

Puget Sound Region



Pre-Hospital Emergency Triage and Treatment



**Annex
July 2014**



Regional Catastrophic Disaster Coordination Plan

Part 1: User Guide

Part 2: Annex

The above links will take you directly to the User Guide or the Annex.

Pre-Hospital Emergency Triage and Treatment Annex

User Guide

Puget Sound
Region



Pre-Hospital
Emergency Triage
and Treatment
Annex
July 2014



Regional Catastrophic Disaster
Coordination Plan

User Guide Purpose

This User Guide is designed to 1) provide an overview of the Pre-Hospital Emergency Triage and Treatment (PETT) Annex and to 2) be a practical, hands on mechanism for navigating regional coordination of pre-hospital response. The User Guide is not a replacement for the full text of the Annex.

How to Use this Guide

This document provides an overview and practical guide to using the Pre-Hospital Emergency Triage and Treatment Annex. The full text of the Annex is contained in Part 2 of this document.

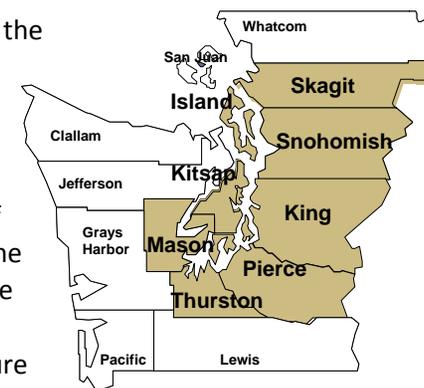
- Clicking on a blue box with page number (p. #) will bring you to relevant information within this User Guide and full Annex document.

 +  After clicking on a blue link, hold the **Alt** key down and press the **left arrow** key to return to the page you were viewing.

- Clicking on [blue links](#) will bring you to relevant external resources.

Context

When planning for and responding to the medical or health needs of victims in a catastrophe, Emergency Medical Services (EMS), Public Health, and the medical community must be partners in promoting a continuum of care that stretches from the field to the hospital or point of definitive care. The *Pre-Hospital Emergency Triage and Treatment Annex* provides the structure and processes that are necessary to facilitate communication among EMS, Public Health, and the medical community during response.



The Annex was developed to promote collaboration in the 8-county Puget Sound Regional Catastrophic Preparedness Grant Program (RCPGP): Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, and Thurston, and the tribal nations, cities and towns within these counties.

The Annex supports the regional [Coordination Plan](#).

0-12 hours

12- 72 hours

72 hours – 1 week



A

ELEMENTS OF INFORMATION
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EMS COORDINATION GROUP

B

Activate EMS Coordination Group (p. UG-4)

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EMS Group Response According to Tiered Incident Levels (p. UG-8)

TIP:

Clicking on the highlighted blue page number

(p. #) to the right of each topic will take you directly to that page within the User Guide.

After clicking on a page number, hold the **Alt** key down and press the **left arrow key** to return to the page you were viewing.



Elements of Information

Once an incident occurs, EMS agencies and hospitals need to develop a regional situational awareness relative to pre-hospital emergency triage and treatment. The table below summarizes the types of information that would be requested from different entities to inform EMS Coordination Group meetings. See Appendix E [\(p. 53\)](#) for more detailed reporting templates that may be used during incident response.

Sample Essential Elements of Information (EEI) Template for Regional Situational Awareness

<p>Fire/EMS</p> <ul style="list-style-type: none"> • Status of EMS personnel • Field Treatment Site status 	<p>Public Health</p> <ul style="list-style-type: none"> • Hazard-specific information
<p>Medical Program Director</p> <ul style="list-style-type: none"> • Priorities for pre-hospital response • Potential changes in standard of field practice and patient care 	<p>Regional DMCC</p> <ul style="list-style-type: none"> • Status of hospitals • Status of medical surge strategies that may impact pre-hospital response • Estimated number of casualties

Activation of EMS Coordination Group

Any core member of the EMS Coordination Group, as well as County Emergency Managers, County or City Fire Chiefs, or a County Executive or City Mayor (or his/her designee) within the Puget Sound Region may request the implementation of this annex.

If any of these conditions apply...

- A potential or imminent threat of a catastrophic incident
- Implementation of more than one County, City and/or Tribe Mass Casualty Incident (MCI) plan
- Declaration of emergency by at least one local jurisdiction or tribal authority
- Governor-declared State of Emergency
- Request/initiation of regional DMCC for patient distribution
- Implementation of local and/or State Public Health and medical emergency response plans
- Determination by EMS officials that regional information sharing is needed to develop common situational awareness and facilitate strategic or policy level coordination
- Determination by a jurisdiction that it can provide assistance to affected jurisdictions during a catastrophic incident
- Any incident that has a catastrophic impact on critical infrastructure, including communications and transportation systems within the region

... Activate the Regional EMS Coordination Group by ... [\(p. 14\)](#)

- Contacting the **Pierce County Department of Emergency Management** at 253-798-7470
- Requesting that the Duty Officer notifies all EMS Coordination Group core members that a meeting has been requested
- Providing the Duty Officer with the date and time for the virtual meeting, as well as the desired method of communication

The **Pierce County Everbridge** emergency notification system is the default method of communication

If telephone and internet connections are unavailable, the EMS Coordination Group Coordinator, or any core member of the EMS Coordination Group in the Coordinator's absence, may initiate the regional call on satellite phone or amateur radio through County EOCs.

EMS Group Role

The EMS Coordination Group provides senior leadership and strategic coordination to pre-hospital planning and response to actual or potential catastrophic incidents affecting the Puget Sound Region.

The Group's **primary roles** include:

- **Gather incident information** from jurisdictions in order to develop common situational awareness of the region's pre-hospital status and response needs.
- **Develop recommendations on strategic or policy-level issues** related to the region's pre-hospital response. Issues may include:
 - Prioritization of pre-hospital response requirements when the region's pre-hospital response system is severely strained or overwhelmed.
 - Establishment and operation of Field Treatment Sites.
 - Distribution of patients within the regional health care system based on patient need(s) and a concurrent assessment of hospital capabilities during incident response.
 - Implementation of State protocols establishing the standard for field performance in a catastrophic incident.

EMS Coordination Group has no decision-making authority; its recommendations are intended only to provide decision makers with the information they need to understand the region's pre-hospital response needs so they can make informed decisions.

Vertical Coordination (p.19)

The formal pathway for incident management coordination and support flows from local jurisdictions to their respective County Emergency Operations Center (EOC), then to the State EOC, and finally to the Federal Government.

The EMS Coordination Group does not usurp or infringe upon this coordination structure.

Instead, the EMS Coordination Group provides a mechanism for pre-hospital responders to collect and share information in order to develop regional situational awareness and recommendations on strategic or policy-level issues related to the pre-hospital response.

EMS Group Composition and Structure

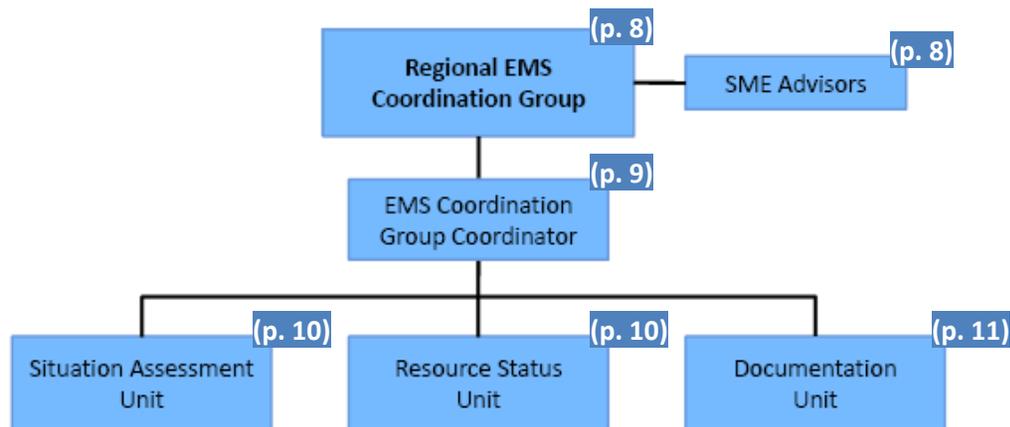
Group Composition (p. 7)

Senior-level administrators or officials:

- County Fire Chiefs’ representative (counties may default to County ESF 4)
- Regional DMCC Representative (Harborview Medical Center) and back-up DMCCs (Multicare Good Samaritan Hospital and Providence Everett Medical Center)
- County Public Health Officer (counties may default to County ESF 8)
- Medical Program Directors (eight counties and City of Seattle)
- Washington State ESF 8 representative

Organizational Structure

EMS Coordination Group is supported by EMS Coordination Group Coordinator, Situation Assessment Unit, Resource Status Unit, and Documentation Unit.



Core Members’ Responsibilities

- Provide input on the pre-hospital response needs.
- Develop consensus-based recommendations to prioritize pre-hospital response needs across the region.
- Develop consensus-based strategic or policy recommendations for the pre-hospital response.
- Communicate regional situational awareness and Group’s recommendations back to their respective Agency Administrator.
- Coordinate the implementation of Washington State protocols that establish the standard for field performance for EMS.
- Support the Regional DMCC in promulgating a strategy for the efficient distribution of patients to area hospitals.
- Attend functional meetings annually for trainings/exercises, to review this annex, develop policies and procedures, and maintain up-to-date membership.

EMS Coordination Group Meetings

The purpose of the meeting is to facilitate coordination and discussion around policy-level issues that require EMS Coordination Group input.

WHO	EMS Coordination Group members	WHAT	EMS Coordination Group Chairperson will moderate discussion:	TOOLS
WHEN	Time for the initial call set by core member who requests activation of the EMS Coordination Group. Subsequent calls as needed.		<ul style="list-style-type: none"> • The Chairperson introduces an issue/problem. • Representatives and SME advisors discuss the specific issue/problem and its implications for the regional pre-hospital response, and identify options or potential solutions. • The Group develops a consensus-based recommendation for the issue/problem. 	Agenda – Appendix F (p. 55) Guide for Chairperson and Coordinator – Appendix G (p. 57)
WHERE	Virtually: through the Pierce County Everbridge emergency notification system.			

Issues to solve

The following are examples of potential strategic or policy-level issues that may be appropriate for consideration by the EMS Coordination Group during incident response. This list is not meant to be comprehensive and may be modified as more information is gained through EMS Coordination Group trainings or exercises.

- Development of common regional situational awareness for the pre-hospital response
- Development of a plan for regional patient distribution when local healthcare facilities are overwhelmed
- Development of recommendations for pre-hospital response priorities when multiple incidents are occurring simultaneously across jurisdictions within the region
- Development of recommendations for use of limited pre-hospital resources
- Coordination of Field Treatment Sites during incident response
- Guidance on Personal Protective Equipment (PPE) for pre-hospital responders
- Coordination/implementation of crisis standards of care or WMD Field Protocols

Tiered Incident Levels

The implementation levels of the EMS Coordination Group are aligned with the five levels of incident complexity, or “incident levels” used in local emergency planning within the Puget Sound Region: [\(p. 15\)](#)

Incident Level & Operational Impact	EMS Coordination Group Action Items
<p>Levels 5 & 4 Impact Levels: “Normal” or “Low”</p>	<p>EMS Coordination Group Coordinator conducts routine activities:</p> <ul style="list-style-type: none"> • Maintains contact lists, documents resources, tests communication systems, and conducts annual trainings.
<p>Level 3 Impact Level: “Moderate”</p>	<p>EMS Coordination Group Coordinator conducts activities to be on standby:</p> <ul style="list-style-type: none"> • Notifies Group members and relevant planning partners, tests communication systems, updates relevant information, and gathers information on incident threat.
<p>Level 2 Impact Level: “High”</p>	<p>The EMS Coordination Group is activated:</p> <ul style="list-style-type: none"> • Convenes via conference call. • Reviews the status of regional MCI caches, discusses/documents local mutual aid and resource sharing, and identifies potential resource requests. • Develops and disseminates pre-hospital status summaries for the Puget Sound Region and any consensus-based strategic or policy recommendations, if applicable, to relevant planning.
<p>Level 1 Impact Level: “Severe”</p>	<p>All action items listed in Level 2 are completed. Additional potential actions:</p> <ul style="list-style-type: none"> • Develops consensus-based recommendations prioritizing requests for State and Federal pre-hospital assistance. • Discusses strategic or policy issues. • Gathers information (via State ESF 8 representatives) on the activation of NDMS teams and potential forward movement of patients outside of the Puget Sound Region. • Identifies pre-hospital resources in the Puget Sound Region needed to move patients to evacuation airheads, if requested by NDMS.

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Puget Sound Region



Pre-Hospital Emergency Triage and Treatment

Annex
July 2014



Regional Catastrophic Disaster Coordination Plan

RECORD OF CHANGES

The following table provides a record of major changes made to the Pre-Hospital Emergency Triage and Treatment Annex since the date of publishing the first draft to keep the plan consistent with current policies.

Date of Change	Part, Annex, or Attachment Changed	Posted by
03/28/11	Initial PETT Annex Approval	Vickery/Hastings
11/30/12	Update EMS Coordination Group Contact List	DeBell
11/30/12	Add Field Treatment Site Guidance Document	Pearson
11/30/12	Add Sample MCI Plan and MCI Best Practices	Johanns
10/01/13	Add Training and Exercise Section	Harmon
10/01/13	Update EMS Coordination Group Contact List	DeBell
02/01/14	Add Medical Resource Surge Tool	DeBell
02/12/14	Incorporated EMS transportation resource requests into the document	D. Johanns
05/31/14	Incorporated Active Shooter Rescue Task Force Best Practices document and Forward Movement of Patients Concept of Operations	D. Johanns
05/31/14	Updated Contact List	C. DeBell
7/15/14	Addition of User Guide	BERK

Puget Sound Regional Catastrophic Preparedness Program PRE-HOSPITAL EMERGENCY TRIAGE AND TREATMENT ANNEX

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I. OVERVIEW AND ASSUMPTIONS

A. Purpose

This annex to the *Puget Sound Regional Catastrophic Disaster Coordination Plan* provides a strategic framework for regional coordination to plan for or respond to any naturally occurring or man-made catastrophe. Such incidents may produce medical surge demands that stress or overwhelm Emergency Medical Services (EMS), Public Health, and health care organizations in the Puget Sound Region and require a regionally coordinated response to promote continuity of patient care from the field to the hospital or other definitive care site. This annex provides the necessary coordination structure and processes to facilitate a multi-jurisdictional, multi-disciplinary pre-hospital response to a catastrophe.

The EMS Coordination Group, which is presented in this annex as a regional entity to facilitate pre-hospital coordination during a catastrophe, does not usurp or infringe upon the formal chain of command during incident response. Likewise, the coordination processes used by the EMS Coordination Group do not replace established mechanisms for incident management support, which flow from local jurisdictions to their respective County Emergency Management Agency and then to the Washington Military Department, Emergency Management Division. Rather, this annex provides a mechanism for pre-hospital responders to collect and share information in order to develop regional situational awareness and recommendations on strategic or policy issues affecting the pre-hospital response. These recommendations are intended to help decision makers better understand the region's pre-hospital needs so they can make informed decisions in support of the region's planning for and response to catastrophic incidents (see section IV).

B. Scope

This annex applies to EMS providers, public health officials, Medical Program Directors, health care organizations, and any other entities responsible for providing or coordinating Pre-Hospital Emergency Triage and Treatment (PETT) in the Puget Sound Region of Washington State. For the purposes of this annex, the Puget Sound Region (Figure 1-1) is defined as the Seattle Urban Area (UA)/Combined Statistical Area (CSA), and includes the counties of: Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Thurston; local jurisdictions and Tribal governments located therein; as well as associated public, private, and non-profit businesses. The Puget Sound Region is located in Federal Emergency Management Agency (FEMA) Region X.

This annex addresses the overall coordination of field triage, treatment, transportation and disposition of patients inside the Puget Sound Region, from first alarm through the emergency medical and hospital system response.

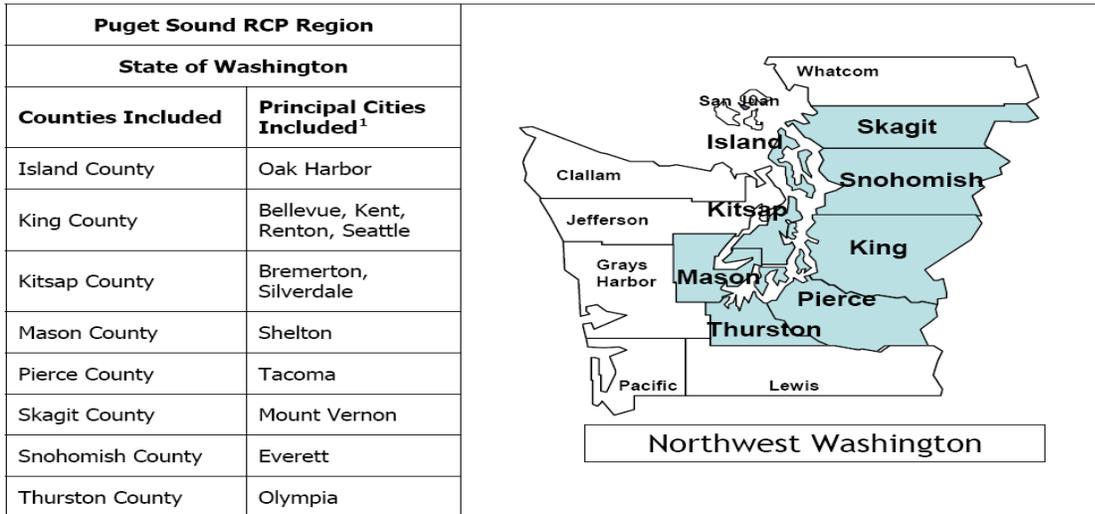


Figure 1-1: Designated Region for Catastrophic Coordination

C. Situation

Demographics

According to the U.S. Census Bureau, the estimated population in 2009 of the Seattle-Tacoma-Olympia Combined Statistical Area was nearly 4.2 million people. This represents a 13 percent increase in the population size for the CSA since 2000. The City of Seattle has the largest population of any metropolitan area in the Puget Sound Region with approximately 582,454 people, or a population density of 6,717 persons per square mile. The region’s other major cities include Bellevue to the east (population of 118,186 and population density of 3,940/sq mile); Tacoma to the south (population of 196,532 and population density of 3,931 persons/sq mile); Everett to the north (population of 98,514 and population density of 3,079 persons/sq mile); and Bremerton to the west (population of 35,295 and population density of 1,604/sq mile).

Table 1-1 provides basic demographic information relevant to the PETF capability for the eight counties within the Puget Sound Region.

Table 1-1 Demographic characteristics for the Puget Sound Region

County	Total Population (2011 est) *	Population density (persons per sq mile - 2010) *	Number of hospitals +	Number of licensed beds ±	Trauma services
Island	78,971	376	1	51	1 (level 3)
King	1,969,722	912	20	5271 (67% located in the City of Seattle)	1 (level 1) 1 (ped level 1) 3 (level 3) 4 (level 4) 1 (level 5)
Kitsap	254,633	635	2	297	1 (level 3)
Mason	61,019	63	1	68	1 (level 4)
Pierce	807,904	476	5	1,244	2 (level 2) 1 (level 3) 1 (level 4) 1 (ped level 2)
Skagit	118,109	67	3	68	1 (level 3)
Snohomish	722,400	341	4	699	1 (level 2) 1 (ped level 3) 3 (level 4)
Thurston	256,591	349	2	509	1 (level 3)

* U.S. Census Bureau. State and County Quickfacts. Available at: <http://quickfacts.census.gov/qfd/states/53000.html>.

+ Washington State Hospital Directory, Available at: www.doh.wa.gov/portals/1/Documents/5300/HospDirWOther.xls; note that these figures do not include DoD or VA facilities, or specialty hospitals (e.g., psychiatric facilities).

± Washington State Hospital Directory, Available at: www.doh.wa.gov/portals/1/Documents/5300/HospDirWOther.xls

Hazards

Washington State’s Hazard Identification and Vulnerability Assessment (April 2009) and local Comprehensive Emergency Management Plans identify the technological and natural hazards that are present and pose a threat to the people, property, environment, and economy of Washington State and the Puget Sound Region. The Puget Sound Region faces a diverse range of hazards that could develop into catastrophic incidents. Relevant risks to the region include natural disasters (e.g., earthquakes, volcano eruptions, floods, landslides, wildfires, tsunami, and severe storms/weather events); biological incidents (e.g., pandemic influenza, bioterrorism); large-scale accidental or intentional explosions, possibly with chemical or radiological components (e.g., manufacturing/storage/transportation accidents or terrorist related explosive devices); and technological (human-caused) hazards.

Planning Assumptions

- General planning assumptions for the coordination of the regional response to a catastrophic incident are outlined in the *Puget Sound Regional Catastrophic Disaster Coordination Plan* and are applicable to this annex as well. The following planning assumptions are specific to the pre-hospital response to a catastrophic incident.

- The initial pre-hospital response to a catastrophe will rely almost exclusively on local jurisdictional assets in the affected area. State or Federal resources may not be available during the first 48-72 hours of response.
- An EMS Coordination Group will convene, *only as necessary*, to develop regional situational awareness and provide strategic and policy-level coordination for the pre-hospital response, without impacting local protocols or plans for tactical response.
- During a catastrophic incident, competing demands may require resource prioritization and rationing. The EMS Coordination Group will develop consensus-based recommendations regarding the prioritization of pre-hospital response requirements in the region. The EMS Coordination Group will use the processes outlined in this annex to develop its recommendations.
- Weapons of Mass Destruction (WMD) Field Protocols and/or existing State Medical Program Director Protocols are State protocols that establish the standard for field performance in a Mass Casualty Incident (MCI). WMD Field Protocols are available at: <http://www.doh.wa.gov/Portals/1/Documents/Pubs/530142.pdf>.
- A Field Treatment Site (FTS) may be used for short-term (usually not more than 48 hours) patient collection, triage, and the provision of emergency field treatment until patients can be safely transported to a hospital or other appropriate health care facility, evacuated from the region, transported to a fatality management site, or sent home. An FTS is considered part of the pre-hospital response system and EMS is responsible for its operation. An FTS may be established in strategic locations at or near an incident site(s).
- Alternate Care Facilities (ACFs) may be used to augment the medical surge capacity of the region's health care system. An ACF provides for the long-term (usually longer than 48 hours) medical sheltering and provision of urgent (non-acute) care services and select traditional inpatient services in locations where these services are not typically provided. An ACF is typically pre-identified within a jurisdiction and is part of the health care system's strategy to augment surge capacity.
- In a catastrophe, the volume of patients requiring medical treatment will likely overwhelm the surge capacity of hospitals and other health care facilities in the Puget Sound Region. Patients will need to be evacuated outside of the Puget Sound Region for care under the *Regional Medical Evacuation and Patient Tracking Mutual Aid Plan (MAP)*.
- Detailed tracking and patient identification during a catastrophic incident will be initiated at the hospital or point of definitive care. EMS is a partner and stakeholder in effective patient tracking.
- During a catastrophic incident, one hospital may be designated to serve as the Disaster Medical Control Center (DMCC) for the Puget Sound Region. This function (also referred to as Hospital

Control) provides EMS with a coordinated and planned distribution of patients to area hospitals or other health care facilities based on patient needs (clinical management) and concurrent assessment of hospital capabilities during the distribution. For the purpose of this annex, the terms DMCC and Hospital Control are synonymous.

- Harborview Medical Center (HMC), the only Level 1 Trauma Center in Washington State, will assume primary responsibility for the regional DMCC function during a catastrophic incident. In the event HMC is not able to serve as the regional DMCC, a backup facility will be chosen from the following candidates:
 - Providence Regional Medical Center, Everett (North boundary)
 - MultiCare Good Samaritan Hospital, Puyallup (South boundary)
- In a catastrophe, the Governor of Washington State will request Federal assistance under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. A resulting Presidential declaration of emergency or major disaster may trigger the activation of the National Disaster Medical System (NDMS) subsequent to a State request for medical assistance. Absent a Stafford Act declaration, the Secretary of the U.S. Department of Health and Human Services (HHS) may request activation of the NDMS in a declared Public Health Emergency.
- Under Presidential disaster and Public Health Emergency declarations, the Secretary of HHS may implement temporary waivers of certain Medicare, Medicaid, and Children's Health Insurance Program requirements under section 1135 of the Social Security Act. This includes waiver of Emergency Medical Treatment and Labor Act (EMTALA) sanctions for direction or relocation of an individual to receive a medical screening examination in an alternative location pursuant to an appropriate State emergency preparedness plan, or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency.
- A long-term care facility evacuation plan for King and Pierce Counties, developed under the Regional Catastrophic Preparedness Grant Program, includes mutual aid agreements for resource sharing and does not rely principally on EMS resources to transport individuals to receiving facilities. Similar plans in other counties across the Puget Sound Region are not yet developed (as of October, 2012).

II. SYSTEM DESCRIPTION FOR PRE-HOSPITAL COORDINATION

This section describes the purpose and composition of the EMS Coordination Group, as well as the roles and responsibilities of this group during the response to catastrophic incidents.

A. EMS Coordination Group Overview

Role of the EMS Coordination Group

The EMS Coordination Group provides senior leadership and strategic coordination to the pre-hospital planning and response to actual or potential catastrophic incidents affecting the Puget Sound Region. *It is important to emphasize that the EMS Coordination Group does not become involved in tactical response decisions. These decisions will be made by responsible officials at the jurisdictional level under their existing authorities, policies, plans, and procedures.*

A primary role of the EMS Coordination Group is to gather incident information from jurisdictions in order to develop common situational awareness of the region's pre-hospital status and response needs. Any one or more of the following sources may be used to obtain incident information for the pre-hospital response:

- City, County and State Emergency Operations Centers (EOCs)
- Regional DMCC
- Medical Program Directors
- EMS Coordination Group representatives
- Open-sources (e.g., news media, radio, Internet).

In addition, the EMS Coordination Group may develop recommendations on strategic or policy-level issues related to the region's pre-hospital response. Such issues may include, but are not limited to, the following:

- Prioritization of pre-hospital response requirements when the region's pre-hospital response system is severely strained or overwhelmed. The following criteria will be used as the basis for developing recommendations related to prioritization of pre-hospital response needs for the region:
 - Life Safety
 - Responders
 - Public
 - Incident stabilization
 - Property conservation
 - Environmental impact
- Establishment and operation of Field Treatment Sites
- Distribution of patients within the regional health care system based on patient need(s) and a concurrent assessment of hospital capabilities during incident response
- Implementation of State protocols establishing the standard for field performance in a catastrophic incident.

- Development of a comprehensive medical transportation asset plan recommendation that will consider both EMS and inter-hospital transfers needs, what types of transportation assets are required, what agencies could provide those assets, and where the assets should be directed.

Because the EMS Coordination Group has no decision-making authority, its recommendations are intended only to provide decision makers with the information they need to understand the region's pre-hospital response needs so they can make informed decisions. Therefore, EMS Coordination Group recommendations are disseminated in print and/or electronic format to the following entities:

- Emergency Support Function (ESF) 4 (Firefighting) and ESF 8 (Public Health and Medical Services) representatives at the respective County Emergency Operations Centers (EOCs) and the Washington State EOC (ESF 8 only). The ESF 4 and 8 representatives are responsible for keeping Emergency Managers apprised of EMS Coordination Group recommendations.
- County/City Fire Chiefs
- Regional DMCCs
- County/City Medical Program Directors
- Public Health Officers
- Health Care Coalitions
- Other multi-agency coordination groups that either have a role in supporting the pre-hospital response or may be impacted by the pre-hospital response
- Other entities, as deemed appropriate by the EMS Coordination Group.
- The process by which the EMS Coordination Group's recommendations are communicated to external stakeholders is described in the next section of this annex.

Composition of the EMS Coordination Group

The EMS Coordination Group consists of a core membership that convenes virtually (typically via a conference call) whenever this annex is implemented. Core members are responsible for helping to develop regional situational awareness and consensus-based recommendations, when necessary, on strategic or policy issues related to the pre-hospital response. The core membership consists of:

- County Fire Chiefs' representative (counties may default to County ESF 4)
- Regional DMCC Representative (Harborview Medical Center) and back-up DMCCs (Multicare Good Samaritan Hospital and Providence Everett Medical Center)
- County Public Health Officer (counties may default to County ESF 8)
- Medical Program Directors (eight counties and City of Seattle)
- Washington State ESF 8 representative
- Washington Ambulance Association representative

EMS Coordination Group representatives should be senior-level administrators or officials who are authorized to represent the interests of, and speak on behalf of, their constituency in EMS Coordination Group deliberations. One representative may represent a group of agencies or organizations on the EMS Coordination Group (e.g., one Medical Program Director may represent multiple counties). In addition, each core member must identify and train two backup representatives to assist the primary representative or represent him/her in EMS Coordination Group deliberations if the primary representative is unavailable.

The EMS Coordination Group has the flexibility to call on a variety of subject matter experts (SMEs) during response to provide guidance, on an as-needed basis, depending on the type of incident and the jurisdictions involved. SME advisors provide advice or guidance only; they do **not** have direct input into EMS Coordination Group recommendations. Potential SME advisors include, but are not limited to, the following:

- County Coroner(s) or Medical Examiner representatives
- Non-Governmental Organization (NGO) representative(s) (e.g., American Red Cross)
- Healthcare Coalition representative(s)
- Fire and EMS representative(s) from jurisdictions outside the Puget Sound Region
- Washington State Department of Transportation representative or local jurisdiction transportation representatives
- Others, as deemed appropriate by the core members of the EMS Coordination Group

B. EMS Coordination Group Components and Roles

This section describes the organizational structure (Figure 2-1) and roles of the EMS Coordination Group and its supporting elements, which include the EMS Coordination Group Coordinator, Situation Assessment Unit, Resource Status Unit, and Documentation Unit.

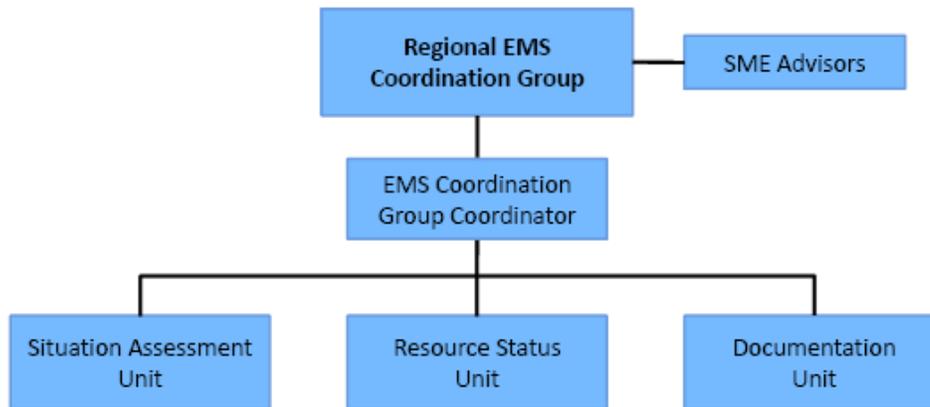


Figure 2-1: EMS Coordination Group Organization Chart

Responsibility of EMS Coordination Group Core Membership

As stated previously, the core membership of the EMS Coordination Group will participate in virtual meetings during the response to any catastrophic incident that affects the Puget Sound Region. The timing and frequency of these virtual meetings will be incident-specific. The core member who requests activation of the EMS Coordination Group will set the time for the initial call depending on the unique parameters of the incident. A schedule for subsequent meetings (if Group members determine additional meetings are necessary) will be established during the first meeting (default time for subsequent meetings will be 11:00 a.m.). In order to minimize the burden placed on EMS Coordination Group members, the meetings will be held only as necessary, and they typically will occur virtually through a dedicated teleconference and/or web-based system.

Core members of the EMS Coordination Group:

- Provide input on the pre-hospital response needs within their jurisdiction or area of responsibility in order to develop common situational awareness of the region's pre-hospital response.
- Develop consensus-based recommendations to prioritize pre-hospital response needs across the region. Representatives may also collectively develop recommendations on how requests for supplemental pre-hospital assistance should be prioritized through established State procedures.
- Develop consensus-based strategic or policy recommendations for the pre-hospital response, including guidance on how to address or resolve conflicting policies among agencies or jurisdictions.
- Communicate regional situational awareness and the EMS Coordination Group's recommendations back to their respective Agency Administrator.
- Coordinate the implementation of Washington State protocols (alternate standards of care, WMD Field Protocols, etc.) that establish the standard for field performance for EMS providers in consultation with EMS County Medical Program Directors.
- Support the Regional DMCC in promulgating a strategy for the efficient distribution of patients to area hospitals based on patient needs and a concurrent assessment of hospital capabilities during incident response.
- Take part in functional meetings annually for trainings/exercises, to review this annex, develop policies and procedures, and maintain up-to-date membership.

EMS Coordination Group Chairperson

The EMS Coordination Group will elect a Chairperson, who is responsible for encouraging full participation among EMS Coordination Group members by ensuring a fair and transparent process for providing input and developing recommendations. In addition, the Chairperson may represent the interests of the EMS Coordination Group to other functional area leaders within the Puget Sound Region or to other coordination groups (e.g., Regional Multi-Agency Coordination Group) when preparing for, responding to, or recovering from a catastrophic incident.

The Chairperson position shall rotate every two years among the EMS Coordination Group's core membership via open nominations and a majority vote. Nominees must be from a city or county other than the incumbent's. A backup should also be designated in the event the Chairperson is not available to participate in the EMS Coordination Group meeting.

EMS Coordination Group Coordinator

In order for the EMS Coordination Group to function effectively and efficiently during incident response, an administrative support structure must be in place. This support structure is led by the EMS Coordination Group Coordinator, who has the following responsibilities:

- Maintain the EMS Coordination Group's core membership list, including up-to-date and redundant emergency contact information for representatives and their backups.
- Establish and disseminate EMS Coordination Group meeting schedules and agendas to the core membership.
- Invite SME advisors to participate in EMS Coordination Group meeting at the request of the core membership.
- Moderate EMS Coordination Group meetings to keep discussion on track and ensure that all agenda items are addressed.
- Oversee the Situation Assessment Unit, Resource Status Unit, and Documentation Unit to ensure pertinent information is collected, collated, and disseminated to EMS Coordination Group core members and other relevant parties. Depending on the size and complexity of an incident, and staff availability, the EMS

Coordination Group Coordinator may also support/fulfill the functions performed by one or more of these units during incident response.

- Ensure adequate equipment and supplies are available and operational for EMS Coordination Group meetings and functions, including dedicated, redundant telecommunications systems, web-based applications/tools, and accessible information technology (IT) support.
- Assist in planning and developing annual EMS Coordination Group trainings and exercises.

The Coordinator position will be held by the Central Region EMS and Trauma Council – Pre-Hospital Sub-Committee Chairperson or his/her designee.

Situation Assessment Unit

The Situation Assessment Unit collects and collates pertinent information on the incident (e.g., activation status of County/State EOCs, transportation issues, weather conditions) and the pre-hospital response from affected jurisdictions and agencies to provide regional situational awareness. The intent is to provide the EMS Coordination Group with a high-level snapshot of the incident. This support unit also gathers information from the Resource Status Unit on critical resource needs and the availability of resource caches in the region. The Situation Assessment Unit may use any of the following sources to gather this information:

- County EOC and Washington State EOC Situation Reports (SitReps) or the region's Incident Snapshot (ISNAP) report, which provides a high-level impact assessment during a catastrophic disaster. The Situation Assessment Unit will coordinate with the ESF 4 or ESF 8 representatives in the EOCs to collect this information.
- Regional and local DMCCs
- EMS Coordination Group representatives
- Medical Program Directors
- County Public Health Officers
- Washington Ambulance Association (will provide status of all private ambulance providers in the state of Washington)
- News media, radio, Internet, social media, etc. (however, preference should be given to verifiable information reported by emergency management authorities)

Depending on the size and complexity of an incident, the Situation Assessment function may be filled by the EMS Coordination Group Coordinator or another person that can assist the Coordinator in providing this support. This position will be held by the Central Region EMS and Trauma Council – Pre-Hospital Sub-Committee Chairperson.

Resource Status Unit

The primary role of the Resource Status Unit is to track pre-hospital resource needs (requests) and availabilities of pre-hospital equipment and personnel throughout the incident. Specifically, this function entails:

- Obtaining input from County EOCs on critical pre-hospital resource needs (e.g., mass casualty caches/trailers, Personal Protective Equipment (PPE), and Metropolitan Medical Response System (MMRS) antidote stockpiles)
- Maintaining a database of resource cache availability in the region and assisting the EMS Coordination Group Coordinator in developing displays to facilitate EMS Coordination Group deliberations (*see Appendix C for a summary of existing Pre-Hospital Emergency Triage and Treatment caches in the region*).

- Providing resource status updates to the Situation Assessment Unit, as requested, to assist in providing situational awareness for the regional pre-hospital response.
- Tracking the current and future needs for transportation assets and the local capability to meet those needs. When the needs outpace the capability, begin the process of identifying the best route of requesting additional units.

Documentation Unit

The Documentation Unit maintains a written record of all EMS Coordination Group meetings and archives this information so that it is easily accessible and can be used to inform After-Action Reviews or the development of trainings/exercises. The following types of information may be recorded and maintained by the Documentation Unit:

- Attendance and notes taken from all EMS Coordination Group meetings/calls
- Situational awareness for the regional pre-hospital response
- EMS Coordination Group recommendations and the criteria used by the EMS Coordination Group to develop its recommendations

After each EMS Coordination Group meeting/call, the Documentation Unit will disseminate any recommendations the EMS Coordination Group develops to Emergency Managers and County and Washington State EOCs (through the respective ESF 4 and ESF 8 representatives), and other relevant groups in the region via email, print, conference call, Web sites, etc. In addition, the Documentation Unit prints and archives any recommendations, signed and dated by the EMS Coordination Group Chairperson.

C. Meeting Format and Decision-Making Process

EMS Coordination Group Meeting Format

The EMS Coordination Group typically meets virtually during a catastrophic incident through the use of secure web-conferencing or teleconferencing capabilities. The EMS Coordination Group Coordinator tightly facilitates the meetings using a pre-established agenda in order to limit time commitments and keep the focus on strategic or policy issues relevant to the pre-hospital response.

The EMS Coordination Group Coordinator will begin each meeting by conducting a roll call and providing situational awareness for the regional pre-hospital response. Potential issues to address include an assessment of the pre-hospital system for incident and non-incident related demands, resource needs, projected reduction of available EMS staff and other pre-hospital response capability (e.g., equipment and supplies). The EMS Coordination Group Coordinator will also brief any new developments since the previous meeting and review previous recommendations from the EMS Coordination Group.

The EMS Coordination Group Chairperson will moderate discussion on strategic or policy-level issues that require EMS Coordination Group input (see Appendix D). The following discussion format is followed during the meeting (see Appendix F for a sample agenda):

- The EMS Coordination Group Chairperson introduces an issue/problem
- Representatives and SME advisors discuss the specific issue/problem and its implications for the regional pre-hospital response, and identify options or potential solutions
- The EMS Coordination Group Chairperson, in collaboration with the representatives, develops a consensus-based recommendation for the issue/problem.

The EMS Coordination Group Coordinator schedules the next meeting before the group adjourns. The EMS Coordination Group Coordinator forwards notes from the meeting, including any recommendations that the group develops, to the Documentation Unit to be archived and disseminated to relevant County/State agencies or other organizations.

Decision-Making Process

Only core members of the EMS Coordination Group may develop recommendations for the pre-hospital response. All issues brought before the EMS Coordination Group will be acted upon by *consensus* and result in one of the following actions:

- **Option 1:** Make a collaborative recommendation and assign responsibility and expectation for implementation
- **Option 2:** Defer the decision for consideration at a later date (e.g., until more information has been collected)
- **Option 3:** Defer decisions that are beyond the scope of the EMS Coordination Group to the appropriate authorities.

D. EMS Coordination Group IT/Telecommunications

Communications and information technology (IT) systems, to include teleconferencing or web-based conferencing capability, must be available 24/7 for use by the EMS Coordination Group. The Pierce County Everbridge emergency notification system will be utilized as the primary system to support teleconferencing capability for the EMS Coordination Group during incident response (see Implementation Triggers and Protocols for further information on how regional conference calls will be initiated).

In the event that primary telephone lines and cell phone communications are unavailable, there are two methods of alternate communication methods: Satellite Phone and Amateur Radio Emergency Services (ARES). The preferred method if our primary and backups are unavailable will be via Satellite Phone. Satellite phones are available in hospitals and EOCs. . They are not dependent on infrastructure for usage. Another system available for use in a catastrophe when other systems are not available is ARES. ARES systems allow many users at once and can be very conducive to a rapid, wide spread means of communication among decision makers. Regional ARES volunteers exist and function as enabled in Washington Administrative Code (WAC) 118-04. These volunteers are great resources, but it is worth noting that ARES is not secure, which may be of concern to the EMS Coordination Group.

Protocols for the use of communications technology should be defined during preparedness planning and shared with representatives on the EMS Coordination Group.

III. CONCEPT OF COORDINATION

This section describes the authorities and triggers for implementing this annex in a catastrophe. It describes the various implementation phases and the role of the EMS Coordination Group during each phase. This section also describes how the EMS Coordination Group coordinates with and disseminates its recommendations to jurisdictional officials that have authority and responsibility for emergency response.

A. Authority for Annex Implementation

Any core member of the EMS Coordination Group, as well as County Emergency Managers, County or City Fire Chiefs, or a County Executive or City Mayor (or his/her designee) within the Puget Sound Region may request the implementation of this annex.

B. Implementation Triggers

Triggers that could require implementation of this annex include, but are not limited to, any one or more of the following conditions:

- A potential or imminent threat of a catastrophic incident
- Implementation of more than one County's, City's and/or Tribe's Mass Casualty Incident (MCI) plan
- Declaration of emergency by at least one local jurisdiction or tribal authority
- Governor-declared State of Emergency
- Request/initiation of regional DMCC for patient distribution
- Implementation of local and/or State Public Health and medical emergency response plans
- Determination by EMS officials that regional information sharing is needed to develop common situational awareness and facilitate strategic or policy level coordination
- Determination by a jurisdiction that it can *provide* assistance to affected jurisdictions during a catastrophic incident
- Any incident that has a catastrophic impact on critical infrastructure, including communications and transportation systems within the region.

C. Protocol for Requesting EMS Coordination Group Activation

If any one or more of the above triggers is met, or in the presence of another indicator of an actual or impending catastrophic incident, any core member of the EMS Coordination Group, or other authority as specified in Section A above, may take the following steps to initiate a regional conference call for the EMS Coordination Group:

- Contact the Pierce County Department of Emergency Management (DEM) by calling **253-798-7470** and ask for the Duty Officer.
- Request that the Duty Officer notifies all EMS Coordination Group core members that a meeting has been requested.
- Provide the Duty Officer with the date and time for the virtual meeting, as well as the desired method of communication (Everbridge emergency notification system will be the default). This information will be provided to core members in the notification message. (Please note: it may be advisable to schedule the initial call within a few hours of the incident so that EMS Coordination Group members have time to gather data and develop a situational assessment for their area of responsibility.)

- Identify the purpose of the meeting and specify any key strategic or policy issues (if known at the time) that will be discussed during the meeting.
- If telephone and internet connections are unavailable, the EMS Coordination Group Coordinator, or any core member of the EMS Coordination Group in the Coordinator's absence, may initiate the regional call on satellite phone or amateur radio through County EOCs.

Participants on the first EMS Coordination Group regional call may include all core members of the EMS Coordination Group, as well as the EMS Coordination Group Coordinator and support staff (Situational Assessment Unit, Resource Status Unit, Documentation Unit), as needed.

D. Tiered Incident Levels for Annex Implementation and EMS Coordination Group Response

Implementation of this annex is designed to be flexible in response to changes in the size, scope, or complexity of a disaster threat or actual incident. Consequently, the implementation levels of the EMS Coordination Group, and corresponding actions items, are aligned with the five levels of incident complexity, or "incident levels" used in local emergency planning within the Puget Sound Region.

Thus, the incident levels for the EMS Coordination Group build upon one another, such that the EMS Coordination Group activities defined for one level carry over as the EMS Coordination Group transitions to the next highest level. Activities conducted for purposes of routine plan maintenance or responder education, training, and exercising are noted under Incident Levels 5 and 4 in Table 3-1.

The following table provides the scope of EMS Coordination Group response actions, based on the five incident levels.

Table 3-1: EMS Coordination Group Action Items

Incident Level & Operational Impact	EMS Coordination Group Action Items
<p><u>Levels 5 & 4</u></p> <p>Impact Levels: “Normal” or “Low”</p> <p><i>Daily Pre-Hospital Operations. Routine emergency situations in which EMS requirements are addressed through local resources</i></p>	<p>The EMS Coordination Group Coordinator conducts the following activities to maintain the structure and capabilities of the EMS Coordination Group:</p> <ul style="list-style-type: none"> • Develops and maintains the EMS Coordination Group membership list and contact information • Documents MCI resource caches that exist in the region and identifies potential gaps • Identifies and conducts annual tests of the primary and backup communications systems used by the EMS Coordination Group • Develops and conducts annual trainings and exercises for the EMS Coordination Group, documents lesson learned, and implements corrective actions as needed. • Works with the Washington Ambulance Association representative to maintain awareness of current regional private medical transportation capabilities.
<p><u>Level 3</u></p> <p>Impact Level: “Moderate”</p> <p><i>An emergency situation or threat that poses a potential catastrophic risk to the region (e.g., major storm risk or a large, pre-planned event)</i></p>	<p>The EMS Coordination Group Coordinator conducts the following activities:</p> <ul style="list-style-type: none"> • Notifies EMS Coordination Group core members to be on standby in the event the situation changes and requires that the EMS Coordination Group convenes • Notifies relevant planning partners for situational awareness of pre-hospital resources • Contacts the Washington Ambulance Association to establish current regional private medical transportation capabilities • Notifies Situation Assessment Unit, Resource Status Unit, and Documentation Unit leads to be on standby or to collect and/or disseminate information, as needed • Tests the EMS Coordination Group primary and backup communications systems • Updates status of regional MCI caches

Incident Level & Operational Impact	EMS Coordination Group Action Items
	<ul style="list-style-type: none"> • Reviews/updates information reporting templates to ensure relevant situation data can be collected for the specific hazard • Gathers information on the incident or threat (through the Situation Assessment Unit) and disseminates a regional situational assessment to EMS Coordination Group core members, as needed • Verifies that the Regional DMCC is activated.
<p><u>Level 2</u></p> <p>Impact Level: “High”</p> <p><i>An emergency situation that poses a probable or imminent catastrophic threat to the region, or an emergency situation that requires regional coordination but may not be catastrophic.</i></p>	<p>The EMS Coordination Group is activated (supported by the Situation Assessment Unit, Resource Status Unit, and Documentation Unit, as needed) and conducts the following activities:</p> <ul style="list-style-type: none"> • Convenes via conference call (or other available communications mechanism) to develop situational awareness of EMS response requirements in the Puget Sound Region • Reviews the status of regional MCI caches, discusses/documents local mutual aid and resource sharing, ambulance availability, and identifies potential resource requests for State, inter-State, or Federal assistance, if applicable • Develops and disseminates pre-hospital status summaries for the Puget Sound Region and any consensus-based strategic or policy recommendations, if applicable, to relevant planning partners (e.g., County and State ESF 4 and ESF 8 representatives).
<p><u>Level 1</u></p> <p>Impact Level: “Severe”</p> <p><i>The scope of the emergency has expanded to the point that limited or no additional EMS resources are available in the Puget Sound region. State, inter-State, and Federal assistance is required.</i></p>	<p>All action items listed in Level 2 are completed, if not already done. In addition, the EMS Coordination Group may do the following:</p> <ul style="list-style-type: none"> • Develop consensus-based recommendations prioritizing requests for State and Federal pre-hospital assistance. The actual requests for assistance are made in accordance with established State procedures • Discuss strategic or policy issues, such as the potential need to establish FTSS or implement MCI standards of field performance in accordance with State protocols • Gathers information (via State ESF 8 representatives) on the activation of NDMS

Incident Level & Operational Impact	EMS Coordination Group Action Items
	teams and potential forward movement of patients outside of the Puget Sound Region <ul style="list-style-type: none"><li data-bbox="667 352 1235 457">• Identifies pre-hospital resources in the Puget Sound Region needed to move patients to evacuation airheads, if requested by NDMS.

IV. COORDINATION WITH OTHER INCIDENT MANAGEMENT ENTITIES

Figure 4-1 shows the formal pathway for incident management coordination and support (designated by solid black lines), which flows from local jurisdictions to their respective County Emergency Operations Center (EOC), then to the State EOC, and finally to the Federal Government. **The EMS Coordination Group does not usurp or infringe upon this coordination structure.** Instead, the EMS Coordination Group provides a mechanism for pre-hospital responders to collect and share information in order to develop regional situational awareness and recommendations on strategic or policy-level issues related to the pre-hospital response.

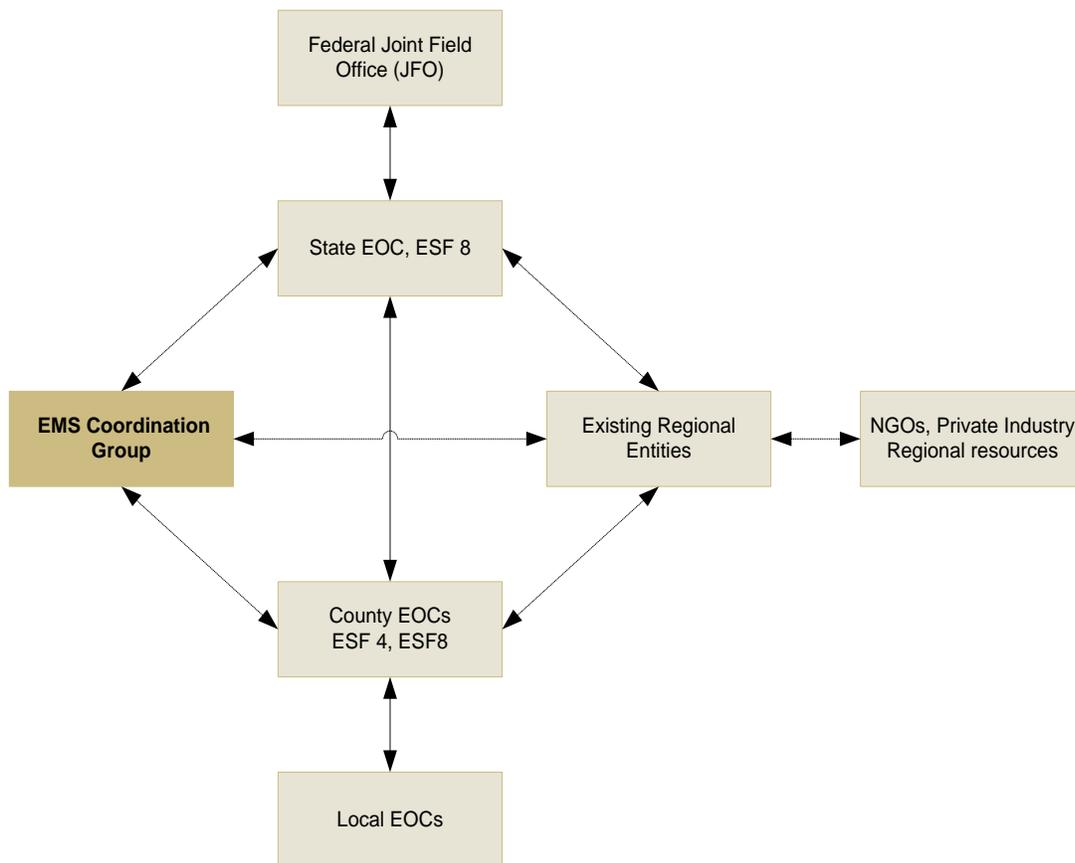


Figure 4-1: Regional EMS Coordination Group Information Flow Diagram

A. Coordination with County/Tribal Governments

During an emergency, County and Tribal EOCs are activated to support Incident Command and coordinate the response activities of County/Tribal governments, unincorporated areas, and other entities within or adjacent to their jurisdictional boundaries. The EMS Coordination Group facilitates information sharing and multi-jurisdictional pre-hospital response coordination for the Puget Sound Region.

The EMS Coordination Group regularly coordinates with County/Tribal government authorities primarily through the County/City Fire Chiefs or County Medical Program Directors who serve as core members of the EMS Coordination Group. During incident response, EMS Coordination Group recommendations are disseminated to the appropriate ESF 4 and ESF 8 representatives at the County EOCs to keep County Emergency Managers apprised of the region's pre-hospital response needs and to help Emergency Managers make informed decisions about allocating resources.

B. Coordination with Regional DMCC

The DMCC serves as a conduit for information exchange and common situational awareness between local EMS and hospitals during incident response. The DMCC provides EMS with a planned distribution of patients to hospitals and other health care facilities in their jurisdiction based on patient needs and a concurrent assessment of hospital capabilities.

In a catastrophic incident, the Regional DMCC communicates with the local DMCC, who in turn communicates with local hospitals and health care facilities to obtain status updates. The local DMCC aggregates the data for the Regional DMCC so they can coordinate patient distribution. The Regional DMCC also coordinates with activated NDMS to facilitate patient movement out of the Puget Sound Region, if necessary.

The EMS Coordination Group coordinates with the Regional DMCC via the Regional DMCC representative(s) who serves as a core member of the EMS Coordination Group.

C. Coordination with State Government

The EMS Coordination Group shares information and maintains communications with the State EOC through the State ESF 8 representative that serves on the EMS Coordination Group. The State ESF 8 representative or Washington State Department of Health EMS SME may provide information on the availability of pre-hospital resources to assist the EMS Coordination Group in its deliberations. It is important to emphasize that the EMS Coordination Group does not make resource requests to the State or to local Emergency Managers; it merely provides consensus-based recommendations that help to establish regional priorities for the pre-hospital response. Participation represents one way that the Washington State Department of Health may "lean forward" to fulfill its mission.

D. Coordination with the Federal Government

The EMS Coordination Group coordinates with the Federal Government *indirectly* through the State ESF 8 representative who serves as a core member of the EMS Coordination Group. All requests for and receipt of Federal assistance for the pre-hospital response are coordinated through the State EOC or the Federal Joint Field Office (if operational) in accordance with established State protocols.

The EMS Coordination Group *may* help coordinate "on the ground" response operations with deployed NDMS teams for patient movement if so requested by County or State Emergency Management. The EMS Coordination Group may provide strategic guidance on the pre-hospital response as it relates to forward patient movement operations. NDMS and other supplemental teams from outside the region may provide liaisons to the EMS Coordination Group.

V. INFORMATION COLLECTION AND DISSEMINATION

A. Information Reporting Template

The EMS Coordination Group will develop a standardized template to collect information from County ESF 4 and ESF 8 representatives (see Appendix E for a sample template). The reporting template will assist the EMS Coordination Group in developing and maintaining situational awareness of the Pre-Hospital Emergency Triage and Treatment response.

As needed, the ESF 4 and ESF 8 representatives will supply the appropriate information to their respective Emergency Manager for dissemination via the Public Information Officer or the Joint Information Center.

VI. TRAINING EXERCISE AND EVALUATION

A. Overview

Training, exercise and evaluation programs exist in emergency management programs within the eight county Puget Sound Regional Catastrophic Preparedness Grant Program area. City, county, state, federal and tribal governments as well as private businesses, non-governmental entities, and citizen groups recognize the need to work together to build disaster resilient communities. An overview of training, exercise and evaluation as it relates to regional catastrophic planning efforts can be found in the Puget Sound Regional Catastrophic Strategic Plan.

This Section identifies training, exercise and evaluation activities as they relate specifically to this Annex. Training may range from orientation presentations to seminars focusing on specific aspects of the plans or procedures. Training may be very subject specific to include something as simple as how to complete forms associated with this annex. Exercises will also range from simple discussion based tabletops to more complex operations based exercises such as functional or full scale.

This Annex to the Puget Sound Regional Catastrophic Disaster Coordination Plan provides a strategic framework for regional coordination to plan for or respond to any naturally occurring or man-made catastrophe. Such incidents may produce medical surge demands that stress or overwhelm Emergency Medical Services (EMS), Public Health, and health care organizations in the Puget Sound Region and require a regionally coordinated response to promote continuity of patient care from the field to the hospital or other definitive care site.

The Annex provides the necessary coordination structure and processes to facilitate a multi-jurisdictional, multi-disciplinary pre-hospital response to a catastrophe. The EMS Coordination Group is the entity by which this coordination can be achieved. The primary role of the EMS Coordination Group is to gather incident information from jurisdictions in order to develop situational awareness of the region's pre-hospital status and response needs. In addition the EMS Coordination Group may develop recommendations on strategic or policy-level issues related to the region's pre-hospital response. Such issues may include, but are not limited to the following:

- Life Safety
- Incident stabilization
- Property conservation
- Environmental Impact
- Field Treatment Sites
- Distribution of patients

B. Training

Training Needs

Specific Training needs identified by the Training and Exercise Team are related to the core capabilities of the plan. Stakeholders should be specifically educated on the following:

- Recognize the triggers for convening the EMS Coordination Group
- Activate the EMS Coordination Group using the 'Everbridge' calling system or the back-up option(s)
- Identify strategic issues the EMS Coordination Group will need to address following a catastrophic event
- Identify the differing triggers for, and roles of, Field Treatment Sites and Alternate Care Facilities.
- Recognize roles and responsibilities as part of the EMS coordination group

Training and Exercise Strategy

The original training and exercise goal is to conduct outreach meetings, seminars, Table Top Exercises and Functional Exercise to test and validate the Annex. Seminars will target individuals from each of the eight RCPG Counties who would likely be designated to serve on the EMS Coordination Group. Participants will engage in a cross-disciplinary manner with small groups of representative medical program directors, fire chiefs and public health officials from one or two adjacent counties. The seminars will be informational in nature designed to build awareness of the Annex and its components. Tabletop Exercises will validate the PETT Annex and test the stakeholders on the training they have received in the preceding seminars. Gaps, weaknesses and assumptions in the current PETT Annex will be identified. The Table Top Exercise will be followed by a Functional Exercise. Each Exercise will test the PETT Annex plan and process including:

- Activation of the plan
- Communication of the EMS Coordination Group
- The ability of EMS coordination Group to achieve situational awareness
- The ability to prioritize the Pre-Hospital Response
- Ability to make recommendations to the decision makers in the field
- Test triggers for the use of Field Treatment Sites and Alternate Care Facilities

An After Action Review will be written for the Table Top Exercise. Gaps and weaknesses will be identified and recommendations for improvement to the plan will be spelled out in an Improvement Plan. The final recommendations from the Improvement Plan will then be incorporated in future sustainment activities.

Related Training Courses

None are currently identified.

Exercises

Exercises improve readiness by providing a way of testing plans and procedures in a reasonably safe and non-critical environment. They can help clarify roles and responsibilities, improve interagency coordination, and find gaps in resources and plans. For individual participants, skills can be honed or opportunities for improvement can be identified.

In the years since the 2001 terrorist attacks, a standardized approach to exercises has been adopted by many jurisdictions nationally including the State of Washington and most jurisdictions within the State. This approach, the Homeland Security Exercise and Evaluation Program (HSEEP) provides standardized policy, methodology, and language for designing, developing, conducting, and evaluating exercises. All jurisdictions in this region utilize HSEEP guidelines in their exercise planning.

Utilizing the concept of a progressive exercise series, exercises can be planned in a cycle that increases in complexity. Each successive exercise may build on the scale and experience of the previous one. Discussion based exercises include seminars, workshops, tabletops and games. Generally participants are all in the same room (or joining through telephone or video conferencing) and engage in facilitated discussions. Operations based exercises focus on action-oriented activities and include the deployment of resources and personnel. They include drills, functional exercises and full-scale exercises.

In order to test cross-jurisdictional concepts of this plan, there is a need to exercise with multiple jurisdictions. The Washington State Emergency Management Division has previously led multi-jurisdictional exercises and has been a partner in catastrophic planning efforts. Counties, cities, and other partners identified in this annex should exercise together to test cross-jurisdictional plans as well as local plans. Efforts should be made to coordinate training and exercises of regional plans with other training and exercise efforts by using the Washington State Emergency Management Division Training and Exercise calendar posted on their web page at www.emd.wa.gov.

Discussion Based Exercises include Seminars, Workshops, Tabletops, and Games. The following table shows the types and general information regarding discussion based exercises that pertain to this annex through 2015. As future dates are determined, they will be identified on a calendar or schedule.

Table 4-1 PETT Annex Discussion Based Exercises

Year	Description	Jurisdictions	Type of Exercise (Seminar, Workshop, TTX, Game)
2011			
2012	(4) Seminars	ESF8 , Public Health, Medical Program Directors, Emergency Managers	Workshop
2012	Tabletop Exercise	ESF8 , Public Health, Medical Program Directors, Emergency Managers	TTX
2013	Medical Surge Tool	8 County PH Officers	Workshop
2013	PETT Annex Outreach	8 Counties	Seminar

2014	PETT Annex Outreach	8 Counties	Seminar
2015	PETT Annex Outreach	8 Counties	Seminar

Operations Based Exercises include Drills, Functional Exercises, and Full Scale exercises. The following table identifies anticipated operational exercises over the next five years. As dates are determined, they will be noted on an agreed upon Training and Exercise calendar or schedule.

Table 4-2 PETT Annex Operational Exercises

Year	Description	Jurisdictions Involved	Type of Exercise (Drill, FE, Full Scale)
2011			
2012	Evergreen Quake FE	6 counties, State, feds, others	FE
2013	Sustainment	EMS Coordination Group	TTX/FE
2014	Sustainment	EMS Coordination Group	TTX/FE
2015	Sustainment	EMS Coordination Group	TTX/FE
2016	Cascadia Fault FE	Counties, States, Feds	FE

D. Evaluation

Evaluating exercises, major events, and incidents provides a forum where personnel can identify strengths, weaknesses and gaps to plans and training as well as areas that need improvement. An After Action Report (AAR) should be written any time this plan is utilized in an operations based exercise or an actual event or incident. The AAR should be completed in a timely manner following the completion of an exercise, generally within 90 days.

Multiple steps make up the exercise evaluation process including the identification, collection and analysis of data that relate to exercise objectives. An After Action Report (AAR) is the document that describes what happened during the exercise. Based on observations and analysis, the AAR discusses exemplary practices, highlights issues that need to be addressed and recommends improvements. A Corrective Action Plan is part of the AAR and includes a list of recommendations, due dates and responsible organizations for implementing recommended actions. In some cases, plans and procedures may need to be modified or additional training may be required.

An After Action Review was completed for the Fall 2012 Tabletop exercise. Recommendations shall be implemented as is practical and as funding allows. Recommended changes have been written into the Pre-Hospital Emergency Triage and Treatment Annex.

VII. ANNEX DEVELOPMENT AND MAINTENANCE

The EMS Coordination Group will annually assess the need for revisions to the Pre-Hospital Emergency Triage and Treatment Annex based on the following considerations:

- Changes to State or Federal regulations, requirements, or organization
- Implementation of tools, procedures or resources (e.g., regional MCI caches) that alter or improve upon annex components
- Lessons learned from EMS Coordination Groups trainings and exercises, or from actual activation
- The need for additional subsidiary appendices to develop response capabilities or eliminate capability gaps, as suggested by EMS Coordination Group members or developed by the Puget Sound Regional Catastrophic Planning Team (RCPT).

The Regional EMS Coordination Group Coordinator is responsible for the maintenance, revision, and distribution of the Pre-Hospital Emergency Triage and Treatment Annex. The EMS Coordination Group Coordinator will maintain a record of amendments and revisions, as well as executable versions of all documents, and will be responsible for distributing the plan to all applicable agencies.

VIII. RECOMMENDATIONS

This section identifies and describes key issues or planning/funding gaps that may affect EMS Coordination Group operations. These issues/gaps require additional work to resolve:

1. Nomination and selection of EMS Coordination Group Chairperson in accordance with processes outlined in this annex.
2. Sustainment of staffing for the EMS Coordination Group Coordinator position, as well as the positions in the Situation Assessment Unit, Resource Status Unit, and Documentation Unit.
3. Provision of dedicated and reliable secondary and tertiary IT/Communications infrastructure needed to support the EMS Coordination Group during incident response.
4. Determining which agency/authority will maintain responsibility for tracking and documenting financial expenditures related to EMS Coordination Group preparedness planning, training/exercising, and response activities.

IX. AUTHORITIES AND REFERENCES

The *Puget Sound Regional Catastrophic Disaster Coordination Plan* provides generally applicable authorities, requirements, references and regulations for the Regional Coordination Plan, including the Pre-Hospital Emergency Triage and Treatment (PETT) Annex. This section highlights relevant legal authorities and Mutual Aid Agreements that apply to eight-county Puget Sound region, as listed below.

Local

- Seattle Disaster Readiness and Response Plan
- King County Fire Resource Plan
- Pierce County MCI Plan

Regional

- Regional Catastrophic Disaster Coordination Plan
- Washington State Region 3 Hospitals Memorandum of Understanding (MOU)
- Washington State Region 7 Healthcare Inter-Jurisdictional Mutual Aid Agreement (*April 2009*)
- Regional Hospital Control Plan
- Regional Medical Evacuation and Patient Tracking Mutual Aid Plan (MAP)
- Pacific Northwest Emergency Management Arrangement (PNEMA)

State

- Washington Administrative Code (WAC)
- Revised Code of Washington (RCW)
- Washington State Emergency Operations Plan (*April 2009*)
- Washington State Mass Casualty – All-Hazards Field Protocols
- Washington State Fire Services Resource Mobilization Plan
- Cross-Border Ambulance Reciprocity (#05-01), Washington State Department of Health, Office of Emergency Medical Services and Trauma System, Effective November 30, 2003.
- Public Health Mutual Aid Plan Standard Operating Procedures (SOPs) of the Inter-jurisdictional Public Health Mutual Aid Agreement (MAA) (*January 2009*)
- Mass Casualty – All Hazards Field Protocol (*January 2008*)
- Emergency Vaccination Information for EMS Personnel (*September 2009, please refer to the active DOH website for the current version and updates*)
- Emergency Management Assistance Compact Agreement

Federal

- FEMA National Incident Management System (December 2008)
- Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act), 42 U.S.C. §5121-5206
- Homeland Security Presidential Directive 5, Domestic Incident Management (February 28, 2005)
- Presidential Policy Directive 8, National Preparedness (March 30, 2011)
- National Response Framework (March 22, 2008), including the Catastrophic Incident Annex and the Catastrophic Incident Supplement
- DHS National Planning and Execution System (draft March 27, 2007)

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APPENDIX A: ANNEX GLOSSARY

All-Hazards: Describing an incident, natural or manmade, that warrants action to protect life, property, environment, and public health or safety, and to minimize disruptions of government, social, or economic activities.

Alternate Care Facility: An area where *long-term* (usually longer than 48 hours) medical needs sheltering, urgent (non-acute) care services, and select traditional inpatient services are not usually provided, but which is deliberately repurposed for provision of such services during disasters that overwhelm the existing healthcare system. Locations of potential ACFs are usually pre-identified, and the ACF is considered part of the healthcare system's strategy to augment surge capacity.

Cache: A predetermined complement of tools, equipment, and/or supplies stored in a designated location, available for incident use.

Catastrophic Incident: Any natural or manmade incident, including terrorism, which results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions.

Chain of Command: A series of command, control, executive, or management positions in hierarchical order of authority.

Coordinate: To advance systematically an analysis and exchange of information among principals who have or may have a need to know certain information to carry out specific incident management responsibilities.

Disaster Medical Control Center (DMCC): The hospital responsible for providing EMS with a planned distribution of patients to area hospitals based on patient needs (clinical management) and concurrent assessment of hospital capabilities during the distribution. For the purposes of this plan, Harborview Medical Center is designated as the primary Regional DMCC to coordinate patient distribution across the Puget Sound Region with Providence Regional Medical Center, Everett (North boundary) and MultiCare Good Samaritan, Tacoma (South boundary) designated as backups. *(Synonymous with Hospital Control for the purposes of this annex)*

Emergency Management Assistance Compact (EMAC): A mutual aid agreement between states and territories of the United States. EMAC complements the national disaster response system. EMAC is used alongside federal assistance or when federal assistance is not warranted.

Emergency Medical Services (EMS): This term refers to medical treatment and care that may be rendered at the scene or any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities. *(RCW 70.168.015)*

Emergency Operations Center (EOC): The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, Regional, Tribal, City, County), or some combination thereof.

Emergency Support Functions (ESFs): Used by the Federal Government and many State governments as the primary mechanism at the operational level to organize and provide assistance. ESFs align categories of resources and provide strategic objectives for their use. ESFs utilize standardized resource management concepts such as typing, inventorying, and tracking to facilitate the dispatch, deployment, and recovery of resources before, during, and after an incident.

Federal: Of or pertaining to the Federal Government of the United States of America.

Field Treatment Sites (FTS): An area that is designated by emergency officials for the *short-term* (usually not more than 48 hours) collection and triaging/sorting of patients and the delivery of emergency field treatment until patients can be safely transported to a definitive care facility, evacuated from the region, transported to a fatality management site, or sent home. FTSs are part of the pre-hospital response system and are generally not pre-identified but are established at or in proximity to the incident site or in strategic locations near the disaster area for geographically dispersed incidents.

Fire Chief: Includes the chief officer of a statutorily authorized fire agency, or the fire chief's authorized representative. Also included are the Department of Natural Resources fire control chief, and the Department of Natural Resources regional managers. (*Washington State Fire Services Resource Mobilization Plan*)

Hazard: Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Hospital: Refers to a facility licensed under Chapter 70.41 RCW, or comparable health care facility operated by the Federal government or located and licensed in another State. (*RCW 70.168.015*)

Incident: An occurrence or event, natural or manmade, which requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Jurisdiction: A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., Federal, State, Tribal, and local boundary lines) or functional (e.g., law enforcement, public health).

Mass Casualty – All-Hazards Field Protocols: Developed by the Washington State Department of Health, Office of Emergency Medical Services and Trauma System, these field protocols are intended to:

- Provide direction for the use of appropriate emergency medical procedures in an all-hazards environment, to be employed by Washington State Certified EMS personnel while working under the direction of the County Program Medical Director;
- Provide for the standardization of pre-hospital care in Washington State;
- Provide base hospital physicians and nurses with an understanding of what aspects of patient care have been stressed to EMS personnel and what their treatment capabilities may be;
- Provide EMS personnel with a framework for pre-hospital care and an anticipation of supportive orders from Medical Control; and
- Provide the basic framework on which Medical Control can conduct quality improvement programs.

Mass Casualty Incident (MCI): Sometimes called a Multiple Casualty Incident, an MCI is an event resulting from man-made or natural causes which results in illness and/or injuries which exceed the Emergency Medical Services (EMS) capabilities of a locality, jurisdiction and/or region.

Medical Control: Will be provided by county pre-hospital patient care protocols. "Pre-hospital patient care protocols" means the written procedures adopted by the County Medical Program Director (MPD) which direct the out-of-hospital emergency care of the emergency patient. These procedures shall be based upon the assessment of the patient's medical needs and what treatment will be provided for emergency conditions.

National Disaster Medical System (NDMS): A Federally coordinated system that augments the Nation's medical response capability. The overall purpose of the NDMS is to establish a single, integrated national medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters. NDMS, under Emergency Support Function #8 – Public Health and Medical Services, supports Federal agencies in the management and coordination of the Federal medical response to major emergencies and federally declared disasters.

National Response Framework (NRF): Guides how the Nation conducts all-hazards response. The Framework documents the key response principles, roles, and structures that organize national response. It describes how communities, States, the Federal Government, and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. And it describes special circumstances where the Federal Government exercises a larger role, including incidents where Federal interests are involved and catastrophic incidents where a State would require significant support. It allows first responders, decision-makers, and supporting entities to provide a unified national response.

Patient Care Procedures: The written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with statewide minimum standards. The patient care procedures shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients shall be consistent with the transfer procedures in chapter [70.170](#) RCW.

Pre-Hospital: Means emergency medical care and transportation rendered to patients prior to hospital admission or during interfacility transfer by licensed ambulance or aid service under chapter 18.73 RCW, by personnel certified to provide emergency medical care under chapters 18.71 and 18.73 RCW or by facilities providing Level V trauma care services as provided for in this chapter. (*RCW 70.168.015*)

Pre-Hospital Patient Care Protocols: The written procedures adopted by the emergency medical services medical program director which direct the out-of-hospital emergency care of the emergency patient, which includes the trauma patient. These procedures shall be based upon the assessment of the patient's medical needs and what treatment will be provided for emergency conditions. These protocols shall meet or exceed statewide minimum standards developed by the department in rule as authorized in Chapter 70.168 RCW.

Puget Sound Region: For the purposes of this plan, the Puget Sound region is defined as the Seattle Urban Area (UA)/Combined Statistical Area (CSA), which includes the eight Puget Sound counties (Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Thurston) and select major cities located therein.

Situational Assessment (report): Document that contains confirmed or verified information and explicit details (who, what, where, and how) relating to an incident.

Situational Awareness: The ability to identify, process, and comprehend the critical elements of information about an incident.

Stafford Act: The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, as amended. This Act describes the programs and processes by which the Federal Government provides disaster and emergency assistance to State and local governments, Tribal Nations, eligible private nonprofit organizations, and individuals affected by a declared major disaster or emergency. The Stafford Act covers all hazards, including natural disasters and terrorist incidents.

Threat: An indication of possible violence, harm, or danger.

Trauma: A major single or multisystem injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability. *(RCW 70.168.015)*

Triage: The sorting of patients in terms of disposition, destination, or priority. Triage of pre-hospital trauma victims requires identifying injury severity so that the appropriate care level can be readily assessed according to patient care guidelines. *(RCW 70.168.015)*

Tribal Government (Tribes): Authorized representatives of Federally Recognized Tribes that are sovereign governments within the United States. Within Washington State, Tribes interface with the State during disasters in a very similar manner as other types of local government with respect to seeking supplemental response and recovery support.

APPENDIX B: EMS COORDINATION GROUP CONTACT LIST

This appendix provides contact information for EMS Coordination Group core members, as well as their designated primary and secondary backup representatives. This information should be reviewed, verified, and updated annually, or whenever there is a change in the composition of the core membership.

Table B-1: EMS Coordination Group Contact List

County	Medical Program Director	Coordinating Disaster Medical Control Center (DMCC) for the 8-County Region, and Primary Backups ¹	Fire Chiefs' Representative (Default: Emergency Support Function [ESF] 4)	County Public Health Officer (Default: ESF 8)	Department of Emergency Management (DEM) Contact
Island Lead	Dr. Paul Zaveruha Island County EMS 360-661-2005 zaverp@whidbeygen.org		H.L. "Rusty" Palmer South Whidbey Fire and EMS 360-321-1533 Chief@swf.org	Brad Thomas Local Health Officer 360-914-0840 b.thomas@co.island.wa.us	Eric Brooks 360.240.6672 e.brooks@co.island.wa.us
Alternate	Chris Tumblin 360-678-7620 360-914-0472 cell tumblc@whidbeygen.org			Roger Case (MRC) 360-929-5083 rogerc@oakharbor.net	
King Lead	Dr. Mickey Eisenberg King County MPD 206-295-6170 gingy@uw.edu	Anne Newcombe Harborview 206-744-6141 enewcomb@uw.edu	John Herbert King County Medic One 206-707-6560 cell John.herbert@kingcounty.gov	Dr. David Fleming, MD Local Health Officer (info only)	Walt Hubbard, Director walt.hubbard@kingcounty.gov
Alternate	None	ED Charge RN 206-744-4025 enewcomb@uw.edu	Chris Tubbs Mercer Island Fire 206-275-7960 206-910-6258 cell Chris.tubbs@mercergov.org Jonathan Larson 206-255-5575 Jonathan.larson@seattle.gov	Duty Officer 206-296-4606	

¹Other DMCC contacts in the eight-county Puget Sound Region are noted in the Additional DMCC Contact table on page B-6.

County	Medical Program Director	Coordinating Disaster Medical Control Center (DMCC) for the 8-County Region, and Primary Backups ¹	Fire Chiefs' Representative (Default: Emergency Support Function [ESF] 4)	County Public Health Officer (Default: ESF 8)	Department of Emergency Management (DEM) Contact
Kitsap Lead		Mike Wernet Chief 360-509-6009 mwernet@skfr.org		Dr. Scott Lindquist, MD Health Officer 360-337-5235 lindqs@health.co.kitsap.wa.us	Director 360-204-6702
Alternate				Jessica Guidry Emergency Preparedness Coordinator Ph:360-337-5267 Fax:360-475-9267 Jessica.guidry@kitsappublichealth.org	
Mason Lead	Dr. Joe Hoffman Ph:360 427-9595 hoffmanjoe@aol.com		Tim McKern Fire Chief Central Mason Fire and EMS 360-426-5533 x500 360-507-2279 cell 500@mason5.org	Vicki Kirkpatrick Director of Public Health 360-427-9670 ext. 582 vickik@co.mason.wa.us	
Alternate			Michael D. Patti Asst. Fire Chief Central Mason Fire and EMS 360-432-5170 360-507-2276 cell 502@mason5.org		

County	Medical Program Director	Coordinating Disaster Medical Control Center (DMCC) for the 8-County Region, and Primary Backups ¹	Fire Chiefs' Representative (Default: Emergency Support Function [ESF] 4)	County Public Health Officer (Default: ESF 8)	Department of Emergency Management (DEM) Contact
Pierce Lead	Dr. Clark Waffle 253-798-7722 cwaffle@co.pierce.wa.us	Lucas Hopkins 253-376-3683 Lucas.hopkins@multicare.org	Roger Edington Medical Services Officer, Tacoma Fire Department 253-591-5705 253-606-9005 cell redingto@cityoftacoma.org	Dr. Anthony Chen, MD 253 798-6500 253-377-1134 cell achen@tpchd.org	Norma Pancake EMS Office Administrator 253-798-7722 npancak@co.pierce.wa.us
Alternate	Norma Pancake EMS Office Administrator 253-798-7722 npancak@co.pierce.wa.us	Lucas Hopkins 253-376-3683 cell Lucas.hopkins@multicare.org		Nigel Turner Director Communicable Disease Control 253-798-6500 niturner@tpchd.org	
Skagit Lead	Dr. Don Slack Skagit County MPD 360-770-8271 donslack@mac.com		Earl Klinefelter Director Skagit County EMS 360-428-3230 360-661-7415 cell eark@skagitems.com	Peter Browning Public Health Director 360-336-9380 health@co.skagit.wa.us	Mark Watkinson Skagit County DEM Coordinator 360-338-1139 360-708-6100 cell markw@co.skagit.wa.us
Alternate					
Snohomish Lead	Dr. Eric Cooper 425-551-1270 eric.cooper@snocountyems.org	Julie Zarn Providence Everett Medical Center 425 261-3024 Julie.zarn@providence.org		Dr. Gary Goldbaum, MD Health Officer 425-339-5200 ggoldbaum@shd.snohomish.wa.gov	Tamara Doherty Deputy Director 425-766-0806 cell 425-388-5066 Tamara.doherty@co.snohomish.wa.us

County	Medical Program Director	Coordinating Disaster Medical Control Center (DMCC) for the 8-County Region, and Primary Backups ¹	Fire Chiefs' Representative (Default: Emergency Support Function [ESF] 4)	County Public Health Officer (Default: ESF 8)	Department of Emergency Management (DEM) Contact
Alternate	Marsha Parker Snohomish County EMS Office Administrator 425-551-1270 marsha.parker@snocountye.ms.org	Kelly Allen Trauma Coordinator Providence 425-261-3014 Kelly.allen@providence.org		Tim McDonald Emergency Preparedness Coordinator 425-339-5251 tmcdonald@shd.snohomish.wa.gov	
Thurston Lead	Dr. Larry Fontanilla 360-259-8266 Larry.fontanilla@medic-one.thurston.wa.us		Asst. Chief Jim McGarva President, Fire Chief's Assn., Thurston County 360-239-3587 cell jmgarva@ci.tumwater.wa.us	Rachel Wood, MD 360-219-8007 cell Rachel.wood@lewiswcountywa.gov	Sandy Johnson EM Coordinator 360-239-4419 cell 360-754-3360 johnsons@co.thurston.wa.us
Alternate	Dr. Bill Hurley 360-259-8492cell hurleyw@uw.edu		Steve Brooks VP, Fire Chief's Assn., Thurston County 360-239-8593 cell sbrooks@laceyfire.com		
State of WA ESF #8 Lead	Duty Officer DOH 360-888-0838 Hanalert@doh.wa.gov				
Alternate	Sally Abbott 360-236-4037 Sally.Abbott@doh.wa.gov Mike Smith 509-329-2201 509-939-2341 cell Mike.smith@doh.wa.gov				

EMS COORDINATION GROUP INITIAL CHAIRPERSON:

Thurston County Medical Program Director – Dr. Larry Fontanilla
Chair rotates every two years; nomination and majority vote

EMS Coordination Group Coordinator Initial Designee: Central Region EMS and Trauma Council-Pre-Hospital Sub-Committee Chairperson Dr. Michael Sayre 614-738-0947 sayrem@uw.edu		
Situation Assessment Unit Joshua Pearson Seattle Fire Dept. 206-255-6871 cell Joshua.pearson@seattle.gov	Resource Status Unit Daniel Johanns Seattle Fire Dept. 206-902-8088 cell Daniel.johanns@seattle.gov	Documentation Unit Charles De Bell Seattle Fire Dept. 206-255-7753 cell Charles.debell@seattle.gov

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APPENDIX C: REGIONAL MCI RESOURCE INVENTORY

This appendix will provide an overview of mobile MCI resource caches for Pre-Hospital Emergency Triage and Treatment across the Puget Sound region. The purpose of this inventory is to better understand what resources exist across the region, where they are located, and under whose authority they are maintained (along with appropriate contact information). The inventory will also aid in identifying resource gaps that may require requests for State or Federal assistance.

- Resource categories may include: hospitals; medical transport; skilled nursing facilities/residential care facilities; local medical response teams; local specialized non-medical response team (Hazmat, etc.); significant providers of medical supplies and equipment; regional healthcare coalition leads.
- Inventories should be updated annually.

Table C-1: Regional MCI Resource Inventory

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
Island County	Oak Harbor Fire Department	Two trailer units	Medical equipment to treat 25 patients; includes medical supplies, backboards, oxygen manifold system, START program, generator and lights	Oak Harbor Fire Department owns and maintains the units and the cache is sustainable. Funds are available and an inventory is maintained	Units available under mutual aid agreement with all fire and law enforcement in Island County, Whidbey General Hospital, and the Puget Sound Federal Fire Department at Naval Air Station Whidbey Island	Support vehicles available	On-duty personnel available

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
	Whidbey General Hospital; South Whidbey Fire & Rescue; Naval Hospital Oak Harbor	Multiple decontamination tents	Multiple decontamination tents; hospitals have limited personnel trained in decontamination procedures	Whidbey General POC: Larry Wall, 360-675-1131 South Whidbey POC: Chief Palmer, 360-321-1533 Naval Hospital POC: Jean Lord, 360-257-9471	Contact POC	Decontamination equipment in trailers at Whidbey General South Whidbey & Naval Hospital status unknown	Unknown
King County	Bellevue Fire Department	Medical Supply Unit -1 (MSU -1)	Tents, heaters, generators and lights Can manage ~80 non-ambulatory patients Emphasis on decontamination support, BLS, limited ALS	Cache maintained by Station 9 Captain with support from EMS Division of Bellevue Fire Department	Can be deployed to any current fire zones in King, Pierce and Snohomish County No other pre-existing agreements, but with BC approval, unit should be available to other areas	Self supported / stand alone	Cross-staffed at a fully paid station, ready for immediate deployment with 2 personnel
	Public Health – Seattle King County	Public Health Preparedness and Healthcare Coalition regional cache	520 beds 3 military grade liquid oxygen system for 200+ patients 20 oxygen distribution kits Over 300,000 masks, respirators, defibrillators, other medical kits and supplies for acute care and inpatient services for up to 500 patients/7 days	Contact Bryan Heartsfield, PHSKC, 206-263-8716 Sustainable but some supplies are perishable Replenished through Federal reimbursement funding or local funding	Mutual aid agreements exist between most Public Health departments. Activation of MOA is coordinated and a request form. Contact Public Health Preparedness section or the Public Health On Call Duty Officer	Contract services provided by Evergreen Moving and Storage	24 hour on-call duty officer available. Internal call tree to authorize, initiate contract and move materials

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
	Renton Fire & Emergency Services Department	Red Cross storage container at Fire Station 16 Valley Medical Center Red Cross owns equipment at Renton Community Center	Red Cross: cots and minimal shelter capabilities Valley Medical Center: capabilities unknown Renton Community Center: 100 cots and 200 blankets	Red Cross POC: 206-323-2345; 12923 156 th Avenue, SE Valley Medical Center: 400 SW 43 rd Street	Contact Red Cross for specific procedures	Contact Red Cross for specific procedures	Contact Red Cross; city does not have anyone assigned to the equipment
	Seattle Fire Department (SFD)	MCI Van	Backboards for 100 patients; EMS supplies including ALS and BLS to treat ~100 patients	SFD Station 21	Contact Seattle Fire Department's Fire Alarm Center to request either MCI1 or the MAB	Cargo van with no trailers or attachments	Staffed by on-duty crews
		Medical Ambulance Bus	Capable of transporting a combination of up to 20 non- ambulatory, 10 wheelchair, or 24 ambulatory patients	SFD Station 39		Bus style ambulance	

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
King County (cont.)	TBD	Seattle Tacoma International Airport (Seatac) Cache managed by the Fire Department MCI van cached at South King Fire & Rescue Station 26 and maintained by Zone 3 cooperative agencies Federally supported light rail cache managed by the Tukwila Fire Department	Seatac Airport and Zone 3 cache contain BLS disaster supplies – boards, straps, wound supplies, etc. Tukwila cache – MCI material but also equipment for Light Rail extrication	Port of Seattle (POS) owns and maintains the airport cache Tukwila is responsible for light rail cache. Zone 3 cache is a cooperative effort, contact South King Fire and Rescue	Airport cache is available County-wide Zone 3 cache is available to all locations within Zone 3 Unknown if light rail cache is deployable outside of Tukwila	Airport cache - 40" van container Zone 3 cache - vehicle cache Light rail cache - trailer	All caches are deployable upon request

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
Kitsap County	Bainbridge Island Fire Department (BIFD)	BIFD Cache	Inventory for treating trauma injuries Bandages, splints, backboards, blankets, IV supplies, intubation for 15 patients, two 10'x10' pop-up shelters, N95 masks, gloves, mass decontamination equipments and other EMS supplies 2010 Purchasing Program will allow care for 15 red, 20 yellow, and 25 green patients	BIFD owns and maintains MCI Cache BIFD POC: Captain Butch Lundin (blundin@bifd.org) or FF/EMT Jason Livdahl (jlivdahl@bifd.org), 8895 Madison Avenue, Bainbridge Island, WA 98110, 206-842-7686 BIFD fully resupplies the cache	Cache deployable in any jurisdiction when requested pending staff availability Cache dispatch through CENCOM or DEM	Cache trailer at Fire Station 21 with available towing vehicle	Duty personnel or on-call personnel will respond with cache
	South Kitsap Fire Rescue (SKFR)	SKFR Cache	Lights, medical supplies and equipment to set up colored treatment areas No special equipment Treat ~25 patients	SKFR owns and maintains cache; resupplied by department using them	Cache requested through 911 system County-wide mutual aid agreement in place	Cache unit can be moved; no plans in place to move other supplies	Duty career staff to respond upon request
Mason County	Mason County Department of Emergency Management/ Mason County Fire Department 5	See Cache Content	Backboard for 50 patients; oxygen and other accessories for a 5-person MCI	Mason County Fire Department 5	Contact MACECOM	1-ton pickup for MCI trailer	Staff available from Mason County Fire Department 5
	Mason General Hospital (MGH)	See Cache Content	Contact Andrew Bales at MGH	Contact Andrew Bales at MGH	Unknown	Limited transport capability	Unknown

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
Pierce County	Tacoma Fire Department (TFD)	Mobile patient cache and resupply cache for 100 patients	<p>CBRNE PPE and specialized countermeasure pharmaceuticals for 100 responders</p> <p>Oxygen cache of 50 size "K" with transfilling and manufacturing capability; 200 patient treatment capability</p>	<p>City of Tacoma Fire Department, 901 Fawcett Avenue, Tacoma, WA 98402, 253-591-5705</p> <p>Cache is sustained with MMRS grant funds, all perishables are rotated or replaced prior to expiration</p> <p>Replenishment plan in place</p>	<p>MMRS cache is mobile and deployable outside of jurisdiction.</p> <p>Request through TFD Dispatch Center or TPCHD Medical Group if activated.</p>	<p>Mobile cache in 36ft trailer with dedicated tow unit.</p> <p>Resupply, PPE and oxygen caches are palletized and can be move by several vehicles in the TFD fleet.</p>	Duty TFD are responsible for moving caches

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
	Lakewood Fire Department (LFD)	BLS, "Multiple Casualty/disaster Response" trailer. 2000lb payload, 7-pin electrical, 2-5/16" two ball (provided) trailer	See "MCI Electronic Inventory", approximately 200 patients treatment capability	<p>Lakewood Fire District 2, 10928 Pacific Highway SW, Lakewood, WA 98499</p> <p>Rick Jankowiak Office 253-983-4571; Cell: 253-377-3508; Fax: 253-588-2317</p> <p>Maintained and serviced by Lakewood Fire Department EMS Division</p> <p>No provisions or arrangements for replenishing stock or durable items if utilized, lost or broken</p> <p>Maintenance and resupply will be provided by LFD EMS Division through General Operations Budget</p> <p>Resupply requirements have not been arranged. Expect that utilizing agencies will provide adequate resources to restock MCI capability</p>	<p>Contact Lakewood Fire On-Duty Battalion Chief: 253-582-4600 (non-emergency); or through Pierce County Lakewood FireComm: 253-983-4563 or 911 during emergencies</p> <p>Trailer can be utilized outside of Pierce County by special request or Washington State mobilization requirements/plan</p>	<p>LFD has capability to tow the trailer for local use. LFD has limited capability to deliver to any outside requesting agency. Without special arrangements or direct coordination with the On-Duty Battalion Chief, requesting agencies should provide towing capable vehicle and driver</p>	<p>On-duty personnel will be assigned as necessary to respond to emergency scenes</p>

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
	Gig Harbor Fire Department – MCI 51	Gig Harbor Fire & Medic One – 50 Patient MCI Trailer at Station 51	Spine boards, bandage supplies, tarps, lights, generator, wheel carts for stretcher, etc. Medical PPE – BLS Supplies for up to 50 patients No CBRNE capability	Gig Harbor FD, 10222 Bujacich Road, NW, Gig Harbor, WA 98332, 253-851-3111 Gig Harbor Fire & Medic One owns and has budget for replacement of used supplies PRN. BLS supplies – very few are perishable	Request through FireComm Dispatched as needed or requested B51 will deploy Can be deployed anywhere in Pierce County through County wide mutual aid agreement	Tow vehicle available	On-duty staff will be assigned by B51 to respond with trailer when requested
Skagit County	Skagit County EMS	5 MCI trailers	Generic mass casualty supplies and PPE but no CBRNE capability	Earl Klinefelter, Cell: 360-661-7415 Skagit County EMS owns and maintains MCI trailers with the help of the host fire agency that houses them Replenished as needed	Cache could be used as needed in a mutual aid scenario if needed – in conjunction with 911 dispatch, Department of Emergency Management, and Skagit EMS approval	All host Fire Departments have the capability to haul MCI trailers	Only Mount Vernon FD, Burlington FD and Sedro-Woolly FD have this capability for personnel 24/7
Snohomish County	City of Everett Fire Department	City of Everett – MCI trailer Paine Field – MCI bus	50 backboards with supplies for 50 patients	Cache is part of the Everett Fire Department Restocked as budget item Maintained with monthly inventory check	Call dispatch – SnoPac and request MCI vehicles Special request through dispatch Call on-duty Battalion Chief and request equipment as needed; or Addressed as a Zone Response in the form of a Strike Team or Task Force	Vehicle available	On-duty personnel can deploy with trailer

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
Thurston County	Thurston County Fire Department	2 MCI trailers: 1 in Tumwater and 1 in East Olympia	Backboards (40), oxygen manifolds, basic BLS and ALS equipment for up to 60 patients, assuming 1/3 "Green" patients No special equipment	Tumwater Fire Department, Lt. Gary Burkhardt, gburkhardt@ci.tumwater.wa.us Thurston County Fire Department #6, A/C Mark Nelson, mnelson@eofd.org Thurston County Medic One will replenish supplies For out of county response, expect reimbursement or the ability to file a claim for incident-related damage to equipment	TFD trailer dispatched on second alarm MCI in Thurston County FD #6 trailer dispatched on third alarm MCI in Thurston County Deployment to other locations by request – would require agreements (i.e. Mobe agreement) Contact Capcom at 360-704-2749 for out of county response	Cache is contained in a trailers	On-duty personnel can deploy with trailers
Grays Harbor County	Aberdeen Fire Department (AFD)	MCI trailer stored at City of Aberdeen public works motor pool	42 backboards, MCI triage tags, tarps, oxygen manifolds, splinting and bandage supplies, mass decontamination shelters (for ambulatory and non-ambulatory victims)	Aberdeen Fire Department and available on mutual aid request. Nothing perishable	GH County mutual aid agreements in place	AFD Command Unit or heavy duty tow vehicle (standard hitch) available	No one assigned For Deployment within city of Aberdeen, on-duty or call-back Aberdeen Fire Department personnel would deploy For outside response area, call back personnel would deploy

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
Pacific County	Raymond Fire Department	1 MCI trailer	Basic BLS equipment, backboards, collars, bandages, oxygen manifold for up to 30 patients	Raymond Fire Department Initial timeline supplied by Homeland Security Region 3 No agreement with Region 3 to sustain supplies	Available to any agency in Homeland Security Region 3, although no written agreement in place	Cache contained in trailer	May be deployed outside of agency by on-duty personnel, depending on staffing levels. Likely need to call in personnel

APPENDIX D: EXAMPLE STRATEGIC OR POLICY-LEVEL ISSUES FOR EMS COORDINATION GROUP DISCUSSION

The following are examples of potential strategic or policy-level issues that may be appropriate for consideration by the EMS Coordination Group during incident response. This list is not meant to be comprehensive and may be modified as more information is gained through EMS Coordination Group trainings or exercises.

- Development of common regional situational awareness for the pre-hospital response
- Development of a plan for regional patient distribution when local healthcare facilities are overwhelmed
- Development of recommendations for pre-hospital response priorities when multiple incidents are occurring simultaneously across jurisdictions within the region
- Development of recommendations for use of limited pre-hospital resources
- Coordination of Field Treatment Sites during incident response
- Guidance on Personal Protective Equipment (PPE) for pre-hospital responders
- Coordination/implementation of crisis standards of care or WMD Field Protocols

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APPENDIX E: SAMPLE ESSENTIAL ELEMENTS OF INFORMATION (EEI) TEMPLATE FOR REGIONAL SITUATIONAL AWARENESS

Provided below is a sample reporting template that may be used during incident response to collect EEI needed by EMS Coordination Group core members to provide common regional situational awareness of the pre-hospital response.

Natural Disasters (e.g., earthquake, volcano, flood, winter storm)	
<p style="text-align: center;"><u>Fire/EMS</u></p> <ul style="list-style-type: none"> • Boundaries of major incident sites (e.g., collapsed structures, roadways, etc.) • Access points to incident sites (for staging personnel, equipment, transport vehicles) • Estimated number of casualties (distinguish critical / non-critical, if possible). • Status of EMS Personnel • Medical transportation needs • Project resource gaps/shortfalls • Field Treatment Site status 	<p style="text-align: center;"><u>Public Health</u></p> <ul style="list-style-type: none"> • Public Health orders • Status of pharmacies and public health resources • Alternate Care Facility status
<p style="text-align: center;"><u>Medical Program Director</u></p> <ul style="list-style-type: none"> • Priorities for pre-hospital response • Potential changes in standard of field practice and patient care 	<p style="text-align: center;"><u>Regional DMCC</u></p> <ul style="list-style-type: none"> • Status of hospitals • Status of medical surge strategies that may impact pre-hospital response • Estimated number of casualties

Terrorist Incident involving CBRNE	
<p style="text-align: center;"><u>Fire/EMS</u></p> <ul style="list-style-type: none"> • Boundaries of major incident sites (e.g., collapsed structures, roadways, etc.) • Access points to incident sites (for staging personnel, equipment, transport vehicles) 	<p style="text-align: center;"><u>Public Health</u></p> <ul style="list-style-type: none"> • Hazard-specific information • Relevant modeling information (plume modeling, etc.) • PPE guidance for EMS personnel

<ul style="list-style-type: none"> • Estimated number of casualties (reported as Critical / Non-critical, if possible). • Status of EMS Personnel • Medical transportation needs • Project resource gaps/shortfalls • Field Treatment Site status • PPE guidance for EMS personnel 	
<p style="text-align: center;"><u>Medical Program Director</u></p> <ul style="list-style-type: none"> • Priorities for pre-hospital response • Potential changes in standard of field practice and patient care • PPE guidance for EMS personnel 	<p style="text-align: center;"><u>Regional DMCC</u></p> <ul style="list-style-type: none"> • Status of hospitals • Status of medical surge strategies that may impact pre-hospital response • Estimated number of casualties

Naturally Occurring Infectious Disease Outbreak (e.g., influenza pandemic)	
<p style="text-align: center;"><u>Fire/EMS</u></p> <ul style="list-style-type: none"> • Status of EMS Personnel • Project resource gaps/shortfalls • Field Treatment Site status • Medical transportation needs • PPE guidance for EMS personnel 	<p style="text-align: center;"><u>Public Health</u></p> <ul style="list-style-type: none"> • Hazard-specific information • PPE guidance for EMS personnel • Estimated number of casualties
<p style="text-align: center;"><u>Medical Program Director</u></p> <ul style="list-style-type: none"> • Potential changes in standard of field practice and patient care • PPE guidance for EMS personnel 	<p style="text-align: center;"><u>Regional DMCC</u></p> <ul style="list-style-type: none"> • Status of hospitals • Status of medical surge strategies that may impact pre-hospital response • Estimated number of casualties

APPENDIX F: EMS COORDINATION GROUP MEETING AGENDA

[Meeting Date and Time]

Agenda Item	Responsibility
1. Roll Call	Coordinator
2. Situation Assessment Summaries by Jurisdiction	County Fire Chief (or other delegated authority)
3. Report on Critical Resources	Coordinator
4. Review current recommendations for regional pre-hospital response priorities	Coordinator
5. Issue identification/discussion	All, led by the Chairperson
6. EMS Coordination Group recommendations	Chairperson
7. Necessary Actions/Follow-up	Coordinator
8. Schedule Next Conference Meeting/call	Coordinator

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APPENDIX G: GUIDE FOR CHAIRPERSON AND COORDINATOR

Time: _____
 Date: _____
 Chairperson: _____
 EMS Group Coordinator: _____

Agenda Item 1: Roll Call

Coordinator:

First, we will ask for DMCC representatives.

Then we will go County by County in alphabetic order, starting with Island County, and ask which representatives are on the call from each discipline:

- *Public Health*
- *Medical Program Director*
- *Fire/EMS*

If you are representing one of these disciplines please signify by saying “aye” and tell us your Name and Agency. If you are representing more than one discipline, please let us know.

Jurisdiction	Discipline	Agency	Name
State/Regional DMCC	DMCC	HMC	
		Good Sam Puyallup	
		Prov Everett	
Island	PH		
	MPD		
	Fire/EMS		
King	PH		
	MPD		
	Fire/EMS		
Kitsap	PH		
	MPD		

	Fire/EMS		
Mason	PH		
	MPD		
	Fire/EMS		

County	Discipline	Agency	Name
Pierce	PH		
	MPD		
	Fire/EMS		
Skagit	PH		
	MPD		
	Fire/EMS		
Snohomish	PH		
	MPD		
	Fire/EMS		
Thurston	PH		
	MPD		
	Fire/EMS		
State Dept of Health			
Federal HHS			
FEMA			

SME			

Agenda Item 2: Regional Situational Assessment (needs)

Coordinator: We want to get information relevant to regional situational assessment:

By this we mean information on your situation that has or could have regional impact on pre-hospital treatment and response. We don't need local impacts. Please be as concise as possible. Refer to your situational assessment templates.

We are going to do this similar to Roll Call, starting with the DMCC situation and needs. Then we will go county-by-county in alphabetical order.

DMCC Situational Assessment:

North Region (Prov Everett and St. Joseph's):

Central Region (Harborview):

West Region (Good Sam and St. Peters):

Northwest Region (Harrison):

Coordinator: *Now we want to hear from others with potentially regionally significant issues. We will go County by County, and end with the State.*

Island County – Regional Situational Awareness (needs)

-

King County – Regional Situational Awareness (needs)

-

Kitsap County – Regional Situational Awareness (needs)

-

Mason County – Regional Situational Awareness (needs)

•

Pierce County – Regional Situational Awareness (needs)

•

Skagit County – Regional Situational Awareness (needs)

•

Snohomish County – Regional Situational Awareness (needs)

•

Thurston County – Regional Situational Awareness (needs)

•

Coordinator: State DOH Rep: Any Regional Situational Awareness issues for us?

Agenda Item 3: Report on Critical Resources

Coordinator: Now we want to identify what the critical resource needs are: **What** is your highest priority resource need at this time? **Quantify** if you can, and tell us **where /how soon** you need these resources. I will again start with the DMCCs and roll through each County alphabetically.

	<i>Critical Resource Needs</i>	<i>Notes</i>
DMCCS: <u>North Region (Prov Everett and St. Joseph's):</u>		
<u>Central Region (Harborview):</u>		
<u>West Region (Good Sam and St. Peters):</u>		
<u>Northwest Region (Harrison):</u>		

	Critical Resource Needs	Notes
Island County		
King County		
Kitsap County		
Mason County		
Pierce County		
Skagit County		
Snohomish County		
Thurston County		
State DOH		

Agenda Item 4: Review of Current Recommendations for Pre-Hospital Response Priorities

*(CHAIR facilitates this item) Skip this for the 1st call.
 This is a 2nd Call + item: Review recommendations from last call: anything to add or change?*

Current Recommendations	Status/Changes Recommended

Agenda Item 5: Issue Identification and Discussion

Agenda Item 6: Recommendations

Coordinator: Here is where we identify the major regional issues and figure out what recommendations we may want to make. There are two major types of recommendations:

- Resource Allocation –including Patient movement*
- Operational Issues like standard of care, PPE. Let’s take these in turn.*

*Chair and Coordinator may want to **nominate some issues** for a consensus recommendation.*

*First identify list of possible resource allocation issues.
Second, identify if there are operational issues on which to make recommendations.*

*Then we move on to **Agenda Item 6: The CHAIR facilitates** this discussion.
What recommendations would the group like to make with respect to the issues identified? Chair and Coordinator may want to propose recommendations with respect to each item.*

RESOURCE ALLOCATION ISSUES		
Issue	Rationale /Considerations	Recommendation of EMS Coordination Group?
1.		
2.		
3.		
4.		
5.		

STANDARD OF CARE / PPE ISSUES		
Issue	Rationale /Considerations	Recommendation of EMS Coordination Group?
1.		
2.		
3.		
4.		
5.		

Agenda Item 6 Continued: Any other Recommendations?

Agenda Item 7: Follow up Actions

Coordinator: *Personnel from each County should designate someone to convey all recommendations coming out of this call to their respective EOC managers.*

All personnel on the call are responsible for getting the word out about this recommendation to their respective agency and fellow agencies. You may want to use your ESF or equivalent representative at the County EOC to help you get the word out.

Other follow-up actions?

Agenda Item 8: Next Conference Call – Date and Time

(Coordinator should recommend a date and time for the next call to the group. If the group concurs, Coordinator should follow up to ensure the Everbridge system does the call out.)

- We are adjourned at _____ hours

APPENDIX H: TRAINING FOR EMS COORDINATION GROUP MEMBERS

NIMS/ICS trainings include special courses designed for multi-agency coordination participants and staff. The EMS Coordination Group Coordinator and Agency Representative positions should be able to participate in at least one training course and one exercise each year.

Trainees should be limited to no more than three at any one time and coordinated through the EMS Coordination Group Coordinator.

NOTE: ICS-100 through 400 should be taken before filling the EMS Coordination Group Agency Representatives and Coordinator positions.

Additionally, the following courses are available to provide background training for EMS Coordination Group positions:

- M-480 – Multi-Agency Groups – Eight-hour course with classroom instruction and exercises for EMS Coordination Group Agency Representatives and Coordinator positions.
- I-401 – Multi-Agency Coordination and MAC Groups – Seven-hour course with classroom instruction and exercises for EMS Coordination Group Agency Representatives and Coordinator positions.
- IS-701 – Multi-Agency Coordination Systems – Online and classroom course and exercises for broad understanding of the NIMS coordination system.
- ICS-700 NIMS
- ICS-800 NRF
- IS-650 (FEM 143): Building Partnerships with Tribal Governments

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APPENDIX I: PUGET SOUND REGION FIELD TREATMENT SITE PLANNING GUIDANCE

I. INTRODUCTION

In a Mass Casualty Incident (MCI), the goal of the pre-hospital response is to triage and transport patients to hospitals or other healthcare facilities as quickly as possible so that they can receive definitive care under the supervision of licensed medical professionals. Constraints on available resources (i.e., personnel, equipment, supplies, and transport vehicles) may require first responders to modify their scope of practice in order to do the greatest good for the greatest number of people. In addition, delays in identifying an appropriate “receiving” facility may require the establishment of treatment areas at or near the incident scene(s) for the temporary collection and triaging/sorting of patients, as well as the provision of emergency field treatment. However, even under these conditions, patients typically are transported to a hospital within a relatively short period of time (e.g., minutes to hours).

Catastrophic incidents are different. They can create such a significant surge (or multiple surges) in the number of patients requiring medical evaluation and treatment that the local healthcare system cannot meet the demand. Moreover, catastrophes may directly impact healthcare facilities or local infrastructure (e.g., transportation routes), thus making it impossible to transport patients to hospitals in a timely manner. When this occurs, pre-hospital responders may have to treat patients in the field for an extended period of time until other medical surge strategies can be implemented.

Although significant progress has been made over the past decade in planning to address medical surge (e.g., expanding capacity in hospitals, establishing Alternate Care Facilities, evacuating patients out of the region), the resulting strategies have focused mainly at the hospital or facility level and have not adequately addressed the pre-hospital response. The strategies can also take significant time to put in place (hours to days), resulting in a gap in the capability to treat large numbers of patients. Pre-hospital MCI plans in the Puget Sound Region have focused on short-term tactics and have not addressed how Emergency Medical Services (EMS) would support a prolonged field response.

One approach to enhance pre-hospital surge capacity is to establish Field Treatment Sites (FTS). A FTS is a location—facility-based or tented/free-standing—that is designated by emergency officials for the *short-term* (usually not more than 48 hours) collection and triaging/sorting of patients, and the delivery of emergency field treatment until patients can be transported to a hospital or appropriate definitive care facility. The FTS is similar in concept to treatment areas used during MCIs, with the added capacity and capability to manage large numbers of patients over an extended period of time. In this way, the FTS provides a temporary bridge between the pre-hospital and hospital settings to sustain emergency care until more permanent medical surge measures are implemented.

A. Purpose

The purpose of this document is to establish a common definition, planning assumptions, and expectations for FTSs and their role in supporting the pre-hospital response when incident circumstances prevent patients from being transported to local/regional hospitals in a timely manner. This document provides a framework that emergency planners in the Puget Sound Region can use to develop operational FTS plans for their jurisdiction. It serves as an appendix to the *Puget Sound Region Pre-Hospital Emergency Triage and Treatment Annex* and is intended to promote regional consistency in FTS planning.

B. Scope

The local County/City Fire and EMS authority has the primary responsibility to establish, operate, and maintain field triage and treatment activities until patients can be safely transported to receive definitive care. The guidance provided in this document applies to Fire/EMS, medical planners, Medical Program Directors, Public Health Officers, and associated pre-hospital partners and stakeholders.

C. Key Definitions

Alternate Care Facility (ACF): An area where *long-term* (usually longer than 48 hours) medical needs sheltering, urgent (non-acute) care services, and select traditional inpatient services are not usually provided, but which is deliberately repurposed for provision of such services during disasters that overwhelm the existing healthcare system. Locations of potential ACFs are usually pre-identified, and the ACF is considered part of the healthcare system's strategy to augment surge capacity.

Casualty Collection Point: A specific location where casualties are assembled to be transported to a hospital or definitive care facility, or evacuated out of the region.

Catastrophic Incident: Any natural or manmade incident, including terrorism, which results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions.

Disaster Medical Assistance Team (DMAT): A group of professional and para-professional medical personnel organized to provide rapid-response medical care or casualty decontamination during a terrorist attack, natural disaster, or other incident in the United States. DMATs are part of the National Disaster Medical System and operate under the authority of the Department of Health and Human Services (HHS).

Disaster Medical Control Center (DMCC): The hospital responsible for providing EMS with a planned distribution of patients to area hospitals based on patient needs (clinical management) and concurrent assessment of hospital capabilities during the distribution. For the Puget Sound Region, Harborview Medical Center is designated as the primary Regional DMCC to coordinate patient distribution with Providence Regional Medical Center, Everett (north boundary) and MultiCare Good Samaritan, Tacoma (south boundary) designated as backups (synonymous with Hospital Control).

Field Treatment Site (FTS): An area that is designated by emergency officials for the *short-term* (usually not more than 48 hours) collection and triaging/sorting of patients and the delivery of emergency field treatment until patients can be safely transported to

a definitive care facility, evacuated from the region, transported to a fatality management site, or sent home. FTSs are part of the pre-hospital response system and are generally not pre-identified but are established at or in proximity to the incident site or in strategic locations near the disaster area for geographically dispersed incidents.

Field Triage: The process of rapidly categorizing a large number of patients according to the severity of their injury in order to prioritize their extrication and extraction to the treatment areas.

Mass Casualty Incident: Any incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident.

Medical Control: Physician direction over pre-hospital activities. Also includes written policies, procedures, and protocols for pre-hospital emergency medical care and transportation.

National Disaster Medical System (NDMS): A Federally coordinated system that augments the nation's medical response capability. The overall purpose of the NDMS is to establish a single, integrated national medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters. NDMS, under Emergency Support Function #8 – Public Health and Medical Services, supports Federal agencies in the management and coordination of the Federal medical response to major emergencies and Federally declared disasters.

Treatment Area: The designated area for the collection and treatment of patients before they can be transported to a hospital or definitive care facility.

II. FTS PLANNING ASSUMPTIONS

- Catastrophic incidents are likely to produce a significant number of patients requiring medical evaluation and treatment and may overwhelm or severely disrupt the existing healthcare system.
- Hospitals in the Puget Sound Region routinely operate at or near capacity and will not be able to handle the large patient surge generated by catastrophic incidents that cause significant numbers of casualties.
- Hospitals and other healthcare facilities may be severely damaged or destroyed in a catastrophe.
- Transportation routes may be severely damaged or destroyed in a catastrophe, making it impossible for EMS to transport patients to healthcare facilities in a timely manner.
- There may be an insufficient number of transportation assets (ambulances, etc.) available after a catastrophe to meet the demand for casualty transportation.
- Hospitals may receive significant numbers of casualties outside of the formal EMS transport system.
- Crisis standards of care and temporary changes to normal standards of practice for EMS personnel may be necessary during the response to a catastrophic incident.
- In a catastrophe, first responders will provide the highest level of patient care that is possible in accordance with available personnel, resources, and supplies. Impacts to

resource availability and supply chains may require modifications in the practice of emergency field treatment.

- Patient decontamination may be necessary for certain types of events (e.g., chemical, radiological incidents) before EMS patient transport or hospital admission can occur.
- The probability of patient survival is greater at a hospital or other definitive care facility than in the field; therefore, patients should be transported to a hospital or healthcare facility as soon as it can be safely arranged.

III. FTS ACTIVATION

Recognizing the need for and activating a FTS to support the pre-hospital response to a catastrophe will be an important factor in maximizing the numbers of lives saved. The activation decision will be based on confirmation or strong suspicion that the region's emergency medical system is overwhelmed or nearing its breaking point or that the pre-hospital response system cannot transport patients to healthcare facilities in a timely manner. The request to activate a FTS may come from several sources, including the Incident Commander, local Public Health Officer, Regional DMCC, County Medical Program Director, or the regional EMS Coordination Group. **FTSs must be responsive to the immediate medical needs of patients; therefore, a FTS should be established within 4-12 hours of an activation decision.**

A. Authority

The authority to formally activate a FTS resides with the Incident Commander or Unified Area Command, in close consultation and collaboration with the Regional DMCC, local Health Officer, Medical Program Director, or the EMS Coordination Group. Potential indicators or triggers for FTS activation include the following:

- Regional hospitals are overwhelmed or are expected to become overwhelmed by the numbers of casualties seeking medical evaluation and treatment.
- Substantial damage to or loss of function at regional hospitals results in a significant loss of medical surge capacity within the regional healthcare system.
- Regional transportation resources are insufficient to meet the patient surge demand and/or transportation routes to hospitals are blocked, severely damaged, or destroyed.
- Sufficient mutual aid required to treat or transport casualties is not readily available.
- Any combination of the above indicators.

When one or more of these indicators is present, a FTS can be activated to provide EMS personnel with a designated location to transport, triage, and initiate basic life-saving or life-sustaining interventions until further transport can be arranged to a definitive care facility either inside or outside of the affected region. The FTS helps to maximize the efficient use of limited personnel and resources by concentrating victims in one location.

It is important for regional planners to note that local officials may not always be able to control the decision to activate a FTS. Because of the nature of catastrophes, a FTS may arise spontaneously and rather quickly with little pre-planning or advanced warning anywhere that

large numbers of patients gather to seek care (e.g., fire stations, parks, churches, or community centers). Therefore, it is critical for regional partners to coordinate and share information with one another during response to help them quickly recognize when such conditions are present so that appropriate resources can be identified and allocated to meet the need.

B. Length of Operation

Once established, a FTS will operate until all patients have been transported to a local or regional healthcare facility, evacuation staging area, or fatality management center, or released home.² It is generally assumed that a FTS will stand down operations within 48 hours of the initial activation, or as soon as patients can be safely transported to receive definitive care. This 48-hour period should allow sufficient time for other medical surge strategies (e.g., hospital decompression, establishment of ACFs) to be implemented.³

Many factors will ultimately determine the length of operation for an FTS in supporting the pre-hospital response. These factors may vary by jurisdiction as well as by the specific circumstances of the incident. However, the priority always should be to transport patients to an appropriate healthcare setting as soon as it can be safely arranged. This will provide the best chance for a successful outcome and will allow EMS staff to return to their regular duties in supporting the emergency medical system.

C. Location

In consultation with emergency management authorities, Fire/EMS and local health and medical planners may pre-identify potential facilities within a jurisdiction to house a FTS (sample selection criteria are presented below). Alternatively, a FTS may be established in a “building of opportunity” or tent(s) during the incident response. Consideration should be given to locating FTSs in the following areas:

² Adapted from California Emergency Medical Services Authority, *California Disaster Medical Response Plan (EMSA #218)*; September 2007.

³ In contrast, once established, an Alternate Care Facility may operate for several days or weeks to meet the medical sheltering or treatment needs of the affected population.

- In proximity to the incident site/disaster area (either in a fixed structure or a portable tent)
- Near hospitals or casualty collection points that may be used as staging areas for evacuating patients out of the region
- In strategic locations for geographically dispersed incidents.

The following criteria may be considered in evaluating potential FTS locations:

- Accessibility to major transportation corridors, as well as an area for staging air-based transportation assets (e.g., helicopter)
- Ability to shelter FTS staff and patients from the elements (e.g., rain, snow, wind) and provide a temperature controlled environment (working heating, ventilation, and air conditioning (HVAC) system)
- Ability to provide basic utilities (water, electricity) and services (bathrooms, food storage/prep area)
- Ability to accommodate large numbers of casualties
- Ability to provide a relatively secure and safe space for staff, volunteers, patients, and their loved ones.

As noted earlier, it is important to recognize during preparedness planning that FTSs may arise spontaneously in locations where injured people congregate after a disaster. Thus, FTS planning should be flexible enough so that personnel and supplies can be set up in locations where large numbers of patients have gathered. It may be easier to move EMS personnel and supplies to these locations than it will be to move patients to the pre-designated sites.

In some instances, an ACF eventually may be established in the same location as a FTS if the site meets the requirements of the ACF. This may occur out of necessity when there are few buildings of opportunity in the affected jurisdiction that meet the requirements of a FTS or ACF. When this occurs, responsibility for operations at the site should transition from EMS to the local health authority as soon as possible, thus allowing EMS personnel to return to their normal duties. Jurisdictional planners should coordinate FTS and ACF planning activities to ensure that there is a clear understanding of the respective roles of these surge strategies and how they are implemented.

D. FTS Staffing

A recognized challenge with standing up and operating a FTS will be staffing. When a FTS is first activated, it is anticipated that local Fire/EMS personnel will provide the core staffing for the FTS. Depending on the jurisdiction's particular needs and the availability of personnel and resources, staffing may be augmented with properly credentialed health and medical volunteers, EMS personnel from outside the affected area (obtained through mutual aid), and/or State and Federal disaster medical teams (e.g., Disaster Medical Assistance Teams). While planning efforts should examine all potential sources of staff, the core staffing component will be local EMS providers. Operational FTS plans at the jurisdictional level should define a clear process and establish procedures for integrating non-EMS personnel into FTS operations if they were available.

The staffing composition for a FTS will depend on many incident-related factors and may vary substantially across local jurisdictions within the region depending on how the FTS is being used to address medical surge needs. Table 1 provides a sample staffing structure for a 50-patient FTS per 12-hour shift, assuming the specified distribution of injury or illness severity among the patient population. **Important Note: the example is provided for illustrative purposes only and to aid local planners in developing an operational FTS plan. It does not—and is not intended to—establish a regional expectation or precedent for what constitutes an acceptable level of staffing at a FTS.**

Table I-1. Sample staffing level for a 50-patient FTS per 12-hour shift, assuming 10% of patients are categorized as immediate (Red), 20% are delayed (Yellow), and 70% are minor (Green).

Position	Staff Composition
Non-Medical	
• FTS Supervisor/Commander	1 Fire/EMS
• Safety/Security Officer	1 Fire/EMS
• Public Information Officer	
• Operations Section Lead	1 Fire/EMS
• Logistics Section Lead	1 Fire/EMS
• Planning Section Lead	
Medical	
Triage Team	1 paramedic; 2 EMTs
Treatment Team Leader	1 paramedic
• Red (assumes 5 patients)	2 paramedics
• Yellow (assumes 10 patients)	1 paramedic; 3-4 EMTs
• Green (assumes 35 patients)	6-8 EMTs
Transport Team Lead	1 EMT or paramedic

In addition, it is important to consider and plan for the various types of logistical support (e.g., water, food) that might be required to operate a FTS. This support may come from a variety of sources depending on the jurisdiction and the role that the FTS will fill during the response. Potential partners or stakeholders should be identified early on and invited to participate in FTS planning efforts. Key partners and stakeholders may include public health, hospital or healthcare community, law enforcement (to provide security for staff, patients, loved ones, volunteers, and bystanders), social services, public works, American Red Cross, faith-based organizations, volunteer groups, and the private sector.

IV. Scope of Care

The following types of services may be provided at a FTS:

Triage: During a catastrophe, triage will be an ongoing process in which patients are assessed at multiple intervals to determine the severity of their injuries and to prioritize them for treatment and transport. At an incident scene, EMS personnel will conduct an initial assessment to determine which patients should be taken to a FTS; when possible, patients with life-threatening injuries should be transported directly to a hospital while those with minor or non-urgent needs should be cared for at a FTS. This will allow hospitals to focus on treating those with the most serious medical needs.

Patients transported to a FTS will be re-triaged upon arrival in order to assess their treatment and/or transportation needs. Although different protocols may be used for triage, the FTS will be organized according to the following categories:

- **Red (Immediate)**: Patients in this category are the most critical and should be transported as soon as possible to a hospital or definitive care facility.
- **Yellow (Delayed)**: Patients in this category require medical intervention and eventually need to be transported to the hospital for treatment. Patients in this category are the second highest priority for transport.
- **Green (Minor)**: Patients in this category require general assessment and may be released after the provision of some minor treatment (e.g., minor wound cleaning and dressing). If transport to a hospital or ACF is necessary, this is the lowest priority group for transport.
- **Black (Expectant)**: Patients in this category arrive deceased or die at the FTS. Patients in this category should be transported to a fatality management center, if one has been established.

Treatment: The focus of any treatment activities will be to do the greatest good for the greatest number of people and to provide the highest level of care possible given resource availability. Because EMS personnel will serve as the primary source of staffing for the FTS (at least initially), treatment rendered in a FTS setting will include basic measures to keep patients alive until they can be transported for definitive care and to manage pain and discomfort to the maximum extent possible.

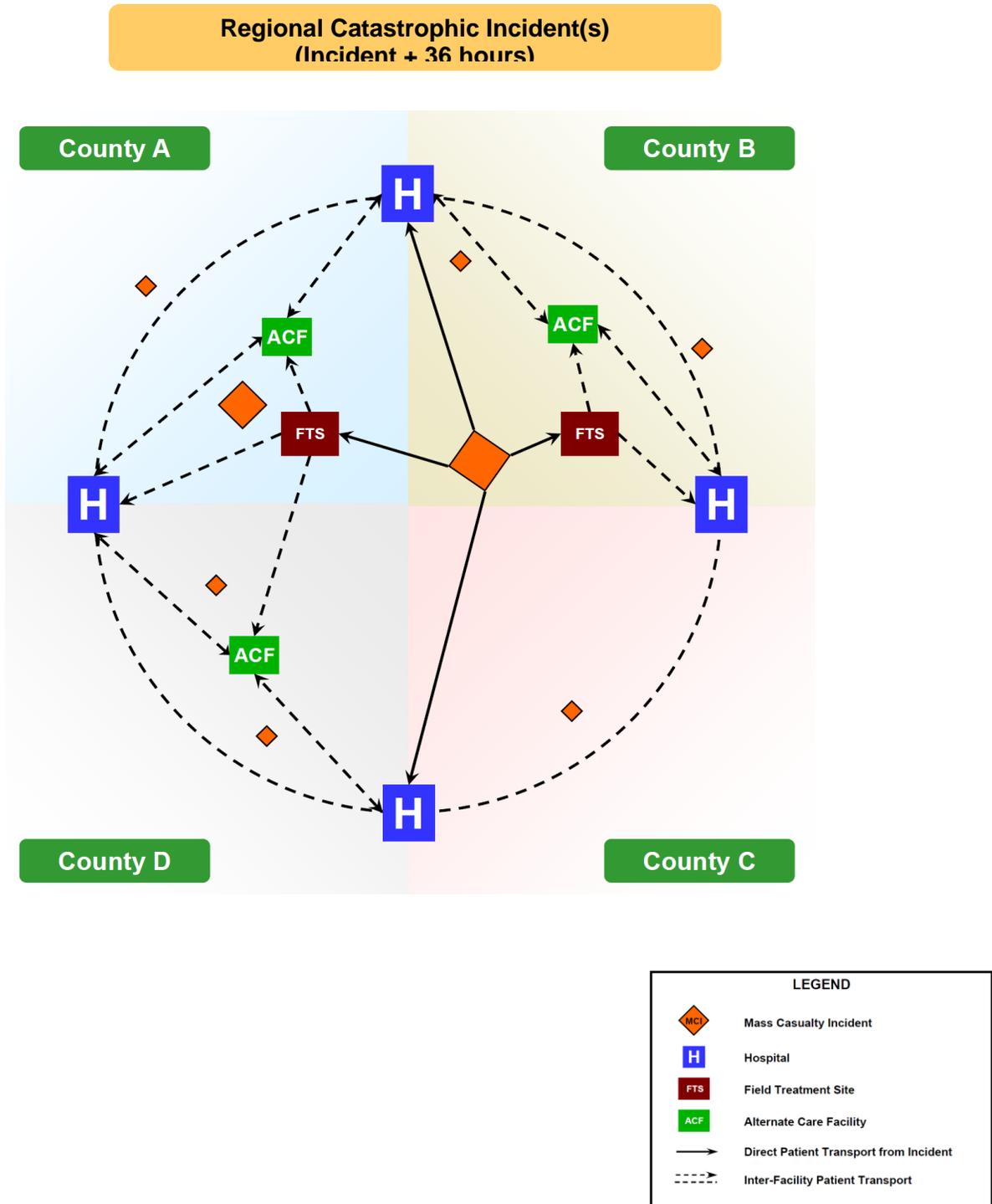
Unless otherwise specified, emergency field treatment provided at a FTS will follow and be consistent with the respective jurisdiction's MCI plan and established patient treatment protocols for crisis standards of care (as defined by the community). Treatment protocols will aim to provide the best care possible for as many people as possible given expected shortfalls in medical resources and staffing.

Patient Transport: During response, patients can be transported from the incident scene to an FTS, ACF (if established), or directly to a hospital. It is assumed that a majority of patients may self-transport to a FTS to receive medical evaluation and treatment.⁴

Once at an FTS, patients can be transported to a hospital, an ACF (if one exists), casualty collection point or evacuation staging area, fatality management center, or released home. Because of significant constraints on personnel, resources, and the level of care that can be provided at an FTS, priority should be given to transporting patients from an FTS as soon as an appropriate receiving facility can be identified and transportation can be arranged. Figure 1 shows the potential transport pathways between an FTS and an ACF or hospital. Note that in the figure, FTSs and ACFs appear to be physically separated; however, as stated earlier in this document, a FTS and ACF may be collocated if the site meets all of the necessary requirements.

⁴ Following a catastrophe, people will adopt strategies that they believe will be most effective in gaining access to medical care or support services.

Figure 1. Potential pathways for patient movement through the emergency medical system during the response to a catastrophe (*note: for simplicity, the figure only shows movement of patients from one MCI location; however, in a real disaster patient movement would occur from each of MCI location (orange diamonds)*).



V. Pre-Incident Planning⁵

In order to establish an FTS quickly after an incident, the Puget Sound Region should plan for FTS operations before an incident occurs and consider the following activities in the planning process:

- Assign a lead agency and/or point-of-contact (POC) in the Puget Sound Region who will maintain and update this appendix, as needed.
- Arrange the necessary approval process for activating an FTS; this may involve actions by the local political body.
- Establish Memorandums of Understanding (MOU) with pre-hospital care providers, partners, and stakeholders (e.g., private EMS providers, security/law enforcement) for resource and personnel support.
- Identify available personnel and material resources throughout the region that can support FTS operations; this includes identifying and qualifying personnel to serve in FTS command positions.
- Provide training for appropriate personnel in subjects relating to FTS operations (i.e., Incident Command System functions and command structure).
- Develop a general FTS layout to illustrate components and patient flow within an FTS. Appendix A provides a diagram depicting a generic layout for a FTS based on the requirements identified in this document; that diagram can be used as a starting point.
- Develop necessary checklists for applicable FTS job functions.
- Develop procedures to demobilize FTS operation.
- Conduct drills and/or exercises to test the region's FTS plan.

VI. Demobilization

Once the initial activation decision is made, the relevant jurisdiction's ESF 8 authority should consider when and how the FTS will be demobilized. Planning for demobilization should begin as early as possible to ensure a smooth transition and return of the pre-hospital system to its normal (or new normal) operating status.

As the response progresses, the need to maintain FTS operations may no longer exist. Collaboration among the Incident Commander/Unified Area Command, FTS Supervisor, local Public Health Officer, Medical Program Director, Regional DMCC, ESF 8 lead, and the EMS Coordination Group will aid in determining when a FTS can cease operations. The primary criterion for FTS demobilization is the capability to transport all patients to a local/regional hospital, ACF, evacuation staging area, fatality management center, or to release them home.

⁵ Adapted from the Florida Department of Health, Pre-Hospital Planning Emergency Medical Response, Alternative Medical Treatment Site (AMTS) Plan, August 30, 2006.

VII. Logistical Requirements

FTSs require substantial logistic and personnel support including, but not limited to, law enforcement/security, fire/EMS, public works, public health, mental health, and social services. This support will be coordinated through local Emergency Operations Centers in accordance with pre-existing mechanisms for incident management support.

Appendix B provides a sample resource inventory list for a FTS based on the anticipated scope of care for patients. Jurisdictional emergency planners developing an operational FTS plan may use this list as a starting point and tailor it according to their unique needs based on the expected role that the FTS will play in their communities. MCI caches positioned throughout the Puget Sound Region can be used to support FTS operations.⁶

VIII. Partners and Stakeholders

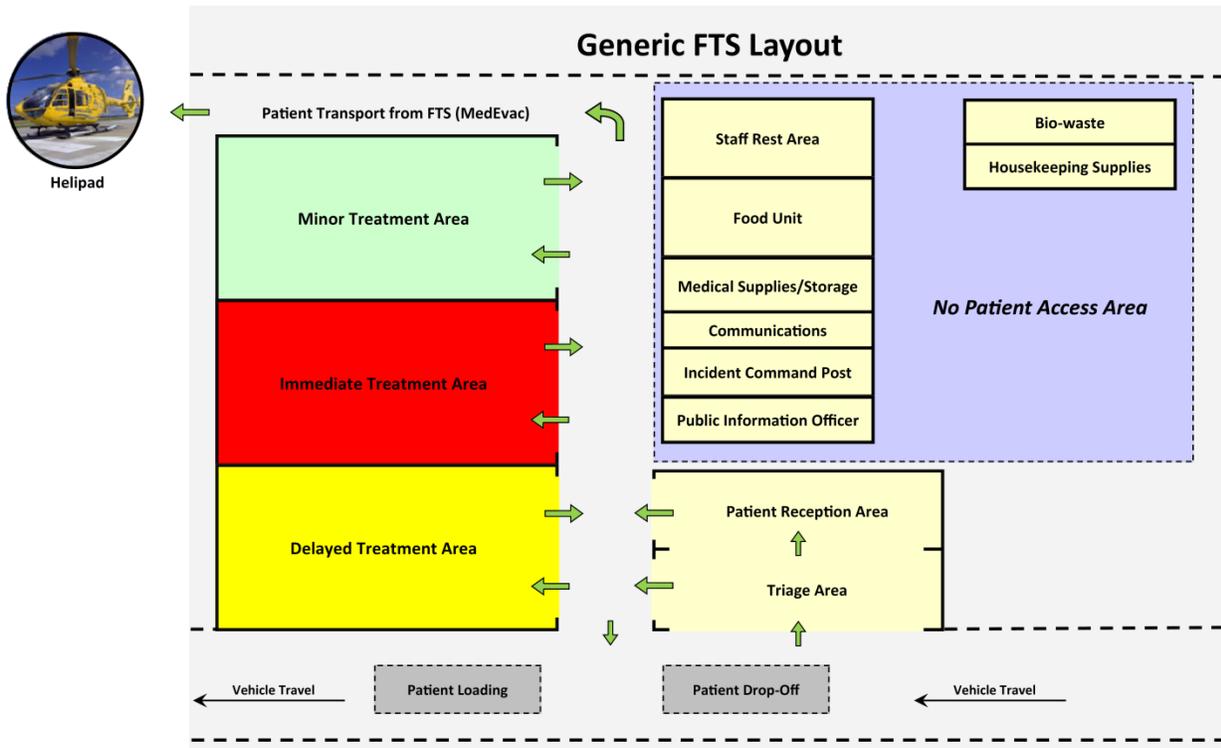
Although EMS personnel have the primary responsibility to establish, operate, and sustain FTS operations during a catastrophe, there must be close coordination among all entities engaged in the pre-hospital and healthcare system response. The following is a list of potential partners and stakeholders that may support FTS operations:

- Local Public Health Official
- County Medical Program Director
- Regional and local DMCCs
- Medical Reserve Corps or other volunteer groups
- American Red Cross
- Public Works
- Transportation
- Social Services
- Mental Health
- Disaster Medical Assistance Team (DMAT)
- U.S. Public Health Service Commissioned Corps
- Local, State, or Federal law enforcement.

⁶ The *Pre-Hospital Emergency Triage and Treatment Annex* contains a comprehensive list of Puget Sound Regional MCI Resource Inventory.

SAMPLE FTS LAYOUT DIAGRAM

Provided below is a sample diagram for the layout of a potential FTS. It shows patient flow into and out of the FTS, as well as patient movement among different treatment areas within a FTS. It also highlights areas that, although not directly related to patient triage or care, are needed to support FTS operations, such as medical supplies/storage.



RESOURCE CACHE INVENTORY

The Resource Cache Inventory specifies the minimum and optimal resource requirements for an FTS operation and is organized into the following categories:

- Patient Care Consumables
- Oxygen and Respiratory Equipment
- Diagnostic Supplies
- General Supplies
- Cardiac Care Supplies
- Immobilization Devices
- Medications
- Administrative Supplies

Initial resources for a FTS will likely come from equipment and supplies carried on ambulances and other emergency response vehicles. Additional supplies/resupplies may come from existing MCI caches located throughout the Region, other regional stockpiles, as well as materiel provided through mutual aid or State and Federal assistance.

The following table provides an initial list of base resources and supplies for a FTS.⁷ This list may be expanded upon and further developed as appropriate given the FTS mission in the jurisdiction and in accordance with resources that may be available through local or regional MCI caches, mutual aid, and State or Federal assistance.

Item Description	24-Hour Quantities	Total Amount Required per 48-Hour Operating Period
Alcohol swabs	4 boxes	4-8 boxes
Arterial tourniquet	6	6
Backboards	50	50
Bandages/dressing (ABD pads)	25	50
Bandages/dressing (sterile multi-trauma – various sizes large and small)	25	50
Bandages (sterile burn sheets)	12	24
Bandages (triangular)	12	24
Band-Aids	2 boxes	4 boxes
Basins, bath	20	40
Bathing supply, prepackaged (e.g., Bath in a bag (TM))	50	100

Item Description	24-Hour Quantities	Total Amount Required per 48-Hour Operating Period
Bedpans – regular/disposable	25	50

⁷ The list of initial resources and supplies was constructed using the inventories of the City of Seattle MCI Trailer, as well as the City of Bellevue Fire’s Medical Supply Unit. These inventories were compared to resource lists from the Agency for Healthcare Research and Quality, Disaster Alternate Care Facilities: Selection and Operation, Level III – Comprehensive ACF Cache, October 2009; the Pennsylvania Modular Emergency Medical System Cache Inventory List; the American College of Surgeons, American College of Emergency Physicians, National Association of EMS Physicians, American Academy of Pediatrics, and Pediatric Equipment Guidelines Committee, “Equipment for Ambulances; the Florida Department of Health Pre-Hospital Planning Emergency Medical Response – Alternative Medical Treatment Site Plan; and the Disaster Medical Assistance Team (DMAT) 72-hour Supply Cache.

Blankets	50	50
Beds/Cots (have extras available to replace broken equipment)	50	50
Cold Packs	25	50
Emesis basins	25	50
Facial tissue, individual patient box	25 boxes	50 boxes
Gauze pads, non-sterile, 4x4 size	10 boxes	20 boxes
Gloves non-sterile, small/medium/large (latex and non-latex)	2 boxes each size	12 Boxes
Goggles/face shields, splash resistant, disposable	50	100
Gown, patient	50	100
Gown, splash resistant, disposable	24	48
Hand cleaner, waterless alcohol-based	20	40
IV catheters, 18 g with protectocath guard	50/box	1 box
IV catheters, 20 g with protectocath guard	50/box	1 box
IV catheters, 22 g with protectocath guard	50/box	1 box
IV catheters, 24 g with protectocath guard	50/box	1 box
IV fluid bags, D5 1/2NS, 1000cc	5 cases	10 cases
IV fluid bags, NS, 1000cc	5 cases	10 cases
Kling	6 boxes	12 boxes
Large Add sets	25	50
IV tubing w/ Buretol Drip set for peds	10	20
IV tubing w/ standard macrodrip for adults	25	50
Mask, N95, for staff (particulate respirator)	50	100
Needles, Butterfly, 23g	50/box	1 box
Needles, sterile 18g	1 box	2 boxes
Needles, sterile 21g	1 box	2 boxes
Needles, sterile 25g	1 box	2 boxes
Pen Lights	12	24
Iodine swabs	2 boxes	4 boxes
Restraints, Extremity, soft - adult	12	24
Sharps disposal containers - 2 gallon	5	5
Sheets, disposable, paper, for stretchers and cots	100	200
Syringes, 10cc, luer lock	1 box (100 ct)	2 boxes
Syringes, 3cc, luer lock, w/ 21g 1.5" needle	1 box (100 ct)	2 boxes
Tape, silk - 1 inch	12 rolls	24 rolls
Tape, silk - 2 inch	6 rolls	12 rolls
Terri towels	25 rolls	50 rolls
Tongue depressors	100/box	1 box
Triage tags		
Urinals	50	50

Oxygen and Respiratory Equipment (Per 50-Patient Unit)	
Item	Quantity (per Unit)
Bag-Valve-Mask w/adult ad peds masks & tubing	10
Cascade gauge for oxygen cylinders	6
Catheters, suction	20
Connector, 5 in 1	8
Intubation equipment with oral airways/ET tubes; adults & peds	2 sets
Mask, oxygen - nonrebreather, adult	20
Mask, oxygen - nonrebreather, pediatric	10
Nasal cannula, adult	20
Nasal cannula, pediatric	5
Nebulizer	
Regulator, Oxygen (Flow meter)	1
Suction unit - Portable	4
Tank, Oxygen E-Cylinder (700 L O ₂)	4
Tank, Oxygen H_Cylinder (7000 L O ₂)	4
Wrench, Oxygen tank	2

Diagnostic Supplies (Per 50-Patient Unit)		
Item Description	24-Hour Quantities	Total Amount Required per 48-Hour Operating Period
Glucometer	2	2
Glucometer test strips	1 bottle	2 bottles
Pulse Oximeter	1	1
Single use shielded lancets	25	50
Blood pressure cuff	12	12
Stethoscopes	12	12
Thermometer	12	12
Thermometer probe cover	4 boxes	8 boxes

General Supplies (Per 50-Patient Unit)	
Item	Quantity
Biohazardous waste bags	10
Computer with Web access	1
Housekeeping cart with supplies	1
IV Pole	50
Linens (sheet/pillows/pillow cases/hand towels)	100
Pharmacy cart	2
Scissors (heavy bandage)	15
Stair chair	2
Stretcher	2

Cardiac Equipment
Portable, battery-operated monitor/defibrillator

Immobilization Devices
Backboard, Impervious

Cervical collars
Head immobilization – firm padding or commercial device
Lower extremity (femur) traction devices
Upper and lower extremity immobilization devices (rigid support)

Medications
Albuterol
Epi pens
Oral glucose
Nitroglycerin (sublingual tablet or paste)
Anxiolytics
Intubation adjuncts (including neuromuscular blockers)

Administrative Supplies
Admission history & physical forms
Batteries – 9V; AA; C; D
Black permanent markers
Chart holders/clipboards
Clipboards
Dry-erase markers
File Folders – letter size, variety of colors
Floor lamps
Generators
Generic sign-in, sign-out forms
Light bulbs
Name bands for identification and allergies
Paper clips
Paper punch (3- or 5- hole based on chart holders)
Pens – Black ballpoint
Pens – Red ballpoint
Plain paper
Plastic bags for patient valuables
Stapler and staples
Tape dispenser and tape
Tents/tarps
Trash cans and liners
White boards
Yellow highlighter markers

FTS/ACF MATRIX

The following table highlights the key characteristics/attributes of Field Treatment Sites (FTSs) and Alternate Care Facilities (ACFs). The table provides a useful comparison of how these two components of a community surge strategy support the delivery of medical evaluation and treatment to patients in the Puget Sound Region during catastrophic incidents.

	Field Treatment Site (FTS)	Alternate Care Facility (ACF)
Definition	An area designated by emergency officials for the short-term (usually not more than 48 hours) collection, sorting (triaging), holding, and provision of emergency field treatment for patients until they can be safely transported to receive definitive care.	An area where long-term (usually more than 48 hours) “medical needs” sheltering, urgent (non-acute) care services, and select traditional inpatient services are not usually provided, but which is deliberately repurposed for provision of such services during disasters that overwhelm the existing healthcare system.
Purpose/Gap Filled	<ul style="list-style-type: none"> • Provide a designated location under austere conditions for collecting and holding patients who require medical evaluation and emergency field treatment when transport to a definitive care site is not possible in a timely manner. • Serve the public as a temporary “bridge” between an incident scene(s) and a hospital/definitive care site to facilitate extended patient holding, triaging, and emergency field treatment until other surge strategies (e.g., ACF) can be implemented. 	<ul style="list-style-type: none"> • Deliver medical care for patients for whom adequate and timely care cannot be provided by an existing healthcare sector (e.g., ambulatory care clinics, hospitals, long-term care facilities, or home health services). • Deliver urgent care to reduce patient volume at Emergency Departments (ED) and ambulatory care clinics, so that these sectors can maximize care for other patient needs. • Deliver care that is traditionally provided in inpatient care settings to maximize care for more critically ill patients with potentially survivable conditions. • Deliver care that is usually provided at home with home health services for patients that have insufficient home situations and for when home healthcare services and hospitals are operating above maximal capacity to offload hospitals to maximize care for more critically ill patients.

Scenario(s)	<ul style="list-style-type: none"> • Catastrophic natural (e.g., earthquake, volcano, tsunami) or manmade (e.g., bomb blast) disaster resulting in overwhelming numbers of injuries that can't be transported in a timely manner. • Usually not activated to treat patients in a pandemic or other biological/disease scenario. 	<ul style="list-style-type: none"> • Catastrophic natural (e.g., earthquake, volcano, tsunami) or manmade (e.g., bomb blast) disaster resulting in overwhelming numbers of injuries. • Evacuation of a hospital or Skilled Nursing Facility • Pandemic or other biological event resulting in large numbers of sick.
Lead Agency	<ul style="list-style-type: none"> • County/City Fire & EMS authority is responsible for set up and operation/staffing of the FTS. • Staffing may be potentially augmented by hospital staff (for example, if hospital has lost function and its staff can be reassigned). 	<ul style="list-style-type: none"> • County Public Health authority is responsible for set up and operation of ACF, as coordinated through ESF 8 in the Unified Command Structure (the exception is Mason County, where the responsibility for operating an ACF resides with Mason General Hospital). • Staffed by Public Health nurses, MRC volunteers, hospital staff (for example, if hospital has lost function and its staff can be reassigned).
Authority to Activate	<ul style="list-style-type: none"> • Incident Commander (in consultation with Local Health Officer and EMS Medical Director). 	<ul style="list-style-type: none"> • Local Health Officer.
Indicators for Activation	<ul style="list-style-type: none"> • Regional hospitals and other definitive care facilities are overwhelmed or have sustained substantial damage or loss of function • Transport resources are limited / transportation routes are destroyed or unavailable • Sufficient mutual aid required to treat or transport casualties is not readily available. 	<ul style="list-style-type: none"> • Incident requires medical needs sheltering (e.g., evacuation of a long-term care facility) • Incident causes a surge in patients, overwhelming the capacity and capability of the regional healthcare system to adequately care for those in need, and timely evacuation is not possible • Damage to infrastructure (e.g., hospitals and/or transportation routes) such that there is insufficient capacity or capability to care for those in need, or an inability to transport or evacuate patients in a timely fashion. • Incident produces a combination of these effects.
Deployment/ Set-up Time	<ul style="list-style-type: none"> • 4-12 hours 	<ul style="list-style-type: none"> • 24-72 hours
Operational Duration	<ul style="list-style-type: none"> • Usually no more than 48 hours • FTS is demobilized when injured patients can be transported to a hospital or ACF, or evacuated out 	<ul style="list-style-type: none"> • Usually more than 48 hours • ACF is demobilized when all patients can be transferred to a hospital, sent home or back to a

	of the region to receive definitive treatment.	SNF, or evacuated out of the region.
Location	<ul style="list-style-type: none"> • Building of opportunity or tent(s) • May be located in proximity to the disaster scene or near hospitals; or may be local points that can be used for evacuation out of the region. 	<ul style="list-style-type: none"> • Usually in pre-identified buildings, but can also be housed in tent(s) • Requires availability of all utilities • Must accommodate up to 250 treatment spaces in 50-bed increments • ACFs may use an existing FTS location if it meets the requirements for the ACF.
Patients	<p>Received from:</p> <ul style="list-style-type: none"> • Incident scene(s) • Self-referral <p>Transferred to:</p> <ul style="list-style-type: none"> • Hospital, ACF, or other definitive care site • Evacuation hub (if patient evacuation indicated) • Home • Medical Examiner/Mass Fatality Management site. <p><i>Due to personnel and resource constraints, as well as the level of care that can be provided at an FTS, priority should be given to moving patients from an FTS as soon as an appropriate facility can be identified and transportation can be arranged.</i></p>	<p>Received from:</p> <ul style="list-style-type: none"> • Hospital or Skilled Nursing Facility • Self-referral • Patients transported from an FTS <p>Transferred to:</p> <ul style="list-style-type: none"> • Evacuation hub • Skilled Nursing Facility • Home • Medical Examiner/Mass Fatality Management site. <p><i>Patient admission criteria differ between counties; consult each county's ACF plan for its specific patient admission criteria.</i></p>
Scope of Care	<p>Triage</p> <ul style="list-style-type: none"> • Patients will be triaged upon arrival in order to determine treatment and/or transportation needs. Patient condition will also be continually reassessed. <p>Treatment</p> <ul style="list-style-type: none"> • Emergency field treatment as defined in the relevant jurisdictional MCI plan. 	<p>Triage</p> <ul style="list-style-type: none"> • Patient condition re-evaluated upon arrival at ACFs from FTS, hospitals, or SNF. <p>Treatment</p> <ul style="list-style-type: none"> • As defined for the different tiers according to the relevant jurisdictional ACF plan.

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APPENDIX J: ADVANCING NEW CONCEPTS FOR MCI RESPONSE

Finding time and money for local Multiple Casualty Incident (MCI) planning can be difficult in today's financial and political climate. The constant threat of transportation incidents, violence, hazardous materials releases, natural disasters, and terrorism however show that the need for such planning is at an all-time high. Existing MCI plans in the Puget Sound region have been built around smaller transportation style events. Events from around the United States and internationally show that major incidents can occur anywhere, demanding that MCI plans be revisited to allow for all sizes of MCIs and cooperation between jurisdictional boundaries.

A contemporary MCI plan needs to address many factors, including those that are unique and/or important to the Puget Sound Region. This document seeks to identify those important areas and provide some guidance during the planning process.

Any MCI plan should:

- **Fully define a MCI.** This must include a theoretical definition, such as “as an event resulting from man-made or natural causes which results in illness or injury to a significant number of people,” and may include specific numbers of patients.
- **Be scalable to all sizes of events.** All jurisdictions have the potential for a large number of patients that will quickly overwhelm the available resources. Mutual aid agreements and regional assets are critical for this aspect of planning.
- **Keep the procedures for MCIs as close to normal procedures as possible.** MCI's are low frequency events. By keeping MCIs similar to everyday procedures, skill retention will be higher.
- **Identify tactical benchmarks.** Possible benchmarks include: all patients extracted, all red patients transported, and all patients transported.
- **Recognize that other hazards such as fires or a hazardous materials spill will be present and must be dealt with simultaneously.** Additional staff and resources will be needed to deal with both patient care and any ongoing hazards.
- **Have procedures for scene security.** Numerous security issues may be present at an MCI incident such as bystanders, additional explosive devices, armed suspects, and traffic hazards.
- **Utilize a Public Information Officer (PIO) to act as a liaison with the media.** The media will converge on any major incident and immediately request information. If a PIO has not been designated, information requests will be directed towards the Incident Commander (IC) who is busy trying to run the incident. Current and accurate information needs to be given to the media in a timely manner to prevent inaccurate information being broadcast.
- **Engage regional partners.** MCI responses will include many agencies and jurisdictions. These partners should be included throughout the planning process and be included in the final plan. A few possible partners includes law enforcement, hospitals, public health, fire agencies (if not the primary EMS provider), emergency management, local military bases, bordering EMS agencies, and regional EMS assets.

- **Reduce or eliminate bottlenecks and choke points.** Choke points that delay getting patients to definitive care reduce survivability. A bottleneck such as a single triage gate with the intent of “numbering” each patient with a felt pen needlessly slows patient care and transportation.
- **Be National Incident Management System (NIMS) compliant.** Terminology used in the plan must be in compliance with NIMS and ICS to ensure smooth coordination between agencies and jurisdictions. One example of this is to use the term “Disaster Medical Control Center”, or DMCC, instead of the legacy term of “Hospital Control.”
- **Clearly outline job descriptions.** Job titles should be defined with clear descriptions of tasks and responsibilities. Job Action Sheets or checklists may be created to help with training and exercise as well as real world events.
- **Clearly outline the chain of command at MCI incidents.** Likely utilizing an org chart, the chain of command should be clearly defined using the ICS structure. This also helps define the responsibilities for each position (such as Triage and Extraction falling under the Rescue Group).

RESPONSE:

- **Recognize that MCI patients almost always suffer from traumatic injuries that are most fully treated in surgery at definitive care sites.** Patients are not ultimately saved in the field, but rather in surgery. All patient care decisions should revolve around getting patients to the hospitals as quickly as possible.
- **Recognize that the transportation corridor is critical to the success of rapid transportation.** The transportation corridor should be identified and physically secured by the first arriving units. This is critical to prevent responder vehicles from impeding transport vehicle access.
- **Have plans for bystanders and volunteers.** Bystanders and volunteers will likely be on scene rendering aid before emergency responders arrive. Clearing volunteers and bystanders from a large and/or chaotic scene is not practical, so they must be worked with or around. Volunteers may be carefully utilized putting them in supervised positions equal to their self-claimed knowledge and skills.
- **Include a group tasked with the removal of patients from hazard zone to the treatment area.** Patient removal from the hazard zone will potentially require a large amount of personnel depending on the number and type of patients as well as the geography and hazards of the incident site.
- **Define one or more triage standards while recognizing that all triage standards should result in red, yellow, green, and DOA/expectant patients.** A single jurisdiction may define one specific type of triage standard (START, RPM, Sick/ Not Sick), but a county wide plan may have to make allowances for many different standards.
- **Recognize that triage is an ongoing and dynamic process.** Patients should be reassessed throughout the patient care process for changes in their condition.
- **Designate a Green Patient Manager.** EMS staff needs to quickly evaluate any green patients for injuries that would reclassify them as red or yellow and help with basic treatment of injuries. Law enforcement will also likely want to interview any green patients for information about the incident.

- **Handle DOA/Expectant patients in accordance with their county medical examiners protocols.** Most medical examiners state that the bodies of expectant or DOA patients should not be moved unless necessary for patient care.
- **Define the primary means of transport for patients during an MCI and what alternate resources are available for larger events.** Primary means of transportation is usually by BLS ambulance. Alternate resources can include regional MCI buses, taxi cabs, and public transportation resources. Any resource listed in a plan should have at least a verbal memorandum of understanding (MOU) if not a written MOU with the listed agency to ensure that the resource can actually be used in the event of an emergency.
- **Clearly define how patient distribution will be handled on scene.** Communication with a designated DMCC should be the primary means of patient distribution, but a backup plan should exist if communication between the scene and the hospital is compromised.
- **Designate the type(s) of patient documentation that will be completed on-scene.** Full patient documentation may not be possible or practical in MCIs. Documentation alternatives should be identified and the triggers for their use defined. Possible alternatives include MCI triage tags and truncated medical incident report forms.
- **Patients must be tracked from the incident scene using a tracking system that should easily integrate into the hospital identification system.** All patients should be given a unique identifier that can stay with them from the scene through to the hospital intake system. Bar-coded tags and bracelets are an easy method to accomplish this task while allowing for future use of electronic barcode scanners. Patient tracking assists public health agencies in family reunification efforts.

POST INCIDENT

- **Provide some sort of critical stress debriefing for responders after unique or challenging responses.** The mental health of responders should be considered after challenging or unique responses.
- **Procedures for after action review (AAR) and plan improvement.** Any major MCI exercise or incident should be followed by a thorough review of the incident to identify what went well and which procedures need improvement. The items needing improvement should be incorporated into the MCI plan.

SPECIAL CONSIDERATIONS:

- **Allow for multiple scenes or “fractured” incident sites when parts of the incident scene are inaccessible to each other.** Numerous transportation and terrorist events throughout the world have recently shown the need to be able to operate at multiple sites and/or fractured sites simultaneously. Thought should be given to ICS, resource management for multiple sites, and communication between the sites.
- **Include plans for field treatment sites (FTS).** If patient transportation to a definitive care site is not possible, responders may have to provide emergency treatment in the field for an extended period of time (up to 48 hours) until transportation to definitive care centers can occur. Please refer to FTS planning documents for further discussion on field treatment sites.

- **Include special procedures for possible or known terrorist events.** With the increase of homegrown terrorist attacks, no jurisdiction is immune to the threat of terrorism. Special considerations need to be given to active shooters, explosives, chemical/biological releases, and any other types of terrorist events.
- **Include decontamination (decon) procedures and a notification system to alert hospitals to stand up their decon procedures.** Many of the possible causes of a MCI will require patient decon before transportation can occur. Hospitals should be notified as early as possible that patient decon will be necessary so that they may initiate their decon procedures to handle walk-in patients.

APPENDIX K: SAMPLE MASS CASUALTY INCIDENT (MCI) PLAN

EXECUTIVE SUMMARY

This plan defines a Multiple Casualty Incident (MCI) as an event resulting from man-made or natural causes which results in illness or injury to a significant number of people. Using this definition, an MCI response should be implemented anytime the number of patients does not allow for the day to day standard of care for individual patients. Any fire or EMS agency strives to always provide the best care possible to any patient, but when there are 6, 20, 50, or even 100 or more patients, the goal must be to provide the best treatment possible for as many patients as possible. This means that operations must be adjusted to maximize the efficient use of available resources.

The “Golden Hour” of emergency medicine is a well-accepted concept that states that victims of trauma need to have surgery within one hour of the injury to have the best chance of survivability.⁸ Rapid transportation to definitive care centers therefore is the best way to increase survivability in a MCI event.

This plan seeks to reduce chokepoints and unnecessary actions, and streamline efforts to reduce the time that it takes to remove all patients from the scene. This includes:

- Using the Sick/ Not Sick triage protocol to reduce time spent triaging.
- Eliminating a triage gate.
- Establishing a transportation corridor by the first arriving Fire Department unit to ensure a smooth flow of transportation resources.
- Assigning field triage to the Rescue Group as opposed to the Medical Group.
- Using geographic divisions in larger incidents to speed triage and extraction.
- Scaling patient tracking and documentation with the size and complexity of an incident.

MCI events can be as small as a few patients or as large as hundreds. Flexibility is integrated into this plan to fit all sizes of incidents. Issues related to a fractured or geographically challenging event are also addressed.

This plan is designed to be shared and integrated with local, State, and Federal governmental agencies to ensure coordination and cooperation. During an event, interagency cooperation will be in accordance with the National Incident Management System (NIMS).

⁸ American College of Surgeons (2008). *Atls, Advanced Trauma Life Support Program for Doctors*. Amer College of Surgeons.

PLANNING ASSUMPTIONS

- The traditional definition of a MCI is: Any incident in which emergency medical services personnel and equipment at the scene are overwhelmed by the number and severity of casualties at that incident.⁹ A more specific working definition is anytime the number of patients does not allow for the day to day standard of care for individual patients.
- The priority of an MCI response is to streamline efforts to speed patient transportation to definitive care centers.
- The plan is scalable to all sizes and complexity levels of MCI responses. Actions that delay the treatment or transport of patients may be modified or eliminated as long as it does not increase the risk to responders.
- A transportation corridor needs to be established and secured early in the incident to facilitate rapid patient transport.^{10,11} Multiple corridors with corresponding patient treatment areas may be necessary.
- The SICK/ NOT SICK model can be used for MCI triage. SICK patients will be classified as red. NOT SICK patients will be yellow and green.
- All triage systems produce similar results, resulting in red, yellow, green, and stripped (DOA) patients. Therefore, when working with other agencies, it does not matter if different triage systems are used.
- On scene treatment is dynamic, allowing EMS personnel to alter treatment protocols to match available resources.
- It is generally recognized that similar mechanisms of injury will have corresponding similar patterns of sick and not sick patients.^{12,13} This allows responders to quickly estimate the patient distribution based on total patient count. Using this assumption allows the first in officer to simply state the estimated total number of patients during their initial scene size-up, rather than trying to determine the number of red, yellow, and green patients upon arrival. Assuming 50% of the total patients will be red or yellow allows a quick guide to call for the appropriate amount of resources and establish the scope of the incident.
- Extraction priorities will be dynamic based on severity, access, and resources. It may be necessary or prudent to remove some yellow patients before red patients. Situations such as extended extraction times, yellow patients blocking access to red patients, physical barriers, or a shortage of staffing or resources may necessitate altering extraction priorities.
- A triage gate creates an unnecessary choke point, impeding patient care, and will no longer be used.
- Deceased patients should not be moved or disturbed unless it is needed to extract viable patients.

⁹ Mistovich JJ, Karren, KJ, Hafen, BQ, Werman, HA. *Brady Prehospital Emergency Care. 6th ed.* Upper Saddle River, NJ: Prentice Hall Health; 2000: 866.

¹⁰ Seattle Office of Emergency Management. *Alaskan Way Viaduct Field Exercise After Action and Corrective Action Report.* Seattle, WA: Seattle Office of Emergency Management; 2005.

¹¹ Heightman, AJ. Seattle: Bus off the Aurora Highway Bridge. *Journal of Emergency Services.* 1999; 24(6):86-95.

¹² Arnold, JL; Halpern, P; Tsai, M, Smithline H. Mass Casualty Terrorist Bombings: A Comparison of Outcomes by Bombing Type. *Annals of Emergency Medicine.* 2004; 43(2):263-273.

¹³ Pretto, EA. Framework for Mass Casualty Management and the Role of the Anesthesiologist. *Anesthesia and Disaster Medicine: Part II.* 2003; 1(2)

- The mental health of the responders can be adversely affected by this traumatic type of incident, and the activation of a Critical Incident Stress Management team following the event may be necessary.

DEFINITIONS

Ambulance Coordinator: Person responsible for the ambulance staging area; reports to the Transportation Team Leader.

ABC Field Triage: An algorithm which allows for the rapid categorization of patients dependent on the assessment of Airway, Breathing and Circulation.

Advanced Life Support (ALS): Invasive emergency medical services requiring advanced medical treatment skills as defined by chapter 18.71 RCW.

Alternate Care Facilities: Locations, preexisting or created, that serve to expand the capacity of a hospital in order to accommodate or care for patients during multiple casualty incidents or a biological (epidemic) event that overwhelms local hospital capacity. Patients will always be triaged and transported to the hospital not the ACF

Basic Life Support (BLS): Noninvasive emergency medical services requiring basic medical treatment skills as defined in chapter 18.73 RCW.

Cold Zone: Contains all emergency activities not involved in the hot or warm zones. This includes the treatment area, transportation corridor, command post, green patient area, and staging.

Disaster Medical Control Center (DMCC): Also known as Hospital Control, the Hospital responsible for providing EMS with a coordinated distribution of patients to area hospitals based on patient needs and the hospitals capabilities.

Extraction: The process of moving patients out of the hot zone to the treatment and transport areas.

Extrication: The process of removing a patient from an entrapment.

Field Incident Technician (FIT): An individual assigned to assist with logistical, tactical and accountability functions. Typically a FIT will be assigned to an I.M.S. position such as Operations Section Chief, Branch Director, Group Supervisor, etc.

Field Treatment Site: An area designated by emergency officials for the short-term (usually not more than 24-48 hours) collection, sorting (triaging), holding, and provision of initial, stabilizing treatment of patients until they can be safely transported to a definitive care site or evacuated from the region.

Field Triage: The process of rapidly categorizing a large number of patients according to their severity of injury in order to prioritize their extrication and extraction to the treatment area.

Fractured Incident: Occurs when a physical barrier provides limited access between geographical areas of the same incident.

Green Patient Screening Area: An area dedicated to containment, treatment, and care of patients. Designated as a separate area from Treatment due to the large number of potential patients and the special considerations they may need such as shelter, food and restroom facilities. Depending on the type of incident, they may also be considered witness/suspects and require a law enforcement presence.

Hot Zone: The area that includes any ongoing hazards. The hot zone will be considered a higher risk area and should be restricted to personnel who have donned appropriate PPE and have an assigned task within the hot zone.

Loading Coordinator: Member responsible for the coordination of loading of patients into transportation resources; reports to the Transportation Team Leader.

MCI Response: Varied level of resources dispatched to an incident dependent upon the nature of the incident, the number of patients, and their severity of injury.

MCI Vehicle: A mobile unit with enough EMS equipment and supplies to treat a large amount of patients.

Medical Group Supervisor (MGS): Reports to the Incident Commander or Operations Section Chief. The MGS ensures that Treatment, Transportation, Green Patient Screening, Medical Staging, and Striped (Black/White) Patient functions are performed; delegating positions as necessary.

Medical Communications Manager: Member designated to talk with the DMCC to acquire patient destinations. This person is usually located at the end of the transportation corridor with the Tracking Manager and reports to the Transportation Team Leader.

Medical Control: Physician direction over pre-hospital activities to ensure efficient triage, transportation, and care. Also includes the written policies, procedures, guidelines and protocols for pre-hospital emergency medical care and transportation.

Medical Staging: An area established to maintain medical supplies, personnel and equipment. The Medical Staging Area will not be necessary at all incidents. When it is indicated, the Medical Group Supervisor will assign a Medical Staging Manager.

MSO: Medical Services Officer, an EMS supervisor.

Multiple Casualty Incident (MCI): Sometimes called a Mass Casualty Incident, a MCI is an event resulting from man-made or natural causes which results in illness or injury to a large number of people simultaneously. The effect is that definitive patient care cannot be provided immediately to all and resources must be allocated

Paramedic: A person who has been trained in an approved program to perform all phases of prehospital emergency medical care, including advanced life support, under written or oral authorization of an MPD or approved physician delegate; and

Patient Tracking: A system integrated with other healthcare providers to follow patient progression through an incident from initial contact to final disposition.

Remote Treatment Area: An additional treatment area set up in conjunction with a transportation corridor that is distant from the hot zone to help stage patients closer to the transportation resources.

Sick/ Not Sick: The sick/ not sick approach to triage utilizes the EMT's knowledge and experience to rapidly evaluate a patient's physiological status. The sick patient is categorized as red. The not sick patient is considered green if they are able to get up and walk on their own and yellow if they have injuries preventing moving themselves.

Striped (black/white) Patient Area: An area dedicated to the holding of any patients that expire after they have been extracted from the hot zone.

Tracking Manager: Member responsible for collecting patient barcode information, general condition (red, yellow, or green), and destination from each patient as they are transported from the scene for patient tracking purposes. This person is usually located at the end of the transportation corridor with the Medical Communications Manager and reports to the Transportation Team Leader.

Transport Corridor: Ingress and egress for patient transport.

Treatment Area: The designated area for the collection and treatment of patients. A colored flag will identify each treatment area.

- Red: An area where patients require immediate assistance
- Yellow: An area where patient injuries are serious (delayed) but not life-threatening
- Green: The area where patients with minor injuries are kept
- Black: An area where the deceased are placed

Treatment Tag: A tag attached to a patient listing patient's vitals and injuries. Medical shall designate when this form will be utilized.

Triage: A process of prioritizing patients based on the severity of their condition. This rations patient treatment efficiently when resources are insufficient for all to be treated immediately. Triage at a large incident is a dynamic ongoing process. Patients will be triaged and may have their status changed as they are moved from the hot zone to the hospital.

Triage Flagging Tape: A color coded identification system used to designate medical priority of patients during a Multiple Casualty Incident.

- Red Flagging (immediate patient)
- Yellow Flagging (delayed patient)
- Green Flagging (minor patient)
- Striped (black/white) Flagging (deceased patient)
- White Flagging – Haz-Mat incidents only (decontaminated/clean patient)

Flagging will be used if the hot zone is geographically dispersed enough that duplication of triage may occur, resulting in a delay in patient movement.

Warm Zone: The transition area between the hot and cold zones during a Haz-Mat incident where decontamination procedures will occur.

CONCEPT OF OPERATIONS

A. Initial Incident Actions

The initial IC will complete or assign the following:

Primary actions:

- Initial and size-up reports
- Identify and secure the transportation corridor
- Perform a risk assessment
- Give assignments to incoming units

Secondary actions:

- Begin hazard mitigation for the purpose of reducing the immediate danger to patients, rescuers, and the public.
- Establish Recon Group
- Identify operational zones
- Coordinate with law enforcement to secure the transportation corridor and identify operational zones
- Designate a green patient area and have all green patients move to that location
- Begin extraction and treatment of patients as possible considering available resources

B. Tactical Benchmarks

- All patients extracted.
- All red patients transported.
- All patients transported.
- Any tactical benchmarks appropriate for hazard mitigation.

C. Scene Security

Scene security will be the responsibility of law enforcement, but fire and EMS personnel must stay alert to potential security issues including but not limited to:

- Additional Explosive Devices (see the Terrorist Attacks section)
- Crowd control
- Traffic control

The situation may cause the delay of certain operations while law enforcement clears the hazard area. Clear and consistent communication between fire, EMS, and law enforcement is critical to maintain security.¹⁴

¹⁴ Seattle Office of Emergency Management. *Alaskan Way Viaduct Field Exercise After Action and Corrective Action Report*. Seattle, WA: Seattle Office of Emergency Management; 2005.

D. Operational Zones

Initial companies need to clearly establish hot, warm, and cold zones (Appendix A, G). These zones should be clearly communicated to all on scene responders. Larger sites may need to be secured by law enforcement.

E. Transportation Corridor

The transportation corridor must be established early and clearly communicated by the first arriving company officer during the size-up report. The exact street, entry point, exit point, and direction of flow must all be determined and communicated. Law enforcement should be directed to clear and protect the designated corridor; all other apparatus should keep this location clear. Some incidents may require law enforcement to extend the protected corridor all the way to the hospitals.^{15,16}

All apparatus operators must keep the transportation corridor clear.

Medic Units will not be parked directly in the corridor, but should be located in or near the patient treatment area.

F. Transportation Resources

The preferred method of transportation during an MCI is by BLS ambulance. Larger incidents may require the use of non-traditional assets such as buses, taxis, or Access vans (Appendix DD).

During the initial stages of an MCI, Medic and Aid Units should not be used for transport.

Ambulance staff should remain with their vehicles to prevent them from becoming entangled in other tasks and risk clogging the transportation corridor with unmanned vehicles. For the same reason, patients should be brought to transportation resources rather than send ambulance staff to retrieve patients.

Use of MCI Transportation Buses should be considered as they become available in the Puget Sound region.

G. Treatment Area

The patient treatment area will be established in conjunction with the transportation corridor. It should be adjacent to the transportation corridor to facilitate communication, tracking, and patient transfer.

The Treatment Team Leader will be responsible for the treatment area.

Extracted patients will be delivered directly to the treatment area unless diverted to the transportation corridor by the Treatment Team Leader. Extraction teams may triage/retriage patients to the appropriate colored treatment area. A triage gate will not be used.

Large incidents may necessitate treatment areas with separate areas and staff for red and yellow patients.¹⁷ Multiple treatment areas with corresponding transportation corridors may be needed. Treatment needs to request enough staff to care for the expected number of patients.

¹⁵ Heightman, AJ. Seattle: Bus off the Aurora Highway Bridge. *Journal of Emergency Services*. 1999; 24(6):86-95.

¹⁶ Seattle Office of Emergency Management. *Alaskan Way Viaduct Field Exercise After Action and Corrective Action Report*. Seattle, WA: Seattle Office of Emergency Management; 2005.

¹⁷ Heightman, AJ. Seattle: Bus off the Aurora Highway Bridge. *Journal of Emergency Services*. 1999; 24(6):86-95.

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by Treatment Team Leader in accordance with standing orders and/or direction from Medical Control (See Field Treatment).

H. Triage

Triage will not be the responsibility of a single responder, but will be a collective and ongoing effort to constantly evaluate patients at every step in the MCI process. The Sick/ Not Sick triage standards will be used to evaluate patients.

Field triage will be the responsibility of the Extraction/Triage Team Leader within the Rescue Group.

I. Green Patient Area

The initial companies will direct those patients that can walk to a designated area of refuge, or green patient area. Ideally, this area would be:

- Close to the treatment area
- Close to the transportation corridor
- Easily secured
- Sheltered from the elements

Facilities, or “shelters of opportunity,” that may include large sheltered areas, bathroom facilities, showers, or kitchens can be used for the green patient area if available and in close proximity to the incident.

The Green Patient Team Leader will be responsible for the Green Patient Area.

Law enforcement may need to detain people in the green patient area for questioning as witnesses or suspects.

J. Striped (Black/White) Patient Area

The striped (black/white) patient area will be the holding location for any patients that expire after they have been extracted from the hot zone.

Patients that are identified as striped inside of the hot zone should not be removed from the hot zone unless under the direction of the county medical examiner. Movement of these patients may be necessary to access live patients, but should be minimized.

The medical examiner will assume responsibility for this area upon their arrival.

K. Fractured Incidents

When a physical barrier limits or prevents access between geographical areas, the incident is considered fractured. Fractured incidents may require branch level organization with the need for full or partial duplication of ICS positions, resources and staff for each area.

If functional areas are duplicated (multiple transportation corridors, treatment areas etc), each area must have its own ICS positions.

If multiple Transportation Team Leaders are being utilized, each may contact the DMCC for patient destinations separately.

Transportation resources requests will be handled by Operations in fractured incidents.

Fractured Incidents will be incredibly staffing intensive. IC's must be aware to call for adequate staffing early.

PATIENT DISPOSITION

A. Decontamination

Any MCI (natural or intentional) may include the release of hazardous materials (Haz-Mat). Responders will need to evaluate the potential need for Haz-Mat and decontamination (decon) procedures. If a hazardous materials release is known or suspected, a Haz-Mat response should be requested if not already dispatched.

As soon as an MCI Haz-Mat is suspected, Medical should notify the DMCC (Hospital Control) that an MCI Haz-Mat incident has occurred and to expect potential self-referred contaminated patients.

If decontamination procedures are required, the IC must ensure that a large enough footprint has been established for both gross and technical decon. In addition, rotation of staff will require additional companies.

B. Patient Sheltering

Every attempt should be made to provide shelter for the patients in the patient treatment and green patient areas. The shelter should provide protection from the hazards, weather, media, and the public.

Shelters of opportunity, or existing buildings, should be considered first. Priority will be given to structures with bathroom facilities, running water, and those that can be easily controlled. If no existing buildings are easily accessible or adjacent to the transportation corridor, then temporary shelters may be used. Possible temporary shelters include:

- Tents
- Public transportation buses

When choosing a shelter, the possibility for an expanding incident needs to be considered, ensuring patients are not placed into an existing or future hazard zone.

C. Field Treatment

Field treatment will follow current EMS MCI protocols as decided by the Medical Program Director.

The amount and type of treatment performed in the treatment area will be determined by the Treatment Team Leader in conjunction with the MGS and the DMCC (Hospital Control). Patient stabilization will be the priority, but the decision to perform further intervention should be based on the following factors:

- Injury severity
- Injury type
- Length of time until the patients are transported
- Available ALS and BLS staffing in the treatment area
- Number of Patients

D. Patient Tracking

Patient tracking should be used to track the progress of every patient from the scene through to definitive care.

E. Documentation

Whatever form of documentation is chosen for MCI events, it should never delay patient care or transportation.

JOB ASSIGNMENTS

A. Incident Commander

The Incident Commander (IC) has overall responsibility for the incident. This position will be established by the first arriving company officer, but should be assumed by a chief officer. Additional command structure will follow ICS..

B. Medical Group Supervisor

The role of the Medical Group Supervisor (MGS) should initially be filled by a senior member from the first arriving ALS unit. This role should be assumed by an MSO/MSA. The Medical Group Supervisor is responsible for the following:

- Transportation
- Treatment
- DMCC notification
- Green patient management

Note that the Medical Group Supervisor will not be responsible for field triage. Field triage is now the responsibility of the Extraction/Triage Team Leader.

C. Treatment Team Leader

The Medical Group Supervisor will designate an ALS member to be the Treatment Team Leader who will be responsible for the following:

- Receiving patients from extraction teams
- Supervising the treatment of patients
- Managing the treatment area
- Prioritizing patients for transport
- Coordinating with the Transportation Team Leader
- Overseeing the striped (black/ white) patient area

The level of care provided in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by the Treatment Team Leader in accordance with standing orders and/or direction from Medical Control (See Field Treatment).

The Treatment Team Leader, with input from the Transportation Team Leader, may elect to have patients delivered directly to the transportation corridor for transport.

The Treatment Team Leader must request adequate staffing and resources to care for the expected number of patients.

D. Transportation Team Leader

The Medical Group Supervisor will designate an ALS member to be the Transportation Team Leader who will be responsible for the following:

- Communicating with the DMCC
- Keeping a total patient count of all transported patients by using the patient tracking system
- Coordinating with the Treatment Team Leader
- Coordinating with ambulance coordinator
- Ensuring every patient that is transported has an associated barcode tag

The Transportation Team Leader will assign patients to transporting units as those resources arrive. Constant communication between the Transportation and Treatment Team Leaders is important to ensure patients are ready for transport as units become available.

Larger incidents may require that the Transportation Team Leader delegate tasks by designating a Medical Communications Manager, a Loading Coordinator, a Tracking Manager, and/or an Ambulance Coordinator.

E. Green Patient Team Leader

As soon as possible, a Green Patient Team Leader will be designated. Responsibilities may include:

- Ensure a green patient area has been established
- Coordinating with law enforcement
- Medically evaluating all patients, upgrading patients to red or yellow as needed, and moving those patients to the treatment area(s)
- Providing basic medical care
- Requesting logistical support such as Port-a-potties, water, blankets, etc
- Considering the need for emotional support including department chaplains, family members, or outside counseling support
- Tracking patients (inside the green patient area)
- Documenting patients (inside the green patient area)
- Assisting other agencies to address victim assistance/family reunification

The Green Patient Team Leader should request enough staffing to handle all of the aspects involved with the green patient area.

F. Rescue Group Supervisor

The Rescue Group Supervisor should be designated early by the IC and will have the following responsibilities:

- Extraction /Triage
- Extrication

The Rescue Group Supervisor will determine if the use of triage flagging tape is necessary. Triage flagging tape should be used if the incident scene is geographically dispersed enough that duplication of triage efforts will cause a delay in patient movement.

The Rescue Group Supervisor may choose to utilize either functional groups, geographical divisions, or a combination of the two to most efficiently accomplish their tasks.

G. Extraction/Triage Team Leader

The Extraction/Triage Team Leader will be responsible for ensuring that all patients are triaged and removed from the hot zone.

Extraction teams will be composed of 2 or more responders and will be responsible for patient removal from the hot zone, field triage and delivery to the appropriate treatment area.

Extraction teams may use a variety of equipment to help move patients. These can include:

- Backboards
- Mega Movers
- Stokes Baskets

H. Extrication Team Leader

An Extrication Team Leader may be established to oversee patient disentanglement and technical rescue. When trapped patients are found, the extrication teams will be sent to assist with the technical removal of those patients.

Extrication teams must prioritize their operations to provide the greatest good for the greatest number of patients. Patient condition, removal complexity, and estimated time of removal should all be considered when deciding extrication priorities.

Mutual Aid and Outside Agency Assistance

A. Fire Department Mutual Aid

The IC should consider asking for the following mutual aid resources:

- ALS Strike Forces – 2 ALS Medic Units, 1 MSO
- Regional MCI Vehicles
- BLS Aid Cars
- Engine and/or Ladder Truck task forces
- Regional HazMat Units
- Regional Heavy Rescue Units

B. Law Enforcement

Law enforcement will be involved with any MCI event in multiple ways and have their own priorities depending on the type of event (transportation event, terrorist attack, etc.). Requests for assistance in securing a transportation corridor, establishing an evacuation zone, and assisting with the green patient area must be made early to give law enforcement enough time to get enough staffing on scene to help.

It is critical that a unified command is established early so that all agencies can operate cohesively to try and stabilize the event.

Multiple law enforcement agencies exist within the Puget Sound region, and the location and type of MCI event will dictate which agency will have jurisdiction over the event.

C. Field Treatment Sites

There may be times when it becomes impossible to move patients from the incident site creating the need to establish a Field Treatment Site (FTS) to hold patients until they can be safely transported to a definitive care site or evacuated from the region. Reasons for creating an FTS include any time the event:

- Produces a surge in patients that overwhelms the capacity and capability of the regional healthcare system to adequately care for those in need and timely evacuation to other regions is not possible;
- Damages infrastructure (e.g., hospitals, transportation routes) to the extent that there is insufficient capacity or capability to care for those in need or an inability to transport the injured to healthcare facilities or evacuate them out of the region in a timely fashion;
- Produces some combination of the above.

An FTS should only be activated for a short time (usually 24-48 hours), giving hospitals time to enact their internal patient surge procedures and/or time to coordinate patient movement out of the area.

D. Terrorist Attacks

If the MCI is the result of a known or potential terrorist attack, additional considerations need to be addressed:

- Any unexplained explosion or explosion from a terrorist device should be assumed to have dispersed a hazardous substance such as radiation or a nerve agent.
- Additional explosive devices that target first responders or the public may be in the area.
- The terrorist or terrorists may still be in the area and suspicious behavior should be noted and passed on to law enforcement.
- If patients show signs or symptoms of a HazMat exposure, emergency decon must be performed before patient contact is made.

If one has not already been called, the IC should immediately request an MCI HazMat response.

Any known or potential terrorist event should be handled as a HazMat incident per the local HazMat protocols.

E. Operational Zones

Personnel will designate a hot zone, a warm (transition) zone, a cold zone, and the exclusion zone (the outer perimeter) for MCI's. This is necessary to provide for crowd control and keep nonessential rescue personnel out of the danger zone.

The hot zone will include the area of any non-ambulatory patients that have not been removed as well as ongoing hazards. The hot zone will be considered a higher risk area, and should be restricted to personnel who have donned appropriate PPE, and have an assigned task within the hot zone.

The warm zone is the transition area between the hot and cold zones, and will contain any decontamination procedures.

The cold zone will contain all emergency activities not involved in the hot or warm zones. This includes the treatment area, transportation corridor, command post, and staging.

The exclusion zone will be the outside limit of the cold zone. The public and media will be located outside the exclusion zone. Small incidents will allow scene tape to be used to physically designate the exclusion zone. Law enforcement should be used in larger incidents to secure the exclusion zone.

Standard patient contact PPE is required for any personnel involved in patient care. A higher level of PPE may be required in the hot zone depending on hazards or operations. Individuals are responsible for using the proper PPE according to their duties.

It may be necessary to establish multiple hot or warm zones depending on the size and scope of the incident.

F. Possible Transportation Resources

The preferred method of transport during an MCI event is BLS ambulances. Possible transportation assets available during an MCI could include, but are not limited to:

- Private ambulance agencies
- Fire Department aid cars
- Metro/school buses
- Access Vans
- Mutual aid Fire Departments
- Airlift Northwest
- Coast Guard
- Military
- Taxi's

APPENDIX L: MEDICAL TRANSPORTATION ASSET RESOURCE REQUEST POSSIBILITIES

A catastrophic incident will require a large amount of medical transportation assets between EMS and inter-facility transportation needs. This need will likely outpace any local jurisdictions ability to provide vehicles, equipment, and personnel, requiring a request(s) for additional resources. This document lists the most common ways of requesting those resources at a local, county, state, and federal level.

- **Pre-existing mutual aid agreements** – Requests should be made through local dispatch centers for transportations assets from jurisdictions with pre-existing local-to-local mutual aid agreements. This option may be severely limited during a catastrophic incident due to neighboring jurisdictions also operating at or above maximum capacity.
- **Private ambulance resources** – A request may be made to bring private ambulance resources into a jurisdiction. Calls should be made directly to the requested private ambulance company, though it may be possible to call one private company and request additional resources from additional companies. Private companies may require a signed contract to ensure coverage of costs before they will commit resources to a jurisdiction. Questions may be directed to the Washington Ambulance Association (253-279-1435). The current private ambulance providers in the Puget Sound Region are listed below:
 - **American Medical Response (AMR)** – 206-444-4444 (Seattle), 253-584-7574 (Pierce County), 360-866-2266 (Thurston County)
 - **Rural Metro** – 425-228-6164
 - **Tri-Med** – 206-243-5622
 - **Airlift Northwest** – 1-800-426-2430 or 206-329-2569
 - **Falck Ambulance** – 425-248-4100
- **Washington Intrastate Mutual Aid System (WAMAS)** – WAMAS provides a simple framework to request resources (including medical transportation assets) between local jurisdictions (city, county, and tribal) where a preexisting mutual aid agreement does not exist. Currently fire districts cannot use WAMAS. State EMD should be contacted if a local jurisdiction is using WAMAS. For additional information, contact county EOCs or the Washington State EMD website:
http://www.emd.wa.gov/logistics/logistics_ResourcesforEmergencyManagers.shtml
- **Non-traditional transportation assets** – Non-traditional, or auxiliary, transport resources including school buses, mass transit buses, and limited mobility vans can serve as a critical resource during catastrophic events. Medical staff and equipment will likely have to be provided to travel with these assets if transporting patients with anything more than extremely minor injuries

and illness. It is best if a preexisting Memorandum of Understanding (MOU) is in place between the local (city or county) jurisdiction and any agency that may provide these assets. Contact Washington State Department of Health (DOH) for planning guidance and sample plans and MOUs.

Washington State Department of Health has created a planning tool for local jurisdictions to use when planning for medical transportation issues during catastrophic events. This planning tool includes information on current transportation assets throughout the state as well as contact info for various personnel and organizations involved in catastrophic medical transportation planning. The planning tool can be found on the Washington DOH website at:

<http://www.doh.wa.gov/ForPublicHealthandHealthcareProviders/EmergencyPreparedness/PatientTransport.aspx>

- **Washington State Fire-Mob** – Local jurisdictions and emergency management may make a request for medical transportation assets through Fire-Mob by making a request to the Fire-Mob regional coordinator and/or the local fire department. Contact the county EOC to identify the regional Fire-Mob coordinator.
- **EMAC** – The Washington State EMD may request medical transportation assets from Oregon, Idaho, and Vancouver BC through pre-existing agreements. This requires an emergency proclamation from the Governor of Washington. Request should be made through county EOCs.
- **FEMA Ambulance Contract** – The Washington State EMD may request FEMA to activate the FEMA ambulance. This will bring up to 300 ground ambulances, 25 rotary ambulances, and 25 fixed wing ambulances into the state within 24 hours. This requires an emergency proclamation from the Governor of Washington and the President of the United States. Request should be made through county EOCs.

APPENDIX M: SAMPLE ACTIVE SHOOTER MCI: RESCUE TASK FORCE CONCEPT OF OPERATIONS

I. PURPOSE

To achieve the greatest lifesaving and life preservation possible in the high risk, low frequency environment associated with Active Shooter and Mass Casualty Incident (MCI).

II. ASSUMPTIONS

- Law Enforcement (LE) and Fire/EMS must plan and train together for significant incidents prior to implementing joint operations
- LE and Fire/EMS must utilize Unified Command
- By the nature of the threat, LE will be the initial lead agency and identify the hot, warm, and cold zones
- Fire/EMS must have adequate operational plans in place to deal with an MCI in the cold zone prior to implementing warm zone operations
- Fire/EMS must ensure that Law Enforcement is familiar with MCI operations, including the importance of a transportation corridor

III. DEFINITION

A Rescue Task Force (RTF) is a multi-disciplinary group comprised of Fire/EMS personnel and Law Enforcement personnel designated to operate in the Warm/Indirect Threat Zone. LE personnel will provide dedicated protection for Fire/EMS rescue personnel. Fire/EMS personnel will provide immediate lifesaving treatment and extract victims while there is an on-going ballistic or potential IED threat in an adjacent Hot/Direct Threat Zone. Fire/EMS personnel will don appropriate personal protection equipment (PPE) when assigned to an RTF. Minimum RTF personnel include two LE personnel for protection and three Fire/EMS members for extraction. This capability can be deployed to support operations associated with, but not limited to, the following:

- Active shooter in a school, business, mall, conference, special event, etc.
- Any other scene that is or has the possibility of an on-going ballistic and/or potential IED threat.

IV. GENERAL

- LE will be the lead agency and shall establish Unified Command (UC)
- Prior to deploying an RTF, threat zones must be identified:
 - **Direct Threat Zone (Hot Zone)** - Any area in the incident scene in which there is a direct and immediate threat to persons or providers.

- **Indirect Threat Zone (Warm Zone)** - Any area in the incident scene where there is a potential hostile threat to persons or providers, but the threat is not direct and immediate. This is the area of operation for the RTF.
 - **Cold Zone** - Areas where there is little or no threat. The area where the RTF delivers extracted victims. Fire/EMS conducts treatment and transport operations in this area. UC will be located in this area.
- UC (through use of ICS) will deploy RTFs into Indirect Threat Zones.
 - Casualty Collection Points (CCPs) are designated locations at the transition between threat zones where victims are temporarily deposited. CCPs incorporate cover and concealment to the best extent possible. CCPs may be utilized when relocating patients from the Direct Threat Zone to the Indirect Threat Zone and/or the Indirect Threat Zone to the Cold Zone.

V. OPERATIONS

Fire/EMS Resources: If there is an indication that an incident involves an active shooter, a “Mass Casualty Incident” (MCI), or it’s local equivalent, should be dispatched. Personnel and resources must be adequate to provide Triage, Treatment and Transport in the Cold Zone as well as addressing any personnel needs for the RTF. Care must be taken to provide additional personnel and resources to address any other ongoing threat(s). e.g. HazMat or Fire as a weapon.

LE Resources: LE must be prepared to respond in accordance with Active Shooter protocols. Such protocols may include Contact Teams or equivalent units to respond into the Hot Zone to mitigate ongoing threats. Additional, resources such as Bomb Squads, SWAT Teams, a Rapid Deployment Force (RDF), and other command and control elements should be considered.

Special Considerations: In general, LE operations will proceed per established guidelines; Fire/EMS operations will be adjusted as follows:

Fire/EMS Staging

The first arriving unit will identify and announce a staging location for all incoming units outside the Cold Zone and prepare for coordinated efforts through Unified Command

1. Cover and concealment should be considered when selecting the staging location. Apparatus placement and routes of travel away from the staging location should be considered in the event emergency egress is required.
2. Responding units will choose a route of travel to the staging location that keeps them clear of the incident location in order to increase safety
3. All units will respond to a single staging location to ensure coordinated effort in the face of ongoing threats
4. Incident specific MCI and RTF concepts and assignments will be reviewed prior to advancing into the Cold Zone

Radio Communications: Agencies must pre-plan how to communicate. This may include pre-planned dispatch center operations and/or common frequencies, channels, or talk groups as well as face-to-face communications.

VI. Equipment

1. RTF members will respond with the appropriate level of PPE for the expected trauma
2. Agencies must address issues surrounding body armor
3. Ancillary WMD equipment and personnel may be useful. e.g. radiation, chemical or biological detectors
4. Appropriate immediate lifesaving treatment supplies and victim extraction equipment will be brought to the scene

VII. Deployment

1. When formed, RTFs will deploy to the Indirect Threat Zone to begin extracting victims to a designated CCP
2. RTFs will be assigned sequential radio designators for use by Unified Command. RTFs are not to deploy unless they have at least two LE personnel capable of providing dedicated security. Members will not self-deploy into the Indirect Threat Zone.
3. LE personnel will control movement of the RTF
4. The first RTF to make entry may transmit pertinent medical and/or rescue information. e.g. number of injured patients
5. When RTFs make entry they will treat the injured in a manner consistent with Tactical Emergency Casualty Care (TECC) guidelines. i.e. An RTF will conduct rapid triage of the victims within their secured area of influence. Immediate lifesaving treatment (trauma dressings, tourniquets, etc.) will be applied to stabilize victims for extraction. Victims will be extracted to the Cold Zone or designated CCP in order to receive further treatment.
6. Ambulatory victims not requiring RTF intervention will be directed by LE/RTF to self-evacuate via the designated corridor
7. Deceased victims will be visibly marked to allow for easy identification and to avoid repeated triage by other RTFs
8. LE members of an RTF will provide dedicated security in the Warm Zone at all times

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APPENDIX N: FORWARD MOVEMENT OF PATIENTS – DISASTER MEDICAL CONTROL CENTER COORDINATION OF PATIENT MOVEMENT

Planning Assumptions:

- Regions that are the hardest hit will exceed their local healthcare capabilities and will need outside assistance.
- Hospitals within a disaster zone will receive a major surge of patients from both self-referring patients and Emergency Medical Service (EMS) transports from the field.
- EMS agencies may have to hold patients in the field at either ad-hoc or planned Field Treatment Sites (FTS) due to hospital overload or infrastructure failure.
- Patients may need to be moved across county lines to ensure that patients are matched to receiving hospitals that have the necessary resources for patients' unique needs.
- Public health agencies and/or healthcare coalitions may set up alternative care facilities (ACFs) as a surge strategy, to decompress hospitals, or both.
- The regions and the State will try to maximize use of healthcare beds within Washington prior to moving patients out of state. This may include movement of patients outside of the Puget Sound Regional Catastrophic Preparedness Grant Program area.

Roles and Responsibilities:

Within Washington State, designated Disaster Medical Control Centers (DMCCs) at area hospitals in each of the nine homeland security and public health regions, are responsible for coordinating patient distribution with EMS and hospitals in their service area during mass casualty incidents. For the purposes of the forward movement of patients within this plan, the DMCCs will serve as the key conduits of coordination within the area.

Disaster Medical Control Center – The DMCCs will monitor hospital bed availability and will provide recommendations on where EMS should transport patients from the field when possible. The DMCCs also provide initial situational awareness on impacts to hospitals in a disaster. Data may be collected through multiple sources including WATrac, the statewide system for monitoring hospital availability and status, as well as by radio or phone.

During a disaster situation where large numbers of patients will need EMS transport, DMCCs will no longer provide destinations for specific patients en masse from the field, but will provide an overall situational awareness and general bed availability at the region's hospitals. DMCCs will primarily assist with coordination of patient placement for those with specialty needs (e.g. burn beds, pediatric services, ICU, surgery).

Information that the DMCC might be expected to provide to EMS agencies in support of patient transport is whether parts of a hospital are nonfunctional, whether a hospital is unable to provide specialty care, or if infrastructure to a hospital has been otherwise compromised. This information will also be shared within the local ESF 8 structure or EOC, depending on local protocol.

Throughout the incident, the DMCCs will be expected to determine the availability of specialty care at specific hospitals, and to continually monitor the status of that specialty care so as to direct EMS towards or away from that facility when that specialty is needed or assist hospitals with transfer of patients with specialty needs. DMCCs will collect the information listed in Table 1 from regional hospitals, and be ready to share that information with other DMCCs, EMS, hospitals, public health, and emergency management (per local protocol). If cross county patient movement is necessary, the DMCCs will serve as the primary coordinating entity across jurisdictions. The local DMCC will communicate information to EMS to inform patient distribution decisions. In addition, the DMCCs will serve as a conduit of information to assist public health agencies and the Washington State Department of Health on awareness of patients that may need to be moved out of the Puget Sound area or Washington State.

EMS – EMS agencies should no longer expect DMCCs to direct specific patients to specific hospitals during a disaster, but rather expect DMCCs to provide situational awareness of general hospital capability. DMCCs will try to prioritize assistance for coordination and placement of patients with specialty needs. In a catastrophic incident, it will be up to individual EMS units or agencies to determine where to take patients from the field based on situational awareness provided by the DMCCs, infrastructure status, distance from the disaster site, and any other information that can be gathered.

Hospitals – Hospitals have the responsibility to surge to their maximum capacity and keep open communications to the DMCCs. Hospitals within the affected area should be implementing procedures to create more availability for high acuity patients. Hospitals outside the affected area should prepare to accept a surge of patients either from EMS or from hospitals within the affected zone needing to offload current patients to make room for incoming disaster related patients.

Hospitals needing to open up bed availability will need to follow their own internal policies on which patients are transferred to facilities outside of the area and which patients can be discharged and sent home. Hospitals should forward this information to the DMCCs who will forward that information to public health agencies and healthcare coalitions (unless other local protocol are used). DMCCs may help in placing those patients that will be transferred to other hospitals in coordination with other regional DMCCs, transfer centers, and public health agencies.

Public Health, Healthcare Coalitions and Emergency Operations Centers – DMCCs will need to establish how they will maintain communications to their respective public health, emergency management agencies, and emergency operations centers (EOCs), and follow local protocol for managing requests for resources or assistance. Coordination of the DMCC to the local ESF 8 and emergency management structure should follow normal protocols. In some counties (e.g. King and Pierce) coordination will occur between the DMCC through the area healthcare coalition to public health and emergency management.

Washington State Department of Health – The Washington State Department of Health (WADOH) has a concept of operations that makes WADOH the convening entity for all Washington State DMCCs during a disaster scenario. The information that is expected to be collected would be the number of patients that each hospital can accept, the estimated number of patients in the field, the number of patients that each hospital is expecting to transport to another healthcare facility, what types of needs that patients needing transport will require, and what transportation each hospital will need. Local health departments will work with DMCCs to coordinate with WADOH regarding these efforts. The WADOH maintains a contact list that will include the landline phone numbers, radio frequency or talk groups, and satellite phone numbers (if available) of DMCCs and public health agencies within Washington State.

Table N-1: DMCC Data Collection for Awareness and Patient Distribution:

This information will be collected, as available by DMCCs at least once every operational period to inform EMS and to assist hospitals and local response agencies in coordinating patient movement. If DMCCs are unable to collect this information, every effort should be made by the local healthcare coalition, local health department or local EOC to gather this information. Updates should be provided to the ESF 8/Health and Medical representative and to EMS. Per local protocol, some of this data may be collected at other times by these entities based on agreement with their DMCCs.

INFORMATION GATHERING DATA ELEMENTS

ED Capacity (Normal / Surge): Above At Below

Evacuation yes / no / maybe _____

Operational status: Open with all services / Open with limited services

Key exceptions: _____

Power (grid/generator): yes / no _____

Water: yes / no _____

Steam: yes / no _____

Sewage yes / no _____

HVAC: yes / no _____

Communications status: Full Partial None

Primary: _____

Secondary: _____

Staffing: _____

Equipment: _____

Transportation: _____

Additional Critical Needs: _____

BASIC – Any MCI Scenario when information is available

Bed/Specialty	# Available	Time Period Available
ED Now		
ED within 30 min		

OR within 30 min		
OR within 60 min		
Adult Med/Surge		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Pediatric Med/Surge		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Neonatal ICU		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Adult ICU		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Pediatric ICU		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
CCU		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Airborne Infection Isolation		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Labor & Delivery		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Nursery		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Psychiatric		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)
Telemetry		<input type="checkbox"/> Immediately <input type="checkbox"/> Within 2 hours <input type="checkbox"/> Within 12 hours <input type="checkbox"/> Next Operational Period (____)

SPECIALTY SERVICES (priority during catastrophic incident)

General Surgeon	# Available	Availability
Gynecologic Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Hand Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Neurosurgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Obstetric Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Ophthalmic Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Orthopedic Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Otolaryngology Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Plastic Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____
Urologic Surgeon		<input type="checkbox"/> Available <input type="checkbox"/> Not Available <input type="checkbox"/> Available Within: _____