Mile-High RETAC
Regional
Mass Casualty Incident
(MCI)
Plan

Updated
November 15, 2018

Mile-High Regional Emergency Medical and Trauma Advisory Council (MHRETAC)
Serving the Counties and City and Counties of
Adams, Arapahoe, Broomfield,
Denver, Douglas & Elbert

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ACKNOWLEDGEMENTS

A SPECIAL THANK YOU TO THE FOOTHILLS REGIONAL EMERGENCY MEDICAL AND TRAUMA ADVISORY COUNCIL, MASS CASUALTY COMMITTEE, FOR THEIR PARTICIPATION IN DEVELOPING A MASS CASUALTY PLAN (MCI) AND FIELD GUIDE THAT COULD BE ADOPTED BY OTHER REGIONS

A SPECIAL THANK YOU TO THE MILE-HIGH REGIONAL EMERGENCY MEDICAL AND TRAUMA ADVISORY COUNCIL (MHRETAC), MASS CASUALTY COMMITTEE FOR THE DEVELOPMENT OF THE MHRETAC MCI PLAN, MHRETAC FIELD GUIDE, RESOURCE GUIDE AND RELATED DOCUMENTS

THE MILE-HIGH REGIONAL EMERGENCY MEDICAL AND TRAUMA ADVISORY COUNCIL BOARD OF DIRECTORS HAS APPROVED THIS MHRETAC MCI PLAN AND RELATED DOCUMENTS

1. MHRETAC CONCEPT

The Mile-High Regional Emergency Medical & Trauma Advisory Council (MHRETAC) provides this plan to the agencies, facilities, counties, and state agencies within the boundaries of the MHRETAC with the understanding that it is considered a "living document". Revisions of this plan are always on-going, and the plan will change as new information and data is obtained. Appendices to this plan are continually "in process" as events and data inspired standards are set.

The concept of this MHRETAC MCI Plan is that it is a document that unifies the efforts throughout the MHRETAC to better prepare for mass casualty and mass evacuation incidents. These efforts will ultimately enhance the entire EMS system. This plan has been developed by pre-hospital, hospital-based, emergency management and public health professionals. This design ensures a plan that is a "top-down – bottoms-up" approach.

This plan is meant as a "systems" plan only, and should NOT be interpreted as a functional plan. This plan, along with the MHRETAC Field Guide, should be used as templates to develop individual agency plans that work within our regional system.

The Mile-High RETAC also acknowledges that resources around the state are changing very quickly, so the resource lists and other appendices are subject to change without notice.

A. The MHRETAC as an Agency Resource

Colorado Legislature mandated the development of regional medical systems. Under Senate Bill 00-180, which updated Colorado Revised Statute (CRS) 25-3.5-101 et seq., the "Colorado Emergency Medical and Trauma Services Act" (the Act) further defines the creation of the Regional Emergency Medical & Trauma Advisory Councils (RETACs).

Based on direction provided under the Act, the Mile-High RETAC was created through the Boards of County Commissioners and/or City Council in Adams, Arapahoe, Broomfield City & County, Denver City & County, Douglas, and Elbert Counties. The Commissioners from each county and city and county appoint 3 members representing facilities, pre-hospital and government to serve on the MHRETAC Board of Directors. Representation includes urban, rural and frontier.

This Plan has been approved by the Mile-High Regional Emergency Medical and Trauma Advisory Council Board of Directors, but will be continually updated as a living document.

B. Purpose of Plan

The Mile-High Regional Emergency Medical and Trauma Advisory Council (MHRETAC) was created to develop a comprehensive and regional, emergency medical and trauma care system.

Each Board of County Commissioners and Office of Emergency Management within these six counties and cities and counties will be given a copy of this plan for their review and use as appropriate for their county.

This MHRETAC MCI Plan establishes a basis for unified response to a Mass Casualty or Mass Evacuation incident in the MHRETAC region. The region covers Adams, Arapahoe, Broomfield City & County, Denver City & County, Douglas, and Elbert Counties. The MHRETAC Board of Directors strongly encourages all pre-hospital agencies, facilities, and county emergency managers to develop integrated MCI plans that include working agreements with neighboring agencies and facilities.

Pre-hospital, hospital and county MCI Plans may be tiered to this plan, and agency MCI standard operating guidelines may be tiered to respective county plans.

Successful management of any Mass Casualty or Mass Evacuation heavily depends upon cooperation. successful outcomes from the use of the MHRETAC MCI Plan depend upon cooperation and shared organization and planning among County Emergency Managers, health care professionals administrators in facilities, pre-hospital agencies, disaster related support agencies and government entities at all levels in the counties that comprise the MHRETAC.

C. Administration and Support

The MHRETAC MCI Committee is a standing committee of the MHRETAC. This committee shall work cooperatively with each county's Emergency Manager to link Local Emergency Planning with this MHRETAC Plan.

D. Plan Development and Maintenance:

This MCI Plan was originally written in 2004 through the MHRETAC MCI Committee. The current plan will be distributed via a wide-range of media.

The MHRETAC MCI Committee is responsible for bi-yearly reviews of the MCI Plan and MCI Field Guide. Other revisions can be made at any time that national, state, and federal standards change, upon approval of the committee and the MHRETAC Board of Directors.

Proposed revisions, amendments and other changes shall be referred to the full MHRETAC Council for action.

E. Implementation

Revisions and/or amendments shall be acted upon by the MHRETAC not longer than 60 days after all members have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the committee chair.

2. DEFINITION OF TERMS AND ABBREVIATIONS

AHJ	Agency Having Jurisdiction

CISM	Critical Incident Stress Management
Communications Center	Dispatch Center
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Team
DOT	Department of Transportation
EMS	Emergency Medical Services
EMSystems	Electronic Patient Resource System
EMTS	Emergency Medical and Trauma Services
EPA	Environmental Protection Agency
ETA	Estimated Time of Arrival
Facility	Hospital or other health care facility
MHRETAC	Mile-High Regional Emergency Medical and Trauma Advisory Council
HazMat	Hazardous Material
IAP	Incident Action Plan
IC	Incident Commander
ICS	Incident Command System
IMT	Incident Management Team
MCI	Mass Casualty Incident
MGS	Medical Group Supervisor
MOU	Memorandum of Understanding
MMRS	Metropolitan Medical Response System

NFPA	National Fire Protection Association
NIMS	National Incident Management System
OSHA	Occupational Safety and Health Administration

3. SITUATIONS AND ASSUMPTIONS

Each Agency will define what constitutes a Mass Casualty Incident for their jurisdiction.

Situations

Potential MCIs in the MHRETAC could include

- Major Vehicular Accidents with multiple victims
- Urban, residential and wildland fires
- Severe winter storms or other severe weather or natural disaster related situations
- Public transportation accidents (aircraft, train, bus, chairlift)
- Construction and/or industrial and farm accidents including hazardous materials, or building collapses with multiple victims.
- River and/or localized flooding, dam failures, impassable highways, roads and bridges.
- Healthcare facility or other evacuations.
- Acts of terrorism, bio-terrorism and/or civil disobedience
- Military/Federally related incidents
- Any other incident that overwhelms the capabilities of local emergency response agencies

Assumptions

- When considering activation of this MHRETAC MCI Plan, all emergency response agencies are expected to have policies and procedures to continue meeting local needs through mutual or automatic aid or other agreements.
- Personnel, agencies and/or jurisdictions shall operate during an incident or evacuation under the National Incident Management System (NIMS).
- Facilities and pre-hospital agencies shall participate in periodic training exercises for their MCI/Mass Evacuation Plan.
- MHRETAC recommends that all facilities have an emergency operations plan that addresses MCI and Mass Evacuation.
- Each pre-hospital agency will have an MCI Plan in coordination with the MHRETAC plan and a template will be provided upon request.
- Emergency responders will use any mutual aid agreements and MOU's between regional EMS, hospitals, healthcare facilities and other pre-hospital agencies.

4. CONCEPTS OF OPERATIONS

A. General Scope of the MCI Plan

1. Upon activation of an agency MCI Plan, the Communications Center,

   shall dispatch resources at the request of the Incident Commander at the incident. Communications Centers may utilize the Medical Resource Guide (Appendix D), EMSystem, WebEOC or other resource mobilization guides.
2. The incident will be posted on the EMSystems website according to local jurisdiction protocols.
3. Emergency operations on scene shall be conducted as outlined in the MCI Plan of the agency or individual having jurisdiction (AHJ) or in the MHRETAC Field Guide (Appendix E), and in accordance with legislation, local plans, medical protocol and mutual aid agreements.
4. All MCIs within MHRETAC shall be handled in cooperation with, and under direction of, the agency or individual having jurisdiction (AHJ).

B. MHRETAC MCI Field Guide (Appendix E)

1. Provides a standardized guide to assist in coordination and/or management of any response to an MCI within the MHRETAC.
2. Effectively utilizes various resources for MCI management in the MHRETAC Region.
3. Can assist in evacuation and care for a significant number of patients from any health care facility when the care and transportation of those patients exceeds the capabilities of the locality, facility, or jurisdiction.
4. Will help ensure the largest number of survivors in mass casualty situations or healthcare facilities evacuations.

C. Types of Mass Casualty Events

The classification of the incident shall be determined by the Incident Commander (IC) based upon the needs of the scene and available resources.

1. **LOCAL:** Required resources are available within the agency or immediately available through normal mutual aid.
2. **REGIONAL:** Required resources exceed immediately available mutual aid.
3. **STATEWIDE:** When regional resources are overwhelmed, a statewide incident may be declared. Statewide mutual aid or a county disaster declaration must be activated through the County Emergency Management System.
4. **FEDERAL:** Activation of Federal resources requires a State declaration by the Colorado Office of Emergency Management and the Governor's office.

D. Management Goals

1. Do the greatest good for the greatest number of people.
2. Make the best use of manpower, equipment and facility resources.
3. Avoid relocating the MCI to the receiving facilities.

E. Incident Priorities

1. Facility or agency provider safety, accountability and welfare
2. Life Safety
3. Incident Stabilization
4. Conservation of Property and Evidence

F. Critical Incident Stress Management (CISM)

CISM team can be activated through the local Communications Centers.

5. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. Participants: The regional response to an MCI or evacuation may involve the following:

1. EMS providers with Emergency Response agencies
2. Healthcare facilities
3. Trained First Responders
4. Local, State and Federal government agencies
5. Non-transport support such as Fire organizations, CISM teams, American Red Cross, public utilities, amateur radio and any local volunteer organizations involved in disaster response and recovery operations

B. Local Emergency Plans

1. It is recognized that some localities and each county have a local emergency operations plan.
2. This MHRETAC MCI Plan shall be transparent to, and support any local jurisdictional plan.
3. The MHRETAC MCI Committee may provide planning guidance as needed to assist agencies or facilities in preparation and maintenance of their plan in regard to MCI events.

C. Initial Response to an incident

The MCI Plan calls for use of the NIMS standardized ICS approach to ~~all~~ MCI incidents. Requests for additional resources shall originate from the IC and be routed through the appropriate Communications Center.

D. EMSystems

EMSystems should be used during the incident to notify the region that an MCI has occurred, to monitor hospital capabilities and to assign patient destinations to available healthcare facilities. Events are utilized to inform/warn/query and collect data from users. Examples include public health advisories and incidents, suspicious person, Amber and MCI alerts, system announcements and severe weather. Those designated to create events also have the ability to attach files to events.

Activating MCI Alert

1. To set up an event, click on the events tab in EMSystems. For instructions on setting up an event, go to https://emresource.juvare.com/
2. The person creating the event should identify him or herself and give a report on the incident with type, location, number of patients and a callback number. PSAPs within the region have EMSystem access, and can quickly create and post the MCI Alert.

3. Within the form, complete as much information as possible. In addition, you are able to choose who should be participating in this event.
4. Once the MCI Alert is activated, appropriate notification via EMSystems will be made according to local protocol.

E. Roles and Responsibilities

1. **Hospitals and Healthcare Facilities**
    a. Facilities that are alerted through EMSystem shall provide, through EMSystems, confirmation or adjusted information on the numbers of patients they can accommodate in the three START Triage categories:
        Red: Immediate: May require immediate surgical intervention
        Yellow: Delayed: Definitive treatment may be delayed for hours
        Green: Walking Wounded: May require minor treatment only

    b. Facilities shall activate their own MCI plans for additional staffing based on anticipated patient counts from the scene.

2. **Pre-hospital**
    a. Responding providers, including those responding in privately owned vehicles, shall report to their respective agencies, then report to staging and SHALL NOT self-dispatch to scene of the incident.
    b. To maintain security, all personnel responding to a MCI or facility evacuation shall be required to carry self-identification and proof of affiliation with their agency.
    c. At the discretion of the IC, responding units may be directed to the staging area. They should not be allowed to respond directly to the MCI site unless needed immediately
    d. All pre hospital providers responding to a MCI in the Mile-High region agree to operate under an ICS system, utilizing the START triage system to sort and categorize patients
    e. Local jurisdictions affected by an MCI are responsible for activating mutual aid requests when needed. The request for mutual aid will initially be coordinated through their own Communication Centers. As the incident progresses and the need for regional assets becomes necessary, the County Emergency Management Office will coordinate additional assets through a County to County request and also through the State Department of Emergency Management. Use of the available statewide mutual aid resources available through the Colorado Department of Public Health and Environment (CDPHE) shall be activated by the County Emergency Manager's request to the

State of Colorado or a request may be made through the local health department.

f. Personnel from responding agencies shall be responsible for all of their medical and incident documentation.
g. Pre-hospital agencies shall encourage their providers to participate in on-going training in ICS, START triage system, EMSystem Training, hazard awareness programs and other related MCI skills, along with periodic training exercises.

3. **Emergency Managers**
    a. Emergency Managers are should be notified of an MCI event through their dispatch centers.
    b. Emergency Management will activate their Emergency Operations Center (EOC) if deemed necessary to support the Incident Commanders in the field.
    c. Acquisition of resources that are needed by the incident beyond the capability of the local response agency and the communications center will fall to the Office of Emergency Management (OEM) and the EOC.
    d. A County to County resource request will be coordinated by the EOC.
    e. Additional requests will funnel through the State Office of Emergency Management.
    f. There may also be a coordinated request made through the local heath department to the State Health Department for additional resources.
    g. Typically a local health department liaison will respond to the EOC help coordinate those requests.
    h. Along with the direct coordination between agencies, the use of EMSystems and/or WebEOC in an MCI event is critical and is used by many OEM's to help with resource coordination.
    i. OEM's will ask for a hospital liaison to the EOC to assist with resource and patient tracking.

4. **Public Health**
    a. Public Health Agencies are typically the lead for Emergency Support Function (ESF) 8 to provide a coordinated response to health and medical care needs during and following an emergency or disaster incident.
    b. ESF 8 provides the means for a public health response; (these roles are the first responders) assistance in the evacuation of victims; support to hospitals and nursing homes; provision of emergency mental health crisis counseling for disaster responders; fatality and

morgue management; and the re-establishment of health and medical care systems.

c. For emergency and disaster incidents requiring mutual-aid and local, state or federal assistance, public health will work with counterparts from such entities to seek, plan and direct use of those assets.

d. When an incident is focused in scope to a specific type of a response, such as a mass casualty, the position and functions of ESF 8 will be assumed by appropriate personnel with expertise pertinent to the incident. For a mass casualty, the jurisdictions Emergency Medical Services agency may act as the ESF 8 lead and Public Health would offer a support role to assure that medical personnel, services and facilities are available for responding to an emergency or disaster.

F. Medical Direction/Protocols

1. Medical direction will be maintained by each agency's Medical Director, even outside of local agency's jurisdiction.
2. Patient care shall be rendered in accordance with the established pre-hospital care protocols of each responding agency.

G. Fatalities and Mass Fatalities Incidents

1. It is critical that the Coroner's Office be notified as early as possible in any mass fatality situation.
2. Fatalities and any incident debris need to be left in place to assist the Coroner in identifying victims; deceased person are only moved to rescue salvageable victims.
3. The Coroner and Law Enforcement shall be responsible for scene and evidence security.

H. Universal Precautions

1. All personnel involved in a response to any MCI or evacuation shall comply with standard precautions, to include PPE, body substance isolation, and all equipment and resources for their own personal protection.
2. Individual personnel and/or their agencies should only enter areas and/or perform tasks for which they are trained and have appropriate PPE.

6. DIRECTION AND CONTROL

A. Emergency Communications

1. The Communications Center shall be responsible for posting the incident on EMSystems and advising all receiving facilities of the number of people being transported to each facility, their START category and ETA.
2. The Transportation Group Supervisor shall report to the IC when all patients have been transported from the scene. This is a benchmark to be communicated to the Communications Center and posted to EMSystems.
3. Only in cases of impending cardiac arrest or airway management issues~~,~~ ambulances are permitted to make enroute changes to hospital destination. Notification must be made to the Communications Center.
4. Clear language shall be used in all MCI responses as per ICS standards. Currently, no cell systems have been exclusively dedicated to EMS. Therefore, the public access cellular system is likely to be very busy during an MCI. Once an open cell line has been established by the IC, it should be kept open for the duration of the MCI.
5. If there are issues with access to phone lines due to congestion of the network, facilities should have Government Emergency Telecommunications Service (GETS) cards available to key personnel. These GETS cards provide National Security/Emergency Preparedness (NS/EP) personnel a high probability of completion for their phone calls when normal calling methods are unsuccessful. It is designed for periods of severe network congestion or disruption and works through a series of enhancements to the Public Switched Telephone Network (PSTN). GETS is in a constant state of readiness. Users receive a GETS "calling card" to access the service. This card provides access phone numbers, Personal Identification Number (PIN) and simple dialing instructions.
6. Facilities that have 800 MHz radios available should utilize them as a redundant source of communications. A list of the available channels is attached in Appendix H. The IC should identify the channel being utilized for primary communications during the event.

B. Technical Rescue Operations/Specialized Resources

1. When needs exceed local capabilities or resources, utilize WebEOC to locate specialized resources. Several local teams exist which have technical rescue capabilities.
2. When needs exceed regional resources, additional assistance is available through the Colorado Division of Emergency Management (CDEM).

C. Hazardous Materials

1. A Hazmat activation and notification plan should exist locally for incidents involving hazardous materials. Receiving facilities shall be notified that patients are coming from a hazmat incident in order to prepare to receive contaminated patients
2. Patients shall not be transported unless grossly decontaminated.
3. All healthcare facilities are encouraged to have basic decontamination capabilities to treat patients exposed to hazardous materials.
4. Patient self-transport should be anticipated by the facilities. Isolation and decontamination should be set up and available.
5. Decontamination shall be conducted according to accepted national guidelines established by DOT, OSHA, EPA, NFPA and any local hazardous material response plans

D. Air Operations

1. The Federal Aviation Administration (FAA) regulates airspace over an MCI
2. Requests for restriction of airspace over a MCI should be made by the County Emergency Operations Center to FAA's Denver Air Traffic Control Center (ARTCC) 303.342.1500.
3. ARTCC Operations Manager available 24 hours/7 days – 303.651.4248.
4. In large-scale emergencies Colorado Department of Emergency Managers are available. They can assist with air resource needs.

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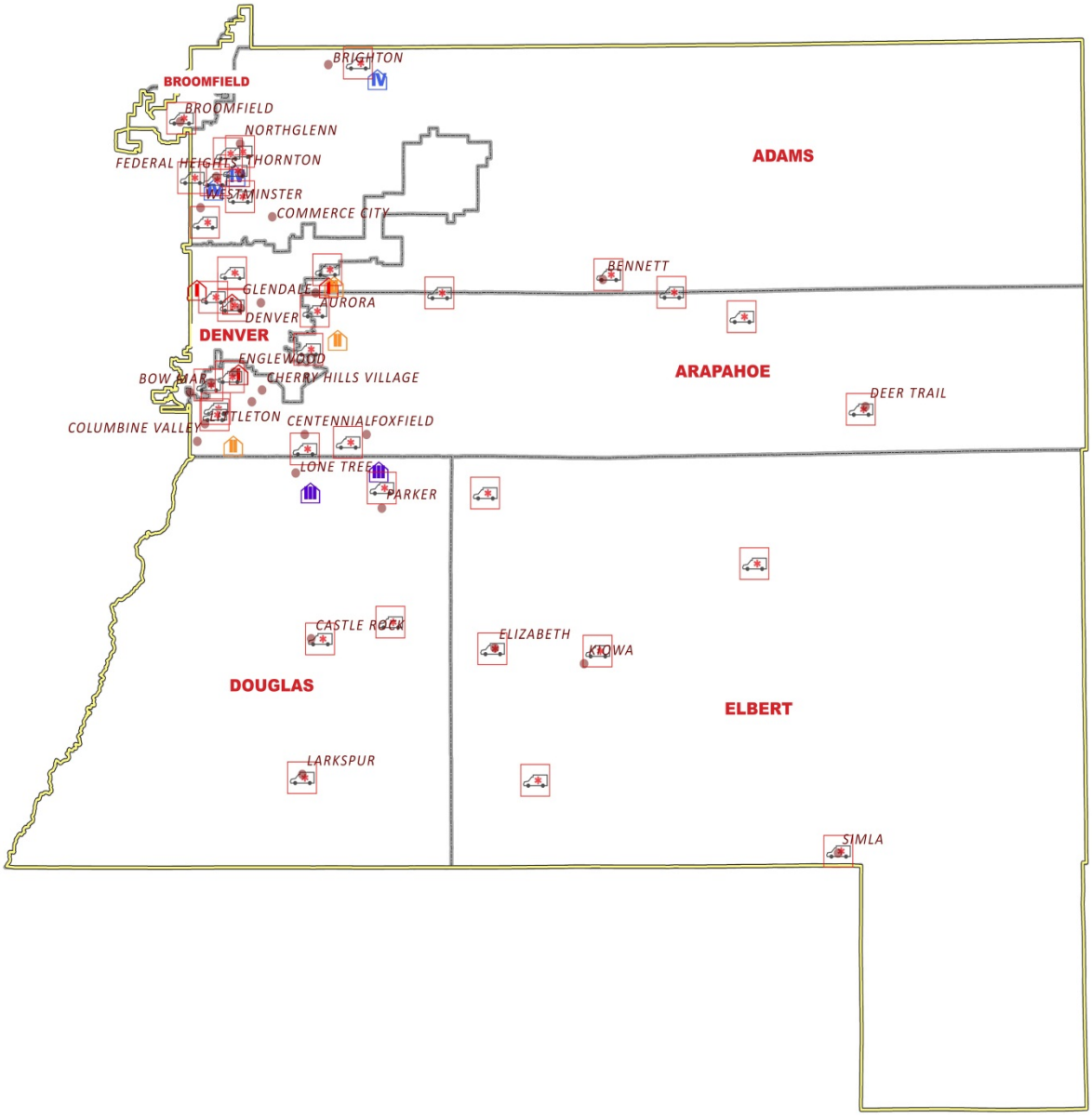
APPENDIX A

MILE-HIGH RETAC MAP


BRIGHTON
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NORTHGLENN
FEDERAL HEIGHTS
THORNTON
WESTMINSTER
COMMERCE CITY
ADAMS
BENNETT
GLENDALE
AURORA
DENVER
DENVER
ENGLEWOOD
BOW MAR
CHERRY HILLS VILLAGE
ARAPAHOE
DEER TRAIL
LITTLETON
COLUMBINE VALLEY
CENTENNIALFOXFIELD
LONE TREE
PARKER
CASTLE ROCK
ELIZABETH
KIOWA
DOUGLAS
ELBERT
LARKSPUR
SIMLA

APPENDIX B

MCI TRANSPORT FORM/BED COUNT FORM

Mile-High RETAC Fire/EMS Agency

MCI Transportation Form

# Victims Reported by Triage Category				
I	II	III	IV	Totals

Date:_____

Incident Location:_____

Emergency Units Responding			

Hospitals						
Can Handle						
# Sent						

Tag Number	Category	Patient Name	Primary Injuries	Emergency Unit Transporting	Time of Departure	Hospital

Notes:

MCI Transport Form for PSAPs/Coms

Mile-High RETAC Communications Office

MCI Transportation Form

# Victims Reported by Triage Category				
I	II	III	IV	Totals

Date:_____

Incident Location:_____

Emergency Units Responding			

Hospitals						
Can Handle						
# Sent						

Emergency Unit Transporting	Arrival at Scene	# Of Patients with Triage Categories	Time of Departure	Hospital	Arrival Time at Hospital

Notes:

APPENDIX C

PREHOSPITAL AGENCY MCI POLICY TEMPLATE #1

STANDARD OPERATING PROCEDURES

STANDARD OPERATING PROCEDURES

EMERGENCY MEDICAL SERVICE

SOP #:

Category: Mass Casualty Incidents

Date: March 13, 2011

I. Purpose:

Rapidly establish triage, treatment and transportation of multiple field casualties.

II. Procedure:

These procedures shall be implemented when personnel on the first arriving unit determine that **three or more ambulances** will be required to transport all victims from the scene to area hospitals. Due to the potential for HazMat or WMD in mass casualty incidents, extreme care should be taken to minimize risk to respondents. Other protocols may need to be integrated.

A. First Arriving Officer Duties:

The Officer on the first arriving EMS or fire unit shall be responsible for the initial scene assessment and coordination of the MCI response. He/she shall then assume Incident Command (IC) per Department Policy and Procedure and notify the Communications Office, designating the incident as an "MCI." The size-up report should also include the nature of the incident and an approximation of the number of victims, allowing the Communications Office to anticipate the resources required to meet the immediate needs.

1. The IC shall direct and coordinate all scene operations.

2. The IC shall designate routes of ingress and egress of ambulances and will notify the Communications Office of those routes on the radio.

3. The IC shall assign personnel to fill the roles of Triage Unit Leader and Transportation Unit Leader. The needs of the scene will help the IC decide the most appropriate personnel to fill these roles. Typically, these assignments will be given to the crew of the first arriving ambulance, to allow those individuals to maintain supervision of medical operations from their arrival until the last patient is transported from the scene ("First in, last out."). In some cases, the assignments may be given to other adequately trained personnel when they are not occupied with other duties, thus allowing ambulance personnel to remain with their ambulances and be available to treat and

transport patients. Another factor that may enter into the assignment of personnel would be the presence of a new ambulance crewmember who is being trained and evaluated and is not yet ready to solely assume one of these assignments.

4. The IC shall determine the need and make requests for resources or personnel that may be necessary for scene operations and management.

B. Triage Unit Leader:

The attendant on the first arriving ambulance assumes the role of Triage Unit Leader until the IC makes the official assignment. Once assigned, the Triage Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews.

1. The Triage Unit Leader's first responsibility is to provide rapid triage using the Simple Triage and Rapid Treatment (START) system for all victims of the incident. This requires the use of Triage Tags. When all victims are located within a small perimeter, the Triage Unit Leader can effectively perform triage for all victims and assign sufficient personnel to provide patient care while they await transportation. When several victims are scattered over a larger area, it may be necessary for the Triage Unit Leader to organize a team of rescue personnel to evacuate victims to a common location (Triage Funnel). The transfer of victims can be facilitated with the use of traffic cones, signs, or lengths of fire hoses deployed in a "cattle-chute" format (positioned from a wide area to a narrow end point). In this instance, the Triage Unit Leader may position himself at the Triage Funnel point to ensure that all victims are evaluated and triaged (or re-triaged).

2. When the transportation of several victims will be delayed, the Triage Unit Leader (in conjunction with the Transportation Unit Leader) may establish Patient Collection and Treatment Areas for each triage category. The location of these areas shall be in a safe area as close as possible to the Ambulance Loading Zone.

3. The Triage Unit Leader is responsible for designating (and communicating to the Transportation Unit Leader) the order of patients to be transported and which patients may require helicopter transportation.

4. When the Triage Unit Leader is the attendant on the first arriving ambulance, he/she resumes his/her original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

C. Transportation Unit Leader:

The driver of the first arriving ambulance will assume the role of Transportation Unit Leader until IC makes the official assignment. Once assigned, the Transportation Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews. The Transportation Unit Leader shall:

1. Be responsible for requesting the response of any additional EMS transportation resources (either to the Communications Office or to the IC/Medical Group Supervisor (MGS). This may include the use of public transportation resources (i.e. buses), for numerous "walking wounded" patients.

2. Determine the divert status of potential receiving hospitals and instruct the Communications Office to contact specific hospitals to alert them of the scope of the incident and to request a report of the number of patients (per triage category) that they are capable of receiving. **Remember:** A non-Trauma Center can often step up their capabilities and become a temporary "Trauma Center" if they are notified early into the incident and given enough time to mobilize staff, operating rooms, etc.

3. Designate the Ambulance Loading Zone and inform the IC or MGS.

4. Be responsible for establishing and ensuring proper placement and staging of all EMS ground and air units.

5. Work with the IC, the Triage Unit Leader, and the Communications Office to ensure that all incoming EMS crews are clearly aware of the following:

   a) Routes for vehicle ingress and egress

   b) Incident conditions and possible hazards

   c) Vehicle staging site (if necessary)

   d) Ambulance Loading Zone, located as close as possible to the Patient Collection and Treatment Area

   e) Location of Equipment Stockpile Area

   f) Key equipment needed from EMS units upon their arrival

   g) The need for drivers to stay with (or near) their vehicles

6. Assign patients to EMS transport units and maintains MCI Transportation Form. The Transportation Unit Leader must “patrol” the Transportation area and be concerned with removing patients from the scene expeditiously, with critical patients transported first, whenever possible. The Transportation Unit Leader should (when possible) avoid assigning more than one critical patient to each transport unit. Assigning one ”Red” and one ”Yellow” patient to each transport unit generally results in more effective patient care when there is only one attendant. It is important that the Transportation Unit Leader stay out of the Patient Collection and Treatment Areas to avoid being “trapped.” To this end, to the Transportation Unit Leader may establish a well-defined “on-deck” area near the Ambulance Loading Zone, where the next patients to be transported will be temporarily placed.

7. Assign hospital destinations to the first “wave” of EMS transport units and communicate it to Communication Center. After the first “wave” of transports from the scene, the Transportation Unit Leader will assign hospital destinations with advice from the Communications Office.

8. In large scale MCIs, the Transportation Unit Leader may assign the responsibility for making hospital notifications to the Communications Office.

9. Be responsible for implementing a system for tracking patients with their transporting vehicles and hospital destinations. The Transportation Unit Leader must ensure that the Triage Tag Tracer Stub is retained for each patient and that a corresponding log is maintained. The Transportation Unit Leader or the MGS is well-advised to appoint an Aide or Scribe to maintain the log.

10. When the Transportation Unit Leader is the driver on the first arriving ambulance, he resumes his original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

The IC may appoint a Medical Group Supervisor (MGS), to whom the Triage and Transportation Unit Leaders will report. In smaller incidents, the MGS may assume the role of Transportation Unit Leader.

D. Transport Unit Crews:

1. Responding Transport Units will obtain information from the Communications Office such as staging location, routes of ingress and egress, and (if available) the identity and location of the Transportation Unit Leader. Transport Units that respond to an MCI after the initial ambulance are responsible for reporting as assigned to the Ambulance Loading Zone or designated staging area.

2. When reporting to the Ambulance Loading Zone, transport unit crews will park their ambulances and then immediately contact the Transportation Unit Leader.

3. The crews should anticipate the rapid assignment of patients for transport, along with a hospital destination, from the Transportation Unit Leader. Transport unit crews must avoid becoming separated from their ambulances so they can load and leave the scene expeditiously.

4. In consideration of the potentially large amount of telephone or radio traffic, hospital notifications should be as concise as possible. In very large scale MCIs, the Transportation Unit Leader may decide to assign hospital notifications to the Communications Office or the Incident Dispatcher if assigned by Command.

5. Freelancing by transport units shall be avoided and may result in release from the incident as determined by IC or MGS.

E. The Communications Office:

1. When personnel at the scene designate an "MCI," the Communications Office is responsible for entering the incident on the EMSystems website.

2. Dispatch available resources to meet the initial needs of the scene per procedure.

3. Contact other transport agencies to inform them of the incident and to determine available resources as necessary.

4. Dispatch additional resources as requested by IC or MGS.

5. Communicate to all responding ambulances designated routes for ingress and egress.

6. Monitor EMSystems website or contact area hospitals as necessary to determine capabilities for receiving patients (number per triage category) and relay information to Transportation Unit Leader.

7. Inform Command and on-scene resources as appropriate.

8. Maintain MCI Transportation Form and record number and type of patients, transport units, hospital destinations and appropriate times (especially arrival times at hospitals). Make recommendations for hospital destinations to the Transportation Unit Leader based upon information from the MCI Transportation Form.

9. When assigned by the Transportation Unit Leader, personnel in the Communications Office will make hospital notifications that should be concise and include:

a) Identification of the transport unit

b) Number of patients with their triage category designation

c) ETA for each transport unit

III. Reference:

Denver Metro Paramedic Protocols
West Metro Fire Rescue EMS SOP #603

PREHOSPITAL AGENCY MCI POLICY TEMPLATE #2

MASS CASUALTY INCIDENT (MCI) OPERATIONAL POLICY

MASS CASUALTY INCIDENT (MCI) OPERATIONAL POLICY

These procedures shall be implemented when personnel on the first arriving unit determine that **three or more ambulances** will be required to transport all victims from the scene to area hospitals. Due to the potential for HazMat or WMD in mass casualty incidents, extreme care should be taken to minimize risk to respondents. Other protocols may need to be integrated.

A. First Arriving Officer

The Officer on the first arriving fire unit shall be responsible for the initial scene assessment and coordination of the MCI response (When arriving first on scene, EMS personnel will initiate these tasks until relieved by fire personnel.). The Officer shall then assume Incident Command (IC) per Interagency Policy and Procedure and notify Dispatch, designating the incident as an "MCI." (The Officer will maintain Incident Command until relieved.) The size-up report should also include the nature of the incident and an approximation of the number of victims, allowing Dispatch to anticipate the resources required to meet the immediate needs.

First Arriving Officer Checklist

- Scene assessment
- Coordination of the MCI response
- Assume Incident Command
- Notify Dispatch, designating the incident as an "MCI."
- The size-up report should also include the nature of the incident and an approximation of the number of victims.

B. Incident Command

1. The first person to assume Incident Command must immediately communicate with Dispatch and designate themselves to this role. Every time IC is passed on to other personnel, the new IC must clearly communicate this to Dispatch.
2. The IC shall direct and coordinate all scene operations.
3. The IC shall designate a dedicated radio frequency for local scene communication (preferably two, one specifically for patient transportation).
4. The IC shall designate routes of ingress and egress of ambulances and will notify Dispatch on the radio.
5. The IC shall assign personnel to fill the roles of Triage Unit Leader and Transportation Unit Leader. The needs of the scene will help the Officer decide the most appropriate personnel to fill these roles. Typically, these assignments will be given to the crew of the

first arriving ambulance, to allow those individuals to maintain supervision of medical operations from their arrival until the last patient is transported from the scene ("First in, last out."). In some cases, the assignments may be given to personnel from a fire unit when they are not occupied with other duties and are adequately trained, thus allowing ambulance personnel to remain with the ambulance and available to treat and transport patients. The Officer should make these assignments after consulting with the senior member of the ambulance crew.

6. Once made, the IC will communicate the assignments to Dispatch.
    a. When a Command Post is established with Unified Command, the IC should participate as the representative of Fire/EMS.
    b. Establish site
    c. Green Light or Flag
    d. Representation by Law Enforcement, Fire, and EMS
    e. Dialogue, consultation, mutual planning and decision-making

<u>Incident Command Checklist</u>

- The IC shall direct and coordinate all scene operations.

- The IC shall designate routes of ingress and egress of ambulances and will notify Dispatch of it on the radio.

- The IC shall determine the need and make requests for resources or personnel that may be necessary for scene operations and management.

- After consulting with the Transportation Unit Leader, the IC shall designate the Helicopter Landing Zone (as necessary) and assign personnel for ground contact.

- When Unified Command is established, represent Fire/EMS.

C. Medical Group Supervisor

The Medical Group Supervisor role may be assumed by the IC in small scenes. When the IC is supervising multiple operations (i.e. suppression, HazMat, etc.), he/she may assign a Medical Group Supervisor.

MISSION of Medical Group Supervisor**:** *To ensure that supervision and coordination is provided for triage, treatment and transportation of all patients.*

Medical Group Supervisor Checklist

- Report and provide frequent updates to the IC.
- The Medical Group Supervisor role may be assumed by the Incident Commander on small incidents
- Dress in identifying vest
- Locate in a visible position
- Assign radio TAC channel for MEDICAL
- Coordinate all medical operations
- Account for all personnel assigned to this group
- Monitor safety and welfare of group personnel
- Appoint and assign UNIT LEADERS and support staff

D. Triage Unit Leader

The attendant on the first arriving ambulance assumes the role of Triage Unit Leader until the IC makes the official assignment. Once assigned, the Triage Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews.

1. The Triage Unit Leader's first responsibility is to provide rapid triage using the Simple Triage and Rapid Treatment (START) system. This requires the use of Triage Tags. When all victims are located within a small perimeter, the Triage Unit Leader can effectively perform triage for all victims and assign sufficient personnel to provide patient care while they await transportation. When several victims are scattered over a larger area, it may be necessary for the Triage Unit Leader to organize a team of rescue personnel to evacuate victims to a common location (Triage Funnel). The transfer of victims can be facilitated with the use of traffic cones, signs or lengths of fire hoses deployed in a "cattle-chute" format (positioned from a wide area to a narrow end point). In this instance, the Triage Unit Leader may position himself at the point of the Triage Funnel to ensure that all victims are evaluated and triaged (or re-triaged).
2. When the transportation of several victims will be delayed, the Triage Unit Leader (in conjunction with the Transportation Unit Leader) may establish Patient Collection and Treatment Areas for each triage category. The location of these areas shall be in a safe area as close as possible to the Ambulance Loading Zone.
3. Assigns personnel to provide patient care and re-triage to victims while they await transportation.
4. The Triage Unit Leader is responsible for designating (and communicating to the Transportation Unit Leader) the order of patients to be transported and which patients may require helicopter transportation.
5. When the Triage Unit Leader is the attendant on the first arriving ambulance, he/she resumes his/her original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

Triage Unit Leader Checklist

- Provide rapid triage using the Simple Triage and Rapid Treatment (START) system for all victims of the incident.
- Perform triage for all victims and assign sufficient personnel to provide patient care while they await transportation if victims are located in a small area.
- Request a team of rescue personnel to evacuate victims to a common location if victims are scattered.
- When the transportation of several victims will be delayed, establish Patient Collection/Treatment Areas for each triage category. The location of these areas shall be in a safe area as close as possible to the Ambulance Loading Zone. The Triage Unit Leader will assign personnel to provide patient care and re-triage while victims are awaiting transportation.
- Designate (and communicate to the Transportation Unit Leader) the order of patients to be transported and which patients may require helicopter transportation.
- Resume original assignment when the last patients are prepared for transport.

E. Transportation Unit Leader

The driver of the first arriving ambulance will assume the role of Transportation Unit Leader until the IC makes the official assignment. Once assigned, the Transportation Unit Leader shall don the appropriate vest, so as to be easily recognizable to all incoming ambulance crews.

1. The Transportation Unit Leader is responsible for requesting the response of any additional EMS transportation resources (either through Dispatch or through the IC). This may include the use of public transportation resources, i.e. buses, for numerous "walking wounded" patients.
2. The Transportation Unit Leader must determine divert status of potential receiving hospitals and instruct Dispatch to contact specific hospitals to alert them of the scope of the incident and to request a report of the number of patients (per triage category) that they are capable of receiving. **Remember:** A non-Trauma Center can often step up their capabilities and become a temporary "Trauma Center" if they are notified early into the incident and given enough time to mobilize staff, operating rooms, etc.
3. The Transportation Unit Leader must designate the Ambulance Loading Zone and inform the IC and ensure proper placement and staging of all EMS ground and air units. Consult with IC to determine best location for a Helicopter Landing Zone when necessary.
4. Requests the response of the MCI Trailer as necessary.
5. Works with the IC, the Triage Unit Leader and Dispatch to ensure that all incoming EMS crews are clearly aware of the following:
    - Routes for vehicle ingress and egress
    - Incident conditions and possible hazards
    - Vehicle staging site (if necessary)

- Ambulance Loading Zone, located as close as possible to the Patient Collection and Treatment Area
- Location of Equipment Stockpile Area
- Key equipment needed from EMS units upon their arrival
- The need for drivers to stay with (or near) their vehicles

6. Assigns patients to EMS transport units and maintains MCI Transportation Form. The Transportation Unit Leader must "patrol" the Transportation area and be concerned with removing patients from the scene expeditiously, with critical patients transported first, whenever possible. The Transportation Unit Leader should (when possible) avoid assigning more than one critical patient to each transport unit. Assigning one Category Red and one Category Yellow patient to each transport unit generally results in more effective patient care when there is only one paramedic attending. It is important that the Transportation Unit Leader stay out of the Patient Collection/Treatment Areas to avoid being "trapped."
7. To this end, it is often advisable to establish a well-defined "on-deck" area near the Ambulance Loading Zone, where the next patients to be transported will be temporarily placed.
8. Assigns hospital destinations to the first "wave" of EMS transport units and communicates it to Dispatch. After the first "wave" of transports from the scene, the Transportation Unit Leader will assign hospital destinations with advice from Dispatch.
9. In very large scale MCIs, the Transportation Unit Leader may assign the responsibility for making hospital notifications to Dispatch.
10. Responsible for implementing a system for tracking patients with their transporting vehicles and hospital destinations. The Transportation Unit Leader must ensure that the Triage Tag Tracer Stub is retained for each patient and that a corresponding log is maintained.
11. When the Transportation Unit Leader is the driver on the first arriving ambulance, he/she resumes his/her original assignment when the last patients are prepared for transport. In most cases, the first ambulance to arrive on scene will be the last transporting ambulance.

<u>Transportation Unit Leader Checklist</u>

- Assume the role of Transportation Unit Leader until IC makes the official assignment.
- Responsible for requesting the response of any additional EMS transportation resources.
- Determine status of potential receiving hospitals and instruct Dispatch to contact specific hospitals to alert them of the scope of the incident and to request a report of the number of patients (per triage category) that they are capable of receiving.
- Designate the Ambulance Loading Zone and inform the IC.
- Requests the response of the MCI Trailer as necessary.
- Works with the IC, the Triage Unit Leader and Dispatch to ensure that all incoming EMS crews are clearly aware of the following:

- Routes for vehicle ingress and egress
- Incident conditions and possible hazards
- Vehicle staging site (if necessary)
- Ambulance Loading Zone, located as close as possible to the Patient Collection and Treatment Area
- Location of Equipment Stockpile Area
- Key equipment needed from EMS units upon their arrival
- The need for drivers to stay with (or near) their vehicles

- Assign patients to EMS transport units and maintain MCI Transportation Form.
- Establish a well-defined "on-deck" area near the Ambulance Loading Zone, where the next patients to be transported will be temporarily placed.
- Assign hospital destinations to the first "wave" of EMS transport units and communicate them to Dispatch.
- After the first "wave" of transports from the scene, the Transportation Unit Leader will assign hospital destinations with advice from Dispatch.
- In very large scale MCIs, the Transportation Unit Leader may assign the responsibility for making hospital notifications to Dispatch.

F. Transport Unit Crews

1. Transport Unit Crews will obtain information from Dispatch such as staging location, routes of ingress and egress, and (if available) the identity and location of the Transportation Unit Leader. They are to report as assigned to the designated staging area or directly to the scene if ordered.
2. When reporting to the scene, transport unit crews will park their ambulances at the designated loading zone or ambulance staging area (if designated) and immediately contact the Transportation Unit Leader (or Staging Officer).
3. The crews should anticipate the rapid assignment of patients along with a hospital destination from the Transportation Unit Leader. Transport unit crews must avoid becoming separated so they can load and leave the scene expeditiously.
4. Hospital notifications should be made and as concise as possible. In very large scale MCIs, the Transportation Unit Leader may assign hospital notifications to Dispatch.
5. Freelancing by transport units shall be avoided and may result in release from the incident as determined by IC.

<u>Transport Unit Crews Checklist</u>

- Obtain information from Dispatch such as staging location, routes of ingress and egress, and (if available) the identity and location of the Transportation Unit Leader.
- Park ambulances at the designated loading zone or ambulance staging area (if designated) and then immediately contact the Transportation Unit Leader.

- Anticipate the rapid assignment of patients for transport and hospital destination.
- Hospital notifications should be as concise as possible.

G. Dispatch

1. When personnel at the scene designate an "MCI," Dispatch is responsible for entering the incident on the EMSystems website.
2. Dispatch available resources to meet the initial needs of the scene per established procedure.
3. At the direction of the IC, designate a dedicated radio frequency for local scene communication and inform all responding apparatus/agencies.
4. Contact other transport agencies to inform them of the incident and to determine available resources as necessary.
5. Communicate to all responding ambulances designated routes for ingress and egress.
6. Monitor the EMSystems website and contact area hospitals as necessary to determine capabilities for receiving patients (number per triage category) and relay information to the Transportation Unit Leader.
7. Maintain the MCI Transportation Form to record number and type of patients, transport units, hospital destinations and appropriate times. Dispatch may make recommendations for hospital destinations to the Transportation Unit Leader upon information from the MCI Transportation Form and EMSystems. When requested by the Transportation Unit Leader, personnel in Dispatch will make hospital notifications that should be concise and include:
    - Identification of the transport unit
    - Number of patients with their triage category designation
    - ETA for each transport unit

<u>Dispatch Checklist</u>

- Enter the incident on the EMSystems website.
- Dispatch available resources to meet the initial needs of the scene per procedure.
- Contact other transport agencies to inform them of the incident and to determine available resources as necessary.
- Dispatch additional resources as requested by IC or designee.
- At the direction of the IC, designate a dedicated radio frequency for local scene communication and inform all responding apparatus/agencies.
- Communicate to all responding ambulances designated routes for ingress and egress.
- Monitor EMSystems website and contact area hospitals as necessary to determine capabilities for receiving patients (number per triage category) and relay information to Transportation Unit Leader.
- Inform IC and on-scene resources as appropriate.

- Maintain MCI Transportation Form to record number and type of patients, transport units, and hospital destinations.
- Make recommendations for hospital destinations to the Transportation Unit Leader based upon information from the MCI Transportation Form and hospital capability reports on the EMSystems website.
- When assigned by the Transportation Unit Leader, Dispatch will make hospital notifications that should be concise and include:
    - Identification of the transport unit
    - Number of patients with their triage category designation
    - ETA for each transport unit

APPENDIX D

MEDICAL RESOURCE GUIDE

SEE ENCLOSED DOCUMENT

APPENDIX E

MHRETAC MCI FIELD GUIDE

SEE ENCLOSED DOCUMENT

APPENDIX F

HOSPITAL SURGE PLAN TEMPLATE

Sample Hospital Surge Plan

Updated April 13, 2011

I. Purpose:

Medical surge capacity refers to the ability to evaluate and care for a markedly *increased volume* of patients that challenges or exceeds normal operating capacity. This increase is widely accepted as 20% beyond the total capacity of the hospital. The surge requirements may extend beyond direct patient care to include such tasks as extensive laboratory studies or epidemiological investigations. Because of its relation to patient volume, surge capacity focuses on identifying adequate numbers of hospital beds, personnel, pharmaceuticals, supplies and equipment. The quantity of each critical asset depends on the systems and processes that:

a. Identify the medical need;
b. Identify the resources to address the need in a timely manner;
c. Move the resources expeditiously to locations of patient need (as applicable); and
d. Manage and support the resources to their absolute maximum capacity.

II. Policy:

This Hospital used a tiered approach to an increase in unplanned patient volume as is outlined in the procedure section.

III. Accountability: All Hospital Associates

1. Procedure

1.1 In most instances this Hospital will defend in place and will manage a surge of patients until resources are exhausted and the hospital can no longer support the patient load. Once all resources have been exhausted or it becomes readily apparent that resources will be exhausted, the hospital Incident Commander will notify the local County Office of Emergency Management (OEM) of needed resources or that the hospital is overwhelmed and will soon no longer be able to support the patient load.

1.2 Tiered Response to Surge:

1.1.1 Internal Surge Response
1.1.2 Healthcare System Response
1.1.3 Community Integration
1.1.4 State Interaction
1.1.5 Interstate Interaction
1.1.6 Federal Interaction

1.3 Internal Surge Response – Tier 1

This Hospital has established steps that will outline preparation for emergency response activation. This includes roles and responsibilities of departments and programs based on the incident command structure (see EOP / Code Grey). The

Incident Command team will determine the length of each operational period – in hours, up to a maximum of 12 hours for a single operational period. They will also set the primary goal of the hospital for the emergency event. The primary goals are:

1.3.1 Ensure patient and staff safety is maintained while minimizing damage to the facility

1.3.2 Modify patient care to accommodate for a surge in patients

1.3.3 Areas of immediate needs for consideration:

1.3.1.1. Patient

1.3.1.1.1. Assess current patient needs

1.3.1.1.2. Communication with physicians for evaluation of early patient discharges

1.3.1.1.3. Set up discharge area for patient waiting transport so that beds can be freed up.

1.3.1.1.4. Cohort patients where possible

1.3.1.1.5. Assess availability of needed Pharmaceuticals

1.3.1.1.6. Set up Surge areas within the hospital

Areas for consideration for internal care sites are PACU, Day Surgery, Wellness Center, Auditoriums, Large Conf Rooms and classrooms, or as identified through the Incident Command Team.

Alternate Care Sites (ACS) sites outside the hospital include schools, Community Centers or free standing hospital surge tents. These should be identified by the local OEM during preplanning activates. The establishment of external ACS will mandate the supply of staff, equipment and supplies to the ACS.

1.3.1.2. Staffing

1.3.1.2.1 Review staffing capabilities

1.3.1.2.2 Additional security needs

1.3.1.2.3 Staffing to move to 12 hour shifts

1.3.1.3 Surge Equipment

1.3.1.3.1 Additional surge equipment i.e. cots, air mattresses, BP cuffs, patient gowns will be stored in the surge trailer.

1.3.1.3.2 Cot inventory = 50.

1.3.1.3.3 MCI/Triage Cart

1.3.1.3.4 The County OEM also has surge trailers with medical supplies that can be deployed if necessary

1.3.1.4 Supplies

1.3.1.4.1 Food (refer to Dietary vendor under MCI plan)

1.3.1.4.2 Linen – Call linen department and notify them of anticipated needs.

1.3.1.4.3 Pharmaceuticals – notify Pharmacy for any anticipated needs.

1.3.1.4.4 Pharmacy to keep list of medications stocked for use in a disaster.

1.3.1.4.5 Pharmacy also has a MOU in place with local distributor for additional medications if needed.

1.4 Healthcare System Response (Tier 2)

This Plan incorporates response plans of healthcare entities that this hospital will interact with during emergency events. If this Hospital becomes overwhelmed such that patient care could be impacted, the Hospital Command Center will notify other regional hospitals for assistance. This support will be managed through the hospitals Hospital Command enters or through a corporate command center if one is established. Assistance may be in a variety of forms – staffing, supplies, etc.

1.5 Local Jurisdictions (Tier 3) (ESF-8)

The Plan is integrated with the County Office of Emergency Management (OEM) for purposes of mass casualty response and emergency event communications. The Healthcare community of this All Hazards Region has a Memorandum of Understanding (MOU) to provide support and resources to affected communities. This hospital will respond to Emergency Department triage capacity requests (number of Red, Yellow and Green patient triage tags) made by the local OEM via 'EMSystem,' the web-based patient transport communication tool that will assist in patient transport management during mass casualty events. As activities increase in the Emergency Department, the communication response on triage capacity will be transferred to the hospital's Incident Command Center for the duration of the event. The hospital Incident Command Center should coordinate with local 911 dispatch, the County OEM the transportation assets needed to move patients, and their medications, supplies, equipment, and staff to an alternative care site(s) when the environment cannot support care, treatment, and services. The movement of patients and other items mentioned can be tracked using the EM System computer program. There are also standard HICS Forms for patient tracking. If it becomes necessary to transport large numbers of patients the Regional Transportation District (RTD) will be contacted for support.

1.6 State Interaction (Tier 4)

Colorado State Government participates in medical incident response across a range of capacities, depending on the specific event. The State may be the lead incident management authority, it may primarily provide support to incidents managed at the jurisdictional (Tier 3) level, or it may coordinate multijurisdictional incident response. Important concepts are delineated to accomplish all of the missions, ensuring that the full range of State health and medical resources are available. If State resources are needed, SNS Stockpile, Surge Push Packs, etc., communication will be through the County OEM.

1.7 Interstate Interaction (Tier 5)

Effective mechanisms must be implemented to promote incident management coordination between affected States. This ensures consistency in regional response through coordinated incident planning, enhances information exchange between interstate jurisdictions, and maximizes interstate mutual aid and other support. Preparedness planning is in place for accepting licensed medical professional volunteers from other states. Upon activation of the Governor's Executive Order for

medical volunteers from other states, this facility will set up a reception point within the hospital for such volunteers. Their credentials will be recorded, a just in time orientation to the hospitals provided and a rapid skills training for biomedical equipment will occur before being approve for the tasks they are assigned.

1.8 Federal Interaction (Tier 6)

This hospital holds a contract with the National Disaster Medical System (NDMS). If a federal disaster is declared in another state, this hospital will support and receive victims based on surge capacity availability. The potential impact on standard activities and overall staffing within the hospital will adjust for the activation of this federal contract. Follow protocols set for patient surge.

If a federally declared disaster is declared in the county or the state, the hospitals will interact with federal authorities such as the National Disaster Medical System and FEMA.

APPENDIX G

MASS FATALITY PLAN

Mass Fatality Plan

1. As previously stated in the body of the MHRETAC MCI Plan, when multiple fatalities are present, the appropriate county coroner should be requested via the communications center as soon as possible by the IC.
2. The North Central Region has developed a Mass Fatality Incident Response Plan. This particular plan is targeted towards the elected county coroners from the ten counties within the North Central Region (Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, and Jefferson).
3. The NCR Mass Fatality Incident Response Plan describes a Fatality Response Team that will coordinate the response to an incident which results in mass fatalities.
4. Law enforcement and county coroners are responsible for site and evidence security.
5. Responders should not move dead bodies unless those bodies are impeding rescue efforts of live victims.
6. Responders should make every attempt to note the location and position of the dead bodies prior to moving them.