are distributed following a disaster.

Clinical Issues

Recommendations in this section are based on the following guidelines:

- There is a need for a standard model for family reunification with guiding principles.
- Keeping families together and prompt matching of children to parents should be a high priority.
- Facilities should be prepared to care for patients of all ages to avoid separation of families.
- During a disaster, children are at increased risk of intentional and unintentional trauma and so, mitigating steps must be considered.

Healthcare providers should incorporate these guiding principles into emergency management plans.

Recommendations:

- Pre-determine processes for identifying children's guardians and reunifying families and include these processes in emergency operation plans and exercises. (100% Approval)
    - For nonverbal or critically ill children, collect descriptive identifying information about the physical characteristics or other identifiers of the child from the adult.
    - Without verification of minimum predefined identifiers, the child should not be released.
- Before a disaster strikes, identify designated shelters that can safely accommodate children, who are with or without a guardian. This requires collaboration between agencies/organizations operating the shelters and healthcare providers. (100% Approval)
- Pre-designate Alternate Care Sites (ACS) that can safely accommodate and provide medical care to children, who are with or without a guardian. This requires collaboration between agencies/organizations operating the ACS and healthcare providers.
    - Alternate care sites are those facilities capable of supporting the ongoing medical needs of children.
- Include care of deceased children in reunification policies and procedures.

- Develop policies and procedures that address the consent process regarding non-emergent medical care of children who are without an identified legal guardian. The policies and procedures should identify circumstances when social service/judicial infrastructure is in place, and when it is inoperable.

- Identify a process for reuniting healthcare providers with their children and incorporate this process into emergency plans. Allowing staff to bring their families to pre-designated locations that are stocked with appropriate resources is essential to sustain adequate clinical staffing.

Non Medical Issues

- Pre-establish release protocols and develop resource lists to ensure appropriate release of children. (100% Approval)

- Prepare, plan and drill for the welfare, safety and security of separated children. (100% Approval)

- Promote participation in a child identification national database.

- Include lock down, crowd management and tracking devices as essential components in providing security for separated children.

- Pre-identify key locations for services related to reunification.

- Establish agreements with external agencies/resources for providing security and extended care for separated children. (100% Approval)

Technology and Tracking

Our Objective – Develop a plan for technology that allows information sharing to a central repository.

We now have opportunities to collect child information, at local levels, to expedite family reunification, which would be accessible in the event of a local, regional or national disaster. Much of this information is already being collected for multiple purposes and can be standardized for use on the federated network.

Create a “trusted” federated network (modeled on ATM network) that consists of local, regional, and national databases accessible for patient identification in the event of a national disaster, and is accessible per World Health Organization Guiding Principles

- These databases include

    - The National Emergency Family Registry and Locator System (NEFRLS), and the National Emergency Child Locator Center (NECLC) (per FEMA ESF #6 National Disaster Response Plan)
    - National Center for Missing and Exploited Children (NCMEC)
    - New York State Operation Safe Child
    - Electronic Medical Records
    - Los Angeles Unified School District

- Develop and implement standard language (identifiers) for documentation. These should include, at a minimum:
    - Name
    - Gender
    - Ethnicity/race
    - Eye color
    - DOB
    - Photo (if available)
    - Fingerprints (if available)
    - Other distinguishing characteristics (i.e. birthmarks, tattoos, scars)

These items would be collected for all databases and linked to the federated network (modeled after the New York state safe child program).

- Utilize the most current, proven technologies for tracking:
    - Wristband Barcode (tracking number) - tracking number also written on child
    - Scanning capability
    - GPS wrist watch, chip in shoe, cell phone (ICE), DNA, facial recognition, implantable device, finger prints

Implement tracking by using a standardized protocol:

- Wristband is placed by designated personnel with intent to track and tracking number recorded on child's person.
    - 1st responders
    - Medical personnel
    - Trained volunteer organizations (Red cross, MRC)

- Universal tracking device (scanner) is placed at every point of entry and way station.
    - Shelter (aid stations)
    - Hospitals
    - Authorized staging areas
    - Morgue

- Wristband scanned to initialize tracking process:
    - Redundant systems should be in place to facilitate the initial entry of the child into the system.

        - Scanner with real time connection
        - Scanner with offline connection (batched entry)
        - Manual entry of tracking number into web based portal
        - Manual entry of tracking number by telephone
        - Manual documentation of tracking number on paper

- Information collection begins and continues at every point of care as additional information is available.
    - Photo identification
    - Physical identification
    - Material identification

- As point of care changes, barcode/tracking number is scanned or documented.

Communications / Information and Regulatory Issues

- Under a declared disaster, HIPAA regulations should be waived for purposes of identifying an individual and allow reunification with family, legal guardian or caretaker.

- All states are encouraged to review and identify regulations that may need to be waived during a disaster in order to facilitate family and child reunification.

- Each jurisdiction, as part of its emergency management plan, should establish reunification plans and processes, including identification of a lead agency.
    - Information sharing and coordination between family information centers (FICs) and lead agency should follow SEMS and NIMS protocols.
    - Utilize 211 as a central communication resource to find a FIC.
    - Ensure lead agency coordinates with NCMEC and other essential reunification agencies.

- Establish FICs at hospitals and other sites such as police / fire stations, schools, community centers, shelter / evacuation centers, alternate care sites, etc., and activate during disasters. (100% Approval)

- The Joint Commission is encouraged to require that hospitals develop family information center plans, with appropriate written policies, procedures and forms, as part of their Emergency Management Program.

- All states are encouraged to require that schools and child care facilities (including camps) have emergency management plans, with minimal standards, that address the process of reunifying families during emergency situations. (100% Approval)

- In order to assist with family reunification during a disaster, schools and child care facilities (including camps) should provide families with information regarding their facility's emergency plan and procedures as legally allowed, including:
    - Evacuation procedures
    - Parent notification process and procedures to pick up children
    - Contact number or alternate way to contact the facility and / or access information (e.g. 211 and media)
    - Plan of action that addresses when emergency contacts are unavailable to pick up child, and that defines coordination with local social service agency
    - Plans to address children's health needs pending reunification

- Modify school emergency contact information card to include health information similar to AAP emergency form.

General Recommendations

The recent earthquake in China vividly demonstrated the difficulties when a disaster impacts children while they are in school or in care facilities. The need to quickly evacuate children from the disaster site typically creates reunification problems. Children with major injuries may be sent for medical care, while others may go to an alternate care facility or to a shelter.

The importance of providing parents with information about the status of the children cannot be stressed enough. In the Chinese earthquake, for example, information would have been comforting to parents who spent days looking for their children. The ability to send and receive information from a central data repository has the potential to quickly provide parents with accurate information about the condition of their children.

In addition, the reunification conferences highlighted the opportunity for drills with the groups involved in both ESF # 6 and ESF #8 in the National Response Plan, down to the detailed level of the hospitals that will be providing care to these patients. This also is an opportunity to educate healthcare workers about the national reunification process. A large scale drill that involves victims moving across state lines and across different care areas (i.e. hospitals, alternate care sites and shelters), similar to the Katrina evacuation, is recommended to test and educate the staff about this reunification process.

It is also important to implement a process with school districts and day care centers, similar to the Operations Safe Child program implemented by the Office of Criminal Justice Operations in the state of New York. If children were registered in a database at an early age, matching could be done with their fingerprints or general description. Any such system would need to allow for periodic updates with current pictures and other identifying information such as scars or other physical marks. Whatever identification

process is administered, it would need to be implemented nationwide, so children can be identified regardless of where the disaster occurs.

It is important that further work be done to address the issues surrounding tracking victims in a disaster and development of a system so when needed, the system is already set up and has been tested in drills.

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