The meeting opened at 9:12 a.m.

Mr. Gavaghan gave the DEMHS Region 3 report: The target date for the completion of the rollout of WebEOC is March 9, 2009. Every town except for two has at least one person who has completed the 3 hour course. WebEOC is being used to track each winter storm and will become the vehicle to communicate information during any emergency. Ms. Duly reported that DPH will be meeting in a few weeks to customize the platform for hospitals. Details on modified training and application will be announced at the March quarterly hospital meeting. A question was asked if members of the RESF-8 group could sign up for this training. A sign up sheet was circulated for those interested and Mr. Gavaghan stated he would make arrangements. Classes are limited to 36 people at the Armory – with difficulty in parking. At the Brainard Road headquarters, the limited number of computers restricts class size to 36 people.

During the discussion, Mr. Falaguerra identified another interagency communication system developed by Accu-Med. This system integrates telephone, Web, and radio communications within a region. He stated he believed several hospitals, the Cities of Hartford and Bridgeport, and locations in New Jersey and the federal government are planning to participate. He can get further information and report at a future meeting if it would be helpful. Dr. Shaw announced that there is funding from the UASI grant to develop a regional information-sharing system, and because there are many products available, there is a need to first step back to identify what are needs are. The US Military Academy has agreed to develop the components of an information sharing system, and $75,000 is available to support this. Work continues to gain authority for transferring these funds from the region to the US Department of Defense.

Ms. Duly gave the DPH report: Jonathan Best was introduced having recently joined the staff to replace Robert Kenny. She announced the second iteration of the Mass Fatalities guidelines is being developed. A Web site at DPH is being developed to provide Mass Fatality planning information and tools. This will be announced separately when it is available as it will be password protected.

Mr. Chiara announced the publication of a statewide directory of resources and links. This document is updated in January and July, and the latest revision will be available for distribution in a week or two. Ms. Duly will send copies to each of the five RESF-8 groups
for distribution. Dr. Shaw stated this would be posted on the CRCOG Web site. Discussion was held about taking this valuable tool and built it into an expanded regional listing. Mr. Gavaghan indicated he has a list of regional contacts, but some of this information should be retained as confidential and not publicly circulated. Further discussion will take place.

Ms. Toppey gave the report for the Volunteer Recruitment and Retention Workgroup: The group is looking for an SOP on volunteer management. Different groups have policies and procedures but these are in different formats making it difficult to consolidate the information. There was some discussion about an electronic data base listing volunteers. This had been attempted in the past, but there wasn’t sufficient technical support to sustain the effort. Another variable being looked at are the designated volunteers as contrasted with the spontaneous volunteers who emerge in a disaster who want to help out. There was some discussion on how to manage volunteers that was submitted to DEMHS. After the report, it was suggested that RESF-9 15 dealing with volunteer management ought to have representation and assist this workgroup.

The Alternate Care Site Workgroup did not have a report: The group will be meeting after this RESF-8 meeting. Mr. Falaguerra reported that the Hospital Section has been working on a draft regional ACS planning document. This will be available for distribution by the April meeting of RESF-8.

A report on behalf of the Exercise Workgroup was provided. The group met Monday of this week and developed a set of objectives that are recommended to be included in the regional exercise program. These objectives were distributed (attachment 1). More details on this exercise program were reported separately, below. Mr. Goodwin read from the minutes of the last Hospital Section meeting on January 21. That group had recommended “to test the ability of vendors to deliver items in a reasonable time to all who make requests” in an emergency. “To limit the complexity of the planning for these exercises, the group decided to focus on just a few types of supplies – simultaneously asking for these from vendors during the exercise. The following were recommended: water, food, expendable medical supplies (gowns and masks), pharmaceuticals and cots.”

Mr. Koscuk gave the report on the Patient Tracking Workgroup. The group has identified the Metro Boston System for patient tracking as a starting point. This system is also being used by Worcester and other areas near Connecticut. Arrangements are being made for representatives of the Metro Boston system to come to the region and make a presentation. The group is also scheduling a webinar with St. Louis officials who are using a similar system. Dr. Shaw congratulated the group on making progress – the findings will be included in March for UASI funding. This will be a “Go Fast” project for rapid implementation.

Dr. Shaw requested that all workgroups keep him on the mailing lists – he wants to attend as many meetings as possible. Also, each workgroup is responsible for keeping their own minutes, and written minutes and reports are to be given to him within 5 days of each meeting.
Dr. Shaw reviewed the present status of the Forward Movement of Patients (FMOP) Plan: A PowerPoint presentation was used (attachment 2). A decision has been taken to move the planning for the forward movement of patients to the state level. Sub state regions have now been asked to develop regional systems. This planning will follow three stages of operations from MCI responses to about 100 casualties, through a public health emergency with up to 1,000 patients to a catastrophe with more than 1,000 patients. For this DEMHS Region II, a task force will be created to define the logistics for implementing our FMOP plan. After the issues are identified, planning will move to solutions.

Dr. Shaw announced a change in the charter for the Public Health Advisory Committee (PHAC): Last month, this group was expanded to be advisory to both DPH and DEMHS. It is now responsible for planning the ESF-8 roles for the State of Connecticut. Each of the five region’s RESF-8 chairman now sits on that committee. The group had been meeting on a quarterly basis, but the new expanded role may require more frequent meetings. One of the initial recommendations of the PHAC was for all regions to apply for “Public Health Ready” status. This application is a 3 year process – Region 3 has already completed this but we will have to reapply in 2010.

Mr. Koscuk presented a report on the regional MCI Protocols. He distributed a final draft of the document he had worked out with the regional medical advisory committee and CMED. This is attachment 3, below. Key points were highlighted. The structure of field operations follows the incident command system. The need exists to share openly information from the scene to all hospitals that may be affected.

Mr. Centrella introduced Andrew Mazzeo and Jeremy Kaufman who represent the Tetra Tech Corporation, the successful bidder for the “Scenario Based Exercise Program” Their business cards are in attachment 4, below. They both spoke outlining the program and expectations. This program will follow national Homeland Security Exercise and Evaluation Program guidelines and will focus of a tabletop exercise in the spring, a functional exercise in the summer, and a full scale exercise in the fall. They encourage everyone who is interested to attend the planning conferences when they are announced. The team will work with groups to review plans and develop the evaluation guidelines. Mr. Centrella will be the project director – communications to the team can be funneled through him or through Mr. Stonoha who will work with the hospitals. Mr. Stonoha distributed the draft objectives by ESF-8 subcommittee. See attachment 5.

The meeting adjourned at 11:38 a.m.

Respectfully submitted

Cressy Goodwin
Recorder
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<tr>
<th>Name</th>
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<td>Glastonbury Police</td>
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<td>David Kosecke</td>
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<td>Betty Horns</td>
<td>North Central EMS/AMED</td>
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<td>Juditha Torpey</td>
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## ATTENDANCE:
### CREPC ESF-8 Meeting

**February 4, 2009**

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<th>Name</th>
<th>Affiliation</th>
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<td>Sandra Shaw</td>
<td>NCCMED</td>
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### CREPC ESF-8 Meeting
### February 4, 2009

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<th>Name</th>
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<td>Co-Mana Caswell</td>
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Objectives for 2009 Exercise series (proposed)
Listed by subsection

EMS
1. Use of SMART Triage tags across all disciplines (EMS, First Responders, Hospitals, CMED)
2. Use of the Region 3 MCI Protocol
3. Use of the CT DPH/DEMHS FMOP Plan, specifically the activation/deployment of EMS Strike teams.
4. Use of the training provided in the EMS Hazardous Training Program
5. EMS integration with Alternate Care Sites
6. Deployment of a CT DPH/DEMHS MCI Trailer
7. Reimbursement for non-traditional EMS Service (#4, #6)

CMED
1. Test Communications between Hospitals, 1st responders and DPH
2. Evaluate MCI Protocols for CMED
3. Assess use of SMART Triage tag system
4. Use of regional Forward Movement of Patient Plan (FMOP)

Hospitals
1. Test Communication capabilities
2. Evaluate Hospital Command center operations
3. Begin and initiate formation of Alternate Care Sites (ACS)
4. Initiate and identify needed equipment and supplies necessary for ACS activation
5. Institute plans for a mass fatality as a result of Pandemic Influenza

Local Health Districts
1. Assess surveillance techniques as a result of Pan Flu outbreak
2. Attempt to isolate and contain further infection of population
3. Begin Public information working within a Joint Information Center (JIC)
4. Prepare to activate a Mass Fatality Plan

Behavioral Health (proposed)
1. Plan and provide community and family support operations
2. Initiate and prepare for mass fatalities

Metropolitan Medical Response System (MMRS)
TBD

Medical Reserve Corps (MRC)
1. Activation of the MRC
2. Activation and Deployment of the MACU

Disaster Medical Assistance Team (DMAT)
1. Activation and mobilization of CT-1 DMAT
Attachment 1 (continued)

Scenario proposal

The forecast in the greater Hartford area predicts a potentially dangerous ice storm. Damaging accumulations of ice on trees and power lines threaten the area along with slick road conditions. Communities have begun employing their emergency operations plans.

Avian influenza has also been detected at all area hospitals. Daily emergency department visits have been steadily rising along with admissions. Hospitals have been able to handle the influx of patients but are concerned that if the numbers continue to grow they will be overwhelmed.

A localized outbreak of avian flu has been found in a number of nursing homes in the region and due to the susceptibility of residents, almost all of the patients have begun to display symptoms of the virus.
The Connecticut FMOP Plan

Presentation to
Region 3 RESF 8
February 4, 2009

MMRS Baseline Deliverable # 7

MMRS Contract Reference
(2002 Statement of Work)

"Develop a component of the MMRS Plan for the Forward Movement of Patients to other areas of the region or nation in the event that local resources are insufficient to provide the definitive healthcare required for all of those directly affected by the event"
**Forward Movement of Patients**

"Most complex issue facing local responders"
- Rapid depletion of local and regional resources
- Hospitals saturated
- EMS transport overwhelmed
- Requires coordinated pre-incident planning from local, state, regional and federal agencies

---

**Key points...**

FMOP is a tough task...
- Requires intense cooperation among hospital and pre-hospital agencies
- Can escalate quickly to the federal response level, but command remains local
- Connecticut's FMOP Plan provides the mechanism for successful resource management at the local/regional level, and for integration of state and federal assets
Attachment 2 (continued)

### Strategies and actions

- **Stage I:** Developing MCI 0 to 100 patients  
  **Strategy:** Assess needs  
  **General Action:** Utilize existing local/regional response structure

- **Stage II:** Public Health Disaster 101 to 1,000 patients  
  **Strategy:** Establish alternate response structure  
  **General Action:** Augment regional resources with state assets

### Strategies and actions

- **Stage III:** Catastrophic Public Health Event 1,001 to 10,000 or more patients  
  **Strategy:** Utilize all available state and federal resources  
  **General Action:** Integrate state and federal resources into regional response structure
**FMOP action plan: Coordination**

- In the early stages of any mass casualty emergency, patients initially shall receive care at local hospitals utilizing their normal operating procedures.
- Once FMOP plan is activated, Regional Coordination Centers (RCC=MACC) manage the local and regional assets, and coordinate influx of state and federal resources into the area.
- State EOC is open to manage all requests for out-of-state and federal resources.
- Region I ERT-A deployed to determine federal resources needed.

---

**Coordination...**

"Think Tank of Health Professionals"
- CRMMRS, CREPC ESF 5, CREPC ESF 8 AND SECTION HEADS, CTDHMHS, CTDPH, CTDOT
- Regional and Federal Agencies Serve as SME's as Needed
- FMOP plan is part of an integrated planning package that includes:
  - Statewide EMS Mobilization Plan
  - Burn Patient Management Plan
Attachment 2 (continued)

**So, what could possibly go wrong?**

- Sub-state regions are at different levels of competence
- To be effective, FMOP must become a 24/7 plan of action
  - We're changing the way we do business in CT
- Employers are reluctant to buy in due to costs of training and upgrades
- Legislative requirements
- The "NIH Syndrome"

**Keys to Success...**

Build on what CMED, EMS and the hospitals do every day

Make sure all state, regional and federal players are in from the get-go

Allow a generous timeframe (September 2009!)

Drill and exercise to test the pieces and to maintain interest
Mass Casualty Incident Communications

Attachment 3

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Attachment 3 (continued)

Mass Casualty Incident Communications

North Central CMED System

Purpose

North Central CMED’s utmost concern is to provide pre-hospital and hospital users with the most efficient and reliable communications system possible.

This information is designed to familiarize you with North Central CMED’s procedures during a Multi-Casualty Incident, and is intended to assist with your communication needs if such an incident occurs.

Any questions or concerns regarding these guidelines should be addressed directly to North Central Connecticut EMS Council Management.
Attachment 3 (continued)

Mass Casualty Incident Communications

Introduction to the Mass Casualty Incident

“Multi-Casualty and ‘Mass Casualty’ traditionally are interchangeable terms in Connecticut. Connecticut’s term references an incident that meets locally defined thresholds in accordance with the jurisdiction emergency response plan.

- Large numbers of injured persons
- Large multi-agency response teams
- Inherently hazardous environments
- High stress environments

Local disaster plans identify the specific formula for each jurisdiction; knowing the local criteria is crucial to early recognition and declaration of MCI.

What is a Mass Casualty?

FEMA Mass Casualty Incident Definition
Mass casualty incidents are incidents resulting from man-made or natural causes resulting in illness or injuries that exceed or overwhelm the EMS and hospital capabilities of a locality, jurisdiction, or region. A mass casualty incident is likely to impose a sustained demand for health and medical services rather than the short, intense peak demand for these services typical of multiple casualty incidents.

What is a Multi-Casualty Incident?

FEMA Multi-Casualty Incident Definition
Multi-casualty incidents are incidents involving multiple victims that can be managed, with heightened response (including mutual aid if necessary), by a single EMS agency or system. Multi-casualty incidents typically do not overwhelm the hospital capabilities of a jurisdiction and/or region, but may exceed the capabilities for one or more hospitals within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents.
**MCI Threshold Definition**

The point at which the number of patients at an MCI and the severity of their conditions are beyond the ability of available resources to provide adequate care.

The day-to-day EMS response is designed to assure scene safety and to triage, treat and transport no more than a few patients. If day-to-day procedures were followed at the scene of a large number of casualties, several problems could occur with scene management, triage, treatment, and transport.

The threshold formula is:

# Ambulances within 15 minutes X 2 victims +1 would constitute an MCI declaration for that community

Example: 6 ambulances X 2 victims = 12 victims
12 victims + 1 = 13 (MCI declaration)

MCI Threshold = 13 victims

If the numbers of victims excedes the threshold, but few, if any, appear to be seriously injured, consideration should be given to not declaring an MCI.

**North Central Region Threshold**

“For Area Hospital Notification Only”

Field units are required to notify North Central CMED of incidents involving:

- Three ambulances to any incident
- Three critical (red) victims and/or
- Ten victims
Attachment 3 (continued)

Mass Casualty Incident Communications

MCI LEVELS

The establishment of MCI levels is to automatically trigger operational movement of resources without the CMED communicator needing special authority/direction. In theory the EMS officer would declare an MCI (level 1-4) and CMED following established protocol would automatically deploy resources as outlined:

Level 1 MCI (11-20 victims)
- 10 Ambulances (no need to specify AI R v RI R)
- 2 EMS Supervisors
- 1 Local MCI equipment resource

Level 2 MCI (21-50 victims)
- 15 ambulances
- 3 EMS Supervisors
- 1 Regional MCI trailer
- Consider 1 bus
- RED Plan Notification

Level 3 MCI (51-100 victims)
- 20 Ambulances
- Consider 2 buses
- 5 EMS Supervisors
- 1 Regional MCI Trailer
- RED Plan Notification

Level 4 MCI (>100 victims)
- 20 Ambulances (per 100 victims)
- Consider 2 Buses (per 100 victims)
- 5 EMS Supervisors (per 100 victims)
- 1 Regional MCI trailer (per 100 victims)
- RED Plan Notification

Hazardous Materials (HAZMAT) Weapons of Mass Destruction (WMD)

HAZMAT, CBRNE/WMD incidents will often require the use of local or regional HAZMAT teams.
Mass Casualty Incident Communications

**FIRST UNIT ON THE SCENE**

First unit on scene gives visual size-up, assumes and announces command, and confirms incident location, then...the 5 S's

SAFETY assessment: Assess the scene observing for:

- Electrical hazards.
- Flammable liquids.
- Other life threatening situations.
- Be aware of the potential for secondary explosive devices.

SIZE UP the scene: How big and how bad is it? Survey incident scene for:

- Type and/or cause of incident.
- Approximate number of patients.
- Severity level of injuries (either Major or Minor).
- Area involved, including problems with scene access.

SEND information:

- Contact CMED with your size-up information.
- Request additional resources.

SETUP the scene for management of the casualties:

- Establish staging.
- Identify access and egress routes.
- Identify adequate work areas for Triage, Treatment, and Transportation.

SMART triage:

- Begin where you are.
- Ask anyone who can walk to move to a designated area.
- Use SMART Triage tags to mark patients.
- Move quickly from patient to patient.
- Maintain patient count.
- Provide only minimal treatment.
- Keep moving!

Remember... Establish COMMAND, SAFETY, SURVEY, SEND, SET-UP AND SMART.
Mass Casualty Incident Communications

Radio Procedures

It is essential that proper radio etiquette is used during transmissions to CMED. Unit to unit communications should be left to a minimum. Use plain language, avoid jargon and codes. Transmissions shall be professional, brief and concise.

When calling a unit or station, identify the unit or station being called then your I.D. Speak clearly into the microphone and build in pauses when giving reports to confirm the other party receives the message.

Notification to CMED for Declared Mass Casualty Incident

Upon declaration of an MCI, per protocol, CMED will confirm receipt of notification, alert area agencies and notify all hospitals in the North Central Region of the developing MCI with a simultaneous broadcast. CMED will not forward information to other agencies, hospitals, etc... until the incident is declared an MCI.

The Medical Branch Director/Medical Group Supervisor will request a CMED channel assignment. Once assigned, the Medical Branch Director/the Medical Group Supervisor will determine and communicate to CMED the following information:

1. Name/Title of the Medical Group Supervisor on scene.
2. Name/Title of the Patient Transportation Unit Leader/Ambulance Coordinator
4. Exact Location (town & street).
5. MCI Level (1-4)
6. Estimated number of victims. (Number of known injuries and estimated possible casualties).
7. Number of ambulances requested to the scene (if CMED is requested to perform mutual aid call out) and if an MCI trailer is needed.
8. Exact ambulance staging area and contact information

CMED Notification to Hospitals for Declared Mass Casualty Incident

Upon confirmation and receipt of declared MCI by the Medical Branch Director/ Medical Group Supervisor on scene, CMED will notify all hospitals in the North Central region of the developing mass casualty incident with a simultaneous broadcast, and telephone communications as necessary.

Patients will be sorted according to SMART criteria of red, yellow, green. Upon receiving direction from the Medical Group Supervisor, CMED will contact all area hospitals to determine red, yellow, and green capabilities.

During the incident, CMED will provide periodic updates to the hospitals in the affected area. These hospitals should report any changes in their status during an incident that may affect scene management, directly to CMED.

CMED will notify hospitals when ambulances depart the scene of an MCI. The following information will be reported for each transport:
Attachment 3 (continued)

Mass Casualty Incident Communications

- Ambulance number and destination hospital
- Patient SMART Tag
- Triage color
- Age and sex of patient(s)
- Nature of injury
- ETA

Incidents involving more than 10 patients CMED will notify Colchester Communications (MEDNET Control) of the incident.

Use of MED Channels during Mass Casualty Incident

MED Channels are used to facilitate your direction requests to CMED. MED channels will not be used as an “EMS ground frequency” or an uninterrupted direct link to any hospital. EMS units responding to an MCI are to sign on with CMED on MED 10. Units will then be directed to the assigned MCI MED channel.

MCI Channel Assignment

To maintain a sound communication system, CMED will authorize up to three MED channels to be used during an MCI.

MCI Command and Control Channel

This channel will be utilized for communications between the Medical Branch Director/Supervisor and CMED. This channel will be used to:

- Coordinate between scene and CMED
- Update CMED with established casualties
- Update CMED with escalation of the incident
- Update scene as to hospital bed availability

MCI Transportation Channel

This channel will be used by the Patient Transportation Unit Leader/Medical Communications Coordinator during MCI operations. The Patient Transportation Unit Leader should give concise patient SMART Tag reports to CMED for hospital notification. This will prevent ambulances from lengthy individual reports. This channel will be used to:

- Request mutual aid
- Coordination of arriving units (directions, new information, staging, etc…)
- Update scene of mutual aid status
- Provide patient reports to CMED
- Provide transportation information to CMED

Note: Entry notifications to the hospitals will be made by CMED. The Patient Transportation Unit Leader/Medical Communications Coordinator should give CMED patient reports which include: Ambulance number and hospital destination, SMART Tag number and color, age and sex, nature of injury, and ETA will be documented on the CMED patient tracking form.
Attachment 3 (continued)

Mass Casualty Incident Communications

**MCI Channel Assignment**

**MCI Additional Channel**

Depending upon the nature and scope of the MCI, North Central CMED may assign a third MED channel. Use of this channel will be determined after discussion between the CMED Center and the Medical Branch Director. Examples for channel use are listed below and are not all inclusive:

- Forward Movement of Patients
- Ambulance Strike Team Request
- Governmental agency requests
- Supply requests
- Stockpile request
- Further scene coordination
- Communication link between medical control hospital and medical control officer on scene. (This will be a non-repeaterized channel).

**MEDNET (CT EMS Communications Network) Notification**

CMED will notify various communications centers and appropriate public safety agencies via MEDNET, as necessary.
Attachment 3 (continued)

Mass Casualty Incident Communications

**Mutual Aid**

Mutual Aid is the process by which resources from one town/service area are deployed to respond to request for service in another town or service area. Mutual aid is used in the following circumstances:

1. There are more calls in a town service area than the primary responder can handle
2. There is need for additional resources above what the town/service provider can provide at a single incident
3. A mass casualty situation has occurred
4. The primary service has failed to initiate a response within established response parameters

As North Central CMED is not the primary dispatch center for any EMS service, they will have no role in mutual aid callout until such time as they are requested to assist in procuring mutual aid or when a MCI declaration occurs. In either instance, at the time of the request, North Central CMED will become the sole agency with the exception of pre-planned Special Operations to request additional units and responses. During Special Operations, it is the responsibility of the EMS Commander to advise CMED of the number of transport units on scene. At the time of the request North Central CMED should be provided with a turnover of agencies requested and responding, their unit numbers, clinical levels and ETA.

North Central CMED as part of the Statewide MEDNET System is responsible for mobilizing EMS assets in its service area for response to major incidents throughout the State of Connecticut. Pending completion of the Department of Public Health EMS Mobilization Plan, North Central CMED and its client EMS Provider Services will be guided by the following principles when requested to provide mutual aid in other areas of the State (outside of Region 3).

1. Only 25% of the on duty ambulance/paramedic units available in the North Central CMED Service area at the time of the request will be allocated to an out of region incident.
2. Upon a state DPH request for North Central CMED service area EMS assets, all EMS provider services will be requested to staff all of their available response units, to ensure coverage in Region 3.
3. At no time will on duty ambulance/paramedic units fall below 75% due to responses requested by the State, other regions or other CMED’s.
4. EMS providers will refrain from deploying assets from their service areas to other areas of the State except as may be directed by North Central CMED.

**Hospital Distribution**

As a general rule, in the case of an emergency, EMS transports patients to the closest geographic hospital. Sometimes, EMS and hospital conditions makes it more appropriate to take the patient to a hospital that is not the closest.

This point-of-entry plan addresses circumstances when, because of the health of the system, the system would benefit from distributing patients to a more distant hospital(s) emergency department. North Central CMED will monitor the overall status of the EMS and hospital systems. In the event of an MCI or other high volume incident or incidents, North Central CMED will assign hospital destinations to transport units.
Attachment 3 (continued)

Mass Casualty Incident Communications

Staging Areas

All responding EMS units should go directly to the assigned STAGING AREA and await further instructions. Do not leave the staging area until you are instructed to do so by the Medical Branch Director/Medical Group Supervisor or the direction of North Central CMED.

Patient Dispersal from the Scene

Patients will be sorted according to SMART Tag criteria of RED/YELLOW/GREEN/BLACK. Upon receiving direction from the the Medical Branch Director/Medical Group Supervisor, CMED will contact all area hospitals to determine RED/YELLOW/GREEN capabilities.

- Red: Priority 1
  Life-threatening but treatable injuries requiring immediate medical attention

- Yellow: Priority 2
  Potentially serious injuries, but are stable enough to wait a short while for urgent medical treatment

- Green: Priority 3
  Injuries that can wait for longer periods of time for delayed treatment

- Black/Blue: Dead/Expectant
  Dead or (expectant still with life signs but injuries are incompatible with survival in austere conditions

To assure hospital capabilities have not reached capacity, transporting units will be assigned hospital destination by North Central CMED.

Patient Dispersal to Receiving Hospitals

Purpose

The purpose of this protocol is to assure that the treatment of patients at the scene of a mass casualty incident and transportation to receiving hospitals is done in accordance with accepted medical and communication standards. Radio traffic should be kept at a minimum. In accordance with the statewide program of Mass Casualty Care in Connecticut, patients requiring advanced life support will have effective medical control communications providing guidance for, advanced life support care without the need for individual orders, alternative transportation for patients receiving advance life support when insufficient ICU unit are available, and assurance that trauma patients are taken to appropriate trauma centers. Communications to hospitals and requests for medical control will be processed through the individual that has assumed responsibility for the EMS function at the scene of an incident.

Scene Management

Upon arrival at the scene of a mass casualty incident, the EMS provider sets up EMS scene control and designates the Medical Branch Director/Medical Group Supervisor per their Mass Casualty Incident Plan. Whenever possible CMED should be advised of the incident’s scope. CMED will alert the hospitals closest to the incident’s scene. During the incident, CMED will provide periodic updates to the hospitals in the affected area. These hospitals should report any changes in their status during an incident that may affect scene management, directly to CMED.
Medical Control / Communication at the Scene

All EMS personnel providing treatment at the scene of a declared Mass Casualty Incident will follow standing orders protocols. **It is not necessary to contact medical control of the individual service. Standing ALS orders will apply during a declared Mass Casualty Incident.** If communication to medical control is necessary, CMED will provide a MED channel for the designated Treatment Officer. The Sponsor Hospital nearest the incident will be designated as the Medical Control Hospital. This should not be considered an “open patch.” The Treatment Officer should establish communication with CMED first to assure that a physician is online.

**Med control policy**

**MEDICAL DIRECTION DURING A MASS CASUALTY INCIDENT**

In order to reduce radio congestion and allow scene personnel to accomplish their tasks during a declared mass casualty incident, all regional protocols will revert to standing orders during this time. However, medical personnel cannot function beyond the scope of their training or above the authorized level of the service with which the personnel are responding. All patients treated under standing orders must have this documented on the PCR.

Nevertheless, scene personnel are encouraged to contact on line medical direction as needed to aid in the treatment efforts.

**After Action Reporting**

The EMS Section of Region 3 Emergency Support Function (ESF)-8 will make itself available to facilitate an After Action Report of any MCI within Region 3. The After Action Report may be requested by the incident agency/town, the Region 3 Medical Advisory Committee (MAC), the Region 3 EMS Council or North Central CMED.
Attachment 4
CREPC ESF 8
Objectives for 2009 Exercise series (proposed)
Listed by subsection

EMS
1. Use of SMART Triage tags across all disciplines (EMS, First Responders, Hospitals, CMED)
2. Use of the Region 3 MCI Protocol
3. Use of the CT DPH/DEMHS FMOP Plan, specifically the activation/deployment of EMS Strike teams.
4. Use of the training provided in the EMS Hazardous Training Program
5. EMS integration with Alternate Care Sites
6. Deployment of a CT DPH/DEMHS MCI Trailer
7. Reimbursement for non-traditional EMS Service (#4, #6)

CMED
1. Test Communications between Hospitals, 1st responders and DPH
2. Evaluate MCI Protocols for CMED
3. Assess use of SMART Triage tag system
4. Use of regional Forward Movement of Patient Plan (FMOP)

Hospitals
1. Test Communication capabilities
2. Evaluate Hospital Command center operations
3. Begin and initiate formation of Alternate Care Sites (ACS)
4. Initiate and identify needed equipment and supplies necessary for ACS activation
5. Institute plans for a mass fatality as a result of Pandemic Influenza

Local Health Districts
1. Assess surveillance techniques as a result of Pan Flu outbreak
2. Attempt to isolate and contain further infection of population
3. Begin Public information working within a Joint Information Center (JIC)
4. Prepare to activate a Mass Fatality Plan

Behavioral Health (proposed)
1. Plan and provide community and family support operations
2. Initiate and prepare for mass fatalities

Metropolitan Medical Response System (MMRS)
TBD

Medical Reserve Corps (MRC)
TBD

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