Tips for Healthcare Facilities: Assisting Families and Loved Ones after a Mass Casualty Incident

Background/Overview

In the immediate aftermath of a mass casualty incident (MCI), survivors and their loved ones will have four fundamental concerns or needs:

1. Determining if their loved one was involved in the MCI;
2. Determining their loved one's whereabouts and welfare (i.e., injury status);
3. Obtaining information regarding the MCI and receiving available resources (e.g., meeting immediate needs such as food, shelter, clothing, and aid); and
4. Receiving their loved one's personal effects.

Recent incidents have shown that people will quickly travel: to where they believe they can locate their loved one (e.g., hospitals, known reunification center, incident site); to a location where someone can provide information about their loved one; or—if they were personally affected by the incident—to a location where they can obtain recovery resources. Identifying best practices and potential challenges is the first step toward optimizing these community services.

> This ASPR TRACIE tip sheet highlights best practices and issues related to planning for, activating, and operating *hospital or healthcare facility* Family Information Centers (FIC)/ Family Support Centers (FSC), in collaboration with Family Reception Centers (FRC) and Family Assistance Centers (FAC). This document provides general considerations for hospital and other community healthcare response providers during planning, response, and recovery efforts. A list of helpful resources is provided at the end of this document.

MCIs highlight the importance of the early establishment of processes for family reunification, notification, assistance, and recovery support. Rapid activation of pre-designated family support locations, related electronic systems (e.g., information sharing, patient tracking, and reunification), plans, and trained personnel are critical to reducing the emotional distress of patients and families and to reducing demands on 911, hospitals, and other systems that may be overwhelmed. Equally important is ensuring that all family support locations are linked to facilitate communication that maintains situational awareness about the general response, resource allocation, and the overall family assistance operation.

TRACIE

There is a significant level of anxiety associated with searching for a missing loved one. There will be delays in gathering data about those missing or located within healthcare facilities, reunification, and notifications due to: lockdown situations and ongoing threats or hazards; the time it takes to safely evacuate a scene; the loss of access or inability to respond to communication devices (for both survivors and those critically injured or dead); and/or patient/victim identification by law enforcement. The lead agency (if law enforcement) may have to concentrate on death notification or investigation support and be unable to allocate sufficient resources to activate an FRC and/or FAC, therefore needing the assistance of healthcare and community partners. People will seek information from social media, traditional media sources, emergency hotlines and call centers, hospitals, law enforcement, fire and emergency medical services, shelters, and the morgue/medical examiner/coroner. While the resources in each community vary substantially, structure and strategies associated with FICs/FSCs, FRCs, and FACs should be part of collaborative disaster response planning involving all community stakeholders.

> Hospitals should integrate their MCI planning and response specific to family support with their healthcare coalitions, emergency management, and local authorities in the event of a large MCI.

Quick Links

[Definitions of Commonly-Used Terms](#)
[Hospital Family Information Center / Family Support Center Planning](#)
[Hospital Incident Command System Activation, Operations, and Roles](#)
[Family Reception Center and Family Assistance Center Planning](#)
[Family Reception Center and Family Assistance Center Activation and Operations](#)
[Communication Planning](#)
[Federal and Private Partner FRC and FAC Support](#)
[Recovery/ Demobilization](#)
[Additional Resources](#)

Definitions of Commonly-Used Terms (Listed in Order of Activation)

The following phrases describe the various types of post-disaster family assistance and are based on location and function. (Though many facilities and jurisdictions use these acronyms interchangeably, for the purposes of this document, hospital assistance centers will be referred to as FICs/FSCs and the community-wide assistance centers will be referred to as FRCs and FACs):

Hospital Family Information Center / Family Support Center (FIC/FSC): A healthcare facility-based location that provides initial information relevant to families arriving at the facility. FICs/FSCs assist with reunification, notification, and providing information and support to patients' loved ones. These operations are the responsibility of the healthcare facility. As soon as the FRC or FAC is opened, most family support functions should be transferred to that location. FIC/FSCs may need to continue to be

TRACIE

open and provide support even if an FRC or FAC is activated. Please note that some hospitals may also use the terms Family Staging Area, Family Assistance Area, or Family Meeting Area to refer to this location.

Family Reception Center (FRC): A centralized, *temporary* location set up in the immediate hours after an MCI for families and friends seeking vetted/legitimate information about loved ones. This center is a jurisdictional responsibility and the lead agency may vary by event type and according to local policy. The FRC may be open for a few hours following an incident and may not have services/resources available for families. The FRC will then transition to a FAC. Please note that some localities will use the term Family Reunification Center.

> Hospitals usually have small family notification rooms within their emergency departments and may be able to expand this service to conference, meeting rooms, or cafeterias. For a larger-scale incident that results in a large number of casualties, however, on-site space will likely be insufficient.

Family Assistance Center (FAC): A secure facility established to provide information about missing or unaccounted persons and the deceased, and to provide a "one-stop shop" of services for victims and their loved ones. FACs may also offer assistance with mental health, spiritual care, and a variety of short-term and longer-term needs of affected family members. Depending on the incident, different agencies may be responsible for activation based on pre-established plans. Law enforcement investigations, including interviews and evidence investigations, may also be one of the ongoing activities at the FAC. If the incident was the result of a crime, and where applicable, victims should receive information from experienced staff about their rights, crime victim compensation, and victim assistance. FACs may not be established until 24-48 hours after an incident (and may be located in the same place as the FRC was).

Hospital Family Information Center / Family Support Center Planning

In the minutes and hours during and after an MCI, people will flock to local hospitals (particularly trauma centers and hospitals closest to the incident), desperate to locate their loved ones. Distraught, they will hope for immediate confirmation that their loved one was or was not involved in the MCI and may not understand the complex process of patient identification and the need for law enforcement and medical examiner/coroner investigations. People will call hospitals in the area of the incident seeking information, particularly when the MCI affects non-residents (e.g., sporting and entertainment venues, university campus events). This may r over-load the hospital switchboards until, and even if, a community/centralized number can be established and staffed.

Hospitals benefit from developing an operational plan that interfaces with a community response to support family members desperate to learn about the status of their loved ones immediately after an incident, but before community resources are made available. Having a solid, exercised family support plan in place will allow a smoother transition to community resources when these are

T R A C I E

activated. Plans needs to be scalable, flexible, and adaptable, and include key triggers for activation. FIC/FSC operations can be organized into three phases:

1. Immediate (establish FIC/FSC, receive patients and loved ones, notification, reunification);
2. Intermediate (concurrent operations with FRC or FAC when majority of patients remain admitted and bulk of loved ones are present in the healthcare facility); and
3. Recovery (majority of patients have been discharged and plans should address assistance with long-term patients admitted).

Coordinating certain functions and resources during the planning process can ensure an efficient, secure, and trauma-informed family check-in and notification process (the following section highlights the Hospital Incident Command System considerations and positions). It is important to set aside spaces for the actions that are separate from patient care areas and away from media attention. (Note: more detailed information is provided in the Los Angeles County Family Assistance Center Planning Guide for Healthcare Facilities.)

> Children may present with patients or unaccompanied *as patients.* A supervised, pediatric-safe area will need to be designated. This area should ideally be separate from the command-type area where children may hear unsettling information. Ensure there is also a process for checking children out to an appropriate caregiver.
>
> *The specifics of this planning are beyond the scope of this document; the ASPR TRACIE Family Reunification and Support Topic Collection includes links to helpful resources.*

Key Considerations and Actions:

- **Conduct an initial check-in of family members and the patient(s) they are looking for.** Include contact information for the family and identifying characteristics of the patient (e.g., hair color, eye color, build, skin color, tattoos, birthmarks, clothing, and jewelry). Sometimes families discover that their loved one did not have a means to communicate or went to a location other than their home.
- It is important to plan for how to determine a loved one's relationship to the patient/victim as many loved ones who will be seeking information may not family or next of kin.
- Establish a **badging/security process** for staff and loved ones to protect site security and unwanted media attention.
- Provide **timely patient lists/access to the electronic health records** from the family support area for the FSC coordinator.
- Ensure that the **coordinator has access** to any jurisdictional patient tracking / incident information system.
- Have a **process for sharing updates with victims' families first, followed by the public** (e.g., message boards, regular verbal announcements, social media). These should occur at defined

T R A C I E

intervals and include situational and hospital information as well as how many unidentified patients remain at the facility and status of a larger family assistance operation.

- Once you are ready to notify family members that information is available about their loved one, take them to a private area that can accommodate the size of the group (should be able to accommodate at least 10 family members).
  - o Those providing this information should be trained professionals that have experience with notification. Try to take into account any cultural and religious sensitivities and know that some loved ones may have access and functional needs and/or disabilities. If the incident is the result of a criminal act, law enforcement, medical examiners, or coroners may perform this function.
- Establish a **process for reconciling unidentified patients** and ensure that it interfaces with the process used by other area hospitals, local law enforcement, and the medical examiner/coroner.
- **Provide healthy snacks and water** for people in the waiting areas.
- Provide access to **telephones, outlets, phone chargers, and internet access** as practical. Internet access may need to be monitored and limited to ensure systems are not overwhelmed. Plan for providing minimal financial support to purchase necessities such as phone chargers.

> Orlando Health's white paper on supporting non-resident/ foreign citizen patients can help healthcare facility emergency planners plan for and better support patients in general and after an MCI.

- Have a process in place for working with foreign nationals and patients that are international visitors (e.g., designating medical proxies, translations services, etc.).

Hospital Incident Command System Activation, Operations, and Roles

> Helpful Resources:
> - HIPAA and Disasters: What Emergency Professionals Need to Know
> - EMTALA and Disasters
> - 1135 Waivers

Activation of the Hospital Incident Command System (HICS) and respective Hospital Command Centers within casualty-receiving facilities is vital to the management of patient surge and concerned family members. Under HICS the **Patient Family Assistance Branch Director** position—which coordinates family support operations—should be activated as early as possible. The Patient Family Assistance Branch Director job action sheet (JAS) requires significant customization by the facility (Appendix IV of the Los Angeles County Family Assistance Center Planning Guide for Healthcare Facilities includes a sample JAS.)

The **Hospital Liaison Officer** communicates with community partners about their status and updates emergency management platforms indicating immediate bed availability and related needs. The sharing of patient tracking information including the survivors and the deceased needs to remain

TRACIE

[HIPAA compliant](#), released with other hospitals, and with approval of local authorities such as law enforcement and the medical examiner as directed. Note that HIPAA has broad exclusions for the exchange of information necessary for family reunification. If there are issues with proposed information exchange, those should be worked out prior to the incident. Some states have additional patient privacy laws beyond HIPAA that should also be taken into consideration.

One role of the **Hospital Public Information Officer (PIO)** is to inform family members about call center numbers and the location of the FRC and/or FAC. They can also assure people who have missing or unaccounted loved ones that the FRC and/or FAC will have updates for them with more information, and that they are communicating with other hospitals. They will also coordinate any press conferences the hospital may conduct regarding patient updates and hospital response efforts. The hospital PIO should also coordinate communications with law enforcement/ investigative PIO to ensure consistent messaging.

Due to the compelling physical and emotional stress experienced by staff/responders who work as a part of FIC/FSC, FRC, and FAC operations, healthcare entities should proactively plan for, staff, and support the **[Employee Health and Well-Being Unit Leader](#) position**.

Emergency Medical Services (EMS) should be a part of the Incident Command/Unified Command structure. Initial patient transport and referral information may be available via their dispatch or operations center and can be shared to facilitate reunification.

- EMS or fire agencies should declare an MCI according to local policies and request hospitals be notified immediately. This is critical to allow for staff and supplies to be mobilized and capacity increased within the emergency department, operating rooms, and intensive care units.
- The dispatch center should have a checklist of notifications which should include supervisory/chief staff, municipal or county emergency managers, public information officer, emergency relief services/partners (e.g., the American Red Cross), victim and witness specialists, local and state health departments, and other stakeholders. Dispatch can continue to provide situational awareness as the incident progresses. They should also have a standard operating guide for how the calls from the community should be handled (e.g., acceptable terminology, high level just-in-time training, pre-scripted templates, and guidance to direct callers to more appropriate resources).

Key Considerations and Actions:

- Prior to an incident:
    - Customize the Family Assistance Branch Chief JAS to meet the needs and logistics of the facility.
    - Conduct planning sessions with hospital general counsel to discuss questions,

concerns, and protocols (particularly for MCI) for sharing patient information, protected health information, HIPAA, and 1135 waivers.

- Upon notification of an MCI, hospitals should activate their hospital incident command centers and become operational within 10-15 minutes (or as soon as it is feasible and safe to do so), even if starting with minimal command elements such as initial notifications and assigning an incident commander.
- As soon as possible, hospital-provided family support services should transition to the inpatient units where patients are located or to the FRC or FAC once operational, and HICS staff should continue to support effort.
- The jurisdictional emergency operations center (EOC) should be activated in large MCI's.
  - A healthcare or healthcare coalition (HCC) representative should have a physical or virtual presence in the EOC to gather and share hospital patient information.

> The activation, management, and demobilization of an FRC and FAC are not typically the responsibility of a hospital or HCC. The lead agency can be local police, fire, or emergency management or a federal agency such as the Federal Bureau of Investigations or National Transpiration Safety Board. The American Red Cross often supports the lead agency in establishing a FAC.

Family Reception Centers and Family Assistance Center Planning

Note: FRCs and FACs have distinct roles (recall the definitions section above) and once the FRC transitions to an FAC, it ceases to operate. For the purposes of this document, FRCs and FACs are included in the same section since some planning considerations overlap, but key distinctions are made as appropriate.

After an MCI, FRCs and/or FACs (or similar temporary locations and call centers) must be established rapidly and with reunification and investigatory support as their primary purpose. Providing death notifications and family support are additional key functions these centers will serve.

Local emergency planners and the county/city manager should have either one centrally pre-identified site or multiple geographically dispersed sites that can serve as FRCs and/or FACs and provide an initial, private, safe gathering place for the loved ones of unaccounted family members. Typically, one site is preferred because more than one can pose staffing and communication challenges; the number of sites will depend on the size and magnitude of the incident. Memoranda of Agreements with such facilities should be completed and these potential sites made known to local HCC members including hospitals, emergency medical service providers, law enforcement, and emergency relief services/partners.

Key Considerations and Actions:

- **Identify sites with potential immediate availability ahead of time** (e.g., municipal park and recreation centers, community centers, hotels, and convention centers). Such venues may be chosen if they are in proximity to—but not within direct view of—the incident site. Ideally, this location would be easily accessible and able to provide sufficient space and services for a significant number of people. Note that some venues may not be appropriate (take into account religious and cultural sensitivities).
    - Knowing ahead of time which facilities have sufficient capacity and capabilities, are compliant with the Americans with Disabilities Act, and have pre-identified 24/7 contact numbers and available staff are best suited so it becomes a "turn-key" operation is important.
    - Emergency planners usually already have relationships with owners of major venues, which can facilitate the identification of sites and development of formal agreements in the planning phase.
- Ensure that staff slated to operationalize an FRC and FAC can be at a designated site **with a goal of having someone on site within 60 minutes of notification**.
- Have **an alternate site with additional capacity available** in the event you need to scale up services. It may be necessary to support an FAC for 1-4 weeks or longer. To avoid confusion and the disruption associated with relocating because of a need for more space, it is best to operate within a larger space from the beginning.
- Once an FRC/ FAC is opened, the **planning for demobilization** should also begin. This enables a smooth transition back for the facility and staff.
- Local emergency management should have a process in place to **rapidly request pre-designated law enforcement, victim/witness specialists, social services, and other personnel** to the FRC/ FAC to initiate services and secure operations.
- Center personnel should have access to radio and phone communications, patient lists, local staff contact lists, and other related information.
- Establish a way to **validate information** about the incident and any decedent-specific information before it is released by credible authorities and in an appropriate manner.
- **Law enforcement should**: coordinate investigation of missing person reports and information; provide security (or coordinate with partners) by setting up perimeters to control access to the location of the FRC and FAC, conduct crowd control, direct traffic, and control media access; and share resources with the public that support reunification and identification.

> People who manage high density locations (e.g., schools, hospitals, stadiums, and entertainment or business centers) should work with local responders to determine an appropriate and accessible nearby "meet-up" site that can be used in the event of an MCI.

TRACIE

- Law enforcement (or in coordination with partners) will **maintain security** from the activation of the FRC, to the switchover to the FAC, and throughout the demobilization process.

FRC and FAC Activation and Operations

Incident Command for the FRC and FAC site is critical to controlling the "organized chaos" that typically follows an MCI and coordinating with the Joint Family Support Operations Center (JFSOC). The JFSOC is an essential element in the control and coordination of the family assistance operation. The JFSOC is a central location where participating organizations monitor, plan, coordinate, and execute the family assistance operation, maximizing the utilization of all available resources and minimizing duplication of services.

An Incident Commander and Command Team should be designated by the lead agency. This facilitates FRC and FAC security liaison capability with Unified Command and community partners, and provides a PIO who can communicate with the Joint Information Center (JIC), and support for operations, logistics, planning, and financial/administrative issues.

Key Considerations and Actions:

- The first thing staff will do once an FRC and FAC is opened is **set up a registration area** for family members.
  - Credentialing badges can be issued for FRC and FAC staff and to identify family members. Planning for credentialing and badging should be done in advance an incident.
  - Have a process in place to handle spontaneous volunteers and news/media reporters. Your plan should include a staging area for both of these groups.
  - If available, have assistance available for those that may need translation services, individuals with specific needs (e.g., nursing mothers and older adults), and those with access and functional access needs.
  - If available, consider having behavioral health professionals staff the entrances and registration areas to provide loved ones support at the beginning of and throughout the process.
- Provide an area and/or staff to provide medical support or referrals for survivors and loved ones.
- Law enforcement and/or the medical examiner/coroner will likely set up a separate area for witnesses and/or loved ones to be interviewed.
  - There may also be a detective, family liaison/ coordinator, or victim navigator or specialist assigned to each family unit.
- **Provide healthy snacks and water** for people in the waiting areas.
  - Only accept food, snacks, and water from known and trusted sources.
  - Consider culturally and situationally appropriate food and beverages.

- **Provide access to telephones, outlets, phone chargers, and internet access** as practical. Internet access may need to be monitored and limited to ensure systems are not overwhelmed.
- Family members who are unable to locate their loved ones should be given a Missing Person form to complete. They can also **share identifying characteristics** of the patient (e.g., pictures, hair color, eye color, build, skin color, tattoos, piercings, clothing, and unique/special jewelry).

> Lessons learned from previous incidents indicate that it may take 48 hours or longer for families to be able to process what they have experienced. Some may experience shock and continue searching for their loved ones despite the information they have been given.

- Families who have not located their loved ones may be paired with an experienced, pre-identified Victim Specialist or a trained companion or community advocate if the incident is not a criminal act, who should remain with them if possible (or at least be accessible) until final notifications are made, as staffing and resources allow.
  - o A companion may also be assigned to families who come to a FAC to access services well after death notifications have been made.
- Ensure the family liaison(s) is clearly visible to center visitors and known by staff so they can quickly direct people to further assistance. Behavioral health and spiritual care providers are essential team members and should be pre-identified, easily visible, and able to report to the FRC and/or FAC.
  - o These individuals should also be specifically trained in how to respond to victims of MCIs.
  - o Determine where in the facility and at what point in the process are most important for them to be present if staffing/resources are limited.
  - o Providing pet therapy may also be considered if available through community partners.
- Official family briefing sessions should be held regularly (at least once a day, ideally twice a day or more frequently as needed). These are held privately within the FRC and/or FAC; media would not be included. Families/loved ones should be notified of any updates before shared with the media and public.
- Media briefings should be held away from the FRC and/or FAC to minimize retraumatization.
- Your media spokesperson will likely

Figure 1. Comfort dogs "Comfort Dogs" consoled Desert Springs Hospital (NV) patients, visitors, and staff after an MCI.

TRACIE

have to respond to the same questions repeatedly throughout media update sessions. The FRC will need to **remain open 24/7** during the initial period after the incident. FACs may also initially be open 24/7, but after a full transition from the FRC to FAC, hours may be shortened.

- FRC and/or FAC staff are typically assigned **12 hour shifts** to support continuity of operations which are then shortened accordingly to accommodate FAC operating hours.
- **Death notifications** are made by bringing each family unit (next of kin and those with the next of kin) into a private, secure room that can hold a minimum of 10 people. This process is often managed by the coroner/medical examiner and/or law enforcement and may be supported by a mental health provider, spiritual care advisor, caseworker, and/or nurse.
- A **pre-established exit route** needs to be in place so that FRC and/or FAC staff can escort and protect family members from the media and other onlookers after such notifications.
- Each decedent's family should be provided with a point of contact that they can reach out to for information about ongoing needs, preferably a trained, pre-identified victim advocate/specialist. Alternatively, each organization represented at the FAC may create and share a mechanism families can use to request contact information or actual services.
- The FRC and/or FAC should **coordinate family services** from a multitude of agencies, including air and ground transportation, emergency relief services/partners, agencies such as Voluntary Organizations Active in Disasters (VOAD), child and family services, healthcare, consulates, translation services, legal aid, lodging, and senior services.
- All persons who participate in an FRC and FAC are expected to follow a **code of conduct** respecting the need for privacy for family members, confidentiality of information, and appropriate behavior. This includes refraining from sharing information about their work on social media. Entities involved in response may wish to consider having a social media policy for staff and volunteers.
- **Donations** to an FRC and/or FAC can come from the immediate community and beyond and may become overwhelming.
  o The PIO should be ready to communicate what types of donations are needed and where to send these if there is such need. They should also work with FRC and/or FAC PIOs to determine if there is an official fund for donated monies and, if so, the preferred donation process. Cash donations can be made to specific organizations.
  o Discourage the public from donating home-cooked foods, and provide a wish list for needed items from commercial vendors (already vetted and known) who want to donate food or water or supplies.
  o Note that certain foods are not appropriate from a food safety perspective (e.g., foods that must be kept at a certain temperature). Furthermore, some foods are not appropriate to serve (e.g., meat on the bone and red sauces) because they may conjure negative images of the incident for some people.
  o Ensure there is a specified schedule and convenient location for donation deliveries.
  o Other communities who have suffered tragedies may extend valuable offers to support response operations. You may wish to accept assistance from local community

services first then reach out to other communities if necessary (note that communities that recently experienced tragedies may wish to assist, but may not have recovered to the extent that they can assist in a healthy way).

As the need for services decreases in the weeks after an MCI, the FAC will hold a final family briefing to explain transitional services and plans (demobilization of a FAC operation should be communicated to families in advance of this briefing). This can include referral to a virtual FAC for callers requesting resources. Note that in some instances, and depending on resources and the incident type, the FAC may need to be predominantly virtual.

Communication Planning

In today's quick-paced environment, social media updates often occur at the same time 911 calls are being made. Community members are able to see and hear the tragedy unfold unfiltered through firsthand accounts, driving the need for a robust, rapid informational response by the jurisdiction. In some areas, an internet-based system may be used to provide updates to hospitals and emergency management. In others, radio communication, phone (landline, VOIP, cell), or paging may be used. Some HCCs have sophisticated web-based systems that can respond to patient name-based queries and provide matches with those names at area hospitals. Though this is beyond the capabilities of most systems at present, it is a valuable asset to be considered. Be aware that communication platforms can be overloaded or otherwise inaccessible just after an MCI. Some large incidents can actually "take down" communications or authorities may need to halt communication technology for security reasons. If power is out or the incident is protracted, cell phone batteries may be drained. Plan accordingly and determine how you will communicate with staff, other community partners, and survivors.

> Public figures (e.g., the mayor, county commissioners, the governor, legislators, and even the President) and celebrities may wish to demonstrate their support. Plan ahead for these VIP visits, as they may consume significant resources that are in short supply.

A 24/7 trigger must be established to be able to initiate communication resources after initial information is known to authorities, ideally within the first 30 minutes of an MCI. Callers want to know what has happened and what should they do. The first messaging might be that an incident has occurred at a specific location, a response is occurring, and callers should remain clear of the area. Specific hazards (e.g., evacuation areas for plume, search for a shooter) should also be announced, as well as any designated number for victim/patient information. Initial municipal text and email notifications about the incident with updates to residents already signed up for alerts can also help.

> A virtual FAC may be used to support those who cannot get to the designated center because they are out of the area or have other circumstances. A mobile FAC may be helpful for local victims who are unable to travel to the FAC. The mobile unit could be deployed to a hospitalized victim or to a family member who is homebound or does not have the technological tools needed to maintain situational awareness.

Pre-scripted messaging can be tailored to support recorded/incident-specific information. There should be an official account designated as the source for all social media messaging, with all other accounts sharing verified information with the official account.

> Anticipate that for every casualty, at least three family members will call for information.

Key Considerations and Actions:

- Communications staff should be trained to work in crisis situations.
- A **Joint Information System (JIS) should be initiated** by the Emergency Operations Center and official information channels established through social and traditional media.
- The hospitals receiving patients may encourage loved ones to text each other (or use social media to communicate) instead of going directly to/ calling hospitals or 911 unless they are experiencing an emergency.
- A **toll-free hotline/call center** should be set up and staffed as practical for community members seeking specific information.
    - Operators should be aware of available resources and how to recommend them to callers.
    - Consider using a local disaster community hotline number or reverse 911 system to share initial and regularly updated messaging.
    - Hotline staff should receive updated patient lists from the hospitals (or other entity such as HCC) and be able to direct family members to the appropriate hospital, FRC, or FAC.
    - Language interpreters and accessibility devices should be available.
- **Include communications planning** that enables staff to be available within the first hour of an MCI and surge up to handle a large number of calls. This will be especially helpful to out-of-area, out-of-state, or international callers who are searching for loved ones.

Federal and Private Partner FRC and FAC Support

Many local, state, and regional agencies have potential roles and responsibilities related to family assistance after an MCI. Healthcare facilities should work with their local law enforcement partners to ensure a seamless investigation and victim advocate process for patients and their loved ones. It may become necessary for the healthcare facility to have a senior law enforcement and fire department representative at the hospital's center during the response phase of the incident to assist with messaging, operations, and logistics. In any type of incident, roles may overlap. In criminal cases, law enforcement or the FBI may be the lead agency for the FRC and/or FAC. In other cases, local emergency management or other local agency may be responsible. In a legislated aviation or rail accident, the FAC is established by the airline or rail carrier and managed by the National Transportation Safety Board's (NTSB) Transportation Disaster Assistance Division. While the American Red Cross does not typically lead FRCs or FACs, they do play a significant support role. The American

TRACIE

Red Cross will mobilize their Disaster Mental Health, Disaster Health Services, and Disaster Spiritual Care teams in addition to leadership to support FAC operations. They may also mobilize volunteers to assist with feeding and supporting family members and first responders as necessary. Table 1 illustrates the roles played by potential lead agency/organization depending on the type of disaster.

Table 1. Incidents and the Role of Lead Agencies and Organizations

Type of Incident/Disaster	Potential Lead Agency/Organization	Description
Legislated Aviation and Rail Accidents[1]	National Transportation Safety Board (NTSB) in coordination with the American Red Cross and the affected domestic or foreign air carrier or rail passenger carrier	Following a legislated aviation or rail passenger accident, the NTSB is responsible for coordinating federal government resources to support local and state governments, disaster relief organizations, and the affected air or rail carrier in order to meet the needs of accident victims and their families. The American Red Cross also holds specific obligations focused on the provision of disaster mental health services to accident victims and their families. Legislated air carriers and rail passenger carriers also hold specific family assistance obligations established in the legislation.[2] They have designated family assistance teams that exercise regularly for such incidents. They also have pre-identified venues that can be used as an FRC and/or FAC. The NTSB Transportation Disaster Assistance (TDA) works closely with federal, state, local, volunteer agencies, and the

---

[1] Aviation and rail accidents are classified as "legislated" by the NTSB if they meet the following criteria established per 49 USC 1136 (aviation) and 49 USC 1139 (passenger rail):

1. Accident occurred in the U.S. or its territories;
2. Accident resulted in a major loss of life; and
3. Accident involving a domestic or foreign air carrier that has economic authority to operate in the U.S issued by the US Department of Transportation (DOT). A list of domestic certificated air carriers is available on the DOT website. With only a few exceptions, all foreign air carriers operating within the U.S. hold economic authority; or
4. Accident involving an interstate intercity rail passenger carrier (i.e. Amtrak) or an interstate or intrastate high-speed rail operator.

[2] Family assistance obligations are set forth in:
- 49 USC 41113: domestic air carrier obligations
- 49 USC 41313: foreign air carrier obligations
- 49 USC 24316: rail passenger carrier obligations

Type of Incident/Disaster	Potential Lead Agency/Organization	Description
		transportation carrier to meet the needs of disaster victims and their families. Information sharing, family counseling, victim identification and forensic services, communicating with foreign governments, and translation services are a few of the services that can be coordinated.
Other transportation accidents investigated by the NTSB, but not covered by federal family assistance legislation (e.g. general aviation, commuter rail, highway, marine and pipeline)	Jurisdiction that has experienced the MCI	The jurisdiction that has experienced the MCI is responsible for coordinating services in support of accident survivors and family members. The NTSB will strive to support the family assistance operation and will serve as the primary point of contact for accident survivors and family members regarding the federal safety investigation. The NTSB will also coordinate with the affected transportation operator, if one exists.
Criminal	DOJ, FBI	In criminal incidents the FBI has a Terrorism Task Force and Victim Assistance Teams which will support a FRC and/or FAC.
	DOJ, Office for Victims of Crime (OVC)	The OVC has a definition of criminal mass violence or terrorism. For incidents that meet OVC's definition of criminal mass violence or terrorism, OVC will offer the state or jurisdiction on-the-ground technical assistance, typically through experienced consultants or OVC staff. This support is designed to help victims and may include assistance in implementing best practices in response, sharing of available resources, conducting a victim needs assessment, victim service mapping, or supplemental funding for victims needs through the Antiterrorism and Emergency Assistance Program (AEAP.) States and jurisdictions can also request training and mass violence planning assistance from OVC.
Other	Lead City or County Government Agency	For multi-casualty incidents or other disasters that are not covered under the Aviation Family Assistance Act of 1996, a local city or county may take the lead to set up and manage a FAC, in coordination with other government and non-government partners including the American Red Cross.

Recovery/ Demobilization

Demobilization of the FRC is dependent on when there can be a transition to a FAC. Law enforcement should maintain security throughout the demobilization process. Final family briefings to explain transitional services should be part of the demobilization process and can include referrals to the FAC or virtual FAC if applicable.

Check out ASPR TRACIE's Select Disaster Behavioral Health Resources page for related articles, plans, tools, and templates.

The recovery process needs to include continuous provision of behavioral health services, spiritual care, or other case work services to support survivors, their loved ones, law enforcement, EMS, hospital staff, and the staff of the FRC and/or FAC as everyone will be affected by participating in the response. It is important that responders and those who staffed the centers receive a trauma debrief and information on available employee assistance programs.

London established a "Family Resiliency Center" after their bombings, acknowledging that many might need emotional support over a longer period of time. Similar centers were established in Las Vegas, Orlando, and Boston. Multiple, coordinated pathways to healing for all involved can help ensure community resilience. It is not unusual for community, family, and responder support to continue for years after an MCI through the formation of memorials and anniversary recognitions. Family members may also engage in advocacy efforts with the goal of preventing similar tragedies. Appropriately providing support to families following a large incident can help promote recovery from a tragedy in the community.

TRACIE

Additional Resources

ASPR TRACIE has developed/assembled a number of published resources that include details associated with the planning and management of FSC/FICs, FRCs, and FACs.

ASPR TRACIE-Developed Resources

- [ASPR TRACIE's Select Disaster Behavioral Health Resources Page](#)
- [ASPR TRACIE's Select Mass Violence Resources Page](#)
- [Communication Systems Topic Collection](#)
- [Emergency Public Information and Warning/Risk Communications](#)
- [EMTALA and Disasters](#)
- [Family Reunification and Support Topic Collection](#)
- [Fatality Management Topic Collection](#)
- [Healthcare Response to a No-Notice Incident: Las Vegas (Webinar)](#)
- [HIPAA and Disasters: What Emergency Professionals Need to Know](#)
- [Hospital Surge Capacity and Immediate Bed Availability Topic Collection](#)
- [Incident Management Topic Collection](#)
- [Information Sharing Topic Collection](#)
- [Mental/Behavioral Health (Non-Responders) Topic Collection](#)
- *The Exchange* [Issue 3: Preparing for and Responding to No-Notice Incidents](#)
- *The Exchange* [Issue 7: Providing Healthcare After Mass Casualty Incidents](#)

Family Assistance Center Resources

California Emergency Medical Services Authority. (2014). [Hospital Incident Command System Guidebook, Fifth Edition](#).

> This guidebook is intended to meet the needs of all hospitals, regardless of their size, location, or patient care capabilities. Updates to this version of the guidebook include greater emphasis on incident action planning, including the introduction of new, more practical tools; and the reformatting, consolidation, or expansion of the Incident Planning Guides (IPGs) and Incident Response Guides (IRGs) for improved application among hospitals.

Chatham Emergency Management Agency. (2013). [Chatham County Emergency Operations Plan: ESF-08 Annex Appendix 8-3: Family Assistance Center.](#)

> This plan includes the Family Assistance Center Concept of Operations and protocols for Chatham Emergency Management Agency (Georgia). It addresses roles and responsibilities of the multiple response agencies.

TRACIE

Government of the District of Columbia. (n.d.). [District of Columbia Family Assistance Center (FAC) Plan.](#) (Accessed 8/8/18.)
    This plan--though specific to the District of Columbia--can serve as a mode for others interested in planning to establish a Family Assistance Center after a mass fatality event to provide services to those seeking assistance regarding the status of their loved ones.

Los Angeles County. (2013). [Family Information Center, Planning Guide for Healthcare Facilities](#).

    This document provides guidance to healthcare entities in the development of a plan to provide information, support services, and reunification assistance to family members of disaster patients. It provides the operational guidance to activate, operate, and demobilize a family information center. Appendices include FIC forms, FIC location set up and criteria, activation flow diagram, just in time training materials, operations flow diagram, patient identification, and mental health resources.

Los Angeles County Department of Mental Health. (2017). [Providing Effective Services to Members of the LGBTQI2-S Community Following Disasters, Public Health Emergencies and Mass Fatality Events.](#)

    Terrorist incidents such as the Pulse Night Club Shooting in June 2016 illustrate how important it is for emergency managers and disaster responders to understand and provide culturally competent disaster assistance to the Lesbian, Gay, Bisexual, Transgender, Questioning, Queer, Intersex, and Two-Spirit (LGBTQI2-S) community; particularly if members of the community are targeted or impacted by a particular disaster. This document lists barriers community members may encounter after an incident and strategies for helping them access services. Links to related resources are provided at the end. This document is also available in [Spanish](#).

Los Angeles County Office of Emergency Management and Los Angeles County Department of Mental Health. (2014). Los Angeles County Operational Area Family Assistance Center Plan (Contact ASPR TRACIE to access this file.)

    This plan provides a framework for the activation, operation, management, and demobilization of a County Operational Area (government led) Family Assistance Center (FAC) during large scale mass casualty incidents (e.g., earthquakes) and local incidents such as shootings and explosions. The establishment of a FAC can: ensure a place for loved ones to gather information; serve as a coordination spot for first responders; and be a location where emotional support and other types of health support can be provided. (The Los Angeles County Operational Area covers all 88 cities and the unincorporated areas in the county).

Louisiana Department of Health and Hospitals. (2006). [Reuniting the Families of Rita and Katrina: Louisiana Family Assistance Center.](#)

TRACIE

This report documents key missions of the Louisiana Family Assistance Center after Hurricanes Rita and Katrina. They provide background on their tasks, challenges, statistics of families supported, and lessons learned. The center was open for 11 months and had 13,197 missing reports filed, 99% of the missing list cleared, and 98% of the human remains have been identified.

Maine Disaster Behavioral Health. (2018). Family Reunification Plan.

This plan includes the Family Assistance Center protocols for Maine Disaster Behavioral Health. It addresses roles and responsibilities of the multiple response agencies, and core and support services.

National Fire Protection Agency. (2018). NFPA 3000™ (PS): Standard for an Active Shooter/Hostile Event Response (ASHER) Program.

The NFPA 3000™ (PS): Standard for an Active Shooter/Hostile Event Response (ASHER) Program identifies the minimum program elements needed to organize, manage, and sustain an active shooter and/or hostile event response program that helps mitigate the risks, effect, and impact on an organization or community affected by these events. Chapter 19 applies to medical facilities who are preparing to receive patients from an active shooter/hostile event, while Chapter 20 addresses comprehensive recovery including the Family Assistance Center.

Northwest Healthcare Response Network and Public Health- Seattle & King County. (2012). Family Reception Services Guidelines for Hospitals, Volume 2.

This document provides guidance for hospitals to activate and operate a Family Reception Services area following a mass casualty or mass fatality event. It includes activation, patient identification and family reunification, demobilization, communications, staffing, and various checklists.

Public Health- Seattle & King County. (n.d.). Mass Fatality and Family Assistance Center. (Accessed 8/8/18).

This site includes mass fatality guidance, tabletop exercises, family reception services guidelines, and planning templates.

Texas Department of State Health Services. (2016). Family Assistance Center Toolkit.

This toolkit provides guidance for FAC site selection, staffing and management, considerations for each key component (e.g., family briefing, call center, behavioral health services), and demobilization.

U.S. Department of Justice, Federal Bureau of Investigation; and National Transportation Safety Board. (n.d.). Mass Fatality Incident: Family Assistance Operations. Recommended Strategies for Local and State Agencies. (Accessed 8/8/18.)

TRACIE

This guide was developed for local and state agencies involved in the response to mass fatality events. It provides an overview of the family assistance process and the FAC operations as they relate to transportation and criminal incidents.

U.S. Department of Justice, Office for Victims of Crime (OVC). (2015). Helping Victims of Mass Violence and Terrorism: Planning, Response, Recovery, and Resources.

This toolkit contains checklists, forms used in previous incidents, and information about family assistance center best practices. It also contains job descriptions and lists of potential partners in response.

U.S. Department of Justice, Office for Victims of Crime (OVC). (2017). Vicarious Trauma Toolkit.

OVC recognized that professionals' response to crime victims can either set a path forward to healing or be re-traumatizing and professionals themselves can be traumatized by these events. The toolkit was developed on the premise that exposure to the traumatic experiences of other people—vicarious trauma—is an inevitable occupational challenge for those helping victims. This publication includes tools and resources to provide the knowledge and skills necessary for organizations to address the vicarious trauma needs of their staff.

Virginia Department of Emergency Management. (2012). Commonwealth of Virginia Family Assistance Center Plan.
This plan provides state agencies (within Virginia) with the management framework under which they will cooperate to establish, operate, and close a FAC. The FAC core and support services are addressed.

Washington Military Department. (2012). Puget Sound Region. Victim Information and Family Assistance Annex: Regional Catastrophic Disaster Coordination Plan.

This plan provides a framework to facilitate multi-county, regional coordination of situational awareness and response related information for the purpose of determining when a FAC is needed after a catastrophic incident. It includes several tools (e.g., checklists, templates, and job action sheets) that may be used for planning or response to implement a FAC.

TRACIE