St. Joseph County, Indiana
Emergency Medical Response Plan

Hospital Control

Beacon Health System
Memorial Hospital South Bend
(574) 647-7777

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Purpose

The purpose of this document is to establish a plan for an immediate, rapid, and efficient response to a mass casualty incident/medical disaster. This document, in conjunction with the Public Health and Medical Services Emergency Support Function (ESF 8), is intended to serve as the guide for the medical component of the Saint Joseph County Comprehensive Emergency Management Plan. It describes the necessary components for coordinating on scene triage, treatment, and transportation of injured patients to receiving hospitals, as well as for coordinating the distribution of injured patients to regional hospitals.

It is understood that many medical and public safety agencies and individuals will be involved in any disaster, and at any one time may be performing some combination of medical, fire, police, military, or other support functions. Although it is clearly not the intent of this plan to inhibit such agencies or individuals from performing his or her assigned tasks, it is intended that all local medical functions will be accomplished according to this plan.

Any emergency medical response directed by or related to this plan will follow the National Incident Management System (NIMS) in establishing the command structure. All positional titles in this plan reflect those assigned by NIMS and, as such, will be used at all incidents managed in accordance with this plan.

All EMS agencies, regardless of affiliation, shall follow this emergency medical response plan when responding to a mass casualty incident in St. Joseph County.

*Note, this is a working document, and as additional committees, recommendations, and integrations are developed, this plan may be amended, as necessary.

Definitions

The following definitions are critical to the understanding and implementation of this plan. As such, St. Joseph County emergency medical responders should make themselves familiar with these terms as they apply to this plan. Note: these definitions apply to their use in this plan and do not necessarily represent the informal daily uses of these terms.

CHEMPACK – CHEMPACK is a national program funded by the Administration for Strategic Preparedness and Response (ASPR) and is an extension of the Strategic National Stockpile (SNS) program. CHEMPACK is a first responder asset that provides antidotes for individuals exposed to intentional nerve agent attacks and large-scale organophosphate (pesticide) poisonings.[1] EMS CHEMPACKs are available at MHSB. Hospital CHEMPACKs are available both Memorial Hospital South Bend and St. Joseph Regional Medical Center Mishawaka. However, if needed, the hospital-based CHEMPACKs may be requested and transported to the scene for EMS use.

Casualty Collection Point (CCP) – A location where casualties are brought after extraction from the hot zone to receive field care, re-triage, and stabilization, while awaiting transfer to definitive care. The CCP should be established in a safe zone, away from immediate threat, but should also have immediate access to transportation networks. An improvised CCP may be created in the warm zone, particularly inside of a building, if full extraction into the cold zone is not safe or feasible. Ideally, when possible, the CCP should be divided into lanes or areas based on triage category. More than one CCP may be established depending on the size and scope of the incident. This may also be known as the "treatment area." Despite being in the cold zone, CCPs must have a secured perimeter.

Hospital Area Command (HAC) – Hospital area command will be established on larger events where multiple casualties are overwhelming multiple hospitals in the area. HAC helps manage resources across multiple facilities, ensuring optimal utilization of resources, and distribution of casualties. Hospital area command will be established by Hospital Control and should include members of local hospitals and healthcare facilities. HAC is beyond the scope of the EMRP, although first responders and on-scene personnel will interact with facilities working under hospital area command.

Hospital Control – The primary hospital system responsible for notifying local and/or regional hospitals of the mass casualty event, tracking patients' transportation destinations, and acting as the hospital liaison for first responders and the Primary Communications Center during a mass casualty incident. A system for communicating with the transportation officer, incident commander, or other on-scene liaison, and ensuring patient volumes have been divided according to the hospital's capabilities and capacity is critical. Hospital control shall also designate a physician for any trauma and medically related online medical consultations during a mass casualty incident.

IDLH – Immediately dangerous to life or health.

Mass Casualty Incident – Any situation involving the injury or illness of a quantity of persons sufficient to overwhelm the usual emergency medical services system in a short amount of time. Mass casualty incidents are taxing to local and regional assets but do not require the assistance of federal assets to mitigate the incident. In this document, the terms medical disaster and mass casualty incident are used interchangeably since the local response provided for in this document is the same for both incident levels. This is also known as a mass patient incident.

Mass Fatality Incident – Any situation involving the *deaths* of a large number of victims sufficient to overwhelm the usual emergency medical response system.

Medical Disaster – Any mass casualty incident that is extensive enough to require the assistance of federal response assets and/or state level response assets from neighboring states. Involvement of federal agencies for regular law enforcement purposes does not necessarily constitute a medical disaster.

Primary Communications Center – The central communications and dispatch agency of the jurisdiction primarily affected by the incident. For the purposes of this plan, the St. Joseph County Public Safety Answer Point (PSAP) ("dispatch") will serve as the Primary Communications Center for all incidents in St. Joseph County. If the St. Joseph County PSAP is out of commission secondary to a disaster, or other event, standard back-up plans should be implemented. See the St. Joseph County Comprehensive Emergency Management Plan for more details.

Response Agencies – Response agencies are all agencies, public or private, that provide resources and/or personnel to act in the mitigation of a mass casualty incident in accordance with this plan. Response agencies may include, but are not limited to: hospitals, fire departments, local, state, or federal law enforcement agencies, EMS agencies, Emergency Management Agency (EMA), military resources, and other local, state, or federal teams.

SJCEMSC – St. Joseph County Emergency Medical Services Committee.

Trauma Center – For St. Joseph County, Memorial Hospital of South Bend is the trauma center. Memorial Hospital of South Bend is a state certified Level II Trauma Center. Memorial Hospital shall designate a physician or surgeon to act as a consultant for any trauma related online medical consultations during a mass casualty incident. Elkhart General Hospital is also a state certified Level III Trauma Center. Depending on the extent of the mass casualty event, it may be necessary to bypass the closer or higher-level trauma center to help distribute patients to help ensure no one facility is overwhelmed.

Unified Command - A team effort to managing an incident, allowing all agencies with geographical or functional responsibility for an incident to assign an Incident Commander to a Unified Command organization/structure.

[1] https://www.in.gov/health/emergency-preparedness/planning-and-preparedness/chempack/#What_is_CHEMPACK_and_what_does_it_mean_for_the_State_of_Indiana_

Education and Training Standards

Each SJCEMSC sponsored agency, including the sponsoring institutions, is responsible for providing emergency medical response education to its own staff, as well as overseeing medical education programs and mass casualty incident training for SJCEMSC sponsored response agencies in St. Joseph County.

Response agencies will be responsible for ensuring command personnel, or those who may potentially fill command roles, are educated in all command positions provided for in this plan. Training shall follow the roles and responsibilities outlined in the position manuals provided in this plan.

Mass casualty incident medical component drills and tabletop exercises will be held as determined by the SJCEMSC or receiving hospitals and may be incorporated into more comprehensive St. Joseph County Emergency Management Agency practice scenarios. Since a medical disaster may overwhelm county assets, drills may include agencies throughout the region. Drills should not only include scene operations, but also simulate the administrative processes of identifying, requesting, mobilizing, assigning, replacing, and demobilizing resources, as well as forming and utilizing a unified command system. These administrative and command processes are as important as on-scene operations.

The purpose of tabletop exercises will be to familiarize representatives with the administrative functions, command functions, and paperwork functions necessary in a mass casualty incident response. Tabletop exercises will also focus on the processes and documentation necessary to request resources from all levels of response agencies, as well as the inventory, mobilization, assignment, maintenance, demobilization, and return to service of all resources. During the debriefing at the end of each tabletop exercise, attending representatives will evaluate and design, or redesign, standardized forms for use by all agencies operating under this plan.

All response agencies and hospitals that operate under this plan will comply with all current and future NIMS training requirements as mandated by the Department of Homeland Security. This training is available online from the Federal Emergency Management Agency (FEMA) Emergency Management Institute at http://training.fema.gov. Failure to meet NIMS training requirements may affect the ability of response agencies and local governments to receive federal and state compensation after a disaster.

Hospital Control

Hospital control shall serve as the authority for notification of local and regional hospitals of an MCI, providing duplicate tracking of patient transportation destinations – in conjunction with the on-scene personnel, providing the transport officer or incident command assistance with patient load leveling across the region, and coordinating an online consulting physician, when the medical director is not available, during a mass casualty incident. Hospital Control staffing should include at least one nurse but may require additional personnel, with varied credentials, depending on the size and scope of the incident. The role of Hospital Control staffing is only to operate Hospital Control. This staffing shall not be used to provide medical care to patients at any time, as doing so would distract them from fully performing the duties of Hospital Control.

Hospital Control shall maintain regular voice communication with the on-scene EMS Branch Director and/or the EMS Transportation Group Supervisor, Incident Commander, or other assigned liaison, such as the medical director during the entire incident or until EMS operations cease, whichever comes first. This communication may be accomplished through any form of telephonic or radio method necessary. Whenever possible, the EMS Branch Director will contact Hospital Control every thirty minutes to provide an update on the current situation. This information can then be disseminated to the area hospitals. If the EMS Branch Director does not contact Hospital Control, it shall be Hospital Control's duty to initiate contact and request that update. The EMS Transportation Group Supervisor shall also remain in regular contact with hospital control to update the patient tracking list and re-evaluate receiving hospitals' capacity for additional patients.

Hospital Control's responsibilities include:

- Initiate mass notification to local and regional hospitals of the mass casualty incident taking place.
- Request all hospitals notified of the mass casualty incident update their Juvare EMResource page.
- Monitor 800 MHz county operations and assigned fireground channel radio traffic to stay informed of transported patients. As the event grows, a dedicated EMS Fireground channel should be assigned. Hospital Control should primarily monitor that channel.
- Stop all incoming transfers to affected hospitals within the Beacon Health System.
- Designate a licensed physician, or physicians, to serve as the contact point for all online medical requests, including treatment authorizations and general consultations when the EMS medical director is not available. If possible, the physician(s) shall be provided with a phone line that is accessible from outside the facility. This phone number shall be provided to the EMS Branch Director, the EMS Treatment Officer, and the EMS Triage officer and used exclusively for online medical consultations.
- Coordinate resources for local and regional hospitals.
- Monitor bed availability at receiving hospitals, as well as the availability of other pertinent medical resources. Hospital Control shall communicate resource availability to the on-scene EMS Transportation Group Supervisor at regular intervals; when possible, this communication should occur at least every 30 minutes.
- Identify the treatment capabilities of all receiving hospitals and provide this information to the EMS Transport Officer, EMS Branch Director, or Incident Commander.
- When necessary, request the establishment of decontamination operations at all receiving hospitals for incoming patients who may have been exposed to hazardous materials and were not decontaminated at the scene.
- Maintain contact with Poison Control in any incident requiring that service, especially in a hazardous materials incident. (1-800-222-1222)
- When necessary, request the hospital-based and regional EMS CHEMPACKS be mobilized at the request of the medical director, online medical control physician, or EMS branch chief.
- Oversee the training and education of Hospital Control personnel prior to, and if necessary, during the incident.
- Help establish a field hospital, as needed and requested.

Ideally, an EMS medical director and/or EMS coordinator will be on scene to assist the Triage Group Supervisor, the Transportation Group Supervisor, or act as a Medical Specialist Consultant for the Medical Branch Director or Incident Commander, wherever it is felt he or she will be the most helpful for the flow and treatment of patients.

Hospital control can be requested/activated at any time but will automatically be activated with an EMS Plan 1 activation.

Area hospital notifications shall be dictated by the following matrix:

EMS Level	Expected Patient Volume	Hospitals Notified
Small	6-15	MHSB, EGH, BGH, SJMMC
Large	16-25	MHSB, EGH, BGH, Gosh, SJMMC, PLY, TRH, CHB, CHN
Regional	> 25	MHSB, EGH, BGH, Gosh, SJMMC, PLY, TRH, CHB, CHN, NWHLP, MC (BKH, Park, CHSJ, NWHV)

Hospitals:
MHSB: Memorial Hospital South Bend
EGH: Elkhart General Hospital
BGH: Beacon Granger Hospital
Gosh: Goshen Hospital
SJMMC: St. Joseph Mishawaka Medical Center (Mishawaka)
PLY: Plymouth Hospital
TRH: Three Rivers Hospital
CHB: Community Hospital Bremen
CHN: Corewell Health Niles
NWHLP: Northwest Health Laporte
MC: Franciscan Michigan City

BKH: Beacon Kalamazoo Hospital
Park: Parkview Fort Wayne
CHSJ: Corewell Health St. Joseph (Michigan)
NWHV: Northwest Health Valparaiso

On-Scene Command Positions

The National Incident Management System (NIMS) will be used in all incidents managed under this plan. The federal government mandated the implementation and use of NIMS by all emergency response agencies and governments by October 1, 2007. All response agencies utilizing this plan should be familiar with and use NIMS on a regular basis. All personnel filling command roles on the scene of an incident managed under this plan shall, ideally, wear a reflective vest with their position printed on the vest. This vest should be worn at all times while on the scene of the incident. The National Incident Management System dictates the command positions and titles that will be used in the case of a medical disaster. These positions are shown on the command chart. The responsibilities of each position are as follows:

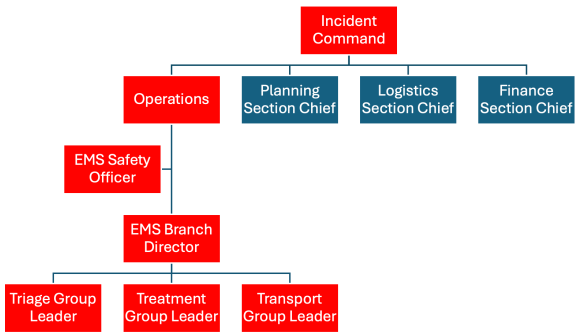
Incident Command

Incident Command is the ultimate authority at the incident scene. As such, in the case of a disagreement between off-scene personnel or Hospital Control and Incident Command, the Incident Commander will have the final say in what course of action is followed. This rule does not apply if the current situation dictates otherwise, due to written laws or the National Response Plan, or in the instance of treatment(s) ordered by on-line medical direction. Directives by online medical consultation shall be followed unless those actions would place the on-scene provider in an unacceptable degree of danger. Incident Command may be comprised of one individual at smaller incidents or several individuals from multiple agencies working in a unified command structure. This structure may grow larger or smaller as the incident progresses. Incident Command is responsible to:

- Establish an incident command post that will provide the necessary tools to assess, plan, and review the incident, as well as provide the space and infrastructure necessary for a unified command structure.
- Schedule periodic briefings with command personnel. These briefings will be used to update all personnel on the situation, evaluate progress, create or modify plans of action, and collect information to be used for press releases. Whenever possible, Hospital Control or Hospital Area Command shall be included in these briefings through phone and/or video conferencing.
- Provide signature authority to command positions as needed. For example, provide ordering signature authority to the Resource Unit Leader.
- When necessary or desirable, replace command personnel with new personnel, ensuring that incoming personnel are briefed by outgoing personnel. No command personnel shall remain in his or her position for longer than 12 consecutive hours or one operational period.
- Review and sign off on press releases prior to release by the Public Information Officer (PIO).

Unified Command

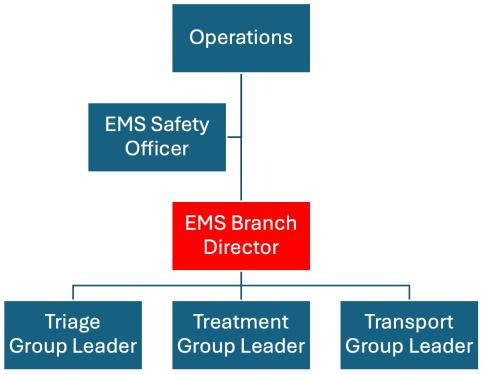
Unified Command is a team effort process, allowing all agencies with geographical or functional responsibility for an incident, to assign an Incident Commander to a Unified Command organization. The Unified Command then establishes a common set of incident objectives and strategies to which all can subscribe. Unified Command will take the place of “Incident Command” on the ICS charts. This is analogous to “command by committee.”



EMS Branch Director

The EMS Branch Director shall be appointed by Incident Command and will report to the Operations Section Chief. In the absence of this position, the EMS Branch Director will report directly to Incident Command. The EMS Branch Director is responsible for all on-scene EMS operations, including triage, treatment, and transportation of victims. *The EMS Branch Director will serve as an on-scene representative for Hospital Control and is responsible for maintaining communication with Hospital Control at all times*. At times, this communication responsibility may be delegated to a medical director or EMS coordinator who are on scene. The EMS Branch Director shall be certified to at least the Advanced EMT (AEMT) level, have completed FEMA Emergency Management Institute certification through at least the ICS-300 level, and shall be a commissioned officer of a fire or EMS department operating under this document. The EMS medical director or EMS coordinator may also fill this role as well. The EMS Branch Director is responsible to:

- Ensure the setup of all medical operations at the scene. If any setup is deemed inadequate, the EMS Branch Director may rearrange operations as he or she deems appropriate.
- Perform continuous assessment of the scene and medical operations and make any necessary adjustments.
- Maintain communications with Hospital Control and provide regular situation updates. When necessary, the EMS Branch Director shall confer with Hospital Control to resolve situations or questions that may arise, particularly involving destinations and treatment.
- Serve as the resource for relaying online medical requests. Once established, this role may be delegated to the Treatment Group Supervisor.
- Maintain communication with Hospital Control for ensuring load leveling of patients across the system. Once established, this role may be delegated to the Transportation Group Supervisor.
- Maintain control over all on-scene medical operations.
- Ensure the safety of all on-scene medical personnel. This is also the role of the EMS safety officer, if this position has been assigned.
- Appoint personnel to fill all needed command roles under the EMS Branch Director's authority.

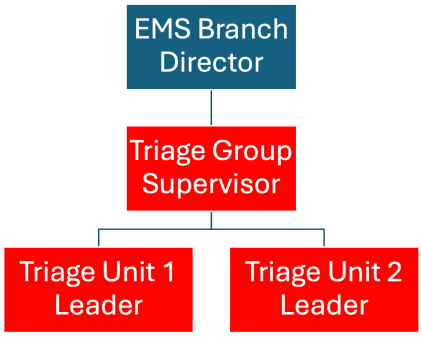


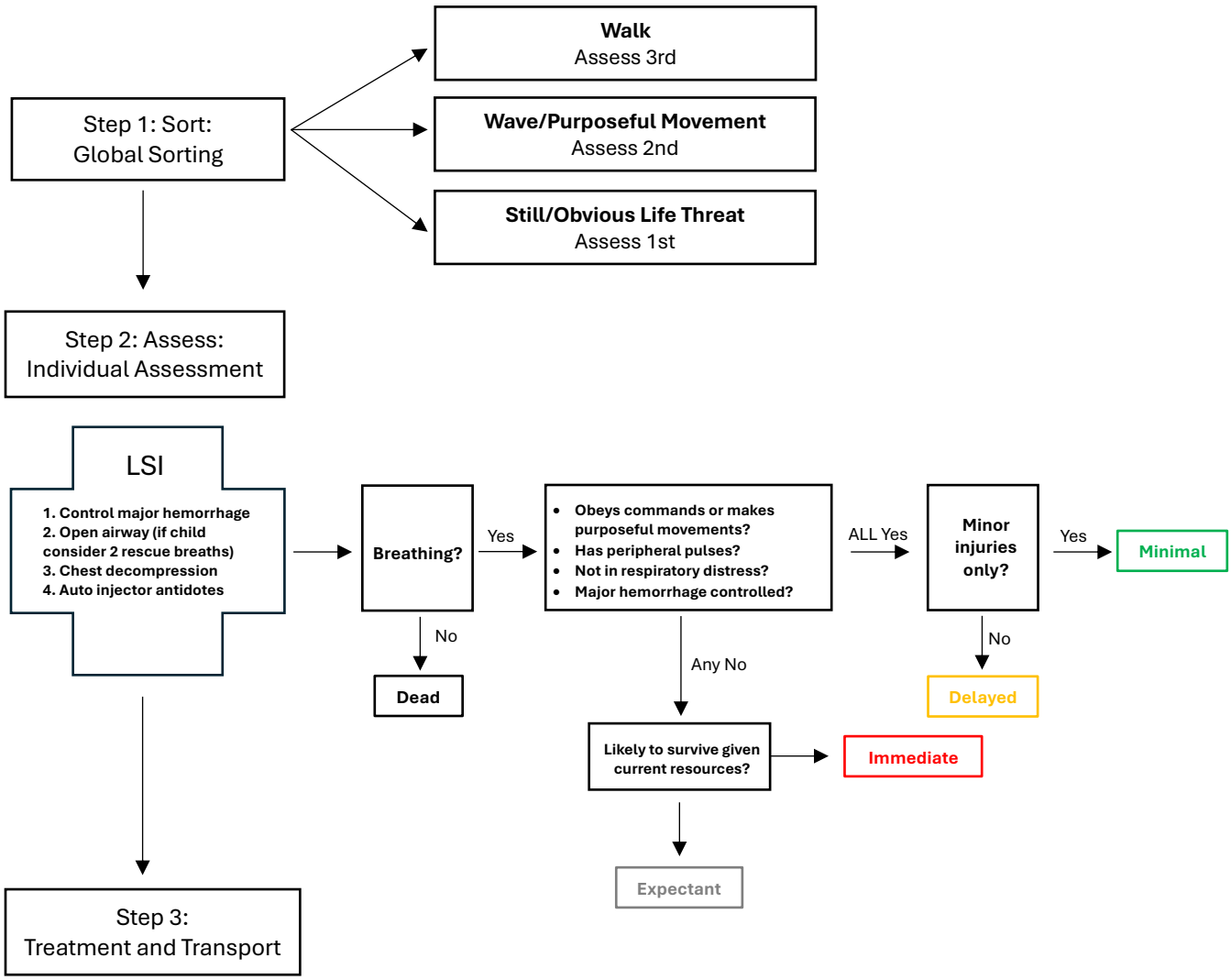
Triage Group Supervisor/Leaders

The Triage Group Supervisor, who reports to the EMS Branch Director, is responsible for overseeing the safe, rapid, and efficient triage of all injured or ill patients on the scene of a multi-casualty incident, as well as the removal of victims from the scene to the Treatment Area. If not yet begun, the Triage Group Supervisor will begin the triage process until provided with personnel to form into units. Once units are formed, each unit will have a Triage Unit Leader, who will report to the Triage Group Supervisor.

The Triage Group Supervisor is responsible to:

- Request and organize sufficient personnel and resources to handle all necessary triage functions in a reasonable amount of time.
- Initiate and manage the triage process, ensuring all patients are triaged utilizing the SALT triage algorithm.
- Ensure all patients on scene are located and triaged with triage ribbons, and that their locations are reported to the EMS Branch Director for rescue, extrication, and/or extraction.
- Ensure all patients are triaged prior to their removal from the scene to the Casualty Collection Point (CCP) or directly into a transportation vehicle for transportation.
- Coordinate, with the Treatment Group Supervisor, the removal of all triaged patients to the Casualty Collection Point (CCP) or directly into a transportation vehicle for transportation.
- Provide periodic status reports to the EMS Branch Director that include estimated number of patients, their severity, and the number of personnel currently working triage.
- Maintain security and control of the areas in which triage is being performed. This shall be done in conjunction with law enforcement.
- Maintain an accounting, and proper ratios, of triage personnel and victims.
- Ensure safety of triage personnel. This is also the role of the EMS safety officer, if this position has been assigned.
- Establish and maintain an inventory of resources and supplies.
- Maintaining contact with operations section chief or haz-mat branch director to setup decontamination strategy for casualties.
- Maintain communication, at all times, with the EMS Branch Director, Treatment Group Supervisor, and Communications Unit Leader.

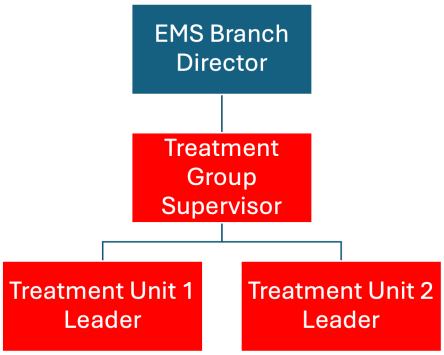



Step 1: Sort:
Global Sorting
Walk
Assess 3rd
Wave/Purposeful Movement
Assess 2nd
Still/Obvious Life Threat
Assess 1st
Step 2: Assess:
Individual Assessment
LSI
1. Control major hemorrhage
2. Open airway (if child consider 2 rescue breaths)
3. Chest decompression
4. Auto injector antidotes
Breathing?
Yes
No
Dead
Obeys commands or makes purposeful movements?
Has peripheral pulses?
Not in respiratory distress?
Major hemorrhage controlled?
ALL Yes
Any No
Minor injuries only?
Yes
Minimal
No
Delayed
Likely to survive given current resources?
Immediate
Expectant
Step 3:
Treatment and Transport

Treatment Group Supervisor/Leaders

The Treatment Group Supervisor, who reports to the EMS Branch Director, is responsible for:

- Verifying the proper triage assignment of all victims
- The provision of medical care to those victims on scene.
- The efficient use and rationing of medical supplies and personnel, inventory, and requesting of resources through the Resource Unit.
- The Treatment Group Supervisor will maintain communications with Hospital Control and will be responsible for relaying all requests from EMS personnel for online medical consultation* to Hospital Control when on-scene or online medical control consultations with the medical director are not available, including requests to administer medications and perform interventions requiring online medical approval.



*Order of medical control requests/consultations during an MCI.

Transportation Group Supervisor

The Transportation Group Supervisor, who reports to the EMS Branch Director, is responsible for ensuring safe, timely, and efficient transportation of patients from the incident scene to receiving hospitals or medical care facilities. Transportation methods may include ground ambulances, rotary-wing ambulances, fixed wing ambulances, mass transit vehicles, or other vehicles capable of transporting patients. The Transportation Group Supervisor shall work in conjunction with the Treatment Group Supervisor and Hospital Control to ensure that patients are transported according to the severity of their injuries/condition and hospital capabilities. While the Transportation Group Supervisor will ultimately determine each patient's destination, the Transportation Group Supervisor will work with the EMS Branch Director and Hospital Control to determine no hospital is overwhelmed.

Each Unit Leader shall ensure his or her group's transportation log is appropriately filled out. If any of the specific transportation unit leader positions are not filled or assigned, it will be the responsibility of the transportation group supervisor to ensure that particular unit's transportation log is appropriately filled out. For example, if there is a Ground Transportation Unit Leader, but no Air Transportation Unit Leader, the Transportation Group Supervisor shall be responsible for appropriately filling out the air transportation log.

Ground Transportation Unit Leader

The Ground Transportation Unit Leader, who reports to the Transportation Group Supervisor, shall be responsible for the requesting, accounting, and assigning of ground-based resources for patient transportation. Until this position is filled, it shall be the responsibility of the Transportation Group Supervisor. The Ground Transportation Unit Leader shall be responsible to:

- Establish staging and patient loading area(s) for ground transportation resources. The Leader will also establish a single route into and out of the loading area.
- Request additional ground transportation units, from the EMS Branch Director, as necessary.
- Maintain an accounting of ground transportation units and their patient capacity based on number and status.
- The Ground Transportation Unit Leader shall work with the Staging Area Manager in determining current and future needs. This becomes particularly important as a transport distances increase, thus, increasing turnaround time, due to overwhelming local hospital resources.
- Ensure the ground transportation log is appropriately filled out and returned at the end of the incident.

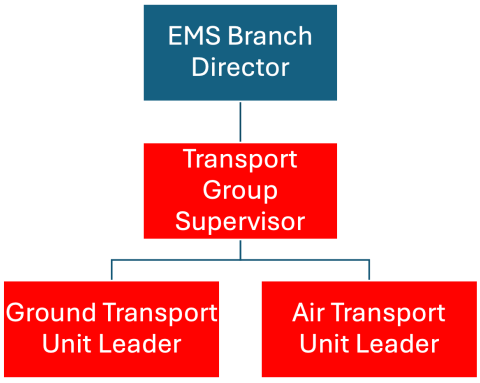
During transports, the transporting unit shall call out on the radio which patients are being transported, which triage color they have been assigned, and the destination hospital. The transportation officer, PSAP, and Hospital Control should all be monitoring the assigned EMS fireground channel.

Air Transportation Unit Leader

The Air Transportation Unit Leader, who reports to the Transportation Group Supervisor, is responsible for the request and coordination of rotary-wing ambulances and, in conjunction with the Ground Transportation Unit Leader, the coordination of ground transportation of patients to and from the landing zone of any rotary-wing ambulance.

The Air Transportation Unit Leader is responsible to:

- Request any needed air ambulance resources from the EMS Branch Director, if not already requested.
- Establish and appropriately mark landing zone(s) for air ambulances and relay the location(s) to the Ground Transportation Unit Leader, Transportation Group Supervisor, EMS Branch Director, and Incident Command.
- Coordinate the movement of patients to the landing zone(s) in conjunction with the Transportation Group Supervisor and the Ground Transportation Unit Leader.
- Establish communication with all responding air ambulances and provide them with any necessary information. At a minimum, the Air Transportation Unit Leader should provide the incident location (in GPS coordinates, if requested), radio frequency for air units, situation updates, landing zone location(s) and hazards, and brief status reports about those patients already designated for loading into each air ambulance.
- Determine the patient capacity of all air ambulances responding to the scene and relay that capacity to the Transportation Group Supervisor.
- Determine safe routes of travel for air ambulances coming to and leaving from the incident scene. Whenever possible, these routes should avoid the incident itself, as well as any Treatment Area, medical supply stockpile, and the Decontamination Area, if one is in operation.
- Hazmat risks should also be relayed to incoming air units.
- Ensure the ground transportation log is appropriately filled out and returned at the end of the incident.



Resource Unit

The Resource Unit Leader is responsible for the procurement, inventory, deployment, accountability, and demobilization of all incident scene resources, excluding communications equipment and medical transportation resources. This includes completing requests for equipment and supplies, performing initial and periodic inventories of available supplies, issuing and recollecting durable equipment, staging response resources (not including ambulances), and maintaining records of expended equipment to be forwarded to the Finance/Administration Section Chief. The Resource Unit Leader is also responsible for overseeing the rationing of expendable supplies to ensure that inventory is not wasted and that supplies are available for the duration of the incident. The Resource Unit Leader will report to the Planning Section Chief. In the absence of that position, the Resource Unit Leader will report directly to Incident Command.

All requests for equipment and supplies will be made to the Resource Unit Leader. These requests will be recorded by the Resource Unit and filled as rapidly and completely as possible. The Resource Unit is also responsible for the acquisition and distribution of command identification vests.

Staging Area Manager

The Staging Area is established by the Operations Section Chief. The Staging Area Manager is responsible for managing the staging area. The Staging Area Manager works to ensure the resources in the staging area are organized and ready to for deployment. The staging area should be close enough to the scene to allow for timely dispatch and arrival of the requested resources, yet far enough away not to interfere with ongoing operations. The Staging Area Manager reports to the Operations Section Chief and works with the Logistics Section Chief to ensure adequate resources are available to mitigate the ongoing scenario. In the absence of an Operations Section Chief, the Staging Area Manager reports directly to the Incident Commander.

Finance/Administration Unit

The Finance/Administration Section, which reports to Incident Command, is responsible for maintaining accurate financial records and controlling expenses associated with the incident. This section is also responsible for receiving, processing, and archiving all documentation completed during the incident. All documentation and reports will be submitted to the Finance/Administration Section as soon as possible after completion. Accurate documentation/accounting and timely completion of reports is essential for financial assistance during disasters.

Medical Unit

For large, IDLH, or disaster response spanning multiple days, a medical unit should be established. The medical unit will be responsible for caring for injured first responders. The medical unit will be under the command of the logistics section chief. The EMS medical director or Incident Commander will work with local hospitals to setup the medical unit. Ideally, this unit will be staffed by physicians, nurses, and paramedics. The Memorial Hospital Surgical Emergency Response Team (SERT) would be an acceptable resource to staff the medical unit.

Communications Unit

The Communications Unit Leader, who reports to the Planning Section Chief, is responsible for the establishment and maintenance of communications between all units on and off scene. The Communications Unit Leader will receive all communication resources that arrive on scene and be responsible for inventorying, issuing/deploying, and recovering all communications equipment. A standardized incident radio communications plan is already established and should be the starting point for all communications needs. Please reference those documents for initial communications plans. *Air EMS operations shall be established on BMA-4*.

Plan Implementation

Implementation of this plan shall be performed in accordance with the guidelines that follow. *This plan is only intended to regulate the medical response to mass casualty incidents*. All other on-scene actions (i.e. rescue, hazardous materials mitigation, law enforcement actions, etc.) shall be performed in accordance with the policies and guidelines established by the response agencies that cover the affected jurisdiction.

Except for the response units specifically working within this mass casualty incident guideline, all mutual aid and assistance requests shall be done in accordance with the response agencies operating guidelines and/or response cards established by the Mutual Aid Box Alarm System (MABAS), if applicable. Requests for additional local, state, and federal resources, shall be conducted through the Saint Joseph County Emergency Management Agency unless otherwise specified by a member of that agency, or by previously arranged permission.

1. Activation

   The Saint Joseph County Emergency Medical Response Plan (EMRP) may be activated at any time, based on information received from either an emergency caller, from on-scene emergency response personnel, or the emergency department based on patient arrival. There are two stages of activation: Standby and Mobilization.

   During the initial activation, the on-scene responder shall indicate a mass casualty incident is anticipated based on the number of *casualties with injuries, but who are expected to survive given the available resources*. This is only a rough estimate but will help delineate to hospital control and dispatch how large of an incident this is anticipated to be. If there is an expectation for a large number of minimal (green triaged) patients, that should be relayed to PSAP and hospital control as well. However, for the purposes of planning for medical asset needs, only those expected to be triaged as delayed (yellow), immediate (red), or expectant (grey) should be used to determine the level of activation. Additionally, while expectant (grey) triaged patients typically are not expected to survive given the available resources, they are included in the activation count as it may help bring additional assets in which would give those patients a better chance of survival. There are also special health focuses which should be relayed, if known. The activation level and special health focuses should be relayed to the response agencies during both the standby and mobilization phases. Note, if, in the opinion of the on-scene personnel, a higher level of activation is required based on the severity of the injured patients, a higher-level of activation is acceptable which will allow for additional hospitals to be notified. Hospital control will be automatically activated with the activation of this MCI plan or an EMS plan 1 or higher unless requested otherwise.

   Severity Level

EMS Size/Level	Expected patient number triaged as Yellow, Red, and Grey
Small	6-15
Large	16-25
Regional	> 25

   Special Health Focuses

   - Chemical
   - Biological
   - Radiological
   - Nuclear
   - Energetic/Explosive/Shooting

Standby

Standby is the period of time extending from the time the first emergency call is received until the completion of a size-up by arriving emergency response personnel. The goal of this period is to notify response agencies of the potential for a medical disaster/mass casualty incident and to prepare assisting agencies and Hospital Control for potential mobilization. During this period, the following actions should be completed:

- Upon receiving reliable information about a possible mass casualty incident (i.e. plane crash, multi-vehicle pile-up, large occupancy structure collapse, etc.), the St. Joseph County PSAP will contact Hospital Control to alert of an incident having the potential to require activation of the EMRP. The activation level and special health hazards should be relayed to the response agencies at this time.
- St. Joseph County PSAP will request Clay Fire CV-1 be placed on standby.
- All response agencies with county-funded mass casualty incident trailers will be notified of the event and shall prepare the trailers for response, including connecting them to their tow vehicles.
- The St. Joseph County PSAP will contact MedFlight, Samaritan, and Lutheran air ambulances and notify them of the incident and the potential for activation, to allow for pre-flight checks to be completed and GPS coordinates, if available, to be plotted. If the incident dictates a high likelihood of critically injured patients, for example a plane crash or school collapse, MedFlight shall be activated at this time and begin flight to the scene as soon as possible. If deemed necessary, other regional rotary-wing ambulances may also be mobilized. MedFlight will be kept apprised of any other rotary-wing ambulances responding. Communications with aircraft will be on BMA-4.
- SBFD Unit 1660 will be contacted and notified of the incident and the potential need for a multi-vehicle ground ambulance response as well as whole blood response.
- St. Joseph County EMS medical directors will also be notified of the potential for a mass casualty incident.
- As necessary, the St. Joseph County PSAP will notify private ambulance companies of the potential need for additional ground ambulances.
- The St. Joseph County PSAP will notify Incident Command when all notification steps have been completed.

Mobilization

The mobilization stage of the EMRP extends from the time of the first scene size-up by an emergency responder until the time the EMRP is fully activated. If possible, all standby steps should be completed prior to the beginning of the mobilization phase of the EMRP. If, based upon scene assessment, mobilization of the EMRP is deemed unnecessary, the St. Joseph County PSAP will advise all entities notified during the standby stage to stand down. During the mobilization stage, the following events should be completed:

- On-scene emergency medical personnel, after scene assessment, will notify the St. Joseph County PSAP to confirm activation of the Emergency Medical Response Plan.
- The St. Joseph County PSAP will contact Hospital Control and advise them of the activation of the EMRP. Hospital Control will be established at this time and will be the point of contact for any further communications from the St. Joseph County PSAP for communication for local/regional hospitals.
- Hospital Control will notify all St. Joseph County hospitals of the activation, as well as other hospitals and medical facilities, as necessary. If deemed necessary, this notification will include all local urgent care facilities as well.
- The St. Joseph County PSAP will transmit a message over the assigned operations frequency stating, “Attention all units: Under the authority of Incident Command, the incident at [Location] has been declared a mass casualty incident. The Emergency Medical Response Plan has been activated.”

- The St. Joseph County PSAP shall notify the St. Joseph County Emergency Management Agency (EMA) and the Red Cross of the activation of the EMRP.
- St. Joseph County PSAP to request Clay Fire CV-1 respond to the incident, as requested by incident command.
- All agencies with county-funded medical disaster response trailers will respond those vehicles to the incident, unless disregarded by incident command.
- If not already launched, MedFlight and any other needed rotary-wing ambulances shall be mobilized to the incident area, if possible.

Once the above tasks have been completed, the St. Joseph County PSAP shall contact Hospital Control, Incident Command, and the St. Joseph County EMA to inform them of the completed activation. Hospital Control will confirm at this time that their responsibilities have also been completed. **At this time, the St. Joseph County EMRP is considered fully activated.**

2. Initial Arriving Unit Responsibilities

The first arriving emergency responder – whether fire or EMS – will perform a scene size-up and report to the St. Joseph County PSAP. At a minimum, this information should include:

- Incident location.
- Type of incident.
- Approximate number and severity of the victims involved.
- Geographic size of the incident, if applicable.
- The number of scenes involved, if known.

If more than one scene is involved, the first arriving responder will stay with the first scene, and subsequent arriving units will proceed to investigate the other scenes. If the severity level (below) has not been established, this should be declared at this time.

The first arriving unit will establish Incident Command. As additional units arrive, Incident Command should be relinquished to personnel more qualified to provide Incident Command for a particular response scenario. Note that most medical disaster scenes involve multiple agencies and types of responders, so even if Incident Command is relinquished, that first arriving responder may be asked to remain at the command post as part of a unified command structure.

3. Triage

The first arriving EMS unit is responsible for initiating triage once scene safety is established. In the initial stages of response, the same unit may be responsible for Incident Command and Triage or Medical Branch Director and Triage. Once additional medical personnel become available, regardless of mode of arrival (ambulance vs. fire truck), they should be assigned to assist with ongoing triage, extraction, or assist in establishing the CCP. The goal is to triage patients based on injuries and provide rapid lifesaving aid. Triage will be performed using the *SALT Triage* algorithm for both adult patients and pediatric patients. During the triage process, only minimal medical interventions should be performed. These include:

- Life-Threatening Bleeding Control – EMS personnel may apply a pressure dressing or tourniquet to stop life-threatening bleeding from an otherwise viable patient. Commercially manufactured or military pressure dressings are recommended for this function. Tourniquets should be rapidly applied to open mangled limbs, limbs exhibiting signs of arterial bleeding, or amputated limbs. The Combat Application Tourniquet (CAT) or SOF-Tourniquet is recommended. While improvised tourniquets may be used, they have proven to be less effective and more likely to cause “pinching” tissue damage under the device.
- Airway – If a casualty is not breathing, EMS personnel performing triage should open the airway using a jaw thrust or head-tilt-chin-lift, as indicated. For a pediatric patient, two rescue breaths may also be given. If repositioning the airway is successful in restoring the

patient's breathing, the EMS practitioner may insert an OP or NP airway device to maintain the airway of an otherwise viable patient who is unable to control his/her own airway, even after being placed in the recovery position.

- Needle Decompression – Needle decompression should be performed for those casualties who are tachypneic with evidence of a pneumothorax. Patients who receive a needle decompression should be noted and extracted to the hospital or CCP expeditiously.
- Antidote Administration – Antidote administration, such as Duodote, should be administered for those exhibiting signs of nerve agent toxicity. Anticonvulsant may also be administered. See CHEMPACK section below. If there is concern for a large number of patients with organophosphate toxicity, the CHEMPACK should be requested early in the course of the event.

Patients will be triaged into one of the following five categories:

- Green "Minor" – Minor injuries that may wait for extended periods of time without comprehensive medical care, may be seen at an urgent care center for medical care, and may not necessarily require care at a hospital; some may only require treatment from on-scene EMS personnel and then can return home to follow-up with a personal physician.
- Yellow "Delayed" – Moderate injuries that may wait several hours for comprehensive medical care after receiving care from EMS personnel but will need to be evaluated and treated at a hospital or clinic prior to being released home.
- Red "Immediate" – Severe injuries that may *not* wait for any extended period prior to receiving comprehensive medical care at a hospital and will require treatment at an Emergency Department and/or surgery to mitigate serious/permanent disability or death; and acute medical conditions requiring immediate care (i.e. ACS, status asthmaticus minimally responsive to EMS treatment, GSW to chest, etc.).
- Grey "Expectant" – Death is expected given the severity of injuries and the resources currently available. Overwhelming odds against survival. However, as additional resources become available, these patients may be transported for immediate evaluation at definitive care.
- Black "Dead" – Dead/already deceased. Apneic.

To begin triage, if possible, the first arriving EMS unit will ask any casualties to move to a predetermined location – likely the developing CCP. Note, there may be more than one CCP for an incident over a large geographic area. For those casualties not able to move to the requested location, the EMS personnel performing triage will move through the casualties placing a triage ribbon onto each casualty. The appropriately colored triage ribbon will be applied to injured casualty based on the SALT triage algorithm. At this time, they become patients. If the patients are not able to be moved from the point of injury due to safety or security reasons, the room, vehicle, or location the victims remain located in should be clearly marked that it has been triaged to avoid re-triaging the same patients. This shall be done with Orange triage/marking ribbon. If feasible, once safe, the victims should be removed from the point of injury to the CCP or transported to the hospital. However, if logistically it makes more sense to leave victims at the point of injury, there should be a clear marking that victims are being left in place, and the Orange marking ribbon shall be left in place. This information shall also be relayed to incident command. As additional ambulance units are arriving on scene, those who are most critically injured (triaged red) should be transported immediately rather than being re-triaged and treated at the CCP. At no time during an MCI should an ambulance transport only one patient. Ideally, patients triaged "green" will not be transported in an ambulance. Once the arriving transport units have been exhausted, the formal CCP should be established to provide on-scene treatment until transportation can be arranged with additional incoming ambulances. EMS practitioners not on transporting units should develop the CCP. Once the patient is taken to the ambulance or the CCP, a triage tag with identifying serial number should be placed on the patient. If the patient is loaded into the ambulance prior to a triage ribbon being applied, a triage ribbon and triage tag with serial number should be applied. The triage tag with serial number will be used for

patient identification and destination tracking. The tag will also be used to record treatments, as necessary. When sufficient manpower arrives, triaged patients will be evacuated to the CCP entrance where they will be reevaluated. This is intended to verify initial triage as well as identify changes in patient condition between initial triage and arrival at the CCP. After triage at the CCP entrance, the affixed triage ribbon will be updated, as necessary. After all patients have been triaged and evacuated to the CCP, the Triage Group Supervisor and Triage Unit positions may be dissolved and personnel reassigned, as needed.

Note, in many recent mass casualty events, a large number of patients self-transported to local hospitals. If that happens, a second triage/CCP area may need to be established *at* the local hospitals. **This pre-plan is currently in development and will be added to the EMRP when finalized.**

Additionally, in larger incidents, a field hospital may need to be established.

An additional Pink marking will be used for patients who need to be decontaminated. Once the *final* decontamination is performed, the pink ribbon shall be removed.

4. Treatment

Rapid establishment of a treatment area is essential to establishing and maintaining control of the incident scene and affected victims. This will be designated as the Casualty Collection Point (CCP). However, for ease of identification for the casualties, it may also be known as the treatment area. Delaying establishment of the Treatment Area can result in confusion and an eventual loss of patient control as ambulatory triaged victims are much more likely to begin self-transportation to the hospital if there is not a clearly identified/readily available treatment area to seek care. This self-transportation can be detrimental to the operations of the emergency departments of receiving hospitals. However, as noted previously, *despite first responders' best efforts, self-transport is still likely to occur*.

As patients are triaged, they should be moved to awaiting ambulances for transport (ie, if there are ambulances waiting, the patients should be taken to the hospital via ambulance and not to the CCP). This is especially true for those triaged immediate (red) or delayed (yellow). As transport units are exhausted, patients should be moved to the CCP. Regardless of ambulance availability, patients triaged as green (minor) should be taken to the CCP and await transport. This is critically important as to assist the local hospitals in not getting overwhelmed with low acuity patients.

To quickly establish a Casualty Collection Point (CCP) and prevent patient self-transportation, the first or second arriving EMS practitioners not working on an ambulance will immediately establish the Casualty Collection Point (CCP). The CCP will be established in a location that is readily visible, within walking distance of the incident, provides safety for responders and victims, provides easy access for ground transportation pick-up, and is large enough to accommodate the number of injured or ill victims. There may be more than one CCP or treatment area depending on the geographic distribution of the incident. If weather conditions are adverse or shade cannot be provided from the sun, an indoor location should be used if available. If a structure is used, the structure should be clearly marked to identify it as the Treatment Area.

The Casualty Collection Point (CCP) should be divided into five treatment zones marked with colors corresponding to the above noted triage categories: Green, Yellow, Red, Grey, and Black. The Casualty Collection Point (CCP) should have **one entrance and one exit**, both of which are to be clearly marked. All patients will be received at the entrance, where they will be re-triaged and a triage *tag* will be applied. The patient will then be placed in the appropriate colored zone for medical care and to await transport. The "dead" (black triage ribbon) collection area should be located away from the green, yellow, red, and grey treatment areas. Note, patients initially triaged as "dead" (black triage ribbon) should *not* be moved from the point of death. The "dead" (black triage ribbon) area of the

CCP should only be used for patients initially alive and moved to the CCP where they subsequently died.

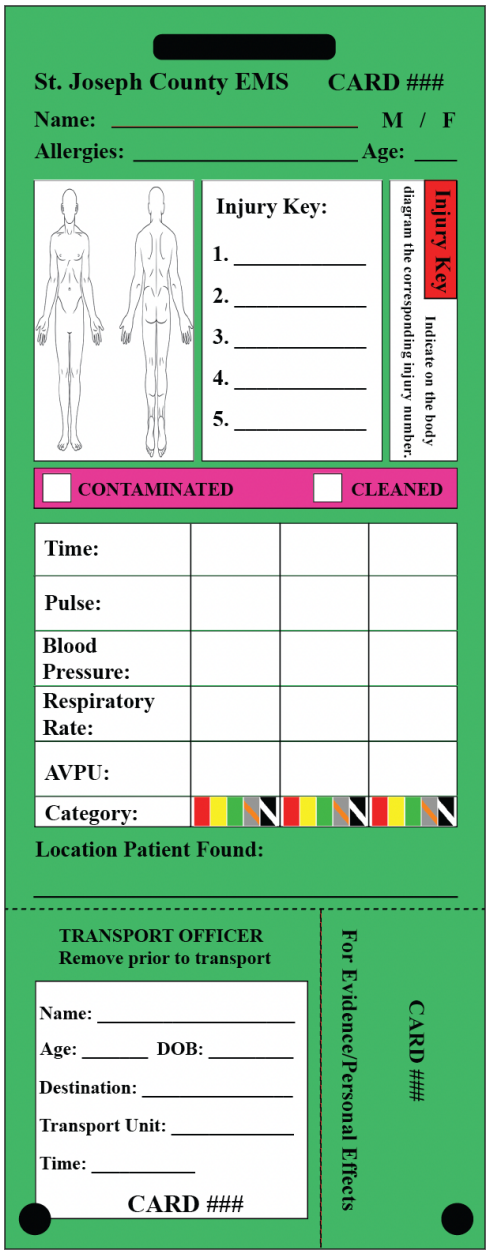
As practitioners become available, each treatment area zone will be staffed with ALS and/or BLS practitioner according to the approximate number of patients to be treated and the severity of the incident. Staffing ratio goals should follow the guidelines in the table below. Each treatment zone will have one person designated by the Treatment Group Supervisor as the Unit Leader for that zone. The Unit Leader will update the Treatment Group Supervisor on patient quantity and status every 20 minutes. Unit Leaders will also prepare lists of needed medical supplies, equipment, and resources to the Treatment Group Supervisor, who will request additional supplies through the Resource Unit. When not performing these duties, the Unit Leaders will provide medical care to patients in their zones.

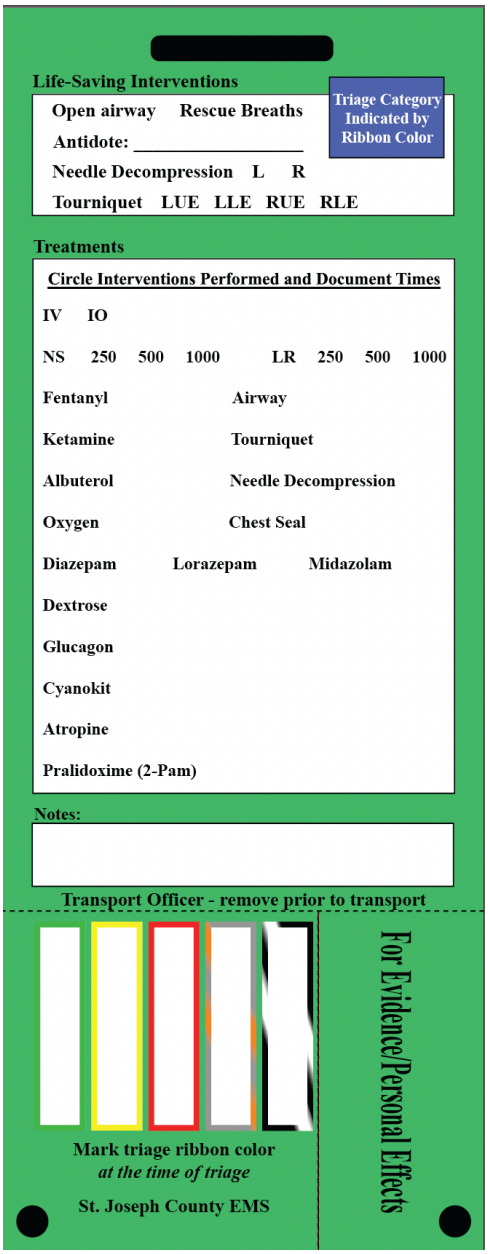
TREATMENT AREA STAFFING GOALS	
Small or Medium (15 patients or less)	
Expectant (Grey)	1 BLS practitioner/15 patients
Immediate (Red)	1 ALS and 1 BLS practitioner/3 patients 4 litter bearers
Delayed (Yellow)	1 ALS practitioner/5 patients 1 BLS practitioner/3 patients 4 litter bearers
Minor (Green)	1 BLS practitioner/10 patients
Dead (Black)	1-2 Law Enforcement Officers/10 patients

Large or Regional (16 or more)	
Expectant (Grey)	1 BLS practitioner/20 patients
Immediate (Red)	1 ALS practitioner/3 patients 1 BLS practitioner/5 patients 4 litter bearers
Delayed (Yellow)	1 ALS practitioner/10 1 BLS practitioner/5 4 litter bearers
Minor (Green)	1 BLS practitioner/15 patients
Dead (Black)	3-4 Law Enforcement Officers/15 patients

For example, a medium sized mass casualty event with 7 patients in the immediate (red) area of the CCP and 5 patients in the delayed (yellow) area of the CCP should staff the immediate (red) zone with 2 ALS and 2 BLS practitioners and the delayed (yellow) zone with 1 ALS practitioner and 1 BLS practitioners.

If any response personnel are seriously injured, they will receive immediate care and, if necessary, transportation to a receiving hospital. When time and resources allow, a *Medical Unit* shall be established to evaluate and treat response personnel. Ideally, this will include physicians, nurses, and paramedics.





Example of Triage Tags to be used during an MCI.

Green background tags (shown above) are training tags.

Blue background tags are MCI tags.

5. Transport

While transportation of patients is important, it must be done in a controlled manner to ensure that all necessary patient-tracking measures are in place, all hospitals are notified of the possibility of an impending patient surge, and all transportation resources are prepared to operate in such a way as to make the flow of traffic to and from the scene safe and efficient. In order to maintain an organized transportation process, the transportation of *isolated* green and yellow patients should be delayed until sufficient transportation resources are on scene and the Treatment Group Supervisor advises that his or her group is prepared to begin patient transportation of lower acuity patients. The exception is when patients triaged Immediate (Red) are being transported, additional lesser acute patients (those triaged yellow and green) should be transported in the same ambulance to allow for decreased scene congestion and decreased resource utilization. Trauma patients requiring immediate surgical intervention will be transported to Memorial Hospital of South Bend to receive definitive trauma care or, if their condition continues to deteriorate to the point where transportation is considered futile, be considered for re-triage to Grey. Those with isolated, non-life-threatening orthopedic injuries may be reasonable to transport to non-trauma centers. Despite technically meeting trauma criteria, while not ideal, it may be necessary to transport some critically ill (triaged red) to St. Joseph Medical Center, Beacon Granger Hospital, or other non-trauma centers for stabilization and subsequent transport back to a higher level of care as surgical resources become available. While this is not ideal, on scene resources, resource utilization, and the likelihood of survival given the situation and current resources should be taken into consideration when making the destination determination for these patients.

The Transportation Group Supervisor is responsible for assigning patients to receiving hospitals and relaying that information to Hospital Control for patient tracking. The Transportation Group Supervisor *and the transport unit* should also track all patient destinations on the EMS MCI Transportation Log. Additionally, Hospital Control shall also track patient destinations. Thus, there will be multiple redundancies to help prevent lost patients. The Treatment Group Supervisor will assign those casualties to available transportation assets. Ambulance personnel will be notified of which patients they are receiving, what the status of each patient is, and to which hospital or clinic the patients are being transported. Patients going to the same hospital should be loaded in the same transportation asset to cut down on transportation times and improve efficiency. Prior to transport, the patient shall receive a triage tag with a unique identification number. This identification number should be documented on the transport log for both the Transportation Group Supervisor or Unit leader, depending on the scale of the incident and number of transportation locations, and the transport log located within each ambulance. Hospital control should also document the patient ID and destination. The hospital shall also track all patients received by EMS on the HICS 254 form. This will allow reconciliation of all transported patients.

When ambulances leave the scene en route to the hospital, the EMS practitioner caring for the casualties or other practitioner in the ambulance will contact the Transportation officer, Hospital Control, and PSAP (all who should be monitoring the same channel) with the number of patients, the destination, triage color, and patient ID number. When en route to the hospital, EMS should give a condensed patient report to the destination hospital.

An example of proper radio report to transport/PSAP/Hospital Control is shown below:

Example: “Transport, Medic 100 is transporting 3 patients to Memorial Hospital. Patient number 1234, triaged red. Patient number 4567, triaged red. Patient 6789, triaged yellow.”

An example of proper radio report to the destination hospital is shown below:

Example: “Memorial Hospital, this is South Bend Fire Department Medic 100 enroute to your facility with three patients, all triaged red. Two have blunt trauma to the chest, one has penetrating trauma to the head. Patient 3 is the most critical and is hypotensive and tachycardic. Do you require any additional information?”

Once patients have been delivered to the hospital, transportation assets will notify the Ground/Air Transportation Unit Leader(s) that they are clear of the hospital and returning to the scene. Transportation vehicles may, in some instances, be loaded with supplies for use at the scene prior to returning to the scene. If such supplies are loaded, the ambulance should first proceed to the Resource Unit to deliver those supplies. Unless told otherwise, the ambulance will return directly to the transportation staging area or landing zone to await patient assignment.

If there are multiple patients with serious injuries and limited ambulance resources, the use of a bus, other form of mass public transportation, or other form of transportation should be considered for evacuation of such patients. Staffing levels of non-ambulance forms of transportation should be based on patient number, injury severity, urgency of evacuation, and available personnel. Staffing decisions should be made by the Ground Transportation Unit Leader in conjunction with the Transportation Group Supervisor.

If there are a large number of ambulatory patients with minor injuries, the use of a bus or other form of mass public transportation vehicle should be considered for these patients after patients with more serious injuries have been evacuated. When a public transportation vehicle is used, an individual licensed for that purpose by the State of Indiana must drive the vehicle. Preferably, the agency from which the vehicle is borrowed from will provide a driver. Vehicles used for patient transportation should be made of materials that may be easily decontaminated. Seating surfaces should be made of vinyl or plastic, and flooring should be made of rubber or vinyl. Vehicles with cloth seating or carpeted flooring is discouraged, due to the risk of staining, damage, and the potential for disease transmission.

Hospital Fixed Allotment Numbers During an MCI

Hospital ED Volume Size	Critical Patients (Red)		Non-Critical Patients (Yellow/Green)	
	Non-Trauma Center	Trauma Center	Non-Trauma Center	Trauma Center
Small (6-15 patients)				
Tier 1	2	--	10	--
Tier 2	3	6	10	10
Large (16-24)				
Tier 1	3	--	10	--
Tier 2	5	10	20	15
Regional (25+)				
Tier 1	No Limit	No Limit	No Limit	No Limit
Tier 2	No Limit	No Limit	No Limit	No Limit

A critical patient is defined as one triaged as Immediate (Red) or Delayed (Yellow), and as resources become available Expectant (Grey).

Tier 1 examples: BGH, Goshen, Bremen, Niles

Tier 2 examples: MHSB, EGH, SJRMC

Numbers can be exceeded if larger numbers of patients are taken to the same hospital in the same transportation vehicle. For example, if 25 “green” triaged patients are loaded into a bus, they can all go to the same hospital, even if it exceeds the recommended system load leveling numbers listed above.

6. Demobilization

Demobilization is the calculated process of releasing response personnel and units from the incident scene and returning them to regular service. A properly planned demobilization will return units to regular service as rapidly as possible while maintaining a complete accounting of issued resources and full re-supply of returning units.

Before the release of units is begun, Incident Command will assign personnel to establish a Demobilization Area. The Resource Unit Leader, or his or her designee, will be responsible for the establishment and operation of the Demobilization Area.

The Demobilization Area should be a central location that all response personnel must pass through prior to being released from the incident scene. The Demobilization Area should be equipped with tables, chairs, and containers for the collection of issued equipment and resources. All completed inventory logs of issued materials and equipment will be provided to the Demobilization Area personnel, in order to log the collection of those materials and equipment. The Demobilization Area should be provided with enough personnel to accomplish all necessary collection, logging, and other demobilization processes.

There are five stages to the demobilization process. These steps, in order, include:

1. Approval for demobilization by Incident Command.
2. Recording of released personnel, which should include name, agency, response unit assigned to, time of release from scene, and destination released to (i.e. home department, standby at another station, etc.).
3. Receipt and logging of all issued materials and equipment. Some examples are cellular phones, radios, gas detection equipment, and durable medical goods.
4. Determination and logging of any injuries and/or exposures to possibly harmful substances. Injured, ill, or potentially exposed personnel should be encouraged to receive medical treatment at a hospital or urgent care clinic and will not be considered released until treatment is complete or the member signs a refusal of care form. Personnel who may have been exposed to a harmful substance should have the exposure logged, submit to a full physical exam by a licensed physician as soon as possible, and undergo medical surveillance for a time period to be determined by a licensed occupational medicine physician.
5. Provision of information regarding any scheduled follow-up meetings, including upcoming critical incident stress debriefings (CISDs) and post-incident analyses. Personnel should also be provided with contact information for available counselors, religious personnel, and psychologists in case of acute grief, posttraumatic stress, or other mental health disturbances.

Mass casualty incidents are dangerous environments filled with graphic injuries, undue hardship, and the deaths of many patients, including children. While many medical care personnel are used to dealing with individual deaths, the deaths of many people in one incident are much more stressful. These images and situations will place response personnel under severe stress and will cause some level of psychological injury to all responders. In order to deal with this stress, CISDs should be held immediately after the incident, as well as one to three days after the incident. During the incident, Hospital Control will contact religious personnel, counselors, and psychiatrists/psychologists from within the hospitals and health systems who can respond to the scene and provide mental health care to all response personnel. Use of these resources is recommended and encouraged for all personnel involved in the response to an incident regulated by this plan, including on-scene, communications, hospital, and other personnel. These religious and mental health resources will remain available in the demobilization area until on-scene operations are complete, after which they will be available at the CISDs and at their regular offices.

Special Considerations

Many special situations may exist or arise when a mass casualty incident occurs. These include a hazardous materials release, continuing violent acts, or the risk of explosive devices.

Hazardous Materials

If the release of hazardous materials is reported or suspected, that release should be dealt with prior to initiating patient care. Hazardous materials responses should be mitigated in accordance with the policies and/or guidelines of the agency having jurisdiction. Agencies and response personnel should only perform mitigation actions to the level at which they are trained and equipped. Triage and removal of patients from the hot zone will only be performed by properly trained and equipped personnel. Hospital Control must be notified as soon as possible of the involvement or potential involvement of hazardous materials. Hospital control shall notify all hospitals expected to receive patients of the potential for a hazardous materials release.

Hazardous materials exposure must be considered in triaging patients who may have been in contact with the material. For example, extremely toxic materials may warrant triaging patients with confirmed exposure as "Expectant" even though their current condition might otherwise result in their triage as "Immediate" or "Delayed." All patients must be stripped of all clothing and thoroughly decontaminated prior to being sent to the Casualty Collection Point. The Treatment Group Supervisor should contact Hospital Control as soon as the hazardous material is identified. All contaminated casualties shall be tagged with a Pink triage ribbon. The pink ribbon should not be removed until a *final decontamination* has been performed.

Hospitals receiving patients who may have been exposed to hazardous materials should establish a decontamination zone outside the Emergency Department. Incoming patients will be received at this location and evaluated for contamination. Secondary decontamination will be performed as deemed necessary prior to the patient being admitted into the Emergency Department. Patients requiring a secondary decontamination should be denoted by a pink ribbon. The pink ribbon should be removed after the *final decontamination*.

Chemical Attacks and CHEMPACKs

The CHEMPACK Program is uniquely different from the Division of Strategic National Stockpile (DSNS) Push Package in that it is stockpiled closer to where it may be needed, or "forward placed." Forward placement enables emergency medical personnel to administer these life-saving drugs in the very short period of time available, which is the basis of the CHEMPACK concept. The CDC, working with the states, assists in the strategic placement of these products into cache sites selected by state, city/local officials. Sites are maintained by the CHEMPACK Program as a sustainable supply of pharmaceuticals readily available to emergency first responders and hospital emergency treatment facilities as a secondary response to supplement local supplies.

The CDC has provided Indiana with 38 CHEMPACK containers: 28 containers designated as Hospital CHEMPACKs and 10 designated as EMS CHEMPACKs. Currently, both the Hospital and EMS CHEMPACK containers have been staged throughout the 10 ISDH Districts under the oversight of a local hospital. CHEMPACKs are divided into two separate containers – a hospital container and an EMS container. However, the *hospital* container can be deployed to the *scene*, if necessary.

CHEMPACKs are intended as a secondary response after exhausting local supplies of medications. CHEMPACKs are used for the treatment of large-scale organophosphate exposures and are limited in their scope of treatment. Currently, St. Joseph County houses both a Hospital CHEMPACK and an EMS CHEMPACK. The EMS CHEMPACK contents are listed below. [2]

EMS CHEMPACK Container – Treatment Capacity 454 Patients		
	Unit Pack	**Cases per Container**
Mark 1 Auto-Injector (2mg/600mg)	240	5
Atropine Sulfate 0.4 mg/ml, 20ml	100	1
Pralidoxime 1gm/20 ml	276	1
Atropen 0.5mg	144	1
Atropen 1.0 mg	144	1
Diazepam 5 mg/ml auto-injector	150	1
Diazepam 5 mg/ml vial, 10ml	50	1
Sterile Water for Injection 20 cc vials	100	2

Memorial Hospital of South Bend houses *both* the hospital and the EMS CHEMPACK containers. The decision to open and deploy a CHEMPACK is a medically necessity decision that must be ordered by an emergency department physician, hospital pharmacist, or EMS medical director. The three following criteria must be met to open and deploy an EMS CHEMPACK:

1. A chemical/nerve agent or organophosphate has been released or is suspected as the source of contamination.
2. A threat exists to the public health of the community and the assets are needed to save human lives.
3. Local resources are anticipated to be inadequate or expanded.

To request activation of the EMS CHEMPACK container:

1. Call the EMS medical director to ask for the EMS CHEMPACK to be deployed OR
2. Call the Emergency Department of Memorial Hospital or St. Joseph Regional Medical Center to request the EMS CHEMPACK be deployed.
    a. An emergency physician or pharmacist can approve the release of the CHEMPACK.

Continuing Violent Acts

As several incidents in recent years have shown, there is a high likelihood that those committing violent acts resulting in a high number of casualties will still be performing those acts upon the arrival of emergency response personnel. When a violent act is reported, such as a mass-shooting event, only law enforcement personnel will report directly to the scene. EMS personnel will respond to a safe location away from the incident scene and standby until law enforcement personnel have secured the scene. A Fire/EMS chief shall report to the command post to establish a Unified Command with law enforcement and assign a Medical Branch Director.

If law enforcement personnel can evacuate victims from the scene, EMS personnel will establish a temporary Treatment Area in a safe location to receive evacuated patients. Law enforcement personnel will be responsible for the evacuation and search of those patients as well as their transportation to the Treatment Area. These patients will be triaged at the entrance to the Treatment Area and then sent to the proper colored treatment section. It is important to note that in an active-shooter/hostile party type scenario, law enforcement will be engaged in suspect apprehension or threat elimination, with little, if any, focus on patient care. It must be understood by all EMS responders that the law enforcement aspect of this type of event may be time consuming. If law enforcement is still focusing on patient suspect apprehension and cannot assist in triage or removing patients from the warm zone, Rescue Task Forces (RTFs) should be established.

If is important that all victims of an intentional act of violence scene be searched by law enforcement prior to entering the CCP.

Rescue Task Force (RTF)

The Rescue Task Force (RTF) model has allowed emergency medical service practitioners to render aid to victims of a shooting while still in the warm zone. This allows for faster triage, extraction, treatment, and transport of victims. The Rescue Task Force integrates both EMS and law enforcement into a single unit. Law enforcement provides security while EMS provides patient triage and extraction to a casualty collection point or ambulance. This idea differs from combat medics. EMS practitioners on a Rescue Task Force team are not armed and do not enter the hot zone. All RTF members shall don a ballistics vest and ballistics helmet or fire helmet prior to entering the warm zone.

The "Hot Zone" is defined as an area where there is a known threat to life. This includes uncontrolled areas where the active shooter could directly engage EMS and law enforcement. This zone is immediately dangerous to life and health (IDLH). EMS *shall not* enter the hot zone.

The "Warm Zone" is defined as an area where there is a minimal to moderate threat to life and safety of EMS and law enforcement. This includes areas cleared, but not yet completed secured, by law enforcement. It also includes areas isolated from the active, on-going threat. Law enforcement protection and ballistic vests are required in this zone.

The "Cold Zone" is defined as an area where there is little to no threat to EMS and law enforcement. It is safe to operate in this zone without lethal protection and ballistic vests. Ideally, in an active shooter or terrorist scenario, law enforcement protection is still available to protect EMS and fire assets caring for the victims.

EMS and law enforcement members assigned to a Rescue Task Force should be trained in RTF operations. RTF operations should be managed by unified command to ensure both law enforcement and EMS command are in agreement on the operations and objectives. RTF operations should take place in the warm zone and never in the hot zone. A CCP should be established in the cold zone, but a temporary CCP be established in the warm zone until evacuation of all patients is completed. The CCP should always have law enforcement/lethal protection.

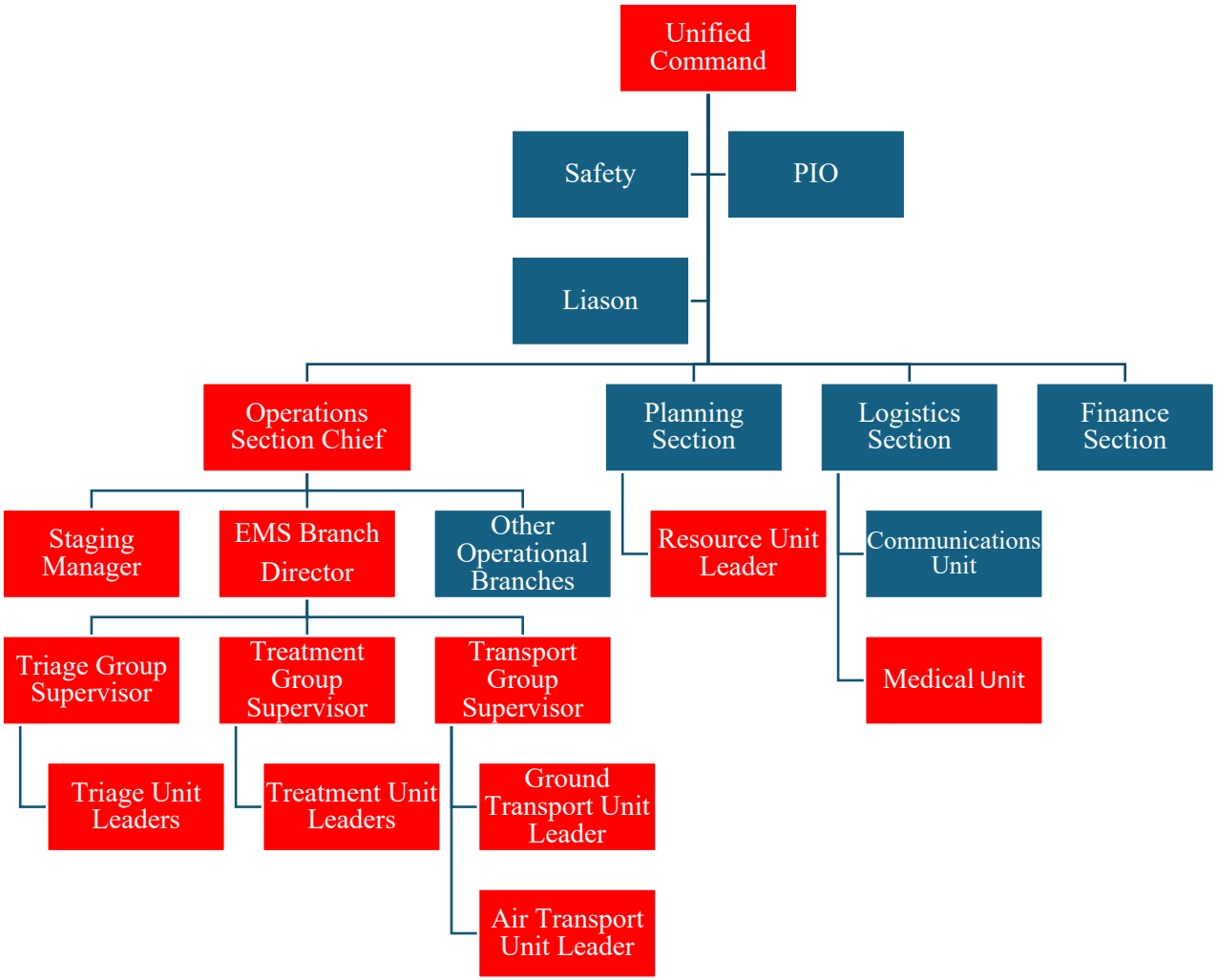
For additional RTF details, see the county-wide active shooter SOP.

Explosive Devices

Explosive devices have become more common in the commission of mass-casualty violent crimes. The use of secondary devices, particularly those targeting first responders, has also become more prominent in recent years. EMS personnel should be alert for any suspicious bags, boxes, vehicles, or any other signs of potential explosive devices. Parking lots full of vehicles, dumpsters, and bushes should be avoided whenever possible. EMS personnel should be especially alert when responding to an incident at which there has already been an explosion or where a mass-casualty violent crime has occurred.

If any potential explosive device is detected or expected, EMS personnel will immediately evacuate to a safe distance and notify law enforcement. EMS personnel will remain clear of the area until law enforcement has identified the scene as secure. Even then, EMS personnel should continue to remain vigilant for any potential device.

NIMS-Compliant Mass Casualty Scene Organization



Mass Casualty Incident Communications Job Aid

Action:	**Performed By:**
1. Activate Hospital Control a. First responding agency or hospital shall contact County PSAP and request activation of the Hospital Control system. i. If *any* EMS plan is activated, it shall automatically trigger activation of Hospital Control. b. Provide the following information, if a first responder agency: i. Agency name ii. There is an MCI as a result of _____ (shooting, bus crash, etc.) iii. Indicate the estimated number of victims. If no estimate can be made at the time, it shall default to a "medium" level or 6-15 patients. iv. Relay any additional pertinent information such as contaminants or special hazards. v. Request a fireground channel c. PSAP shall contact Beacon Transfer Center (574) 647-7777 and request Hospital Control be activated d. PSAP should instruct Hospital Control to monitor the assigned fireground channel. 2. If a hospital is the first to identify an MCI based on the casualties self-presenting, the hospital shall do the following: a. Contact St. Joseph County PSAP and indicate there is a potential MCI taking place. b. St. Joseph County PSAP will determine which first responders will be dispatched. c. PSAP shall contact Beacon Transfer Center (574) 647-7777 and request Hospital Control be activated d. PSAP should instruct Hospital Control to monitor the assigned fireground channel.	First on-scene responder aware of an MCI event or the first hospital to be aware of an MCI event based on the patients arriving
3. Hospital control will send out a mass notification via text, email, and phone to the appropriate hospitals based on the size of the incident. a. The notification shall include: i. --Mass Casualty Notification-- ii. Name of agency, if available iii. County iv. There is an MCI/Mass Casualty Incident at (location) v. This is a result of _____ vi. Estimated number of patients vii. "Please update EMResource capacity immediately" b. Expected number of "red", "yellow", and "grey" patients i. 6-15 ii. 16-25 iii. > 25	Hospital Control

Action:	**Performed By:**
4. Turn the 800 MHz radio to the appropriate county ops or specific fire ground channel as assigned for the incident.	Hospital Control
5. Announce on fire ground channel "County Fire and Incident Command, hospital control is online on fire ground (number)."	Hospital Control
6. Local hospitals should enact the internal disaster or MCI plans to prepare for patient surge, as per internal policy.	Hospitals
7. Login to EMResource.	Hospital Control
8. As needed, EMS Branch Director shall request a dedicated EMS channel for the scene. This channel shall be relayed to Hospital Control. Hospital Control shall monitor this channel and the main operations channel, if possible.	EMS Branch Director
9. Hospital Control will relay, via Everbridge, the EMS channel to all regional hospitals for monitoring. a. "EMS operations are now on (county) (channel)"	Hospital Control
10. Hospital Control shall be in contact with the EMS Branch Director or Triage Group Supervisor every 15-30 minutes or as updates are available to: a. Obtain updated casualty counts and expected number of additional casualties to be transported. b. Give update on hospital volume status. c. Discuss any ongoing or additional needs for the EMS operations. d. Discuss prior transportation numbers, expected destinations of patients, and ongoing bed availability at each receiving hospital.	Hospital Control
11. Hospital Control shall update, via Everbridge, all hospitals every 15-30 minutes on patient counts and give updates on the current situation of the incident.	Hospital Control
12. At the termination of the incident, Hospital Control shall notify, via Everbridge, all local, and regional hospitals to notify them the incident has been resolved and no additional patients will be transported from the scene.	Hospital Control

Area Hospitals

Hospital Name	Designation	Address	ED Contact Number	Travel Time – Ground / Air	Trauma Center?	Burn Center?	Pediatric Center?	Helipad?
Memorial Hospital South Bend	Local	615 N Michigan St. South Bend, Indiana	574-647-7459	4 min / 0 min	Yes – Level II	No	Yes Med/PICU	Yes
St. Joseph Health System – Mishawaka Medical Center	Local	5125 Holy Cross Pkwy Mishawaka, Indiana	574-335-1110	18 min / 4 min	No	No	Yes Med only	Yes
Beacon Granger Hospital	Local	3220 Beacon Pkwy Granger, Indiana	574-647-8788	19 min / 5 min	No	No	No	Yes
Elkhart General Hospital	Local	600 East Blvd Elkhart, Indiana	574-294-2621	31 min / 7 min	Yes – Level III	No	No	Yes
Lakeland Niles Hospital	Regional	31 N St Niles, Michigan	574-683-5510	25 min /NA	No	No	No	No
Goshen Hospital	Regional	200 High Park Ave Goshen, Indiana	574-364-1000	47 min /NA	No	No	No	No
Bremen Community Hospital	Regional	1020 High St Bremen, Indiana	574-546-2211	29 min / 9 min	No	No	No	Yes
Plymouth Hospital	Regional	1915 Lake St Plymouth, Indiana	574-948-4911	39 min / 13 min	No	No	No	Yes
Northwest Health - Laporte	Regional	1331 State St LaPorte, Indiana	219-326-1234	40 min / 13 min	No	No	No	Yes
Northwest Health - Valparaiso	Extended	85 E US Hwy 6 Valparaiso, Indiana	219-983-8311	58 min / 22 min	No	No	No	Yes
Michigan City	Extended	3500 Franciscan Way Michigan City, Indiana	219-877-1616	50 min / 27 min	No	No	No	Yes
Beacon Dowagiac	Extended	420 W High St Dowagiac, Michigan	269-782-8681	42 min / 12 min	No	No	No	Yes
Three Rivers	Extended	701 S Health Pkwy Three Rivers, Michigan	269-278-1145	55 min / 18 min	No	No	No	Yes
Bronson Methodist	Extended	601 John St Kalamazoo, Michigan	269-341-6386	1 hr 27 min / 27 min	Yes – Level I	No, but will accept burns	Yes Med/PICU	Yes
Beacon Kalamazoo	Extended	1521 Gull Rd Kalamazoo, Michigan	269-226-7000	1 hr 32 min / 28 min	Yes – Level II	No	Yes Med/PICU	Yes
Lutheran	Extended	7950 W. Jefferson Blvd Fort Wayne, Indiana	260-435-7001	1 hr 44 min / 35 min	Yes – Level II	No	Yes Med/PICU	Yes
Parkview	Extended	11109 Parkview Plaza Dr Fort Wayne, Indiana	877-774-8632	1 hr 45 min / 35 min	Yes- Level II	No	Yes Med/PICU	Yes

- "Travel Time" calculated from MHSB and are approximate times during *normal operations* with standard traffic patterns and speed.
- This information mirrors that which is required on the NIMS ICS Form 206.
- This list is not comprehensive but instead lists those hospitals regionally which would be most likely to receive patients during an MCI in our county.

Area EMS Agencies

EMS Service	City	Level of Practitioner	Transport/ Non-Transport	Local Staffed Ambulances	Ground/Air
South Bend Fire	South Bend, IN	Paramedic	Transport	7 + 3 chase	Ground
Mishawaka	Mishawaka, IN	Paramedic	Transport	4	Ground
Clay Fire Territory	South Bend, IN	Paramedic	Transport	2	Ground
Penn Fire	Mishawaka, IN	Paramedic	Transport	1	Ground
St. Joseph County FT	South Bend, IN	Paramedic	Transport	1	Ground
Liberty-Green Fire	Liberty Twp, IN	EMT	Transport	1	Ground
Notre Dame Fire	Notre Dame, IN	EMT	Non-Transport	0	Ground
Center Twp Fire	South Bend, IN	EMT	Non-Transport	0	Ground
Madison Twp Fire	Wyatt, IN	EMT	Non-Transport	0	Ground
Walkerton Fire	Walkerton, IN	EMT	Transport	1	Ground
New Carlisle Fire	New Carlisle, IN	Paramedic	Transport	1	Ground
Elkhart Fire	Elkhart, IN	Paramedic	Transport		Ground
LaPorte CO	LaPorte, IN	Paramedic	Transport		Ground
Tri-County	Bremen, IN	Paramedic	Transport		Ground
Plymouth Fire	Plymouth, IN	Paramedic	Transport		Ground
Edwardsburg Fire	Edwardsburg, MI	Paramedic	Transport		Ground
SMCAS	Niles, MI	Paramedic	Transport	4	Ground
Medic 1	St. Joseph, MI	Paramedic	Transport		Ground
Beacon Transport	South Bend, IN	Paramedic/RN	Transport		Ground
Beacon Transport	South Bend, IN	EMT	Transport		Ground
Memorial MedFlight	Elkhart, IN	Paramedic/RN	Transport	1 Helicopter	Air
Lutheran	Knox, IN	Paramedic/RN	Transport	1 Helicopter	Air
Samaritan	Rochester, IN	Paramedic/RN	Transport	1 Helicopter	Air

St. Joseph County EMS Plans

EMS Resources Dispatched				
EMS Plan 1	**EMS Plan 2**	**EMS Plan 3**	**EMS Plan 4**	**EMS Plan 5**
3 ALS Ambulances	3 Ambulances (ALS/BLS)	3 Ambulances (ALS/BLS)	3 Ambulances (ALS/BLS)	3 Ambulances (ALS/BLS)
2 Engine Companies	1 Engine Company	1 Engine Company	1 Engine Company	1 Engine Company
1 Chief	1 Chief	1 Chief	1 Chief	1 Chief
1660	CV-1			
Hospital Control Activation	St. Joseph County EMA			
EMS Resource *Totals*				
4 Ambulances	7 Ambulances	10 Ambulances	13 Ambulances (ALS/BLS)	16 Ambulances (ALS/BLS)
3 Engine Companies	4 Engine Companies	5 Engine Companies	6 Engine Company	7 Engine Company
2 Chiefs	3 Chiefs	4 Chiefs	5 Chief	6 Chief
1660	1660	1660	1660	1660
	CV-1	CV-1	CV-1	CV-1

EMS MCI Patient Transport Log

Incident Name/Location	Operational Period (#)	Page	Form Completed By:
	Date: - Time -	_____ of _____	

Triage Status	Field Triage Tag # (Last 4) Patient Name	Age Sex	Injury Type	Transport Destination	Transport Department	Transport Unit Number	Transport Time	ETA To Destination
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						
Grn Y R Gra		M F U						

Destination Abbreviations							
MHSB	Memorial Hospital South Bend	**BGH**	Beacon Granger Hospital	**CHN**	Niles	**PLY**	Plymouth
SJMMC	St. Joseph Mishawaka Med Cntr	**MC**	Michigan City	**GOSH**	Goshen	**CHB**	Bremen
EGH	Elkhart General Hospital	**TRH**	Three Rivers	**NWHLP**	LaPorte	**XXX**	Other, Specify

Hospital Incident Command System Form 254 (HICS 254)

Incident Name/Location	Operational Period (#)	Page	
	Date: - Time -	_____ of _____	

Triage Area or Specific Treatment Area:

Field Triage Tag # (Last 4)	Medical Record Number	Age / Sex	Name (Last Name, First Name)	DOB	Triage Category	Location/Procedures	Disposition/Time
		M F U					
		M F U					
		M F U					
		M F U					
		M F U					
		M F U					
		M F U					
		M F U					
		M F U					
		M F U					

Prepared By:

Print Name: _____ **Signature:** _____

Date/Time: _____ **Facility:** _____