Region X

MULTIPLE PATIENT MANAGEMENT PLAN

Effective January 1, 2023

Current Version 01162024

Region X Multiple Patient Management Plan
Effective January 1, 2023

The Region X Multiple Patient Management Plan (MPMP) was developed and approved through a collaborative process involving the five Emergency Medical Service (EMS) Systems located within EMS/Trauma Region X of the Illinois Department of Public Health (IDPH) listed below:

- Condell Medical Center EMS System, Libertyville, IL
- NorthShore Highland Park Hospital EMS System, Highland Park, IL
- Northwestern Medicine North Region EMS System, Lake Forest, IL
- Saint Francis Hospital EMS System, Evanston, IL
- Vista Health/North Lake County EMS System, Waukegan, IL

The Region X MPMP is intended to serve as a guideline for the management and transport of patients from incidents involving greater than five patients, not limited to disaster situations. The assumption is that in certain multiple patient incidents, the usual and customary forms of communication identified in the Region X EMS Standard Operating Procedures may be contraindicated as specified in the Region X MPMP. Furthermore, incidents involving mass violence or truncal trauma may result in providers initiating rapid EMS transport over formal on-scene triage/sorting activities.

Field providers, including command staff, as well as the Emergency Communication Registered Nurses (ECRN's) for the participating EMS agencies, resource hospitals and receiving hospitals within Region X will receive initial and ongoing training from their EMS System on the use of the Region X MPMP.

The signatures of the EMS System Medical Directors listed below officially approve the guidelines set forth by the Region X MPMP dated January 1, 2023 for the provision of emergency medical care and transport during multiple patient incidents by Region X EMS personnel and hospital based ECRN's. This Region X MPMP has been approved by the Illinois Department of Public Health based on the approval of the EMS System Medical Directors.

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LOG OF REVISIONS

Date of Change	Page Number	Summary of Revisions
10.12.2021	6	Revised endorsements to reflect current DMSC Committee members
	9	Redefined incident types from number of ambulances needed to number of patients transported and removed "Business as Usual"
	10	Reformatted "*Region X MPMP*" chart to reflect change in definition of incident types and removed Business as Usual
	12	Added language under Medium/Large Scale incident to indicate the need to maintain communication with the Resource Hospital until the scene has been cleared of patients.
	15	Changed LifeSource to Vitalant for blood needs
	16	Added flowchart for incident communications from deleted *Tactical Communications Plan* page
	-	Deleted *Tactical Communications Plan* page
	17	Updated *Hospital/Field Provider Affiliations and Resource Hospital Alt*. to reflect current affiliations
	18	Added Dispatch Center names and updated phone numbers in *Appendix I, Participating MABAS Divisions*
	19	Added *Appendix II* to show Area Wide Fire Depart. Dispatch Centers
	20	Added column for CarePoint Fax to *Appendix III: Are Wide Hospitals*
	29	Updated *O'Hare Incident Participating Calls* contact numbers for ER and Med Control
	31	Added *Appendix VII, Region X School Bus Accident Policy*
	38	Added Illinois Firefighter Peer Support as an agency under *Appendix XI, Post-Incident Recovery Services*
	40	Reformatted Field Provider Log Form
	41	Reformatted Emergency Department Log Form
	43	Added to *Appendix VII, School Bus Accident Log Form*
	-	Removed ICS 214 form from *Appendix VII: Forms*
	44	Removed "RMERT" from *Abbreviations/Acronyms*
7.11.2022	10	Added "Consider MABAS assistance" to medium/large scale incident
	11	Deleted medical categories on *Region X Criteria for Transportation Destination on Small Scale* and listed all medical patients to be transported to closest appropriate hospital.
	11	Added language to Region X MPMP chart to allow for use of electronic reports for large scale/healthcare evacuation if no delay in patient care or returning to service
	40	Added language to identify which hospital to call based on event size. Added patient tracking method on Field Provider Log Form and ED Log Form for hospital capability and patients transported.
	42	Added Healthcare Evacuation checkbox to *After-Action Report* and revised information on form
8.24.2022	7	Added language to assumptions to allow plan use for multiple patient incident consisting of trauma and/or medical patients. Also added assumption language that in the event of scene safety or other unique challenges, patients may be transported prior to hospital notification
	33	Added language to *Training Guidelines* identifying the need for all groups to regularly review the MPMP at all levels of users

10.25.2022	7	Added bullet point under Assumptions allowing the use of alternative triage tags/methods by agencies based on accepted current research on triage and rapid transport of patients
	20	Sorted table of Area Wide Hospital by status: Level I or Level II Trauma Center, Comprehensive ER, Standby ER and Free Standing ER
	21	Addition of Hatzalah Ambulance-Chicago to the Participating Private Ambulance Provider Chart
	28	On the O'Hare Incident/Disaster Plan, changed Our Lady of Resurrection to Community First Medical Center
	34	Added verbiage on Appendix IX: Medical Personnel Requested to The Scene to identify IMERT must be requested through IEMA
10.29.2022	6	Added bullet points "During incidents involving mass shootings or truncal penetrating trauma, rapid EMS transport should be favored over formal on-scene triage/sorting activities. Truncal penetrating wounds are life-threatening regardless of the patient's current condition" and "EMS command should determine if on-scene patient collection/treatment activities are useful based on the nature and size of the incident, number of trained EMS providers, available ambulances and other transport vehicles, scene safety concerns, capacity of nearby hospitals, environmental conditions, and the number of remaining injured patients."
	9	Added verbiage under Triage Tags and Triage Method for Medium/Large Scale Incident "During incidents involving mass shootings or truncal penetrating trauma, rapid EMS transport should be favored over formal on-scene triage/sorting activities."
	9	Added note for Patient Care Report for Large Scale Incident stating "During an incident involving a mass shooting or truncal penetrating trauma, an abbreviated report should be completed in the absence of a triage tag".
11.10.2022	6	Updated e-mail address for Sara Van Dusseldorp
	9	Added a note with verbiage addressing potential for walk-in to overwhelm ER's
	12	Added verbiage under Medium/Large Scale incidents to notify hospital when all patients are transported and scene is "all clear"
	12	Under Hospitals on Bypass, changed "Closest Appropriate" to "Resource Hospital"
	13	Added "EMS Transport" to first bullet point under Small Scale Incident
	13	Under Hospitals on Bypass, changed contact "Closest Appropriate" hospital to "Resource Hospital"
	18	Changed Abbott Park dispatch number and dispatch center. Added a note on their response abilities.
	27	Revised item #2 to read "Governor's office or designee"
	27	Revised item #4 from "REMERT" to "RMERT"
	28	Under 2nd bullet for Implementation, removed contact of "4-4-11" and left as CFD Officer in Charge
	28	Revised to indicate CFD contacting IEMA to request IMRT
12.7.2022	6	Changed Brianna Kuechle to EMS System Coordinator
12.22.2022	21	Deleted Paratech; Added MedEx and Lifeline; Added note that Midwest and Advance are under Elite who coordinates dispatch; place providers in alphabetical order.
6.26.2023	6	Removed Chief Carlson and added Deputy Chief Joel Eaton as new Highland Park Ems System Provider representative. Replaced Martha Pettineo as the Highland Park EMS System Coordinator.

7.12.2023	Cover Page	Revised to show only current version number
	5	Added Appendix VIII Mass Violence Response to Table of Contents and revised Table of Contents to match new corresponding page numbers
	46	Added Appendix VIII Mass Violence Response to MPMP
10.10.2023	7	Removed Tory Nuzzo as the Private provide representative and added Joseph Steiner as the replacement.
11.13.2023	6	Added Raeann Fuller as EMS System Coordinator, Highland Park EMS
	14	Added verbiage to small scale incidents indicating hospital need to contact RHCC if transported patients exceeds the number of patients that can be accepted by the provider's five closest hospitals.
	17	Added verbiage under Resource Hospital Responsibilities indicating that if the number of patients being transported exceeds the number of patients that can be received by the provider's five closest hospitals, the RHCC will be notified.
	18	Revised Provider Affiliations for Condell and Lake Forest
	22	Changed Midwestern Regional Medical Center to City of Hope. Update ER Phone number for Vista East, removed CarePoint Fax number for Vista East

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ENDORSEMENTS

This plan has the endorsement of each of the MABAS Divisions covered within the plan, the Medical Directors of each of the EMS Systems located within the boundaries of this plan and the Disaster Management Services Committee of Region X. The plan has been approved by the Region X Trauma/EMS Advisory Committee as well as the Illinois Department of Public Health.

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INTRODUCTION

The purpose of this plan is to enable Fire/EMS agencies and Region X hospitals to respond effectively and efficiently to multiple patient incidents so as not to tax the resources of any single pre-hospital provider or healthcare facility and to provide optimal patient care. This plan is intended to supplement each participant's individual mass casualty or disaster plan.

ASSUMPTIONS:

- The fundamental principles of risk assessment and risk management are essential to responder safety.
- Multiple patient incidents will occur in Region X.
- Given the population of Region X, responders and receivers should expect patient diversity in an incident, to include (at a minimum) age, gender, and special needs.
- This goal of this plan is to promote proper patient destination in the best interest of patient outcome.
- This plan is motivated by the essential priorities of Fire/EMS service response to a multiple patient incident consisting of trauma and/or medical patients.
- The most probable multiple patient incidents will involve less than five patients.
- The influx of multiple patients from the same incident or the inability to determine scene safety may create unique challenges for both hospitals and field providers including the ability to make proper notification of plan use before transport or arrival of patients.
- Given the challenges of simultaneously caring for multiple patients, altered standards of care may be temporarily required.
- Communication challenges will occur during multiple patient incidents.
- Patient conditions may change en route to the hospital and following initial communications with hospital(s).
- Alterations to modes of transportation or traditional transportation practices may be required, such as more than one patient per ambulance and/or the use of buses or vans to transport patients to regional healthcare facilities.
- Typical transportation routes may be affected by adverse weather conditions, debris or road closures which may impact hospital destinations.
- EMS personnel and hospital-based Emergency Communications Radio Nurses (ECRNs) are well versed in the trauma classification system as outlined by the Illinois Department of Public Health and inherent to the Region X Standing Operating Procedures.
- Region X has adopted the SMART® tag system as the standard process in Region X for identifying the urgency of patient transport. Agencies may choose to use alternate triage tag methods such as wristbands, which identify patients by the same color system. Alternate triage tag methods should be based on accepted current mass casualty research for triage and rapid transport of patients.
- During incidents involving mass shootings or truncal penetrating trauma, rapid EMS transport should be favored over formal on-scene triage/sorting activities. Truncal penetrating wounds are life-threatening regardless of the patient's current condition.
- EMS command should determine if on-scene patient collection/treatment activities are useful based on the nature and size of the incident, number of trained EMS providers, available ambulances and other transport vehicles, scene safety concerns, capacity of nearby hospitals, environmental conditions, and the number of remaining injured patients.

This plan assigns specific responsibilities to EMS providers and hospitals to coordinate resources and activities when an incident involves multiple patients. The plan outlines:

1. An approach that is scalable to the size, nature, geographic specifics, and speed of the event.

2. A classification system which promotes an orderly disbursement of patients to local/ regional hospitals.

3. A uniform operational guideline for handling multiple victim incidents within the structure of the Incident Command System.

4. A communications network linking responding Fire/EMS agencies to receiving hospitals and Region X Resource Hospitals.

5. Responsibilities of responding EMS providers.

6. Responsibilities of hospitals closest to a small scale multiple patient incident.

7. Responsibilities of the Resource Hospitals who shall serve as Hospital Command to assist with transportation management, including, but not limited to, managing logistics, obtaining hospital resource availability, and communicating such information to scene personnel when the number of ill or injured persons exceeds the routine disbursement of patients in Medium and Large Scale incidents.

8. Basic guidelines for the management of an emergent evacuation of a healthcare facility.

Hospitals and Fire/EMS providers in Region X are responsible for functioning as a unified entity in the event of a multiple patient incident. This plan enables all participants to collectively serve their communities and patients with efficiency and competence.

Every agency participating in this plan shall routinely conduct post-action reviews of all training exercises and plan activations to identify areas of improvement and to amend procedures, as necessary. A form to facilitate such review is contained within the plan.

Local government is recognized as the first line of official public response for emergency management activity. In addition to local resources used during a multiple patient incident, county, state, and federal emergency management agencies may be relied upon for support when damage, illness or injury is unusually widespread or severe. Private ambulance providers affiliated with Region X are considered valuable members of the EMS community and as such may be called upon as needed. The Private Provider Emergency Response System (PPERS) has been established in Illinois and may be activated to assist Illinois' Mutual Aid Box Alarm System (MABAS) during incidents involving large numbers of victims. Protocols for activating these agencies reside in the emergency operations plans of local governments, MABAS, and Resource Hospitals.

For additional information regarding this plan, please contact a member of the DMSC Committee listed on the Endorsements page.

DEFINITIONS OF MULTIPLE PATIENT INCIDENT TYPES

SMALL SCALE INCIDENT:

- A **Small Scale Incident** may require more than routine resources to mitigate the incident.
- The incident usually involves the transport of more than 5 but less than 10 patients.
- Command and General Staff functions are activated only if required.
- The incident is generally limited to one operational period in the control phase.
- A written Incident Action Plan (IAP) is not required but other documentation methods may be employed.

MEDIUM SCALE INCIDENT:

- A **Medium Scale Incident** exists when capabilities exceed the typical initial emergency response. The appropriate ICS positions should be added to match the complexity of the incident.
- The incident usually involves the transport of 10 or more but less than 20 patients.
- Some or all of the Command and General Staff positions may be activated, as well as Division/Group Supervisors and/or Unit Leader level positions.
- The incident may extend into multiple operational periods.
- A written Incident Action Plan (IAP) may be required.

LARGE SCALE INCIDENT:

- A **Large Scale Incident** generally extends beyond the capabilities of local control and may require multiple operational periods.
- The incident involves the transport of 20 or more patients.
- Most or all the Command and General Staff positions are filled.
- Many of the functional units may be required and staffed.
- A written Incident Action Plan (IAP) may be required for each operational period.

NOTE:
The definitions of multiple incident types shown above revolve around the transport of patients by EMS providers from the field. It should be understood that some incidents classified as Medium or Large Scale may create an overwhelming increase in the number of “walk-in” patients to area hospital emergency rooms. This influx of multiple patients, both transported and “walk-in”, may create unique challenges for both hospital and field providers, including the ability to assign transport destinations according to this plan. In these instances, communications between the Resource Hospital, Receiving Hospitals and Field Command is imperative to the appropriate distribution of patients based on injuries or illness.

REGION X MULTIPLE PATIENT MANAGEMENT PLAN

Definition	Small Scale Incident At least 5 but less than 10 patients	Medium Scale Incident At least 10 but less than 20 patients Consider MABAS assistance	Large Scale Incident 20 or greater patients Consider MABAS assistance	Evacuation of a Healthcare Facility
Initial Communication	If the number of transported patients is between 5 and 9, contact closest appropriate Hospital to advise of incident and determine their maximum patient availability. State: "We are on scene of a small scale multiple patient incident"	Contact Resource Hospital State: "We are on scene of a (medium) or (large) scale multiple patient incident"		Contact Resource Hospital State: "We are on scene of an emergency evacuation of a healthcare facility"
Initial Information	• Event Description • Estimated number of patients to be transported • Briefly describe pt. condition	• Event Description • Estimate number of patients to be transported • Estimate pt. acuities (R, Y, G) • Closest hospitals		• Event Description • Estimated number of patients to be transported • Closest hospitals • Alternative receiving facilities
Patient Disbursement	Field Command, or designee, coordinates transportation management and destination of patients. Patients should be disbursed to appropriate facilities based on trauma categories and guidelines. Maximum of 2 patients to each hospital unless advised otherwise.	Resource Hospital coordinates transportation management and destination of patients On a large scale incident, the RHCC may be employed for assistance with communications and additional resources		Resource Hospital works in conjunction with field command and administration of affected facility to determine transportation management and patient destination. RHCC may be employed for assistance with communications and additional resources Consider activation of PPERS and/or CHUG
Triage Tags	Triage tags not used	Triage tags MUST be used ***with the exception*** of incidents involving mass shootings or truncal penetrating trauma where rapid transport should be favored over formal triage activities		Triage tags MUST be used
Triage Method	Use rapid assessment to identify patient Category and appropriate hospital determination	START Triage ***with the exception*** of incidents involving mass shootings or truncal penetrating trauma where rapid transport should be favored over formal triage activities		Within facility use Reverse Triage Prior to transport use START Triage
Ambulance to Hospital Communication	Every transporting ambulance contacts their receiving hospital with an abbreviated report State: "We are transporting from a small scale multiple patient incident"	NO contact between transporting ambulance and receiving hospital		NO contact between transporting ambulance/patient transportation vehicle and receiving facilities
Patient Care Report	Complete written patient care reports as usual	Complete written patient care reports as usual	No written patient care reports since Triage Tags serve as written report unless able to complete with electronic means with **no delay** in patient care or returning to service (See note below)	No written patient care reports since Triage Tags serve as written report unless able to complete with electronic means with **no delay** in patient care or returning to service

Note: During an incident involving a mass shooting or truncal penetrating trauma, an abbreviated report should be completed in the absence of a triage tag.

REGION X CRITERIA FOR DETERMINING PATIENT TRANSPORT DESTINATION FOR SMALL SCALE INCIDENT

TRAUMA	
CRITERIA	**DESTINATION**
Traumatic Arrest	Closest Trauma Center
No Airway	Closest comprehensive ER
Systolic Blood Pressure • Adult ≤ 90 (2 consecutive measurements) • Peds ≤ 90 (2 consecutive measurements)	**Highest** level Trauma Center within 25 minute transport time
Category I Unstable Vital Signs • Glascow Coma Scale ≤ 13 with associated head trauma • Respiratory rate < 10 or > 29 (< 20 infant) or need for ventilatory support Anatomic Criteria • Penetrating injury to head, neck, torso and extremities proximal to elbow or knee • Two or more proximal long bone fractures • Unstable pelvis • Chest wall instability or deformity (e.g., flail chest) • Crushed, degloved, mangled or pulseless extremity • Open or depressed skull fractures • Amputation proximal to wrist or ankle • Paralysis	**Highest** level Trauma Center within 25 minute transport time
Category II (Mechanism of Injury) High Risk Auto Crash • Ejection from automobile (partial or complete) • Death in same passenger compartment • Intrusion, including roof, > 12 inches occupant site or > 18 inches any site • Vehicle telemetry data consistent with a high risk for injury • Motorcycle crash > 20 mph • Rollover (unrestrained) Falls • Adult Falls ≥ than 20 feet (1 story = 10 feet) • Peds Falls ≥ than 10 feet or 2X height of child Other • Auto vs. Pedestrian thrown, run over or with > 20 mph impact • Auto vs. Bicyclist thrown, or run over or with > 20 mph impact	**Closest** Trauma Center
Special Considerations Age • Adults ≥ 55 years: risk of injury and death increases • SBP < 110: consider shock if age > 65 years • Low impact mechanisms/standing falls may lead to injury • Children should be preferentially transported to a pediatric capable trauma center Anticoagulation and bleeding disorders: Pts. with head injury at high risk for rapid deterioration Burns: MOI with or without trauma: transfer to closest trauma center Pregnancy > 20 weeks preferentially transported to a facility with emergency obstetrics capabilities EMS Provider judgement	**Closest** Trauma Center If no trauma center, contact Medical Control
If none of the above, Simple Trauma	Closest comprehensive ER

MEDICAL
All medical patients, regardless of stability, are to be transported to the closest comprehensive emergency room.

FIRE DEPARTMENT RESPONSIBILITIES

SMALL SCALE INCIDENT:

- Contact the closest appropriate hospital, may be Resource Hospital in some areas, using normal modes of communication. State, *"We are on the scene of a Small Scale multiple patient incident."* Utilize the **Field Provider Log Form** (Appendix XII) for assistance with field to hospital communication.
- Report event description, estimated number of patients to be transported, general patient descriptions and the closest appropriate hospitals.
- After conferring with the closest appropriate hospital, transport the agreed upon number of patients to that hospital.
- If the closest hospital cannot take all the patients from the incident, Incident Command or their designee will assign each transporting ambulance a destination hospital. ***Transport no more than two patients to each remaining hospital.***
- If EMS desires more than two patients be transported to a hospital, the ECRN at the closest hospital should contact the desired hospital to confirm ***prior to transport.***
- When the number of ill or injured patients exceeds the routine transport of patients to the nearest hospitals, contact the Resource Hospital to coordinate remaining patient distribution.
- Communicate remaining patients' destinations to the closest hospital.
- All transporting ambulances should contact their destination hospitals with patient care reports (abbreviated reports are acceptable). All radio reports must begin with, *"We are transporting a patient from a Small Scale multiple patient incident"*.

MEDIUM or LARGE SCALE INCIDENTS:

- Contact the Resource Hospital IMMEDIATELY using normal modes of communication. State, *"We are on the scene of a Medium/Large Scale multiple patient incident".* Utilize the **Field Provider Log Form** (Appendix XII) for assistance with field to hospital communication.
- Requesting transportation management, report event description, estimated numbers of patients to be transported, estimated patient acuities and closest hospitals. Provide the Resource Hospital with a call-back number.
- After the Resource Hospital reports hospital capabilities, record information and assign patients and destination hospitals to ambulances.
- Maintain communication with the Resource Hospital until the scene has been cleared of patients. For each transporting ambulance, report ambulance number, acuities of patients being transported and destination hospital to the Resource Hospital.
- Once all patients have been transported on a medium or large scale incident (All Clear), notify the Resource Hospital of the number transported to each hospital so that appropriate notification of patient expectations can be made.
- Complete an After-Action Report (Appendix XII) following every multiple patient incident. Fax the report to the EMS Office at the Resource Hospital within 7 days of the event.

HOSPITALS ON BYPASS:

- Contact the Resource hospital regardless of the bypass status to discuss patient disbursement during a Small Scale incident.
- After conferring with field personnel, the Emergency Department physician or their designee will determine if diversion is necessary and may either accept the patient(s) or provide direction to divert the patient(s) to the next most appropriate hospital.
- Hospitals on bypass must receive patients from a Medium or Large Scale multiple patient incident.

EARLY COMMUNICATION WITH THE HOSPITAL IS INDICATED EVEN IF PATIENT COUNTS AND CONDITIONS HAVE NOT BEEN REFINED!

RECEIVING HOSPITAL RESPONSIBILITIES

SMALL SCALE:

Each medical control hospital within Region X must be prepared to manage initial calls from local emergency responders during a Small Scale incident. The closest appropriate, may be the Resource Hospital in some areas, will be contacted by a field provider representative for an initial discussion of patient disbursement. ***During some incidents, it may be possible for the closest hospital to accept all or most patients.***

- Following the initial disbursement of patients by EMS transport to the closest hospital, each area-wide hospital will receive NO MORE THAN TWO patients by EMS transport from a multiple patient incident (according to appropriate trauma triage criteria) without giving specific approval prior to transport.
- In the event that EMS would like to transport more than two patients to a hospital (most often victims from the same family), the ECRN at the closest Hospital will contact the desired hospital to confirm the receipt of additional patients ***prior to transport***.
- Receiving hospitals will be notified of their arriving patients via normal modes of field to hospital communication. Providers will announce, "*We are transporting a patient from a Small Scale multiple patient incident"* at the beginning of their radio report. Most often, this will be the first notification for a receiving hospital that a multiple patient incident has occurred.
- In the event the number of patients being transported exceeds the number of patients that can be received by the provider's five closest hospitals, the RHCC will be notified.
- **Receiving hospitals MAY NOT divert ambulances transporting from a multiple patient incident.**

MEDIUM or LARGE SCALE:

- If patient numbers or acuity prevents the even disbursement of patients to local hospitals, or if field providers need immediate assistance for any reason, field providers will contact their Resource Hospital for assistance with transportation management.
- Upon receiving notification from the Resource Hospital, receiving hospitals should immediately report their ability to accept specific numbers of red, yellow and green patients.
- ***Note: Ambulances transporting patients from the scene will NOT contact the receiving hospital prior to their arrival.***
    - Consider activation of internal hospital mass casualty/disaster plan in order to accommodate a larger number of patients.
    - Be prepared to report availability of medical personnel to send to the scene.
    - Maintain a log sheet of communication with the Resource Hospital.
    - Report increases or limitations in treatment capability to the Resource Hospital.
    - Be prepared to send pre-assembled bags of medical supplies to the scene (per state and regional guidelines).

HOSPITALS ON BYPASS:

- Pre-hospital providers will contact the Resource Hospital to discuss patient disbursement during a Small Scale incident when the closest appropriate hospital is on bypass status.
- After conferring with field personnel, the Emergency Department physician or their designee will determine if diversion is necessary and may either accept the patient(s) or provide direction to divert the patient(s) to the next most appropriate hospital.
- Hospitals on bypass must receive patients from a Medium or Large Scale multiple patient incident.

DO NOT ATTEMPT TO STOP PATIENT FLOW FROM INDIVIDUAL AMBULANCES ***NOT*** ASSOCIATED WITH THE DISASTER SCENE.

(Continued on next page)

Once the Resource Hospital has been contacted by field personnel for assistance with transportation management

ALL COMMUNICATION MUST GO THROUGH THE RESOURCE HOSPITAL!

- Do not attempt to contact the scene.
- Do not attempt to contact dispatch.
- Do not divert individual ambulances.

*Complete an After-Action Report (Appendix XII) following every medium or large scale multiple patient incident. Originals of all log sheets and disaster related records should be forwarded to the hospital EMS Coordinator within 7 days of the event.

RESOURCE HOSPITAL RESPONSIBILITIES

The Resource Hospital is contacted by scene personnel when the number of ill or injured patients exceeds the routine transport of patients to the nearest appropriate hospitals in order to coordinate the remaining patient distribution.

NOTE: *The Resource Hospital may be contacted at any time to assist field personnel.*

Upon notification by scene personnel that a Medium or Large Scale multiple patient incident has occurred, the Resource Hospital will assume the duties of Hospital Command, providing transportation management and serving as Medical Control throughout the incident.

The Resource Hospital shall:

- Initiate a **Hospital Communications Flow Sheet: ICS 214.**
- Collaborate with scene personnel to identify receiving hospitals based upon incident location, transport routes remaining open (consider natural disaster disruptions), volume and acuity of patients, and number of patients already transported.
    - Establish inter-hospital communications with possible receiving hospitals via telemetry, radio intercom, landline phone or MERCI 155.280.
    - Inform the hospitals about the nature of the incident, including approximate number, acuity and type of patients that will be transported.
    - Assess receiving hospitals' resources *(may be incident specific)*:
        - Ability to receive patients, including numbers of red, yellow and green
        - Blood inventory
        - Ability to decontaminate patients
        - Ability to send medical personnel and supplies to the scene
    - In the event the number of patients being transported exceeds the number of patients that can be received by the provider's five closest hospitals, the RHCC will be notified.
- Continue to monitor, log and communicate receiving hospitals' capacity throughout incident.
- Identify and alert additional receiving hospitals as casualty load exceeds the initial receiving hospitals' patient capacity.
- Maintain communication with the scene Incident Commander or their designee, relaying receiving hospital availability and providing on-going transportation management.
- Consider contacting the alternate Resource Hospital for assistance with communication.
- Consider contacting the RHCC if regional coordination or assistance with communication as required. (Highland Park Hospital: (847) 432-2294 or (847) 432-2295)
- Obtain status of specialized facilities as needed (burn units, pediatrics, etc.)
- Consider notifying Vitalant Blood Services at (847) 260-2701 or the emergency hotline at (800) 821-6277 if a multiple patient incident has occurred (if nature of casualties implies need for transfusions).
- Coordinate medical personnel to respond to the site as needed.
- Serve as Hospital Command liaison with disaster and public agencies.
- An After-Action Report (Appendix XII) should be completed following every medium or large scale multiple patient incident. Originals of all log sheets and disaster related records should be forwarded to the hospital's EMS Coordinator within 7 days of the event.

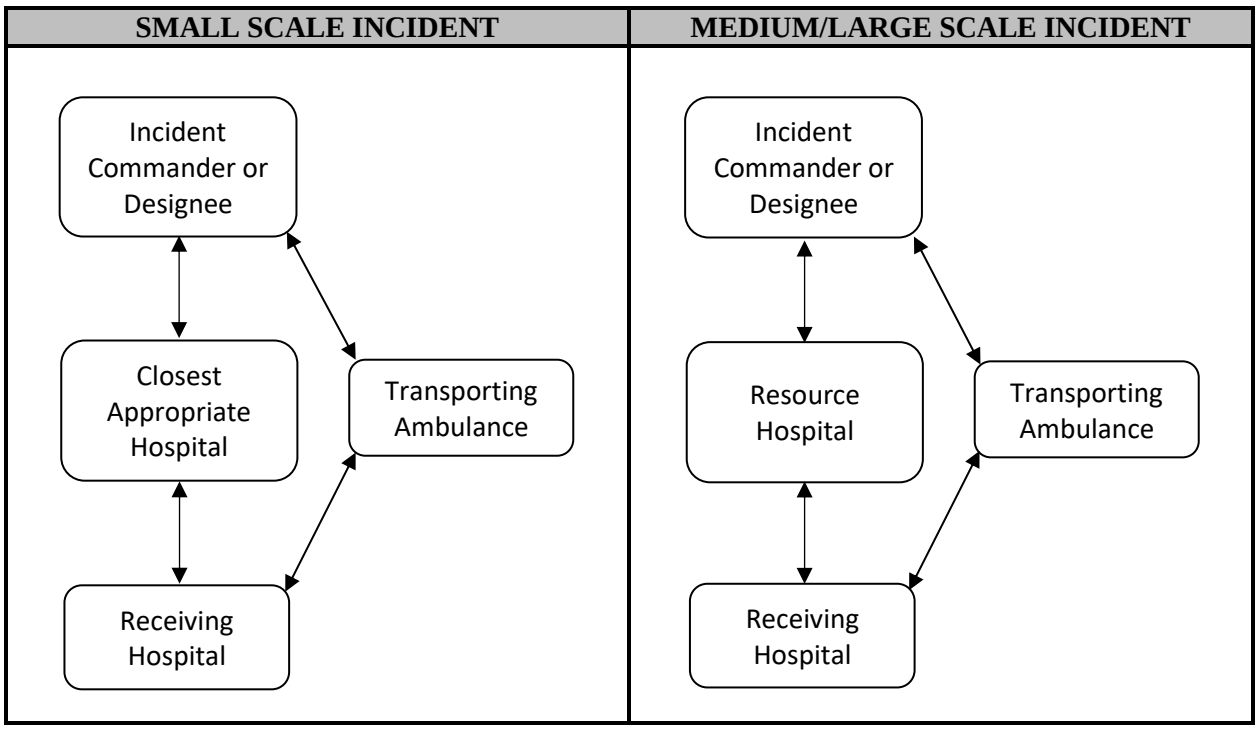
REGIONAL HOSPITAL COORDINATING CENTER (RHCC) RESPONSIBILITIES

The Regional Hospital Coordinating Center (RHCC) is contacted by Regional Resource Hospitals for assistance with communications and obtaining additional resources.

The RHCC shall:

- Initiate a Hospital Communications Flow Sheet: ICS 214
- Collaborate with requesting hospital to determine and attempt to meet logistical needs, including:
    - On-scene medical personnel/teams
    - Medical equipment/resources
- Communicate with other regions for assistance, as needed.
- Contact the Illinois Department of Public Health for assistance and/or notification, as needed.

FLOWCHART FOR ALL COMMUNICATIONS



HOSPITAL/FIELD PROVIDER AFFILIATIONS and RESOURCE HOSPITAL ALTERNATES

During a Medium Scale or Large Scale incident, *Hospital Command will be assumed by the Resource Hospital affiliated with the fire department that has jurisdiction over the incident location*. However, the Resource Hospital may be directly affected by the disaster or overwhelmed by patients and unable to function in that role. In such a case, Hospital Command will be assumed by the first or second alternate hospital, as designated below.

Condell Medical Center serves as Medical Control and Hospital Command for:	
Antioch Fire Department	Round Lake Fire Protection District
First alternate: Vista Medical Center East	Second alternate: Highland Park Hospital

Highland Park Hospital serves as Medical Control and Hospital Command for:	
Deerfield-Bannockburn Fire Protection Dist.	Highland Park Fire Department
Glencoe Public Safety	Northbrook Fire Department
Gurnee Fire Department	
First alternate: St. Francis Hospital	Second alternate: Vista Medical Center East

Lake Forest Hospital serves as Medical Control and Hospital Command for:	
Countryside Fire Protection District	Libertyville Fire Department
Grayslake Fire Protection District	Mundelein Fire Department
Great Lakes Fire Department	Newport Township Fire Protection District
Lake Bluff Fire Department	North Chicago Fire Department
Lake Forest Fire Department	Waukegan Fire Department
Lake Villa Fire Department	
First alternate: Condell Medical Center	Second alternate: Highland Park Hospital

St. Francis Hospital serves as Medical Control and Hospital Command for:	
Evanston Fire Department	Wheeling Fire Department
Lincolnwood Fire Department	Wilmette Fire Department
Northfield Fire Department	Winnetka Fire Department
Skokie Fire Department	
First alternate: Highland Park Hospital	Second alternate: Condell Medical Center

Vista Medical Center East serves as Medical Control and Hospital Command for:	
Beach Park Fire Protection District	Zion Fire and Rescue Department
Winthrop Harbor Fire Department	
First alternate: Condell Medical Center	Second alternate: Highland Park Hospital

APPENDIX I: PARTICIPATING MABAS DIVISIONS

REGION X MABAS DIVISION DISPATCH CENTERS

MABAS Division	Primary Dispatch Center		Back-Up Dispatch Center	
Division 1	Northwest Central	(847) 590-3300	RED Center	(847) 724-5700
Division 3	RED Center	(847) 724-5700	Northwest Central	(847) 590-3300
Division 4	CENCOM	(847) 270-9111	Countryside FPD	(847) 566-4621

MABAS DIVISION 1 AGENCIES

Department	EMS System	Primary Dispatch Number	Dispatch Center
Wheeling	St. Francis	(847) 724-5700	Red Center

MABAS DIVISION 3 AGENCIES

Department	EMS System	Primary Dispatch Number	Dispatch Center
Deerfield-Bannockburn	Highland Park	(847) 724-5700	Red Center
Evanston	St. Francis	(847) 866-5095	Evanston
Glencoe	Highland Park	(847) 724-2121	Glenview
Glenview	Lutheran General	(847) 724-2121	Glenview
Highland Park	Highland Park	(847) 861-9611	Glenview North
Lincolnwood	St. Francis	(847) 982-5300	Skokie
Morton Grove	Lutheran General	(847) 724-5700	Red Center
Niles	Lutheran General	(847) 724-5700	Red Center
Northbrook	Highland Park	(847) 724-5700	Red Center
Northfield	St. Francis	(847) 724-5700	Red Center
North Maine	Lutheran General	(847) 724-5700	Red Center
Park Ridge	Lutheran General	(847) 724-5700	Red Center
Skokie	St. Francis	(847) 982-5300	Skokie
Wilmette	St. Francis	(847) 724-5700	Red Center
Winnetka	St. Francis	(847) 724-5700	Red Center

MABAS DIVISION 4 AGENCIES

Department	EMS System	Primary Dispatch Number	Dispatch Center
Abbott Park[1]	Condell	(224) 667-7970	Global Comms.
Antioch	Condell	(847) 270-9111	CenCom
Beach Park	North Lake County	(847) 599-7000, ext. 0	Gurnee
Countryside	Condell	(847) 362-5244	Countryside
Deerfield (Also Division 3)	Highland Park	(847) 724-5700	Red Center
Grayslake	Lake Forest	(847) 587-3100	FoxCom
Great Lakes	Lake Forest	(847) 688-6902	Norfolk, VA
Gurnee	Highland Park	(847) 599-7000, ext. 0	Gurnee
Lake Bluff	Lake Forest	(847) 861-9611	Glenview North
Lake Forest	Lake Forest	(847) 861-9611	Glenview North
Lake Villa	Lake Forest	(847) 587-3100	FoxCom
Libertyville	Condell	(847) 362-5224	Countryside
Mundelein	Condell	(847) 566-6051	Mundelein
Newport	Lake Forest	(847) 599-7000, ext. 0	Gurnee
North Chicago	Lake Forest	(847) 566-6051	Mundelein
Round Lake	Condell	(847) 270-9111	CenCom
Wauconda	Condell	(847) 438-2349	Lake Zurich
Waukegan	Lake Forest	(847) 599-2608	Waukegan
Winthrop Harbor	North Lake County	(847) 566-6051	Mundelein
Zion	North Lake County	(847) 599-7000, ext. 0	Gurnee

1. Abbott personal do not respond off of Abbott property for EMS calls or Mass Casualty Incidents but will respond to mutual aid requests for Haz Mat incidents.

APPENDIX II: AREA-WIDE FIRE DEPARTMENT DISPATCH CENTERS

Dispatch Center	Primary Dispatch Number	Back-Up Dispatch Center
CenCom	(847) 270-9111	Fox Com
Countryside FPD	(847) 362-5224	Lake Zurich
Evanston	(847) 866-5095	Red Center
FoxCom	(847) 587-3100	CenCom
Glenview South	(847) 724-2121	Glenview North
Glenview North	(847) 861-9611	Glenview South
Gurnee	(847) 599-7000, Dial 0	Waukegan
Lake Zurich	(847) 438-2349	Countryside FPD
Mundelein	(847) 566-6051	Countryside FPD
Norfolk (Great Lakes)	(847-688-6902	N/A
Northwest Central	(847) 590-3300	Red Center
Red Center	(847) 724-5700	Northwest Central
Skokie	(847) 982-5300	Red Center
Waukegan	(847) 599-2608	Gurnee

APPENDIX III: AREA-WIDE HOSPITALS

REGION X RHCC

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Highland Park Hospital	(847) 432-2294	(847) 432-2295	(847) 480-3751	(847) 926-5325

REGION X RESOURCE HOSPITALS

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Condell Medical Center	(847) 362-2963	(847) 573-4258	(847) 990-5300	(847) 990-2992
Highland Park Hospital	(847) 432-2294	(847) 432-2295	(847) 480-3751	
Lake Forest Hospital	(847) 535-7375		(847) 535-6150	(847) 535-7376
St. Francis Hospital	(847) 864-6564	(847) 864-8550	(847) 316-4000	
Vista Medical Center East	(847) 360-4234		(847) 360-4181	

LEVEL I TRAUMA CENTERS / COMPREHENSIVE EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Condell Medical Center	(847) 362-2963	(847) 573-4258	(847) 990-5300	
Evanston Hospital	(847) 492-9453	(847) 492-1457	(847) 570-2111	(847) 570-2932
Lutheran General Hospital	(847) 696-0743	(847) 696-9073	(847) 723-7722	
Saint Francis Hospital	(847) 864-6564	(847) 864-8550	(847) 316-4000	

LEVEL II TRAUMA CENTERS / COMPREHENSIVE EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Alexian Brothers Medical Ctr.	(847) 437-8118	(847) 952-7454	(847) 981-3599	
Glenbrook Hospital	(847) 729-9260	(847) 657-6010	(847) 657-5632	(847) 657-5960
Good Shepherd Hospital	(847) 385-9525		(847) 842-4444	
Highland Park Hospital	(847) 432-2294	(847) 432-2295	(847) 480-3751	(847) 926-5325
Lake Forest Hospital	(847) 295-1440		(847) 535-6150	
Northwest Community Hospital	(847) 259-8720		(847) 618-3913	
Saint Alexius Medical Center	(847) 843-5308		(847) 843-5309	(847) 490-6930
Vista Medical Center East	(847) 360-4234		(847) 360-4181	
Froedtert Pleasant Prairie (WI)	(262) 697-5563			(262) 577- 8202

COMPREHENSIVE EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
Aurora Medical Center (WI)	(262) 694-1968	(262) 694-1973	(262) 948-5640	
Captain James A. Lovell FHCC	(224) 610-1442	(224) 610-1076	(224) 610-5505	(224) 610-5306
Resurrection Medical Center	(773) 774-8455		(773) 990-5255	
Skokie Hospital	(847) 674-2665	(847) 674-2694	(847) 933-6950	

STANDBY EMERGENCY ROOM

Hospital	Medical Control Phone Number		ER Phone Number	CarePoint Fax
City of Hope			(847) 872-6220	.

REGION X FREESTANDING EMERGENCY CENTERS

Hospital	Medical Control Phone Number	ER Phone Number	CarePoint Fax
Northwestern Grayslake	(847) 535-8736	(847) 535-8950	
Vista Lindenhurst	(847) 356-4782	(847) 356-4705	

REGION 9 RHCC HOSPITAL (Information Only)

Hospital	Medical Control Phone Number	ER Phone Number	CarePoint Fax
Sherman Hospital		(847) 429-2950	

APPENDIX IV: PARTICIPATING PRIVATE AMBULANCE PROVIDERS

Private Provider	Dispatch Phone Number	Contact Information
Advance Ambulance[2]	Chicago: (773) 774-8999 Suburbs: (847) 963-8700	Advise dispatcher of need(s) and request that Shift Manager be paged
Ambulnz	Chicago: (773) 429-8880 Suburbs: (708) 478-8880	Advise dispatch of need(s) and request that 'management' be paged
A-TEC Ambulance	(800) 729-2780	Advise dispatcher of need(s) and request that Chief Officer be paged
Elite Ambulance	Chicago: (773) 429-8880 Suburbs: (708) 478-8880	Advise dispatch of need(s)
Hatzalah Chicago[1]	(847) 504-1500	Advise dispatch of need(s)
Lifeline Ambulance	(312) 949-9500	Advise dispatch of need(s)
MedEx Ambulance	(847) 674-9111	Advise dispatch of need(s)
Midwest Ambulance[2]	(847) 745-0050	Advise dispatch of need(s)
Murphy Ambulance	(847) 816-4600	Advise dispatch of need(s)
Superior Ambulance	(630) 832-2000	Advise dispatch of need(s) and request Regional Manager be paged

1. Hatzalah Chicago enhances pre-hospital care and support in the Chicagoland Jewish Community by augmenting the existing services provided by the municipalities by providing emergency medical response 24 hours a day, 7 days a week within defined geographical boundaries in Lincolnwood, Peterson Park, Skokie, and West Rogers Park.
2. Advance Ambulance and Midwest Ambulance are one company with Elite. Dispatch number redirects to Elite.

Private Providers Emergency Response System (PPERS)

Primary Dispatch Number: (800) 558-6050

PPERS was developed to assist fire departments, local health departments, hospitals and healthcare facilities during large-scale disaster events. All major ambulance providers in the Northern Illinois region are members of this disaster response network. Membership to PPERS is selective to ensure that the best resources are deployed for such large scale, disaster events. The ATI dispatch center serves as the communication center for PPERS and coordinates all activities of its members as it is received requests from any government agency and/or healthcare centers.

Collaborative Healthcare Urgency Group (CHUG)

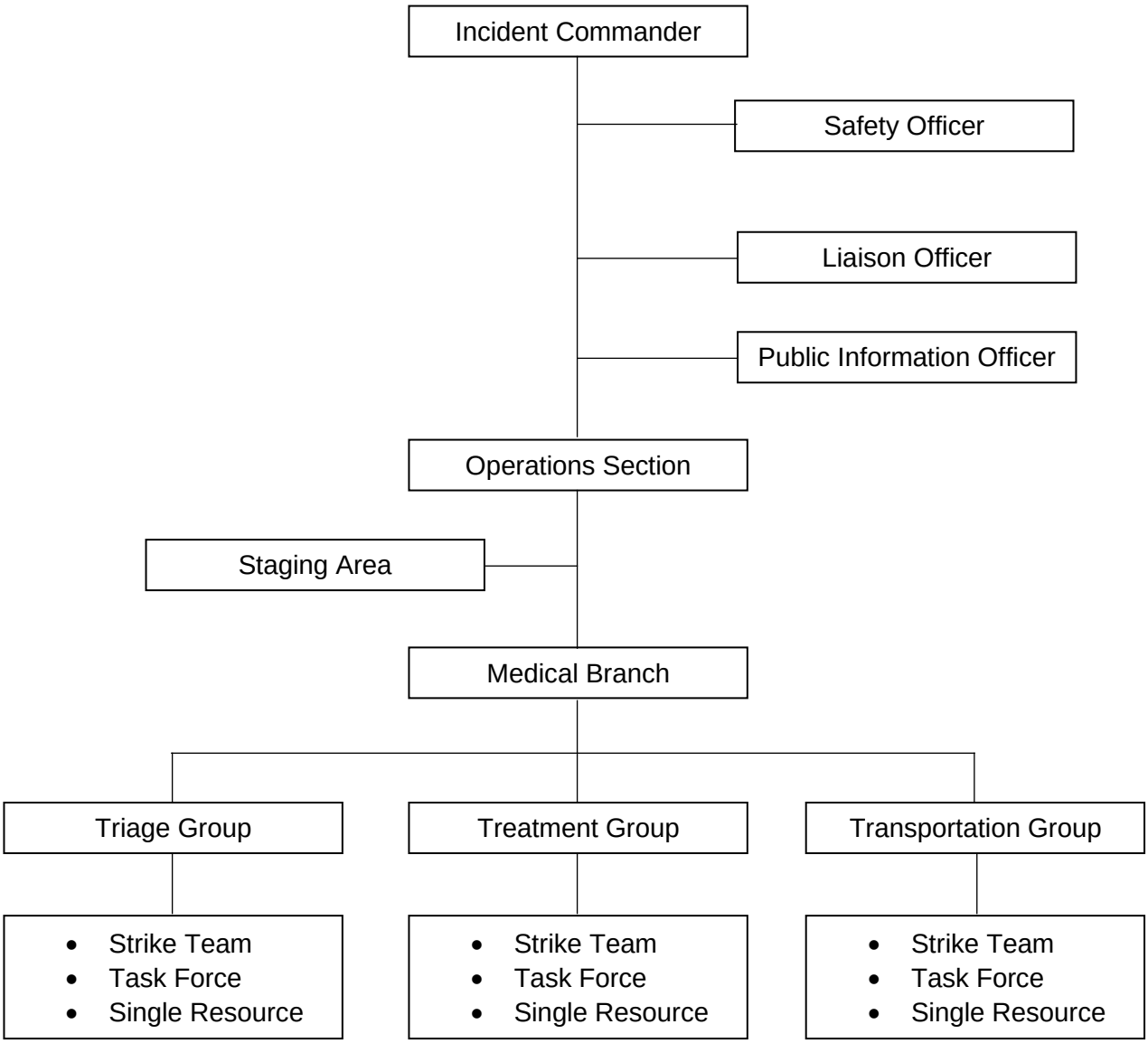
Primary Dispatch Number: (866) 794-2210

At their core, CHUG is a unique mutual aid system for nearly 1,000 healthcare members across the country providing their members with expert coordination of evacuation, transportation, relocation and shelter-in-place services. CHUG also offers expertise with response and restoration services, including fire and water damage, mold remediation, infectious disease clean-up and catastrophic loss.

APPENDIX V: INCIDENT COMMAND POSITION DESCRIPTIONS

The position descriptions contained herein are dictated by experience as necessary for the successful management and resolution of a multiple patient incident. The performance outlines are simply suggestions and are not intended to be viewed as a requirement for activation of the plan.

INCIDENT MANAGEMENT SYSTEM ORGANIZATION



MEDICAL BRANCH

The Medical Branch may be organized as either a separate group or section under the Incident Management System, depending on the scope of the incident. Functions of the medical branch include triage, patient treatment and transportation. A single Medical Group Supervisor at a multiple patient incident may coordinate all these functions. However, such duties may be delegated as appropriate to a separate Triage Unit Leader, Treatment Unit Leader and/or Transportation Unit Leader in a multiple patient incident, overseen by a single Medical Group Supervisor who reports directly to Incident Command.

MEDICAL GROUP SUPERVISOR

Assigned By: Incident Command

Duties: Oversees the medical section of a multiple patient incident. May appoint and supervise triage, treatment and transportation units.

Responsibilities may include:

- Determining the approximate number of patients and extent/type of injuries
- Immediately advising either the closest hospital or the Resource Hospital (depending on the size/scale of the incident) that an incident has occurred, utilizing normal modes of communication.
- Communicating patient numbers and acuity to the hospital.
- Advising the hospital of those hospitals closest to the incident scene.
- Determining the patient destination hospitals for each patient not transported to the closest hospital (during a Small Scale incident) and assigning patients to a transporting ambulance crew.
- Advising transporting ambulances of their assigned destination hospital according to communication received from the Resource Hospital in a Medium Scale or Large Scale incident.
- Maintaining communication with the hospital throughout the incident or appointing a group or branch supervisor to assume communication with the hospital.
- Continually assessing the need for additional ambulances, personnel and equipment, making such requests through Incident Command.
- Assessing the need for medical teams and aero-medical transportation (according to local system policy) in consultation with the Resource Hospital and Incident Command. (If aero-medical transportation is required, staging must be notified by the Medical Group Supervisor to set up an appropriate landing zone.)
- Determining the extent of documentation (in the form of a patient care report) required per incident, relaying information to the Transportation Unit Leader who will pass the information to transporting ambulance crews.
- Ensuring that an After-Action Report (Appendix XI) is generated within 7 days of the incident and that a copy of the report has been faxed to the EMS Office at the Resource Hospital of the host department.

MEDICAL SUPPLY UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: Secures and organizes medical supplies and equipment

Responsibilities include:

- Coordination of needed supplies and equipment including, but not limited to, backboards, oxygen supplies, dressings and bandages, medications, volumes of sterile water, IV fluids and equipment.
- This logistical function may be necessitated in Medium Scale or Large Scale incidents or when specialized equipment and/or supplies are required.
- Additional supplies and equipment may be obtained via mass casualty bags located on each ambulance or by requesting the mass casualty trailer be brought to the scene.

TRIAGE UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: Provides coordination necessary for effective categorization and transportation of patients from the incident to the treatment area.

Responsibilities include:

- Supervision of triage personnel during the initial phase of a multiple patient incident.
- Determining and relaying number of patients and general acuity to the Medical Group Supervisor, updating information, as necessary.
- Reporting any needs regarding equipment and manpower to the Medical Group Supervisor.
- Confirming that ALL patients have a triage tag present and that the appropriate area of the tag has been retained by triage personnel.
- Reporting to the Medical Group Supervisor for reassignment upon completion of triage and transfer of patients to the Treatment Unit Leader.

TREATMENT UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: The designation of the Treatment Unit Leader is intended for use in larger incidents where the Medical Group Supervisor would be unable to coordinate activities in the patient treatment area. Establishes and manages the patient treatment area.

Responsibilities include:

- Overseeing EMS personnel in the treatment and frequent reassessment of patients in the treatment area.
- Prioritization of patients for transport to hospitals.

TRANSPORTATION UNIT LEADER

Assigned By: Medical Group Supervisor

Duties: Establishes loading of ambulances and records patient destination.

Responsibilities include:

- Communication with the Resource Hospital (initial communication may have been established by Medical Group Supervisor or their designee).
    - The Transportation Unit Leader will:
        - give patient numbers and triage categories to the Resource Hospital.
        - receive and record hospital capabilities as reported by the Resource Hospital.
        - give specific hospital destination for each ambulance to the Resource Hospital, including number of patients and triage categories.
        - Advise Resource Hospital when last patient has been transported.
- Establishment of patient loading area allowing for safe and coordinated access and egress of ambulances.
- Communication with Staging Area Unit Leader, requesting specific number and capabilities (ALS, BLS) of available ambulances.
- Notation of each patient's triage tag number on a log sheet.
- Assignment of a destination hospital to each transporting ambulance.

STAGING AREA UNIT LEADER

Assigned By: Operations Chief or Incident Command

Duties: Management of all incoming Fire/Rescue apparatus, ambulances and other resources.

The first unit to arrive at the staging location will typically assume the role of Staging Unit Leader until such time as they are relieved by an officer designated by Operations Chief or Incident Command.

Responsibilities include:

- Maintaining communication with (either Transportation or Treatment Unit Leader) to supply required vehicles.
- Maintaining communication with Incident Command to advise on available resources.
- Sending requested resources to the scene.
- Management of the staging area, assuring orderly parking, maintaining clear access to the incident site.
- Maintaining accountability of available equipment, apparatus and manpower.
- Collection of mass casualty bags located on each ambulance in staging upon request from the Medical Group Supervisor.
- In a large-scale incident, the Staging Unit Leader may need to request additional personnel from Incident Command to assist in these functions.

APPENDIX VI: DISASTER PLAN LEVELS

FEDERAL PLAN

The National Disaster Medical System (NDMS) is a cooperative effort between the Department of Homeland Security (DHS), Department of Health and Human Services (HHS), Department of Defense (DOD), Department of Justice (DOJ), Department of Veterans Affairs (VA), Federal Emergency Management Agency (FEMA), state and local governments and the private sector. NDMS includes Disaster Medical Assistance Teams (DMATs) and Clearing-Staging Units (CSUs) at the disaster site or receiving location, a medical evacuation system and more than 100,000 pre-committed non-federal acute care hospital beds in more than 1,500 hospitals throughout the United States. NDMS does not replace, but rather supplements, state, regional and local disaster planning efforts. The program provides for "mutual aid" among all parts of the nation and is able to handle large numbers of patients that might result from a domestic disaster situation or an overseas conflict.

In the event of a major disaster, the Governor of an affected state may request federal assistance and the President may make a declaration of a major disaster or an emergency either before or after the incident occurs. The presidential declaration triggers a series of federal responses coordinated by FEMA. These operations may include activation of NDMS when appropriate. Upon system activation, the NDMS operations support center is activated to coordinate federal health and medical responses to the disaster.

NDMS Plan Activation Sequence

1. A mass casualty incident has occurred requiring NDMS activation.
2. After initial stabilization, patients are transported to a hospital in the area of the mass casualty.
3. Once stabilized, patients are prepared to be transported via the best available means.
4. The Federal Coordinating Center for the areas covered by this plan (Hines VA Hospital) will contact the Governor of Illinois and the Illinois Department of Public Health (IDPH) to notify them that a national disaster has occurred and that the NDMS plan has been activated.
5. Illinois Masonic Medical Center (IMMC) is notified by the IDPH that the NDMS has been activated.
6. IMMC notifies the area wide RHCC hospitals (Highland Park Hospital (HPH) and Sherman Hospital) of the disaster and activation.
7. IMMC, HPH and Sherman Hospital will contact the Chicago and suburban hospitals within their regions to obtain status reports.
8. Once NDMS has been activated, bed status reports will be generated at least every 12 hours until directed to discontinue.
9. IMMC is responsible for assigning receiving hospitals for all patients who arrive via O'Hare International Airport or another designated receiving facility/area.
10. Prior to landing at O'Hare or another designated receiving facility/area, IMMC and the RHCC hospitals will receive manifests giving details of all patients.
11. If medical assistance is required for arriving patients, once hospital assignments have been made, IMMC and HPH will plan for transportation to medical facilities via Chicago Fire Department and other EMS providers for those patients arriving in the area.

STATE PLAN

The State of Illinois Emergency Medical Disaster Plan is not meant to take the place of the NDMS plan, but exists to address the preparedness, response and recovery to an emergency medical situation within the State of Illinois. The goal of the plan is to aid and allow emergency medical services personnel and health care facilities to work together in a collaborative manner in situations where local resources are overwhelmed.

State Disaster Plan Activation Sequence

1. The Governor of Illinois is notified by a local government official (mayor, county commissioner, etc.) that a disaster has occurred. The Governor makes the determination to 'declare' a disaster thereby initiating the state disaster response plan.

2. The Deputy Director of the Office of Preparedness and Response is notified by the Governor's office or designee and activates the appropriate phase of the Disaster Plan (Phase I or Phase II), determines required resources and requests assistance from the appropriate RHCC Hospitals.

    - The RHCC Hospitals covered by this plan include:
        - Region X: Highland Park Hospital
        - Region IX: Sherman Hospital

3. Each RHCC directs the Resource Hospitals within their region to immediately contact each of their Associate and Participating Hospitals. All hospitals in each region will provide accurate information on EMResource.

4. The RHCC hospital shall consider the activation of the Regional Medical Emergency Response Team (RMERT).

5. Every hospital will report on some or all of the following information, based on the level of activation (Phase I or Phase II) via EMResource:

    - ED availability
    - Adult and Pediatric monitored beds
    - Total other beds
    - Total units of blood
    - Number of ventilators – adult, peds, both
    - Number of field bags
    - Number of walking and littered decontamination patients per hour
    - Special needs

6. **All hospitals must continually update required information via EMResource until notified by their Resource Hospitals that the disaster has officially ended.**

O'HARE INCIDENT/DISASTER PLAN
Region XI / City of Chicago EMS System

Implementation:

- This plan is to be implemented if any incident/disaster occurs within the confines of O'Hare Airport/field.
- Advocate Illinois Masonic Medical Center (AIMMC) will be contacted by the Chicago Office of Emergency Communications or Chicago Fire Department (CFD) Officer in Charge.
- Utilize the "O'Hare Disaster Log Sheet" for record keeping.

Upon notification, AIMMC will:

1. Page EMS System Coordinator on their cell at (773) 447-2065
2. Notify the following facilities (see phone sheet):
    - Highland Park Hospital (who will activate their notification list)
    - Resurrection Medical Center
    - Community First Medical Center
    - Swedish Covenant Hospital
    - Additional hospitals may be needed; CFD will advise AIMMC if this need occurs.
    - Highland Park Hospital, ED (847) 480-3751, will call the following facilities (see phone list on page 26)
        - Lutheran General
        - Northwest Community
        - Alexian Brothers (Elk Grove Village)
        - Gottlieb Memorial
        - Westlake Hospital
        - Elmhurst Hospital
        - St Alexius Medical Center (Hoffman Estates)
        - Loyola Medical Center
        - Good Samaritan
3. Notify American Red Cross as a "Heads Up" at (877) 597-0747 (Dispatch 24/7)
4. AIMMC most likely will not receive patients although this depends on the incident occurring.
5. Illinois Medical Emergency Response Teams (IMERT) may be requested by CFD through IEMA to be dispatched to the scene-contact the EMS System Coordinator to arrange teams.
6. ***Maintain communications*** with the ***field*** and ***hospitals*** until "scene cleared" by CFD Incident Command at the scene.
7. ***NOTIFY ALL HOSPITALS*** *once scene is cleared*.
8. Submit paperwork to EMS Coordinator or EMS Office.

Updated January 2017

O'HARE INCIDENT PARTICIPATING CALLS
Region XI / Chicago EMS System

The following is a list of hospitals that have agreed to support O'Hare Airport in the event of an incident/disaster:

ADVOCATE ILLINOIS MASONIC MEDICAL CENTER notifies:			
HOSPITAL	**ADDRESS**	**ED NUMBER**	**MED CONTROL**
Highland Park Hospital	777 Park Avenue West Highland Park, IL 60035	(847) 480-3751	(847) 432-2294 (847) 432-2295
Resurrection Medical Center	7435 West Talcott Avenue Chicago, IL 60631	(773) 990-5255	(773) 774-8455
Community First Medical Center	5645 West Addison Street Chicago, IL 60634	(773) 794-7601	(773) 794-7605 (773) 794-7606
Swedish Covenant	5145 North California Avenue Chicago, IL 60625	(773) 989-3800	(773) 561-1595

HIGHLAND PARK HOSPITAL notifies:			
HOSPITAL	**ADDRESS**	**ED NUMBER**	**MED CONTROL**
Lutheran General	1775 Dempster Street Park Ridge, IL 60068	(847) 696-0743	(847) 696-0743
Northwest Community	800 West Central Avenue Arlington Heights, 60005	(847) 618-3913	(847) 259-8720
Alexian Brothers	800 Biesterfield Road Elk Grove Village, IL 60007	(847) 981-3599	(847) 437-8118 (847) 952-7454 (847) 437-8241
Gottlieb Memorial	8700 West North Avenue Melrose Park, IL 60160	(708) 450-4975	(708) 538-5378
Westlake Hospital	1225 Lake Street Melrose Park, IL 60160	(708) 343-8375	(708) 343-8375
Elmhurst Hospital	155 E Brushhill Road Elmhurst, IL 60126	(331) 221-0202	(331) 221-0202 Same as ED
St Alexius Medical Center	1555 Barrington Road Hoffman Estates, IL 60169	(847) 490-6930	(847) 843-5308 (847) 843-5309
Loyola Medical Center	2160 South First Avenue Maywood, IL 60153	(708) 216-9080	(708) 343-5828 (708) 343-4844 (708) 343-5803 (708) 681-4418
Good Samaritan	3815 Highland Avenue Downers Grove, IL 60215	(630) 275-1160	(630) 968-2150

DATE: _____ **TELE LOG #** _____

TIME: _____ **Page** _____ **of** _____

O'HARE VICTIM INCIDENT LOG

CFD EMS Chief/OFFICER: _____ **PHONE #:** _____

INCIDENT TYPE: _____

APPROXIMATE # of VICTIMS: _____

SPECIAL CIRCUMSTANCES:

Hospital	Person Notif & Time	# Pts CAN Accept	# Pts SENT	Ambulance Transporting	Comments
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		

All Clear At:_____

ECRN/ECP Signature:_____

Updated: April 2012

APPENDIX VII: Region X School Bus Accident Policy

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: February 2000
REVIEWED: February 2017

POLICY TITLE: SCHOOL BUS ACCIDENTS
POLICY: 7

This policy governs the handling of school bus accidents involving the presence of minors. It is meant to be implemented by EMS personnel in conjunction with their System's policies governing mass casualties. The goal of this policy is to reduce the number of uninjured children transported to hospitals and to reduce EMS scene time and utilization of resources.

Each EMS provider agency within an EMS System is required to design and implement a procedure for discharging uninjured children to their parents/legal guardians or to local school officials who are willing to take custody of the children. The provider may adopt whatever policy it chooses that will best accomplish the goal of transferring custody of uninjured children to the parents/legal guardians or school officials. It is recommended that these policies be developed with the joint input of local school officials and provider legal counsel.

Once it is determined that minor children are not injured, the custody and responsibility for these children will remain with the EMS provider agency until the children are transferred to parents or school officials.

PROCEDURE:

1. Upon arrival at the scene

    a. Determine the category of the accident

    CATEGORY A BUS ACCIDENT - significant injuries present in one or more children or there is a documented mechanism of injury that can reasonably be expected to cause significant injuries.

    CATEGORY B BUS ACCIDENT - minor injuries present in one or more children and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children may also be present.

    CATEGORY C BUS ACCIDENT - no injuries present in any children and no obvious mechanism of injury present.

    b. Determine if implementation of this policy is appropriate. Implement this policy only if the accident is a Category B or Category C bus accident.

    All children involved in a Category A accident will be transported to the hospital(s). Do not implement this policy if the accident/incident is a Category A bus accident/incident-follow multiple victim and disaster preparedness policies for all Category A bus accidents/incidents and transport all children/students to the hospital(s).

    c. Other injured patients are treated and transported as required. For adults. Follow your EMS System's policy.

    d. Contact Medical Control, advise of the existence of a Category B or C bus accident, and determine if a scene discharge of uninjured children by the emergency department physician in charge of the call is appropriate.

e. Implement provider procedures for contacting parents/legal guardians or school officials to receive custody of the uninjured children.

f. The provider agency then transfers the custody of the minor children, consistent with its own policies and procedures, to parents/legal guardians or school officials.

g. The school representative will then follow their own policies to include informing the parent(s)/legal guardians as regards the accident/incident

2. **DISPOSITION OF UNINJURED CHILDREN:** This policy only governs the disposition of uninjured children. A list of children who have been determined to be uninjured by medical personnel will be completed at the scene of the accident. All uninjured students will be discharged to the custody of school officials upon approval of Medical Control as per procedure in 1) f. Use your EMS System's approved form for such documentation.

3. **PROVIDER RESPONSIBILITY:** Once the decision is made by the emergency department physician to discharge the children at the scene, it is the responsibility of the local responding EMS agency in charge of the scene to make certain that these children are returned to their parents/legal guardians or appropriate school officials.

CAVEAT

If EMS personnel on the scene feel that any child should be offered medical care or evaluated by the hospital, the child should be transported to the hospital.

NOTE: See Appendix XII for a School Bus Accident Log Form template

APPENDIX VIII: Training Guidelines

In an effort to improve the effectiveness of this multiple patient management plan, all participating hospitals and pre-hospital providers have agreed to adhere to the following guidelines when planning training activities:

FIRE DEPARTMENTS

- Fire Departments will regularly review the Multiple Patient Management Plan and the use during small, medium and large scale incidents.
- Field training exercises may include the transportation of patients to receiving hospitals via ambulances upon mutual agreement prior to the exercise.
- Training for all personnel shall be carried out at the local and division level and include both field providers and command staff. Special emphasis should be given to the job functions associated with the incident management system of organization.
- A variety of training options may be utilized to facilitate this purpose, including lecture/discussion, tabletop exercises and small-scale field exercises.
- Local fire departments are encouraged to continue working with hospitals in their own community that participate in this plan for the purpose of assisting one another in meeting training and hospital accreditation requirements.
- In an effort to maintain proficiency, fire departments may choose to utilize SMART tags with START triage principles during small scale incidents. This is a voluntary endeavor that does not require communication to the receiving hospital.
- Training exercises within the geographic boundaries of this plan shall be communicated to the Resource Hospital for communication back to the Regional DMSC Committee. Knowledge of impending exercises and critiques of said exercises following these drills are essential to a continual assessment of this plan.

HOSPITALS

- ECRN and ER staff will regularly review the Multiple Patient Management Plan and the use during small, medium and large Scale incidents.
- EMS continuing education training with respect to multiple patient incidents will focus on the areas of plan implementation, communication, field triage and treatment.
- ER Staff and ECRN continuing education training with respect to multiple patient incidents will focus on the areas of plan implementation, communication, field triage and treatment.
- Hospitals are encouraged to partner with their local fire department in this in-house training to enhance local preparedness.

PRIVATE AMBULANCE PROVIDERS

- Private ambulance providers will regularly review the Multiple Patient Management Plan and the use during small, medium and large scale incidents.
- Private ambulance companies will work with their Resource Hospital to assure appropriate participation and compliance with the plan.

NOTE: An After-Action Report (Appendix XI) should be completed following all training activities involving the regional Multiple Patient Management Plan within 7 days of the event.

APPENDIX IX: MEDICAL PERSONNEL REQUESTED TO THE SCENE

Incident Command may request hospital-based medical personnel to respond to the scene of an incident for specific needs. This request shall be communicated through the Resource Hospital. Personnel shall be assembled based on the specific need (e.g., surgical, toxicological, psychiatric, etc.).

The medical personnel shall:

- Respond with supplies to meet the needs of the specific incident.
- Respond with a police escort or via other official means of transportation. The escort
- will provide security, ensure a rapid response, and assist with access into restricted areas.
- Report directly to the Command Post.
- Be identified by a green helmet and/or reflective vest indicating “Medical Team”, or other official uniform.

Additional medical personnel may be asked to respond to the scene based upon regional and state protocols, including the Illinois Emergency Medical Response Team (IMERT). A request for such teams must be made by the Resource Hospital to the RHCC Hospital. IMERT must be requested through the Illinois Emergency Management Agency (IEMA).

Self-dispatching of personnel to a disaster scene is STRICTLY PROHIBITED!

APPENDIX X: TRIAGE TAG INSTRUCTIONS

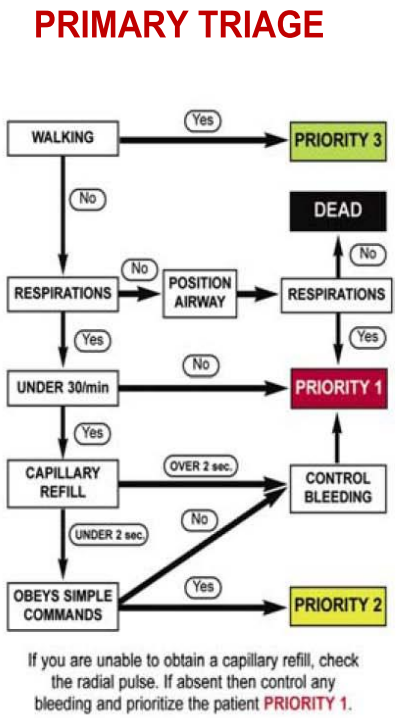
Region X has adopted the SMART Incident Command System® as a standard for the process of START triage which includes the use of specific triage tags. The SMART® tag is designed to show just one color at a time but can be refolded to reflect any change in status. The triage process should be repeated at each link of the incident management chain. The primary (first) triage method will be used to sort victims into groups and is based upon vital signs and level of consciousness. The secondary triage method is utilized to prioritize treatment and transport goals and is based upon anatomic and physiologic criteria. The information included herein applies only to the SMART® System.

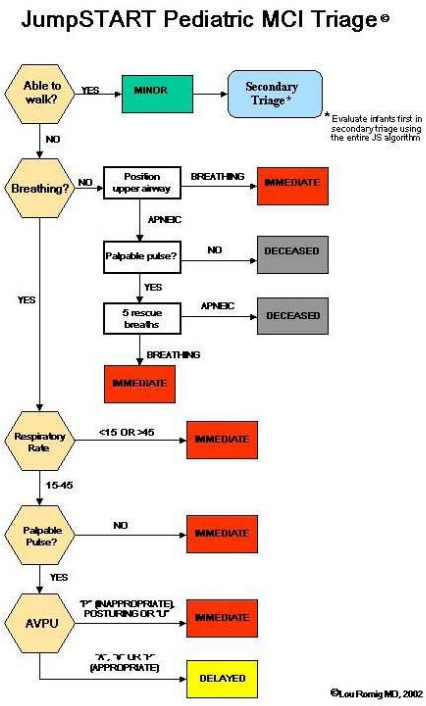
Components of the Triage Pack:

- Folding SMART® triage tags
- Mini-light sticks to identify RED patients at night
- Dead tags
- START Triage prompt cards
- Jump START Triage prompt cards
- Dynamic record of casualties already triaged
- Pencil

Primary Triage Procedure:

1. Triage personnel shall obtain a Triage Pack (designed to be carried on a belt to leave the hands free).
2. Ensure appropriate PPE.
3. The START triage process generally begins with a request for all ambulatory victims to move to an area of refuge (generally tagged Green or Priority 3).
4. Approach each remaining victim and assess triage priority by using the START Triage Prompt Card for adult victims and the Jump START Prompt Card for child victims.
5. Assign triage priority by removing the SMART® Tag from the plastic sleeve and folding the tag so the appropriate color priority is visible.
6. Attach the elastic band to the victim's upper extremity.
7. If light is inadequate at the triage site, use a mini-light stick in addition to Red triage tag to designate most serious victims.
8. Life support interventions should be limited to opening the airway and hemorrhage control. This step may depend upon readily available resources.
9. Upon completion of the primary triage process, victims may be moved to a designated (color-coded) collection area.





Secondary Triage Procedure:

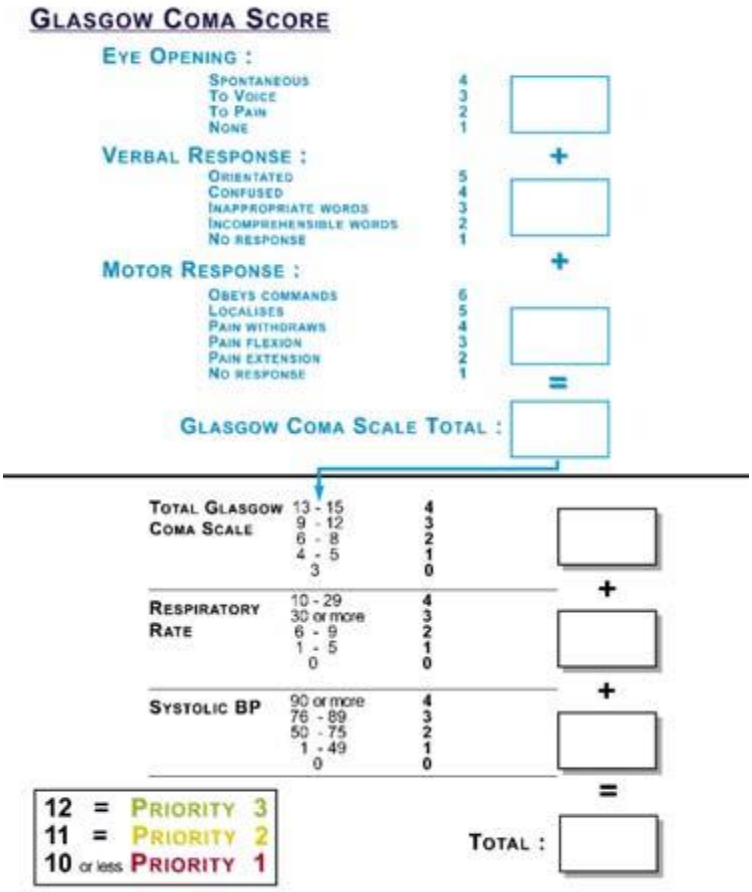
1. Upon arrival in a collection area, each victim should be (re)assessed by using the Glasgow Coma Scale, respiratory rate and systolic blood pressure.

2. The results of the secondary triage will determine treatment and transport priorities.

3. Secondary triage may also result in a change of original assigned priority code. This may be accomplished by refolding, but not removing or replacing, the original tag. Movement of the victim to another collection site is not necessary pending #2, above.

4. Prior to transport from the scene, the tag transport strip will be removed and retained by the transportation officer.

SECONDARY TRIAGE



APPENDIX XI: POST-INCIDENT RECOVERY SERVICES

Multiple agencies provide critical incident stress management. Local emergency services providers are encouraged to have a plan in place for the implementation of post-incident recovery services, including critical incident stress management. Listed below is a selection of groups able to provide such services to emergency personnel.

AGENCY	TELEPHONE NUMBER
Northern Illinois Critical Incident Stress Management Team	(800) 225-2473
Illinois Firefighter Peer Support	(855) 907-8776

APPENDIX XII: FORMS AND LOGS

- Field Provider Log Form
- Emergency Department Log Form
- After-Action Report
- School Bus Accident Log Form
- Abbreviations/Acronyms

REGION X MULTIPLE PATIENT MANAGEMENT PLAN

FIELD PROVIDER LOG FORM

Date: _____ Time: _____ Fire Department: _____

Hospital you are contacting: _____ ED Phone Number: _____

Multiple Patient Incident
(Small Scale: Call closest appropriate hospital) (Medium/Large Scale: Call Resource Hospital)

Hello, this is the "STATE FIRE DEPARTMENT NAME". We are on scene of a Small / Medium / Large scale / Healthcare Evacuation multiple patient incident. The incident is a _____

PROVIDE DESCRIPTION OF INCIDENT TO ECRN.

Our estimated total number of patients to be transported is: _____

We estimate the following types of patients (For small scale, ask how many patients hospital can take):

Red: _____ Yellow: _____ Green: _____ Deceased: _____

If Trauma and known…*We estimate the following number of categorized trauma patients:*

Category I: _____ Category II: _____ Special: _____

Our closest hospitals are (List in order of proximity to incident):

	Hospital Name	Patient Capability			Patient's Transported		
		Red	*Yellow*	*Green*	*Red*	*Yellow*	*Green*
1.							
2.							
3.							
4.							
5.							

If patients have already been transported to a hospital, report those destinations to the ECRN using the chart above. No more than two patients may be sent to hospitals without prior approval from the receiving hospital.

"MY NAME AND CALL BACK TELEPHONE NUMBER IS" _____

POINTS TO REMEMBER:

Maintain communication with the Resource Hospital until the scene has been cleared of patients. For each transporting ambulance, report acuities of patients being transported and destination hospital to the Resource Hospital

Once all patients have been transported on a medium or large scale incident, notify the Resource Hospital of the number transported to each hospital so that appropriate notification of patient expectations can be made.

Use SMART ® Command Board to record hospital availability and patient destinations.

Complete After Action Report and FAX with this form to the EMS Coordinator within 7 days of the incident.

REGION X MULTIPLE PATIENT MANAGEMENT PLAN
EMERGENCY DEPARTMENT LOG FORM

Date: Time: Fire Department:

Type of Incident: Callback Number:

ECRN: ER Physician:

Small Scale Incident: Field Personnel call closest appropriate hospital
Medium or Large Scale Incident: Field Personnel only call Resource Hospital. ECRN responsible to call area hospitals for capabilities.

Small Scale: Medium Scale: Large Scale: Healthcare Evacuation:

Estimated total number of patients to be transported is:

Estimated triage categories: Red: *Yellow:* *Green:* *Black:*

Estimated categorized trauma, if known: Category I: Category II: Special:

Closest hospitals in order of proximity to incident and ability to receive patients:

	Hospital Name	Patient Capability			Patient's Transported		
		Red	*Yellow*	*Green*	*Red*	*Yellow*	*Green*
1.							
2.							
3.							
4.							
5.							

- During a Small Scale Incident, the closest appropriate hospital may assist with patient disbursement as requested by the caller.
- During a Medium or Large Scale Incident, the Resource Hospital will be given the names of the closest hospitals by the caller. **CALL THOSE HOSPITALS FIRST** asking for their ability to receive specific numbers of triage category patients. Use additional forms if it is necessary to contact more than 5 hospitals to distribute transported patients.
- Remind receiving hospitals they will not receive a radio report from transporting ambulances.
- Relay hospital capability information to the fire department caller.
- Contact the RHCC if assistance is required
  - Medical Control: (847) 432-2294 or (847) 432- 2295 or ER Direct: (847) 480-3751
- Upon notification that all patients have been transported on a medium or large scale incident, notify each of the receiving hospitals of the number transported to their facility.
- Complete After Action Report and FAX with this form to the EMS Coordinator within 7 days of the incident.

REGION X MULTIPLE PATIENT MANAGEMENT PLAN
AFTER-ACTION REPORT

Incident Date: | Incident Time: | Primary Fire Dept:

Incident Description:

☐ Small*
☐ Medium
☐ Large
☐ Healthcare Evacuation

Total Pts.: | Red: | Yellow: | Green: | Deceased:

* Only upon request from the EMS System

Please answer the following questions. Use the reverse side for additional comments (take note when faxing form). The success of the plan depends on your detailed comments.

Which hospital was first contacted by field personnel?
What mode of communication was used between field and hospital?
Describe any difficulties with initial communication:
Was it difficult to determine the scale of the incident? If so, why?
Describe any difficulties with triage?
What hospitals received patients and how many:
Describe any difficulties with patient disbursement:
(Small Scale only) Were there any difficulties with ambulance to hospital communication:
Was the two-sided Multiple Patient Management Plan **REFERENCE CARD** used?
Was a Region X Multiple Patient Management Plan **LOG FORM** used?
How effective was the Multiple Patient Management Plan in helping disburse patients from the scene to area hospitals?
Please provide us with any additional information that may be helpful:

Hospital Personnel: Submit this form and Emergency Department Log form to your hospital EMS Coordinator.
Field Personnel: Fax this form and Field Provider Log Form to the Resource Hospital EMS Office.

Region X Emergency Medical Service System
Bus Accident Student Log

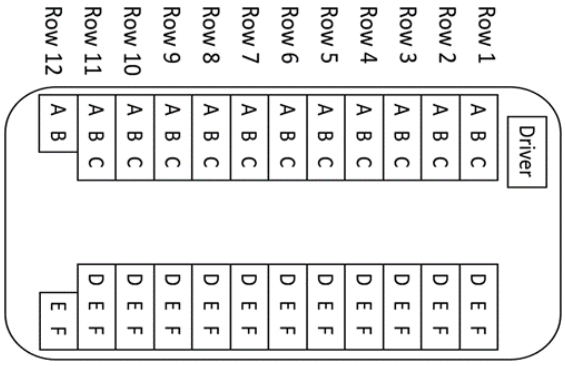
Date of Incident: _____ Incident Number: _____ Page: _____ of _____

Host Department: _____ Location: _____

School Name/District: _____ Bus Number: _____

Per the Region X EMS Policy, the children listed below have been determined to be in a Category B or C accident. These children have been determined to be uninjured and therefore Medical Control has approved discharge to the custody of school officials:

Name	Seat Location (Optional)	Address	Telephone



Signature/Title of School Authorized Representative

Signature/Title of Fire Department Officer

Hospital Contacted and RN/MD Name

White Copy to EMS Agency; Yellow Copy to EMS System; Pink Copy to School Representative; Goldenrod Copy to Local Police

ABBREVIATIONS / ACRONYMS

Altered Standards of Care: When victims' needs outweigh immediately available resources, the usual standard of care may be altered to provide for allocation of scarce resources in order to save as many lives as possible.

CHUG	Collaborative Healthcare Urgency Group, website: http://www.chughurt.com/
DMSC	Disaster Management Services Committee
ECRN	Emergency Communications Registered Nurse
EMResource	Software utilized by IDPH for daily hospital resource availability tracking and event notification.
EMS	Emergency Medical Services
Healthcare Facility	A hospital, nursing home or other fixed location at which medical and health care services are performed.
IAP	Incident Action Plan
IMERT	Illinois Medical Emergency Response Team, website: http://www.imert.org/
MABAS	Mutual Aid Box Alarm System
Multiple Patient Incident	An incident in which there is more than one patient and healthcare needs exceed immediately available resources.
Post-Action Review	Evaluation of actions taken during an incident in order to improve future performance through education or process/policy change.
PPERS	Private Provider Emergency Response System
Region X	EMS/Trauma Region as defined in the IDPH EMS Act: northern boundary of Illinois/Wisconsin state line to Route 83, southern boundary of Chicago/Evanston border to Park Ridge city limits, eastern boundary of Lake Michigan and western boundary of Route 83 to Route 173 west to Route 59 south to Route 60, east to Route 83 to the Lake/Cook county line, east to Milwaukee Avenue then south to Des Plaines River Road, south to Central Road, east to I294, south to Dempster Street, east to the Niles city limits south to the Chicago city limits.
RHCC	Regional Hospital Coordinating Center

APPENDIX XIII: MASS VIOLENCE RESPONSE

When responding to mass casualty incidents, Fire/EMS providers fall back on their training and most often use the traditional approach of triage to prioritize the transport and treatment of patients. When dealing with incidents involving patients from mass violence incidents, research has shown that the typical triage process used in day-to-day operations have less value during mass violence incidents due to time critical injuries and ongoing threats to responders and patients and may result in patients being incorrectly triaged leading to outcome-altering delays in care. Fire/EMS agencies and hospital staff must be aware of the possibility of responding to or receiving patients from multiple patient incidents resulting from mass violence such as:

- Active shooter event
- Blast / Explosive event
- Biological/epidemic/pandemic event
- Chemical event
- Radiological event

During a mass violence incident where, when, and how triage will be done may vary depending on the specifics of the incident, the location, and the resources available. Both pre-hospital providers and hospital providers should understand the concept that triage can be dynamic and reflects patient condition and resources available at the time of the appropriate provider's assessment. During incidents of mass violence, both Fire/EMS agencies and hospital staff will require flexibility in the treatment and transport of patients from mass violence incidents. This flexibility may include:

- Not following the triage protocols outlined in the Region X Multiple Patient Management Plan.
- Not being able to establish structured triage, casualty collection points, or treatment areas due to the large number of patients, the scope/size of the scene, and scene safety issues.
- Understanding that commonly used triage criteria do not include a rapid assessment for presence of truncal penetrating trauma.
- Understanding that bystanders or self-care may be the primary means of initial medical care and/or transport and that there may be a need for extra supplies to effectively control bleeding.
- Fire/EMS agencies may not realize that the hospitals are becoming overwhelmed.

GENERAL CONSIDERATIONS

- In a mass casualty event, a single triage process may not be appropriate for all incidents. Fire/EMS providers should be looking at the principles of triage which include:
  - Doing the greatest good for the greatest number of patients with the resources available.
  - Gaining rapid access to surviving casualties and evacuating them from the hazard area.
  - Providing basic life-saving interventions as soon as it is safe to do so.
  - Transporting the injured to an **appropriate** hospital as rapidly as possible.
  - Prioritize resources to those who are most in need and are salvageable with current resources.
  - Re-triaging patients as the resource situation changes over time.
- Assessment during triage should including the following considerations:
  - How much time is needed to start interventions and how quickly can they be done to be effective?
  - How much healthcare provider expertise is required for successful patient outcome?
  - How many resources, including personnel, are required and available for successful patient lifesaving interventions and outcomes?

- As the number of patients becomes overwhelming, providers may need to consider shifting their focus to prioritize assessment of victims with potential life threats rather than focusing on definitive care for the most critically injured.

- In incidents involving penetrating truncal trauma, categorizing patients as red and yellow based on typical field triage may not be efficient or effective depending on the number of casualties and the safety of the scene. Under- triage and over-triage of patients can be both dangerous and can affect patient outcome.
  - **Under-triage**: Defined as triaging a patient in a lower category than their actual injuries require and means critical injuries may not have been recognized. This can be a risk when a patient is stable with an isolated, externally unimpressive penetrating torso injury that masks major internal injuries.
  - **Over-triage:** Defined as triaging a patient in a higher category than their actual injuries require, thus diverting assessment and treatment resources from those who needed it more. Over-triage is a distinct possibility in mass violence incidents and can rapidly result in trauma center saturation. It may also occur when dealing with pediatric patients due both to child and provider reaction to the situation and injuries.

- All providers must be aware of the need to recognize early shock and potential deterioration in patients triaged as "yellow" with penetrating injuries to the torso. This awareness includes ambulatory patients, normally triaged as "green", that quickly move to safety, even after suffering life-threatening wounds.

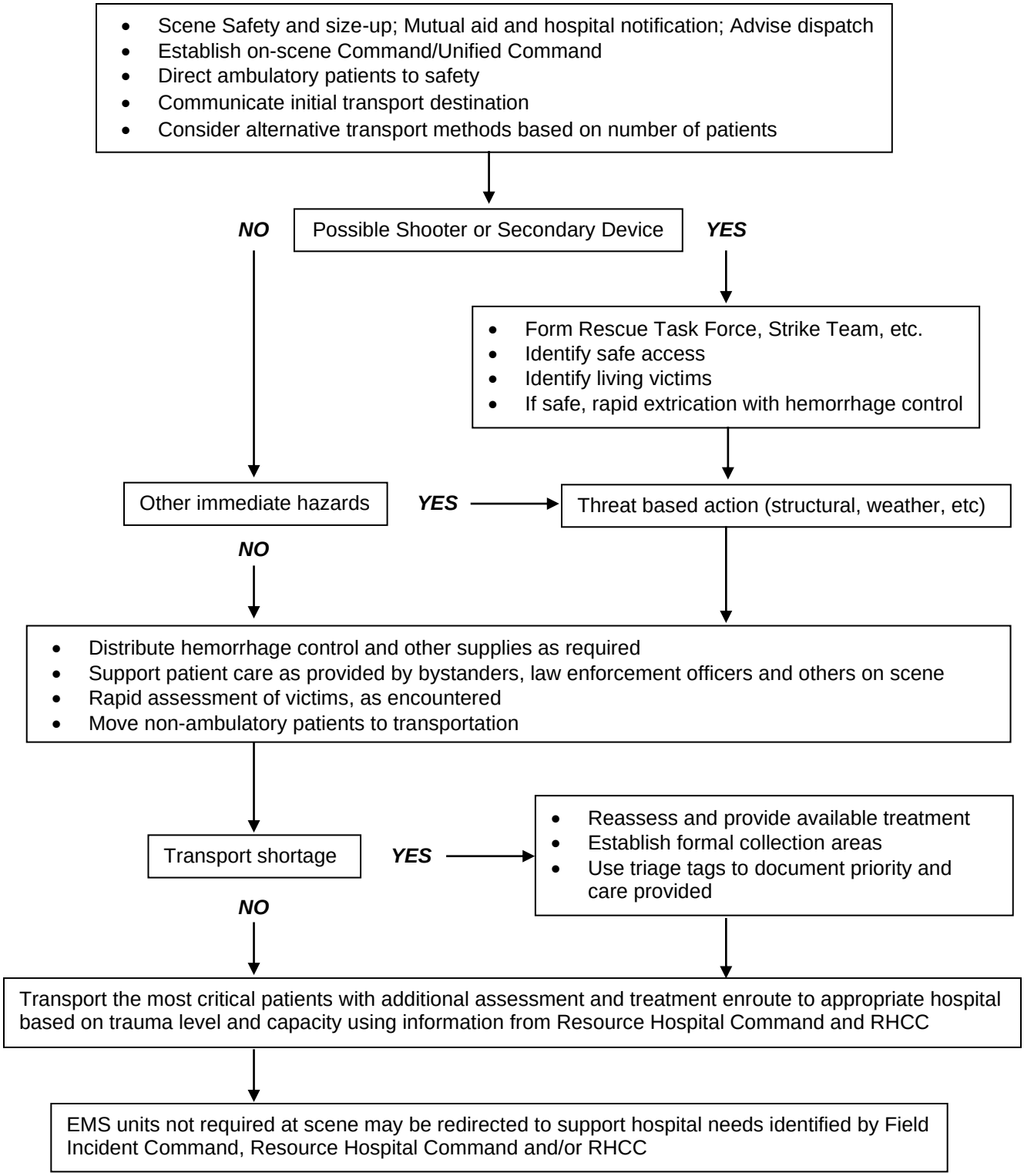
- Incidents involving mass violence are typically dynamic in nature and represent several obstacles to arriving first responders:
  - May be spread across multiple locations.
  - Involve a large number of casualties who cannot be managed by first arriving resources.
  - The geography or safety of the incident may not allow for the setup of a formal staging/collection area as well as making it may be difficult to quickly access and assess the non-ambulatory patients limiting an awareness of the actual number of patients.
  - Have a high potential to require cover or concealment during rescue operations for safety.
  - Have a high potential for victims and bystanders to flee and seek medical care on their own resulting in a disorganized evacuation.
  - Likely to involve immediate or secondary safety threats to the public and providers.
  - The scope and source of the incident may not be apparent on arrival.

- General response strategies to mass violence incidents, as well as any mass casualty incident includes:
  - Scene safety, scene size up and resource request.
  - Establishing Incident Command or Unified Command as soon as practical.
  - Patient access (use Rescue Task Force, Strike Teams, etc. if required).
  - Stop the bleed and other emergency interventions.
  - Triage/Treatment/Transport of patients as necessary.
  - In cooperation with Resource Hospital Command, evaluate appropriate destination for patients and hospital capabilities.
  - Re-evaluate resources and patients throughout incident.
  - Consider releasing extra resources to support community and hospital needs.

- EMS personnel responding to dynamic scenes, such as incidents of mass violence, should be prepared to:
  - Ensure their own immediate safety and establish Unified Command with law enforcement.
  - Maintain situational awareness to provide appropriate information to dispatch to request additional units and resources through mutual aid as well as to update area hospitals about the location and scope of the incident.

- If appropriate and possible, support “buddy” or bystander care by providing treatment materials and just-in-time instruction to immediate responder (bystanders).
- Integrate with law enforcement to create Rescue Task Forces, Strike Teams, etc., casualty collection points and ambulance exchange points.
- Anticipate secondary attacks and direct patients to safety as appropriate.
- When EMS transport is unavailable, direct patients to an appropriate hospital when they cannot or will not wait for EMS transport.
- Plan to transport patients to both trauma centers and non-trauma hospitals, using all appropriate facilities in relation to the scope of the incident.
- Determine the nearest safe ambulance loading area, known as ambulance exchange point, and direct EMS resources to that location.
    - Law enforcement cover should be provided for each ambulance exchange point on active shooter incidents.
    - Ambulances should not be staged at the exchange point to prevent multiple non-designated patient contact.
- Focus on rapid transport of the casualties tagged as “red” or “yellow” to trauma centers rather than areas where collection or categorization of patients is occurring.
- Determine the role, if any, for ongoing casualty collection/treatment points at or near the scene.
- Determine the ability for EMS to support hospitals as on-scene operations conclude if nearby hospitals or trauma centers are overwhelmed.

PRE-HOSPITAL FLOWCHART FOR MASS VIOLENCE RESPONSE



Note: Patient care tasks should be complemented by information received from the Resource Hospital Command and the RHCC, establishing liaison with law enforcement and other agencies in Unified Command to obtain threat and situation information as well as supporting on-scene operations with staging and resources.

EMS TRIAGE
• Responding units should have an abundant supply of SMART® triage tags and/or alternate triage tag methods. Alternate triage tag methods should be based on accepted current mass casualty research for triage and rapid transport of patients. • During incidents involving mass violence, rapid EMS transport should be favored over formal on-scene triage/sorting activities. Truncal penetrating wounds are life-threatening regardless of the patient's current condition. Additionally, if transport is immediately available, there is likely no benefit to a tape or tag. • EMS Command should determine if on-scene patient collection/treatment activities are useful based on the nature/size of the incident, number of EMS providers, available ambulances and other transport vehicles, scene safety, capacity of hospitals, environmental conditions, and number of remaining injured patients. • First responders should be aware that the use of tape or tags may prove to be useless if a Rescue Task Force, Strike Team, etc. simply moves non-ambulatory patients whenever they encounter them. • Triage tags may have their greatest benefit in situations where transportation is delayed, in which case the ability to record vital signs, medications, interventions, and assessments may be valuable. • EMS personnel should be able to provide pertinent patient information to receiving hospital personnel regardless of whether tags or tapes were used.

EMS TREATMENT
• It may be possible that EMS may need to provide just-in-time training and provide supplies for hemorrhage control or other interventions to bystanders in some extreme mass casualty incidents involving mass violence. • Law enforcement officers may perform life-saving interventions prior to or in the absence of adequate numbers of EMS personnel and may move victims to safety prior to the assembly of Rescue Task Force, Strike Team, etc. • Appropriate teams (Rescue Task Force, Strike Team, etc.) should be developed as quickly as possible to rapidly access and evacuate patients through secured areas once the threat has been neutralized or contained.

EMS TRANSPORT
• Transport to an appropriate trauma center for critically injured patients can be lifesaving and is a key triage component. For critical patients, the focus should be on getting to a trauma center as quickly as possible. • Patients with extremity penetrating injury, non-torso shrapnel injury, orthopedic injuries, and amputations may be good candidates for diversion to more distant or non-trauma hospitals even if, based on standard protocols, they would normally go to the closest trauma center. • Transport and destination decisions should revolve around the following questions: – What is the patient's condition? – What is the treatment capacity of the closest trauma center? – What transport resources are available? • If possible, children and parents should generally be kept together. The family member with the most critical injuries should generally guide determination of the destination hospital. This may result in a children's hospital taking care of parents and a non-pediatric center taking care of children. • If EMS Command cannot communicate directly with Resource Hospital Command, an EMS/hospital liaison should be at the Resource Hospital to relay incoming patient information and communicate hospital bed capacity, needs, or other issues.

REFERENCE

Exchange, United States. Technical Resources, Assistance Center and Information. *Mass Casualty Trauma Triage Paradigms and Pitfalls*. Assistant Secretary for Preparedness and Response,2019.