# State of Connecticut

# The Forward Movement of Patients Plan

**The CT Department of Public Health**

**The CT Department of Emergency Management and Homeland Security**

**The Capitol Region Metropolitan Medical Response System**

**FINAL DRAFT VERSION 4.0**
**DECEMBER, 2008**

## RECORD OF CHANGES

### Revision and Distribution

This document will be reviewed annually by the Connecticut Department of Public Health. Changes in the plan will be made available on the Connecticut EMS website and also be distributed through the EMS Regional Council Offices in each of the five DEMHS regions.

Table recording distribution of “change pages”

| CHANGE NUMBER | TYPE OF CHANGE | CHANGE COMPLETED BY | DATE OF CHANGE |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## TABLE OF CONTENTS

**Introduction……** Page 1

**Assumptions……..** Page 1

**Operational Concepts……..** Page 2

**Local Action Plan……..** Page 3

**Incident Matrix……..** Page 5

**Triage, Coordination of Medical Services and Mass Care……** Page 6

**Mutual Aid Agreements……..** Page 6

**Transportation Options……..** Page 7

**Appendix A: Legal Authorities……..** Page 8

**Appendix B: JobDescriptions……..** Page 16

**Appendix C: NDMS Activation……..** Page 24

**Glossary of Terms……** Page 31

**ANNEX A: EMS Mobilization Plan……** Page 32

**ANNEX B: Burn Plan……** Page 47

A copy of the ***Statewide Forward Movement of Patients Plan*** and its annexes will be available to all Hospitals, Local Health Departments and Districts, and EMS providers in the State of Connecticut, and to those agencies and organizations assigned responsibility for the implementation of the plans.

## INTRODUCTION

In a multi- casualty incident (MCI) caused by natural or other means and involving a large number of victims, it is likely that the local healthcare system will be overwhelmed, requiring the rapid forward movement of patients to healthcare facilities in other sub-state regions or states. The State of Connecticut Forward Movement of Patients Plan (CTFMOP) addresses the medical management and the transportation of patients at the local/sub-state regional level prior to implementing the National Disaster Medical System (NDMS). CTFMOP also describes methods for the activation and implementation of the National Disaster Medical System (see Appendix A).

## ASSUMPTIONS

1. The incident and the number of casualties is of such a magnitude that the local community in which the incident occurs will need assistance from other communities or from other sub-state regions, from the State of Connecticut, or from appropriate federal agencies in order to treat and transport such casualties.
2. The US Department of Homeland Security's National Disaster Medical System (NDMS) resources will not be available immediately. Therefore, the State of Connecticut must be prepared to rely on existing transport resources and mutual aid agreements (see Local Action Plan on page 12) for the first 96 hours of an incident. The NDMS must be considered as a secondary resource for transportation of patients to definitive care outside of Connecticut during the first days of a mass casualty incident.
3. Each DEMHS region shall have determined in advance that, upon the activation of the CT Forward Movement of Patients Plan, one Coordinated Medical Emergency Direction (CMED) in each planning region shall be designated as the primary regional CMED, with responsibility for the overall coordination and management of patient transport throughout the duration of the incident.
4. The pre-designated primary sub-state regional CMED will serve as the Coordination Center for all patient transportation requirements within or out of the CT Department of Emergency Management and Homeland Security (DEMHS) planning region in which the incident occurs.
5. The sub-state Regional Emergency Operations Plan (REOP) shall have been activated, starting with a request by an appropriate official to activate the Plan, and a request for resources other than those routinely available in the region.
6. A Unified Command Structure (UCS), involving local and state decision makers, has been established.
7. All local efforts to care for patients, such as instituting plans for local and regional medical surge capacity, augmented staffing and alternative care facilities, have

been exhausted, or are expected to be exhausted, prior to utilization of the NDMS.

8. There is no contraindication (such as disease) that would preclude moving patients out of the area.
9. Under the CTFMOP Plan activation, at least the following Regional Emergency Support Functions (RESF's) shall be required to activate and to be available to assist the UCS:

| | |
|---|---|
| ESF1 Transportation | ESF6 Mass Care, Emergency Services |
| ESF2 Communications | ESF8 Public Health and Medical Services |
| ESF4 Firefighting | ESF13 Public Safety and Security |
| ESF5 Emergency Management | ESF15 External Affairs |

## OPERATIONAL CONCEPTS

### I. Stages of Severity

This plan has been developed to manage three stages of severity of a mass casualty event. These levels are defined as follows:

| | |
|---|---|
| **Stage I:** | Developing Public Health Crisis<br>0 to 100 patients |
| **Stage II:** | Public Health Disaster<br>101 to 1,000 patients |
| **Stage III:** | Catastrophic Public Health Event<br>1,001 to 10,000 or more patients |

The patient numbers associated with each stage are to be considered only as guidelines, since a particular incident may require Stage III procedures even if the number of patients is far less than 1,001.

### II. Strategies and Actions

Each stage of severity requires a different strategic response. This response is implemented through a general action plan suitable for each stage. The following is a list of strategies and general actions for each stage of severity:

| | | |
|---|---|---|
| **Stage I:** | **Developing Public Health Crisis** | 0 to 100 patients |
| | **Strategy:** | Assess needs |
| | **General Action:** | Utilize existing local /regional response structure |
| **Stage II:** | **Developing Public Health Crisis** | 101 to 1,000 patients |
| | **Strategy:** | Establish alternate response structure |

| | | |
|---|---|---|
| | **General Action:** | Augment regional resources with state assets |
| **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 resources into regional response structure |

## III. LOCAL ACTION PLAN FOR FORWARD MOVEMENT OF PATIENTS

In the event of a large-scale mass casualty event or other EMS emergency located within a DEMHS planning region, local and regional mass casualty protocols shall be placed into operation. Steps shall include:

1. In the early stages of any mass casualty emergency, patients initially shall receive care at local health care facilities utilizing the normal operating procedures of those facilities. The Commissioner of the CT Department of Public Health, or his/her designee, shall monitor the capacity of these healthcare facilities to ensure proper handling of patients and appropriate coordination with the designated primary CMED in the DEMHS region in which the incident has occurred.

2. The Medical Group Supervisor or the Medical Branch Director, as part of the established Unified Command System, shall make an appraisal of numbers of casualties, and shall advise the pre-designated primary regional CMED that casualties are anticipated to exceed the local resources available to respond. Based on information from the field, the primary designated CMED may request the activation of the CTFMOP Plan to meet the emergency.

3. CMED will notify the DEMHS Regional Coordinator and the DPH Duty Officer of the nature of the incident and that the CTFMOP plan has been activated, and advise of the potential need for federal assistance

4. CMED or the sub-state regional ESF 8 may provide *notification only* to the NDMS Regional Emergency Coordinators, or to the NDMS Operations Support Center (800 872-6367 extension 2), of the nature of the incident and that the CTFMOP plan has been activated, and advise of the potential need for federal assistance.

5. Requests for activation of the NDMS shall be the responsibility of CTDEMHS or CTDPH.

6. CMED shall coordinate the forward movement of patients (FMOP) following available local and regional plans throughout the incident, and shall participate in FMOP coordination with officials of the National Disaster Medical System.

7. A sub-state Regional Coordination Center (RCC) may be opened and staffed with the appropriate Regional Emergency Support Functions.

8. Since regional hospital bed availability is fluid and dynamic, CMED shall initiate a hospital bed availability call-down, starting locally and then moving to other sub-state regional acute care facilities.

9. CMED shall also notify the other CMED centers statewide via the MEDNET 155.340 MHZ PL 203.5, or the MEDSAT hospital communication system, to start a statewide bed availability count. If necessary, this bed count shall extend to those healthcare facilities beyond CT's borders and nearest to the CT incident location

10. Bed availability estimates shall account for bed types as well as numbers of beds available within each hospital facility, and shall include an estimate of the number of beds that can be made available through the process of early discharges, postponement of elective surgeries, and patient movement to skilled nursing facilities.

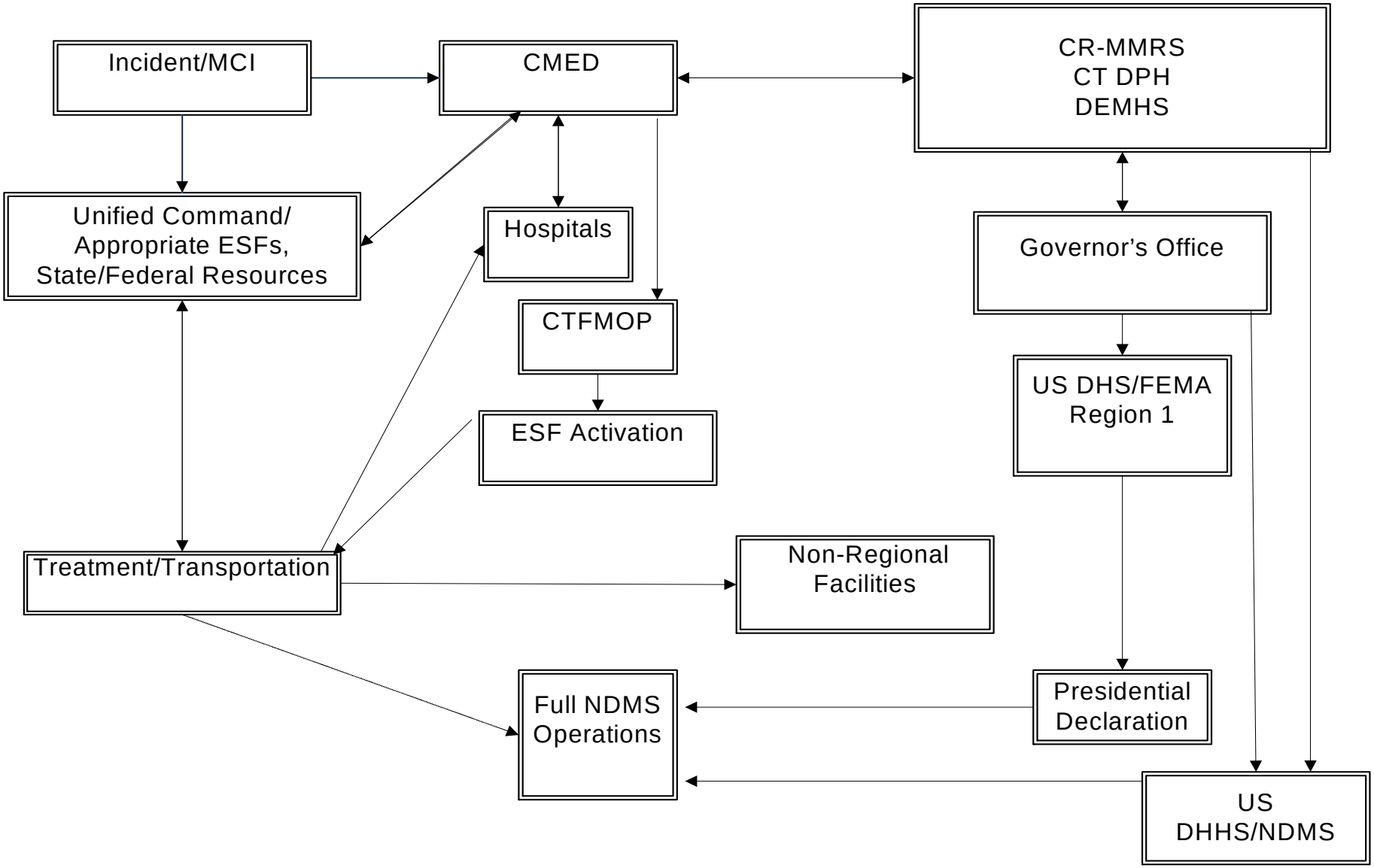
11. When contacted by CMED to advise of the occurrence of a large-scale event and to determine bed availability, each acute care hospital within the DEMHS region where the incident has occurred shall activate its incident command structure, and shall integrate with the local incident command structure as required. Hospital plans regarding surge capacity and possible relocation of hospital resources to alternative treatment sites, or field/mobile treatment sites, shall be activated as appropriate.

12. Participating hospitals and other healthcare facilities shall continue to provide frequent updates on bed availability to CMED or to CTDPH throughout the incident to ensure accurate and timely information.

13. Once the CTDPH Emergency Coordination Center (ECC) is activated and staffed, CTDPH shall coordinate a real time bed availability assessment both internal and external to the state's borders, and provide that information to the five primary designated CMED's.

14. During the event, all patient transportation requests to and from hospitals, or to alternate treatment sites or casualty collection points, shall be forwarded to the pre-designated primary CMED for resource allocation. Inter-facility movement of appropriate, non-contaminated patients shall be accomplished utilizing Advanced and Basic Life Support units assigned to the incident.

**INCIDENT MATRIX**



## IV. TRIAGE, COORDINATION OF SERVICES, AND MASS CARE

The CT Department of Public Health may request Regional Emergency Support Function 8 (RESF 8 Public Health and Medical Services) at the sub-state regional level to convene a Medical Advisory Team (MAT) that, in consultation with the CT Department of Public Health and the CT Department of Emergency Management and Homeland Security, shall advise and assist in coordinating the medical services provided by local medical care providers in the event of a sub-state regional public health emergency. These medical services shall include triage, transportation, medical services including decontamination, and mass casualty.

The Medical Advisory Team shall be designed to allow expansion and contraction of its size and make-up based on the changing nature of the mass casualty incident. Among its responsibilities, the Medical Advisory Team may make recommendations regarding:

1. On-scene safety of first responders
2. Triage of victims to determine degree of exposure and extent of illness
3. Activation of appropriate decontamination procedures, both on-scene and at hospitals and at other designated collection points
4. Implementation of appropriate infection control procedures to contain possible disease outbreaks
5. Activation of the regional plan for the transfer of victims to appropriate medical sites using appropriate medical evacuation systems to ensure patient safety
6. Coordination of the expansion of the healthcare system to meet the needs of the region
7. Coordination of the use of trauma, burn, ICU and other specialized care facilities
8. Facilitation of credentialing and distribution of medical staff to ensure adequate medical services at all participating facilities
9. Implementation of regional and state plans to activate alternative treatment and patient sheltering sites, and assurance of adequate staffing to complete the mission at those locations

## V. MUTUAL AID AGREEMENTS

1. CT Public Health Code Sec.19a-179-3(b) states that the Regional EMS Coordinator shall be responsible for coordinating planning activities related to disasters and mass casualty events and assisting in the establishment of mutual aid agreements, including the development and coordination of treatment and transportation mutual aid agreements for EMS providers within the sub-state region.

2. The CT Department of Public Health shall be the responsible authority for the creation, coordination and monitoring of inter-facility transfer mutual aid agreements to be used for the Forward Movement of Patients.

## VI. TRANSPORTATION OPTIONS

To accommodate the forward movement of patients, all appropriate modes of transportation shall be utilized as needed. Access to these alternative transportation options is available through notice to the DEMHS Regional Coordinator. Assets to be considered shall include any commercial and state-owned buses, fixed and rotor aircraft (military and commercial), commercial and private automobiles and trucks, commercial ferry service and rail (AMTRAK and Metro North Railroad).

## APPENDIX A

## LEGAL AUTHORITIES

### Chapter 368d, Sec. 19a-196b: Response to calls from other municipalities.

Each emergency medical service council and emergency medical service system shall respond to and honor calls from any municipality which participates in another emergency medical service council or emergency communication system, or which is a member of an agency which participates in such council or system.

### Chapter 517, Sec. 28-1: Definitions

(5) "Civil preparedness forces" means any organized personnel engaged in carrying out civil preparedness functions in accordance with the provisions of this chapter or any regulation or order **[**thereunder**]** adopted pursuant to this chapter. All the police and fire forces of the state or any political subdivision of the state, or any part of any political subdivision, including all the auxiliaries of these forces and emergency medical service personnel licensed or certified pursuant to section 19a-179, shall be construed to be a part of the civil preparedness forces. The Connecticut Disaster Medical Assistance Team and the Medical Reserve Corps, under the auspices of the Department of Public Health, the Connecticut Urban Search and Rescue Team, under the auspices of the Department of Emergency Management and Homeland Security, and the Connecticut Behavioral Health Regional Crisis Response Teams, under the auspices of the Department of Mental Health and Addiction Services and the Department of Children and Families, and their members, shall be construed to be a part of the civil preparedness forces while engaging in authorized civil preparedness duty or while assisting or engaging in authorized training for the purpose of eligibility for immunity from liability as provided in section 28-13 and for death, disability and injury benefits as provided in section 28-14. Any member of the civil preparedness forces who is called upon either by civil preparedness personnel or state or municipal police personnel to assist in any emergency shall be deemed to be engaging in civil preparedness duty while assisting in such emergency or while engaging in training under the auspices of the Department of Emergency Management and Homeland Security, the Department of Public Safety, the Division of State Police within the Department of Public Safety or a municipal police department, for the purpose of eligibility for death, disability and injury benefits as provided in section 28-14.

**Sec. 28-6. Mutual aid or mobile support units**.

(a) All civil preparedness units, forces, facilities, supplies and equipment in the state are deemed to be available for employment as mutual aid or mobile support. They may be ordered to duty by the Governor or state director only under the conditions defined in subsection (f) of section 28-7 or section 28-9, except that such civil preparedness units, forces, facilities, supplies and equipment may be employed in another state under the conditions specified in subsection (e) of this section.

(b) Personnel of such civil preparedness units or forces, while engaged in officially authorized civil preparedness duty, shall: (1) If they are employees of the state, have the powers, duties, rights, privileges and immunities and receive the compensation incident to their employment; (2) if they are employees of a political subdivision of the state, and whether serving within or without such political subdivision, have the powers, duties, rights, privileges and immunities and receive the compensation incident to their employment; and (3) if they are not employees of the state or a political subdivision thereof, be entitled to such compensation from the state as is determined by the Commissioner of Administrative Services under the provisions of section 4-40 and to the same rights and immunities as are provided by law for the employees of this state, provided in no instance shall such compensation be determined at a rate less than the minimum wage as determined by the Labor Commissioner. All personnel of mobile support units shall, while on duty, be subject to the operational control of the authority in charge of civil preparedness activities in the area in which they are serving.

(c) The state shall reimburse a political subdivision for the compensation paid and actual and necessary travel, subsistence and maintenance expenses of employees of the political subdivision while in training or on call by the Governor for emergency duty as members of a mobile support unit, and for all payments for death, disability or injury of such employees incurred in the course of such training or duty, and for all losses of or damage to supplies and equipment of such political subdivisions used by such mobile support units.

(d) Whenever the mobile support unit of another state renders aid pursuant to the orders of the Governor of its home state and upon the request of the Governor of this state, this state shall reimburse such other state for the compensation paid and actual and necessary travel, subsistence and maintenance expenses of the personnel of such mobile support units incurred in rendering such aid, and for all payments for death, disability or injury of such personnel incurred in rendering such aid, and for all losses of or damage to supplies and equipment of such other state or a political subdivision thereof resulting from rendering such aid, provided the laws of such other state shall contain provisions substantially similar to those of this section.

(e) No personnel of mobile support units of this state shall be ordered by the Governor to operate in any other state unless the laws of such other state contain provisions substantially similar to those of this section.

**Sec. 28-9. Civil preparedness emergency: Governor's powers.**

In the event of serious disaster, enemy attack, sabotage or other hostile action or in the event of the imminence thereof, the Governor may proclaim that a state of civil preparedness emergency exists, in which event he may personally take direct operational control of any or all parts of the civil preparedness forces and functions in the state. Any such proclamation shall be effective upon filing with the Secretary of the State. Any such proclamation, or order issued pursuant thereto, issued by the Governor because of a disaster resulting from man-made cause may be disapproved by majority vote of a joint legislative committee consisting of the president pro tempore of the Senate, the speaker of the House of Representatives and the majority and minority leaders of both houses of the General Assembly, provided at least one of the minority leaders votes for such disapproval. Such disapproval shall not be effective unless filed with the Secretary of the State within seventy-two hours of the filing of the Governor's proclamation with the Secretary of the State. As soon as possible after such proclamation, if the General Assembly is not then in session, the Governor shall meet with the president pro tempore of the Senate, the speaker of the House of Representatives, and the majority and minority leaders of both houses of the General Assembly and shall confer with them on the advisability of calling a special session of the General Assembly. Upon such proclamation, the following provisions of this section and the provisions of section 28-11 shall immediately become effective and shall continue in effect until the Governor proclaims the end of the civil preparedness emergency:

(a) The Governor is authorized and empowered to modify or suspend in whole or in part, by order as hereinafter provided, any statute, regulation or requirement or part thereof whenever in his opinion it is in conflict with the efficient and expeditious execution of civil preparedness functions. The Governor shall specify in such order the reason or reasons therefore and any statute, regulation or requirement or part thereof to be modified or suspended and the period, not exceeding six months unless sooner revoked, during which such order, modification or suspension shall be enforced. Any such order shall have the full force and effect of law upon the filing of the full text thereof in the office of the Secretary of the State. The Secretary of the State shall, within four days after receipt of the order, cause such order to be printed and published in full in at least one issue of a newspaper published in each region and having general circulation therein, but failure to publish shall not impair the validity of such order. Any statute, regulation or requirement inconsistent therewith shall be inoperative for the effective period of such order or suspension. Any such order shall be communicated by the Governor at the earliest date to both houses of the General Assembly.

(b) The Governor may order into action all or any part of the department, or local or joint organizations for civil preparedness, mobile support units or any other civil preparedness forces.

(c) The Governor shall order and enforce such blackouts and radio silences as are authorized by the United States Army or its duly designated agency and may take any other precautionary measures reasonably necessary in the light of the emergency.

(d) The Governor may designate such vehicles and persons as shall be permitted to move and the routes which they shall follow.

(e) The Governor shall take appropriate measures for protecting the health and safety of inmates of state institutions and children in schools.

(f) The Governor may order the evacuation of all or part of the population of stricken or threatened areas and may take such steps as are necessary for the receipt and care of such evacuees.

(g) The Governor may take such other steps as are reasonably necessary in the light of the emergency to protect the health, safety and welfare of the people of the state, to prevent or minimize loss or destruction of property and to minimize the effects of hostile action.

(h) In order to insure the automatic and effective operation of civil preparedness in the event of enemy attack, sabotage or other hostile action, or in the event of the imminence thereof, the Governor may, at his discretion, at any time prior to actual development of such conditions, issue such proclamations and executive orders as he deems necessary, such proclamations and orders to become effective only under such conditions.

**Sec. 28-9a. Governor's further powers.**

(a) Whenever the Governor proclaims a disaster emergency under the laws of this state, or the President declares an emergency or a major disaster to exist in this state, the Governor is authorized: (1) To enter into purchase, lease, or other arrangements with any agency of the United States for temporary housing units to be occupied by disaster victims and to make such units available to any political subdivision of the state; (2) to assist any political subdivision of this state which is the locus of such housing to acquire sites necessary for such housing and to do all things required to prepare such sites to receive and utilize such housing units by: (A) Advancing or lending funds available to the Governor from any appropriation made by the legislature, the contingency fund established by section 4-84, or from any other source, (B) "passing through" funds made available by any agency, public or private, or (C) becoming a co-partner with the

political subdivision for the execution and performance of any temporary housing for disaster victims' project and for such purposes to pledge the credit of the state on such terms as he deems appropriate, having due regard for current debt transactions of the state; (3) under such regulations as he shall prescribe, to temporarily suspend or modify for not to exceed sixty days any public health, safety, zoning, transportation or other requirement of law or regulation within this state when by proclamation he deems such suspension or modification essential to provide temporary housing for disaster victims.

(b) Any political subdivision of this state is expressly authorized to acquire, temporarily or permanently, by purchase, lease, or otherwise, sites required for installation of temporary housing units for disaster victims, and to enter into whatever arrangements, including purchase of temporary housing units and payment of transportation charges, which are necessary to prepare or equip such sites to utilize such housing units.

(c) Nothing contained in this section shall be construed to limit the Governor's authority to apply for, administer, and expend any grant, gifts, or payments in aid of disaster prevention, preparedness, response or recovery.

(d) "Major disaster", "emergency", and "temporary housing" as used in this section shall have the same meaning as the terms are defined, or used, in the Disaster Relief Act of 1974 (P.L. 93-288, 88 Stat. 143).

**Public Act No. 07-56**. **An Act Creating an Intrastate Mutual Aid System**

Be it enacted by the Senate and House of Representatives in General Assembly convened: Section 1. (NEW) (*Effective October 1, 2007*) Intrastate Mutual Aid Compact.

Article I. Purposes

This compact shall be known as the Intrastate Mutual Aid Compact and is made and entered into by and between the participating political subdivisions of this state. The purpose of this compact is to create a system of intrastate mutual aid between participating political subdivisions in the state. Each participant of this system recognizes that emergencies transcend political jurisdictional boundaries and that intergovernmental coordination is essential for the protection of lives and property and for best use of available assets. The system shall provide for mutual assistance among the participating political subdivisions in the prevention of, response to, and recovery from, any disaster that results in a declaration of a local civil preparedness emergency in a participating political subdivision, subject to that participating political subdivision's criteria for declaration. The system shall provide for mutual cooperation among the participating subdivisions in conducting disaster-related exercises, testing or training activities.

Article II. General Provisions

(1) For purposes of this compact: (A) "Participating political subdivision" means each political subdivision of the state whose legislative body has not adopted a resolution withdrawing from this compact in accordance with the provisions of this article; and (B) "chief executive officer" means the elected or appointed officer granted the authority to declare a local civil preparedness emergency by the charter or ordinance of his or her political subdivision.

(2) On and after the effective date of this act, each political subdivision within the state shall automatically be a participating member of this compact. A participating political subdivision may withdraw from this compact by adopting a resolution indicating its intent to do so. The political subdivision shall automatically be deemed to have withdrawn from this compact upon adoption of such a resolution. The chief executive officer of such political subdivision shall submit a copy of such resolution to the Commissioner of Emergency Management and Homeland Security not later than ten days after the adoption of the resolution. Nothing in this article shall preclude a participating political subdivision from entering into a supplementary mutual aid agreement with another political subdivision or affect any other inter-local municipal agreement, including any other mutual aid agreement, to which a political subdivision may be a party or become a party.

(3) In the event of a serious disaster affecting any political subdivision of the state, the chief executive officer of that political subdivision may declare a local civil preparedness emergency. The chief executive officer of such political subdivision shall notify the Commissioner of Emergency Management and Homeland Security of such declaration not later than twenty-four hours after such declaration. Such a declaration shall activate the emergency plan of operations of that political subdivision, as established under subsection (a) of section 28-7 of the general statutes, and authorize the request or furnishing of aid and assistance, including any aid and assistance provided under the intrastate mutual aid system described in this section. No immunity, rights or privileges shall be provided for any individual who self-dispatches in response to a declaration, without authorization by such individual's participating political subdivision.

Article III. Responsibilities of the Local and Joint Organizations of Participating Political Subdivisions

The participating political subdivisions shall ensure that the duties of their local or joint organizations, as described in subsection (a) of section 28-7 of the general statutes, include the following:

(1) Identifying potential hazards that could affect the participating political subdivisions using an identification system common to all participating jurisdictions;

(2) Conducting of joint planning, intelligence sharing and threat assessment development with contiguous participating political subdivisions, and conduct joint training at least biennially;

(3) Identifying and inventorying the current services, equipment, supplies, personnel and other resources related to planning, prevention, mitigation, response and recovery activities of the participating political subdivisions; and

(4) Adopting and implementing the standardized incident management system approved by the Department of Emergency Management and Homeland Security.

Article IV. Implementation

Any request for assistance made by the chief executive officer of a participating political subdivision who has declared a local civil preparedness emergency shall be made to the chief executive officers of other participating political subdivisions or their designees. Requests may be oral or in writing, and shall be reported to the Commissioner of Emergency Management and Homeland Security not later than twenty-four hours after the request. Oral requests shall be reduced to writing not later than forty-eight hours after the request.

Article V. Conditions

A participating political subdivision's obligation to provide assistance in the case of a declared local civil preparedness emergency is subject to the following conditions:

(1) A participating political subdivision shall have declared a local civil preparedness emergency;

(2) A responding participating political subdivision may withhold or recall resources to the extent it deems necessary to provide reasonable protection and services for its own jurisdiction;

(3) Personnel of a responding participating political subdivision shall continue under the command and control of their responding jurisdiction, including emergency medical treatment protocols, standard operating procedures and other protocols, but shall be under the operational control of the appropriate officials within the incident management system of the participating political subdivision receiving assistance; and

(4) Assets and equipment of a responding participating political subdivision shall continue under the control of the responding jurisdiction, but shall be under the operational control of the appropriate officials within the incident management system of the participating political subdivision receiving assistance.

Article VI. Licenses, Certificates and Permits

(1) If a person or entity holds a license, certificate or other permit issued by a participating political subdivision or the state evidencing qualification in a profession, mechanical skill or other skill, and the assistance of that person or entity is requested by a participating political subdivision, such person or entity

shall be deemed to be licensed, certified or permitted in the political subdivision requesting assistance for the duration of the declared local civil preparedness emergency, subject to any limitations and conditions as may be prescribed by the chief executive officer of the participating political subdivisions, by executive order or otherwise; or by the person or entity's sponsor hospital.

(2) The officers, members and employees of the responding political subdivision, including, but not limited to, public works, firefighting, police or other assigned personnel rendering aid or assistance pursuant to the compact and this section shall have the same duties, rights, privileges and immunities as if they were performing their duties in the responding political subdivision.

Article VII. Reimbursement

(1) Participating political subdivisions shall maintain documentation of all assets provided. In the event of federal reimbursement to a requesting political subdivision, any political subdivision providing assistance under the compact and this section shall receive its appropriate share of said reimbursement.

(2) A participating political subdivision may donate assets of any kind to a requesting participating political subdivision. Unless requested in writing, no reimbursement shall be sought by a responding political subdivision from a requesting political subdivision that has declared a local civil preparedness emergency. Any written request for reimbursement must be made not later than thirty calendar days after the response, except that notice of intent to seek reimbursement shall be given at the time the aid is rendered, or as soon as possible thereafter.

(3) Any dispute between political subdivisions regarding reimbursement shall be resolved by the parties not later than thirty days after written notice of the dispute by the party asserting noncompliance. If the dispute is not resolved within ninety days of the notice of the claim, either party may request that the dispute be resolved through arbitration. Any such arbitration shall be conducted under the commercial arbitration rules of the American Arbitration Association.

Article VIII. Liability

For the purposes of liability, all persons from a responding political subdivision under the operational control of the requesting political subdivision are deemed to be employees of the responding political subdivision. Neither the participating political subdivisions nor their employees, except in cases of willful misconduct, gross negligence or bad faith, shall be liable for the death of or injury to persons or for damage to property when complying or attempting to comply with the intrastate mutual aid system.

## APPENDIX B

### Job Descriptions

*Use in Connecticut Multi-Casualty Incident Responses*

Job Descriptions are presented for each of the following:

Medical Branch Director
Medical Group Supervisor
Triage Unit Leader and Triage Personnel
Morgue Manager
Treatment Unit Leader
Treatment Dispatch Manager
Immediate (Priority 1) Area Manager
Urgent (Priority 2) Area Manager
Delayed (Priority 3) Area Manager
Patient Transportation Unit Leader or Group Supervisor
Medical Communication Coordinator
Ambulance Coordinator
Medical Supply Coordinator

### *Medical Branch Director*

Appointed by and reports to: Operations Section Chief
Supervises: All Medical Functions

1. Review Group assignments for effectiveness of current operations and modify as needed.

2. Provide input to Operations Section Chief for the Incident Action Plan.

3. Supervise Branch activities and confer with the Safety Officer to assure safety of all personnel using effective risk analysis and management techniques.

4. Report to Operations Section Chief on Branch Activities.

5. Maintain Unit/Activity Log (ICS Form 214).

### *Medical Group Supervisor*

Appointed by and reports to: Medical Branch Director or Incident Commander
Supervises: Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader, Medical Supply Coordinator

If hazards exist, the Incident Commander may order patients evacuated, or may control hazards before allowing EMS to enter.

1. Identify the type of incident

2. Estimate the number of victims and their injuries.

3. Coordinate with the command post for site security, traffic and EMS access, including location of any staging areas.

4. Establish Medical Group with assigned personnel, request additional personnel and resources sufficient to handle the magnitude of the incident.

5. Designate Unit Leaders and Treatment Area locations as appropriate

6. Isolate Delayed Treatment Area and Morgue from Immediate and Urgent Treatment Areas.

7. Request law enforcement/coroner involvement as needed.

8. Determine amount and types of additional medical resources and supplies needed to manage the magnitude of the incident. (backboards, litters, stretchers, medical caches)

9. Ensure activation of hospital alert system via CMED with an estimate of casualties.

10. Direct and/or supervise on-scene personnel from agencies such as the coroner's office, Red Cross, law enforcement, ambulance companies, public health agencies, and hospital volunteers.

11. Identify problems and reassign resources as needed.

12. Give periodic reports to the *incident commander*

13. Maintain Unit/Activity Log (ICS 214)

***Triage Unit Leader***

Appointed by and reports to: Medical Group Supervisor or Incident Commander
Supervises: Triage Personnel, Litter Bearers, Morgue Manager

1. Develop organization sufficient to handle assignment.

2. Inform Medical Group Supervisor of resource needs.

3. Assign and supervise triage personnel.

4. Implement triage process.

5. Coordinate movement of patients from the triage area to the appropriate treatment area.

6. Give periodic classification reports to the *Medical Group Supervisor*

7. Maintain Unit/Activity Log (ICS 214)

***Triage Personnel***

Appointed by and report to: Medical Group Supervisor or Incident Commander

1. Report to designated on-scene triage location.

2. Triage and tag injured patients according to the state-mandated SMART System.

3. Color-classify patients and report classification count to Triage Unit Leader.

4. Direct movement of patients to proper treatment areas.

5. Provide appropriate basic life-saving treatment to patients prior to movement as incident conditions dictate.

6. Report classification totals to the *Triage Unit Leader*

***Morgue Manager***

Appointed by and reports to: Triage Unit Leader

1. Assess resource/supply needs and order as needed.

2. Coordinate all morgue activities.

3. Keep area off limits to all but authorized personnel.

4. Coordinate with law enforcement and assist the Coroner or Medical Examiner representative

5. Keep identity of deceased persons confidential.

6. Maintain appropriate documentation.

### *Treatment Unit Leader*

Appointed by and reports to: Medical Group Supervisor
Supervises: All Treatment Area Managers, Treatment Dispatch Manager

1. Develop organization sufficient to handle assignment.

2. Direct and supervise Treatment at Immediate, Urgent, and Delayed Treatment Areas.

3. Mark boundary lines for the red and yellow patients to be located.

4. Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.

5. Request sufficient medical caches and supplies as necessary.

6. Establish communications and coordination with Patient Transportation Unit Leader.

7. Ensure continual triage of patients throughout treatment areas.

8. Direct movement of patients to ambulance loading area(s).

9. Give periodic reports to the *Medical Group Supervisor.*

10. Maintain Unit/Activity Log (ICS Form 214).

### *Treatment Dispatch Manager*

Appointed by and reports to: Treatment Unit Leader

1. Establish communications with the Immediate, Urgent, and Delayed Treatment Managers.

2. Establish communications with the Patient Transportation Unit Leader.

3. Verify that patients are prioritized for transportation.

4. Advise the Medical Communications Coordinator of patient readiness and priority for transport.

5. Coordinate transportation of patients with Medical Communications Coordinator.

6. Assure that appropriate patient tracking information is recorded.

7. Coordinate ambulance loading with the Treatment Managers and ambulance personnel.

8. Maintain Unit/Activity Log (ICS Form 214).

***Immediate Treatment Area Manager***
*Priority 1*

Appointed by and reports to: Treatment Unit Leader

1. Request or establish medical teams as necessary.

2. Assign treatment personnel to patients received in the Immediate Treatment Area.

3. Ensure treatment of patients triaged to Immediate Treatment Area.

4. Assure that patients are prioritized for transportation.

5. Coordinate transportation of patients with Treatment Dispatch Manager.

6. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.

7. Assure that appropriate patient information is recorded.

8. Maintain Unit/Activity Log (ICS Form 214).

***Urgent Treatment Area Manager***
Priority 2

Appointed by and reports to: Treatment Unit Leader

1. Request or establish medical teams as necessary.

2. Assign treatment personnel to patients received in the Immediate Treatment Area.

3. Ensure treatment of patients triaged to Immediate Treatment Area.

4. Assure that patients are prioritized for transportation.

5. Coordinate transportation of patients with Treatment Dispatch Manager.

6. Notify Treatment Dispatch Manager of patient readiness and priority for

7. Assure that appropriate patient information is recorded.

8. Maintain Unit/Activity Log (ICS Form 214).

***Delayed Treatment Area Manager***
*Priority 3*

Appointed by and reports to: Treatment Unit Leader

1. Request or establish medical teams as necessary.

2. Assign treatment personnel to patients received in the Immediate Treatment Area.

3. Ensure treatment of patients triaged to Immediate Treatment Area.

4. Assure that patients are prioritized for transportation.

5. Coordinate transportation of patients with Treatment Dispatch Manager.

6. Notify Treatment Dispatch Manager of patient readiness and priority for transportation.

7. Assure that appropriate patient information is recorded.

8. Maintain Unit/Activity Log (ICS Form 214).

***Patient Transportation Unit Leader or Group Supervisor***

Appointed by and reports to: Medical Group Supervisor
Supervises: Medical Communications Coordinator, Ambulance Coordinator

1. Insure the establishment of communications with hospital(s).

2. Designate ambulance staging areas.

3. Direct the off-incident transportation of patients as determined by treatment need and system status.

4. Assure that patient information and destination are recorded.

5. Establish communications with Ambulance Coordinator.

6. Request additional ambulances as required.

7. Notify Ambulance Coordinator of ambulance requests.

8. Coordinate requests for air ambulance transportation through the Air Operations Branch Director if appointed.

9. Coordinate the establishment of Air Ambulance Helispots with the Medical Branch Director, Medical Group Supervisor or Air Operations Branch Director.

10. Gives periodic reports to the *Medical Group Supervisor*.

11. Maintain Unit/Activity Log (ICS Form 214).

### *Medical Communications Coordinator*

Appointed by and reports to: Patient Transportation Unit Leader or Group Supervisor

1. Establish communications with CMED for hospital alerting.

2. Determine and maintain current status of hospital/medical facility availability and capability.

3. Receive basic patient information and condition from Treatment Dispatch Manager.

4. Coordinate patient destination with CMED.

5. Communicate patient transportation needs to Ambulance Coordinators based upon requests from the Treatment Dispatch Manager.

6. Communicate patient air ambulance transportation needs to the Air Operations Branch Director or Medical Group Supervisor based on requests from the treatment area managers or Treatment Dispatch Manager.

7. Maintain appropriate records and Unit/Activity Log (ICS Form 214)

### *Ambulance Coordinator*

Appointed by and reports to: Patient Transportation Unit Leader

1. Establish appropriate staging area for ambulances.

2. Establish routes of travel for ambulances for incident operations.

3. Establish and maintain communications with the Air Operations Branch Director if assigned regarding Air Ambulance transportation assignments.

4. Establish and maintain communications with Medical Communications Coordinator and Treatment Dispatch Manager.

5. Provide ambulances upon request from the Medical Communications Coordinator.

6. Assure that necessary equipment is available in the ambulance for patient needs during transportation.

7. Establish contact with ambulance providers at the scene.

8. Request additional transportation resources as appropriate.

9. Provide an inventory of medical supplies available in the ambulance staging area for use at the scene.

10. Maintain records as required and Unit/Activity Log (ICS Form 214).

***Medical Supply Coordinator***

Appointed by and reports to: Medical Group Supervisor

1. Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group.*

2. Request additional medical supplies.*

3. Distribute medical supplies to Treatment and Triage Units.

4. Maintain Unit/Activity Log (ICS Form 214).

* If the Logistics Section were established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader.

## APPENDIX C

## ACTIVATING THE NDMS

The National Disaster Medical System (NDMS) is a response element of the Department of Health and Human Services (DHHS). In all cases, authorized officials may make notifications or initiate requests for assistance through the NDMS Regional Emergency Coordinators.

NDMS may be activated under one of several authorities, as described below. Specific procedures include:

1. The Governor of the State of Connecticut, on advice from local and state health officials, can request federal assistance under the authority of the Robert T. Stafford Disaster Relief Act and Emergency Assistance Act. In this scenario, the Governor, through the office of the FEMA Regional Director, requests a Presidential declaration of a disaster or emergency. If declared, the Presidential edict triggers a series of federal responses coordinated by FEMA. Costs for using the system under a Stafford Act declaration may be borne by the federal government, or shared with the State, as specified by the President.

2. Prior to, or in the absence of, a presidential declaration, an authorized official of the CT Department of Public Health, or of the CT Office of Emergency Management and Homeland Security, may request assistance through the NDMS Regional Emergency Coordinators. The State of Connecticut may bear the costs of using the system in this scenario, unless a Presidential declaration follows, or unless the US Department of Homeland Security waives some or all costs.

3. If military casualty levels exceed, or are expected to exceed, the capability of the DOD/VA medical care systems, the Assistant Secretary of Defense for Health Affairs may activate the NDMS. Costs are borne by the federal government.

## REQUESTING FORWARD MOVEMENT OF PATIENTS BY THE NDMS

1. A sub-state Regional Coordination Center and the State Emergency Operations Center shall be activated for an incident that warrants the use of NDMS. At the RCC, medical personnel from hospitals and other healthcare facilities, local health directors, and ESF chiefs shall interact with incident commanders in the field to coordinate the local and regional preparation for NDMS activation.

2. Upon their consensus that the incident threatens to overwhelm regional and state resources and that NDMS activation may be required to move patients

from the region, a request for NDMS assistance shall be initiated as described above.

3. The designated primary regional CMED in closest proximity to the incident shall coordinate the transport of patients to healthcare facilities within the individual region, or to an NDMS casualty collection and staging area (e.g., the Army Aviation Support Facility (AASF) located at Bradley International Airport on CT Route 75 in Windsor Locks, Connecticut), utilizing EMS assets assembled in accordance with the terms of the Connecticut EMS Mobilization Plan, private ambulance companies and other commercial and governmental resources.

4. In the event that the designated primary regional CMED in the affected region is unable to provide this service, a designated primary regional CMED from another DEMHS region or the State EOC shall perform this function.

5. Connecticut military personnel at the AASF shall direct arriving transport vehicles to the designated NDMS receiving area.

6. Patients transported by regional agencies to hospitals or to NDMS collection sites shall be tracked through their triage tags.

## PREPARATION OF PATIENTS FOR FORWARD MOVEMENT

Medical staff at individual hospitals or, if patients are being managed in the field, responding medical staff shall be responsible for implementing those measures that will ensure the safe transportation of their patients.

### *Prior to the Arrival of NDMS*

1. Prior to the arrival of the NDMS on-scene, the designated primary regional CMED shall coordinate the transport of patients to regional hospitals, to regionally established casualty collection points, or to designated NDMS staging areas (eg: Bradley Airfield), utilizing air and ground resources. Ambulance and medical transport resource personnel shall accompany patients to their destinations.

2. Operation of casualty collection points and staging areas shall be accomplished using local and regional personnel and resources for the duration of the incident.

3. In order to activate this process, upon notification by the State Emergency Operations Center, the Regional Coordination Center in the affected DEMHS Region shall deploy appropriate regional resources to establish a patient staging area at the designated location (eg: Bradley Airfield) to

ensure that each patient is stable and has the required support services to be transported safely.

- Regional assets may include but are not limited to the public and private regional Emergency Medical Services (EMS) agencies, the various Medical Reserve Corps and, upon request through the CT Department of Public Health, the CT-1 DMAT.

4. The Connecticut National Guard administration shall designate and operate the Air Receiving Center and Staging Area at Bradley to receive and dispatch air resources for patient transportation.

**When the NDMS Has Been Activated**

Upon notification of the need for federal assistance, the NDMS Regional Emergency Coordinators or other officials of US DHHS/NDMS will assess the need for activation of NDMS (and/or Federal ESF-8) to ensure timely and effective forward movement of patients out of the state. If the National Response Plan is activated by a Stafford Act declaration or under the provisions of PDD 39, an Emergency Response Team-Advance (ERT-A) or other Federal representatives may also be deployed to accurately assess regional and/or state needs.

1. Mission tasking:
    - If the National Response Framework is activated, FEMA shall establish a Joint Field Office (JFO) at an appropriate site. The F-ESF8 and NDMS Representatives assigned to the JFO shall liaise with regional and state health officials in order to coordinate and process requests for assistance in the forward movement of patients.
    - Under a Stafford Act implementation of the National Response Framework, it is the responsibility of the F-ESF8 Representative to assure that detailed tasks are issued with sufficient funds to provide appropriate authorization and to cover foreseeable costs for the activation of the NDMS, including all NDMS elements required to assure completion of the mission.
    - Tasking shall include:
        a) Authorizing the evacuation and transportation of patients
        b) Providing transportation to Federal Coordinating Center (FCC) member hospitals
        c) Paying for certain healthcare expenses
        d) Returning transferred patients to their communities, or making mortuary arrangements for transferred patients who expire.

### *When the NDMS Arrives*

1. When authorized, the NDMS Regional Emergency Coordinator or FCC Emergency Manager shall identify and establish an NDMS receiving area (e.g., Bradley Airfield) for movement of patients to other areas of the region or nation.

2. NDMS personnel shall coordinate the movement of patients from the staging areas to the available transport assets, utilizing available regional personnel whenever possible.

3. NDMS or military medical personnel shall provide care to patients through transfer to appropriate personnel at the receiving facility.

### Patient Regulation and Air Medical Operations

Upon instruction from NDMS, the Global Patient Movement Requirements Center (GPMRC) shall issue bed-reporting instructions to those Federal Coordinating Centers (FCC's) activated to meet the needs of this emergency. The GPRMC shall coordinate:

1. Patient receiving process

2. Obtaining and disseminating patient medical information

3. Acquisition of medical equipment needed for flight evacuation or other transport

4. Communication with NDMS officials regarding aero-medical missions dispatched to the disaster area and on to the FCC's

This process does not exclude the possibility that the need for evacuation could be so immediate that the rapid movement of patients would result in minimal patient information being collected prior to transport.

### FCC Patient Reception Operations

Prior to the arrival of patients, the NDMS Regional Emergency Coordinator and/or FCC Area Coordinator shall activate the area's reception plan, alert triage and administrative teams, litter bearers, patient staging teams, and transportation assets. When transferred patients are received, the FCC Area Coordinator shall notify the GPMRC of their arrival. The FCC Area Coordinator shall then further regulate and move the patients to local member hospitals.

## Coordinating the Forward Movement of Patients

Medical personnel at hospitals, airports and other treatment facilities, and incident commanders and other responders at the scene, shall interact with the sub-state Regional Coordination Center (RCC) to coordinate the forward movement of patients to regional alternative treatment sites or to the designated NDMS patient collection area(s).

The primary designated regional CMED shall monitor the status of individual hospitals and other healthcare facilities in the region, and shall determine the numbers and types of patients requiring transport from each facility, including special equipment requirements.

In conjunction with the primary designated regional CMED, the RCC shall coordinate the deployment of sub-state regional resources for transport and transfer of patients within the region. Transportation resources may include air ambulances, buses, and other resources as required by the severity of the incident.

NDMS shall coordinate the transport of patients to healthcare facilities outside of the state, or to designated NDMS patient collection areas. If the Connecticut National Guard Army Aviation Support Facility at Bradley International Airport is utilized, Connecticut National Guard personnel shall direct arriving transport vehicles to the NDMS collection area. Patients transported to hospitals outside of the region or to NDMS shall be tracked through their triage tags.

## Command and Control

Prior to the arrival of NDMS officials and concurrent with the activation of the regional resource management plan, command and control of the forward movement of patients shall rely on established local incident command procedures emphasizing a Unified Command structure to ensure sufficient input into the command process from public health, medical and emergency medical services professionals.

The State Emergency Operations Center (SEOC) shall maintain liaison with NDMS representatives, and with sub-state regional, state and federal agencies, to ensure smooth patient flow to the staging areas.

Once on-scene, designated personnel from the NDMS shall be responsible for the coordination of forward movement of patients out of the state utilizing the National Disaster Medical System.

The NDMS representatives shall provide the following functions:

1. Organization of transportation assets
2. Notification to receiving hospitals
3. Organization of personnel to staff transport assets in forward movement

4. Organization and management of supplies required for forward movement
5. Coordination with local airports for landing and staging areas

**Establishment of an Airport Staging Area**

In the event that the forward movement of patients through the NDMS is initiated, an airport staging area may be required. The following issues shall be considered when selecting a site:

1. Distance from hospitals and other healthcare facilities to the airport

2. Adequacy of space to develop staging areas

3. Ease of arrival and departure

4. Adequate ramp area to accommodate transport aircraft

5. Availability of local medical personnel and equipment to support the functions of a staging area

6. Access to security personnel to protect patients and transportation assets

The primary airport within Connecticut possessing the facilities to meet the above requirements, and to accommodate the types of aircraft most commonly used for the purpose of forwarding patients, is Bradley International Airport (BDL) in Windsor Locks, Connecticut. The military component of Bradley International Airport carries the designation “Bradley Airfield” (Lat: 41-56-20.000N, Long: 072-40-59.600W).

Other airports that may be considered for use as an alternate site for NDMS operations include:

| Airport | Location | DEMHS Region | CMED |
|---|---|---|---|
| Brainard | Hartford | 3 | North Central |
| Tweed-New Haven | New Haven | 2 | New Haven |
| Groton | Groton | 4 | Groton EOC |
| Sikorsky | Stratford | 1 | South West |
| Oxford | Oxford | 5 | North West PS |

Once tasked by the Global Patient Movement Requirements Center (GPMRC)/National Disaster Medical System (NDMS), Bradley Airfield or other designated airfield, in conjunction with the AASF, shall make available, to the extent possible, those resources required to accomplish the forward movement of patients, including but not limited to:

1. Receive aircraft and ground transport for the forward movement of patients utilizing the National Disaster Medical System (NDMS)
2. Provide and secure access into and out of the airport

3. Make available facilities to support the staging areas and to provide shelter for support personnel
4. Provide security personnel to protect patients and transportation assets

**NDMS Operations**

Upon arrival of the National Disaster Medical System assets, an NDMS Management Support Team (MST) may be established. The MST ordinarily assumes these functions:

1. Support the NDMS on-scene personnel and Disaster Medical Assistance Teams (DMATs)
2. Interface with senior regional or state public health/emergency management officials
3. Serve as the focal point for receiving, assigning and supporting other arriving component teams such as:
    - Veterinary Medical Assistance Teams (VMAT)
    - Disaster Mortuary Operational Response Teams (DMORT)
    - Other specialty teams
4. Establish Field Treatment Sites (FTS) or patient collection areas at or near the incident scene
   (*NOTE: Medical care by regional EMS and medical personnel shall continue until the patient is transferred to the NDMS )*
5. The MST/FTS Guidelines for the transfer of patients out of the region include:
    - Unstable patients (usually determined by the NDMS flight crew) shall not be transported
    - Patients who expire while at the FTS shall be moved to a designated temporary morgue under the supervision of the Disaster Mortuary Operational Response Team – DMORT
    - Patients shall not be transported prior to decontamination
    - In a hazardous chemical or biological environment, all personnel shall don appropriate personal protective equipment and follow prescribed safety precautions
    - Regional patient-tracking procedures shall be utilized until the NDMS takes custody of the patients. The American Red Cross and the NDMS FCC Emergency Manager, utilizing the assets of the NDMS, shall continue to track patients through to repatriation
    - Receiving hospitals shall provide final admission/discharge summaries to the NDMS via the FCC Emergency Manager.
    - If requested by NDMS, pharmaceutical and staffing needs at the FTS may be supported by the procedures outlined in the regional Emergency Management Plan
    - Local/regional law enforcement agencies shall be responsible for traffic control and security of the FTS

## GLOSSARY OF TERMS

| | |
|---|---|
| **CMED** | **Coordinated Medical Emergency Dispatch** |
| **CRMMRS** | **Capitol Region Metropolitan Medical Response System** |
| **CT DEMHS** | **Connecticut Department of Emergency Management and Homeland Security** |
| **CT DPH** | **Connecticut Department of Public Health** |
| **CTFMOP** | **Connecticut Forward Movement of Patients Plan** |
| **DHHS** | **US Department of Health and Human Services** |
| **DHS** | **US Department of Homeland Security** |
| **DOD** | **US Department of Defense** |
| **ESF** | **Emergency Support Function** |
| **FEMA** | **Federal Emergency Management Agency** |
| **MCI** | **Mass Casualty Incident** |
| **MEDNET** | **Connecticut Medical Radio Network** |
| **MEDSAT** | **Connecticut Medical Satellite Radio and Telephone System** |
| **NDMS** | **National Disaster Medical System** |
| **REOP** | **Regional Emergency Operations Plan** |
| **RESF 8** | **Regional Emergency Support Function 8 (Public Health and Medical)** |
| **UCS** | **Unified Command System** |
| **VA** | **United States Veterans Administration** |
| **MCBE** | **Multi-casualty Burn Event, defined as an event where the number of critically burned patients in need of stabilization and treatment following a burn incident exceed presently available or anticipated resources at Burn Centers** |

# Annex A

To the CT Forward Movement of Patients Plan

## THE STATE OF CONNECTICUT
## STATEWIDE EMS MOBILIZATION PLAN


## Connecticut Department of Public Health

**Office of Public Health Preparedness**
**October 2008**

**This page left intentionally blank**

## TABLE OF CONTENTS


| | | |
|---|---|---|
| **INTRODUCTION** | | **page 35** |
| **PURPOSE AND SCOPE** | | **page 35** |
| **ASSUMPTIONS** | | **page 35** |
| **CONCEPT OF OPERATIONS** | | **page 36** |
| **a.** | **Mass Casualty Incident - Levels of Severity** | **page 36** |
| **b.** | **Plan Activation Process** | **page 37** |
| **c.** | **Requesting EMS Mobilization Plan Activation** | **page 37** |
| **d.** | **Ambulance Strike Team / Medical Taskforce Structure** | **page 39** |
| **e.** | **Ambulance/Medical Personnel Qualifications And Training Requirements** | **page 40** |
| **f.** | **Strike Team / Taskforce Leader Qualifications, Training, and Job Responsibilities** | **page 40** |
| **g.** | **Equipment Standards/Requirements** | **page 41** |
| **h.** | **Operational Communications** | **page 42** |
| **i.** | **Demobilization** | **page 44** |
| **PRINCIPLES OF CARE** | | **page 44** |
| **a.** | **Guidelines for Delivery of Pre-Hospital Care** | **page 44** |
| **b.** | **Guidelines for Triage** | **page 45** |
| **APPENDICES** | | |
| **Event Algorithm** | | **page 46** |

## INTRODUCTION

The State of Connecticut Department of Public Health ESF-8 (Public Health and Medical Services) Annex clearly delineates the need for a coordinated, well-defined response to major emergencies and catastrophic disasters by Emergency Medical Services (EMS) resources. Newly emerging threats facing the state and nation have created significant challenges for emergency responders that may require specialized training and equipment for effective mitigation, and would best be accomplished in a well-coordinated manner.

The *CT Statewide EMS Mobilization Plan* (hereafter referred to as the "Plan") identifies a system for the rapid activation and response of EMS resources from many communities in the event of a local disaster that may overwhelm local EMS responders and their normal mutual aid resources.

## PURPOSE AND SCOPE

The purpose of the Plan is to create a practical and regionally deployable incident management system, developed to be consistent with medically acceptable standards of care, to ensure efficient mobilization of Emergency Medical Services (EMS) resources prior to the transport of large numbers of victims of a mass casualty incident (MCI) to their final destination, and maximizing the utilization of local EMS assets prior to and during transport.

EMS personnel are a critical component in any large-scale disaster response, providing medical triage, on-scene medical care, transportation to hospitals, shelter medical care, and other vital services. The Plan provides a means to systematically organize supplemental ambulances and personnel to ensure their prompt deployment to impacted local and regional jurisdictions whose resources are overwhelmed by an emergency.

The Plan is organized and managed to assure that all participants understand their roles in an operational response. The Plan strictly adheres to the established principles of the Incident Command System and is compliant with the National Incident Management System (NIMS). Through the Plan, EMS team members are thoroughly trained to fill the necessary leadership roles for successful mitigation of events. EMS teams that respond under this plan shall mobilize, respond, arrive and depart as a unit for all deployments, using an established accountability system. Movement of staff and equipment shall be authorized only by designated command authorities, and self-dispatch of resources is forbidden.

## ASSUMPTIONS

1. An organized response within the Unified Command framework and using the Incident Command System (ICS) is superior to an unorganized response.

2. Local towns shall develop and participate in a mutual aid plan that can bring up to five additional ambulances into the municipality to provide additional resources.
3. One Coordinated Emergency Medical Direction (CMED) agency has been pre-designated in each of the five DEMHS regions as the primary CMED during a disaster, and shall serve as the coordinating agent for all requests for patient movement within or out of the DEMHS region affected by the incident.
4. In the event of a declared multi-casualty event, EMS units located in any municipality within a given DEMHS region shall be under the control of the designated CMED for that region, and shall not deploy outside of the region unless so assigned by that designated CMED. The only exception to this shall be when that EMS resource is responding as part a pre-existing local mutual aid plan.
5. In preparation for incident response, the RESF 8 (Public Health and Medical Services) and the pre-designated primary CMED in each DEMHS region will work with ambulance providers to identify resources, both personnel and ambulances, to participate in the Plan for the region, and to assure that routine community coverage is not jeopardized by depletion of resources.
6. The incident and the number of casualties is of such a magnitude that a local community may require the activation of mutual aid agreements with neighboring communities and with its DEMHS region, as well as assistance from other DEMHS regions, from the State of Connecticut, or from applicable federal agencies, in order to treat and transport casualties.
7. In the first hours of a mass casualty or catastrophic event, the primary field medical response derives from the local 911 emergency medical service provider(s) and the local community's mutual aid response system.
8. A sub-state Regional Emergency Operations Plan (REOP) has been activated.
9. The CT Department of Public Health (CTDPH) and the CT Department of Emergency Management and Homeland Security (DEMHS) have been notified of the activation of the Regional Emergency Operations Plan.
10. A Unified Command Structure (UCS) involving local, regional, state, and possibly federal and military decision makers has been established.
11. The Plan assumes that the resources of the US Department of Health and Human Service's National Disaster Medical System (NDMS) are not available immediately following a mass casualty occurrence. Therefore, for the first 24-96 hours of an incident, the statewide EMS Mobilization Plan relies on existing transportation resources and mutual aid agreements developed as a part of the planning process conducted in the five planning regions designated by DEMHS.

## CONCEPT OF OPERATIONS

### a. Mass / Multi-Casualty Incident - Levels of Severity

This plan has been developed to manage three stages of severity of a multiple casualty event. The numbers associated with each stage are intended to provide a baseline for planning purposes only. The level of severity is determined by the local Incident

Commander after assessing the number of patients and the local resources available to manage these casualties. The stages of severity are defined as follows:

| | | |
|---|---|---|
| **Level I:** | Developing Mass Casualty | (0-100 patients) |
| **Level II:** | Public Health Disaster | (101-500 patients) |
| **Level III:** | Public Health Catastrophe | (>500 patients) |

### b. Plan Activation Process

Activation of the regional EMS Mobilization Plan is within the authority of the pre-designated primary regional CMED based on its assessment that local EMS resources are, or are about to be, inadequate to meet the needs of the incident, taking into account available resources and demand for service at the time of the request. Any of the following entities may request the activation of the Plan through CMED:

- Local Incident Command
- Sub-state Regional Coordinated Emergency Medical Direction (CMED)
- Local Emergency Operations Center (EOC)
- Sub-state Regional Coordination Center (RCC)
- State Emergency Operations Center (DEMHS)
- DPH Emergency Coordination Center (ECC)

### c. Requesting Assets

An EMS mobilization shall be requested by asset description, i.e., Strike Team (S/T) or Task Force (T/F). Only EMS providers in each region that have met the minimum requirements for training and equipment according to the guidelines set out in the Plan shall be asked to participate in Strike Team or Task Force deployments.

***Each designated primary regional CMED shall serve as the principal developer of the sub-state regional EMS Mobilization Plan. The regional Plan shall include the following***:

- Trigger points for activation of the Plan within the region
- Identification of strike teams and task forces
- Procedure for activation of resources
- Surge staffing plan for the CMED communications center
- Identification of communications paths for activation, command and control
- Identification of pre-planned staging and assembly areas for strike teams and task forces to meet prior to deployment to the incident site
- In the event that the region has more than one CMED, the designated CMED may jointly plan with the other CMED's to allow for the sharing of existing infrastructure and assignment of certain responsibilities in the activation and operation of this plan

***The pre-designated primary regional CMED shall have the following capabilities*:**

- At least three communications operating positions
- At least two dedicated lines to communicate with the hospitals in its region, one of which may be based on the public switched telephone network
- Two-way radio equipment operating on the CMED UHF radio system installed in the Emergency Department of each hospital in the region
- Back up two-way radio equipment on the CMED UHF radio system separate from the primary system

***The designated CMED with jurisdictional authority shall use the Statewide EMS Mobilization Plan to facilitate all requests for EMS resources.***

- Designated CMED shall notify the DEMHS Regional Coordinator of the request for EMS services
- Designated CMED shall coordinate the dispatch and tracking of requested resources within the region
- Designated CMED shall maintain an Emergency Resource Directory listing ALS and BLS transport resources, and ST/TF Leaders within their region
- Designated CMED shall request additional resources from other regional CMEDs, or from other DEMHS regions, or through the CT SEOC if activated
- Designated CMED shall follow any regional EMS notification protocols
- Designated CMED shall provide frequent current situational updates to the State Emergency Operations Center
- The CTDPH ECC/State ESF-8 (SESF-8) representative deployed to the SEOC shall relay information received from the designated CMED to the DPH ECC
- The CTDPH ECC/SESF-8 representative shall assist CMED in identifying available EMS resources and shall coordinate inter-regional response
- The State EOC shall work with other members of the State Mutual Aid System to provide additional resources

***When a request for activation of the plan has been made to the designated regional primary CMED, the following information shall be provided by the requestor:***

- Situation and current status
- Estimated number of patients requiring transport, including a breakdown by categories of patients with special needs / requirements (i.e., burn patients)
- Staging area location (GPS coordinates when available)
- Identification of special hazards if known

***When the designated regional CMED determines that the plan must be activated, the CMED shall:***

- Activate the MEDNET and MEDSAT system and provide the reason for activation and the estimated number of patients in need of transport
- Provide the types and numbers of assets required, designate the location of the staging area, and request the adjacent sub-state region(s) to activate their regional EMS Mobilization Plans

***Ambulance Strike Team (ST) /Task Force (TF) Structure***

For the purpose of this plan, a non-transporting ALS unit shall be staffed by at least one Paramedic. A non-transport BLS unit shall be staffed by at least one EMT-B. A transporting ALS ambulance shall be staffed by at least one paramedic and one EMT-B. A transporting BLS ambulance shall be staffed by at least two EMT-B personnel.

To provide standardization in equipment deployment, specific terminology has been identified to describe the types of resources that might be requested through the EMS Mobilization Plan:

Strike Team (ST): Five (5) like units, e.g. ALS ambulances, with common communications capability and an assigned Strike Team Leader. The Leader shall be in a separate vehicle for mobility, and will meet with the Team at a staging area or other designated location to coordinate their response to, and efforts during, the incident.

Task Force (TF): Five (5) units, which need not be identical, (e.g. three (3) ALS ambulances and two (2) BLS ambulances), with common communications capability and an assigned Task Force Leader. The Leader shall be in a separate vehicle for mobility, and will meet with the team at a staging area or other designated location to coordinate their response to, and efforts during, the incident.

Single Resource: An ALS or BLS ambulance, or a particular type of specialized equipment (e.g., MCI trailer) that may be requested to support the incident. A Single Resource consists of the requested equipment plus the personnel required for proper operation.

> *NOTE: The ambulance industry uses the term "type" to describe the size of the ambulance, the body style of the ambulance, or the number of patients an ambulance can carry. For clarity, it is suggested that both terms (i.e. "Type I – ALS") shall be used when ordering to avoid any confusion.*

Units assigned to an ST/TF shall report as a unit to a pre-identified assembly area within the region. Upon arrival of all component units, and establishment of leadership positions, the strike team(s) shall deploy as directed by the designated regional primary

CMED. Under most circumstances, ST/TF's shall be utilized to support the following missions as determined by the designated regional CMED, including but not limited to:

1. Provide additional EMS Transport units to supplement the 911 system
2. Provide additional EMS Transport units to respond to the scene of a mass casualty incident
3. Provide EMS Transport units to evacuate hospitals and health care facilities
4. Provide EMS Transport units to support hospital efforts to discharge patients due to an actual or anticipated influx of patients (surge)
5. Provide EMS Transport units to support the forward movement of patients to secondary or tertiary care centers best prepared to meet patient needs both within and without the State of Connecticut

*NOTE: In the absence of currently existing cross-border mutual aid agreements, requests for out-of-state deployments of EMS assets shall be managed through the State Emergency Operations Center in accordance with the terms of the Emergency Management Assistance Compact (EMAC).*

### *e. ST/TF Medical Personnel Qualifications and Training*

Minimum Training Requirements:

- Currently certified / licensed EMS provider affiliated with a service
- NIMS IS700
- ICS100 and ICS 200
- SMART Incident Command System (triage system)

Preferred Additional Training and Experience:

- WMD Awareness Course
- ICS 300
- Hazmat - First Responder Operational level, according to curriculum approved by the CT Fire Academy
- 1 year EMS experience

### *f. ST/TF Leader Qualifications, Training, and Job Responsibilities*

Minimum Training Requirements:

- Currently certified / licensed EMS provider affiliated with a service
- ICS 100, ICS 200, 300, and 700
- SMART Incident Command System (triage system)
- Hazmat qualifications set forth in NFPA 473
- Three-years' EMS experience, and at least one-year supervisory experience in EMS or related field
- WMD Awareness Course

*Note: Individuals appointed as Strike Team Leaders shall have their credentials validated by their employer*

***Team Leader Duties and Responsibilities:***

The Strike Team (ST) Leader-Ambulance is responsible for*:*

1. Prior to team deployment, determining the mission duration, special circumstances, reporting location and contact information
2. Assuring the safety and condition of the personnel and equipment
3. Coordinating the movement of the personnel and equipment traveling to and returning from an incident
4. Supervising the operational deployment of the team at the incident, as directed by the Division/Group Supervisor, Operations Section Chief, or Incident Commander
5. Maintaining familiarity with personnel and equipment operations, including assembly, response, and direct actions of the assigned units, and accounting for the team members and equipment at all times
6. Contacting appropriate Incident Command personnel with problems encountered during the incident response, including mechanical, operational, or logistical issues
7. Ensuring vehicles have adequate communications capability (see communications section)
8. Ensuring completion and submission of appropriate ICS documents for timekeeping and demobilization

*In summary, the AST/ATF Leader must have the capability and experience to manage, coordinate, and direct the actions of the ambulance crews for a wide variety of emergency situations. This includes maintaining all required records, and ensuring the logistical needs of all personnel are met during the entire period of team activation.*

### *g. Equipment Standards/Requirements*

ST/TF Ambulance

- Equipment and supplies to meet minimum vehicle standards (ALS or BLS) as identified in 19a-179-18 of the Connecticut Emergency Medical Services regulations
- Personal go-pack to accommodate up to 12-hour deployment
- Current statewide map book / GPS
- Fuel and supply purchasing resources (credit cards, cash)
- 20 Patient Care Reports (PCRs) / ePCR

- 1 SMART Triage pack
- PPE
- 2 Safety Helmets with dust-proof safety goggles
- 4 HEPA masks and 4 dust filters
- 2 Flashlights
- UHF Mobile Radio equipped to operate on all 10 CMED UHF Channels and all CTCSS tones used in the State of Connecticut, as well as all 5 State On Scene Tactical Communications Channels (STOCS), with appropriate CTCSS tones
- Communications equipment capable of communicating with ST/TF leaders and team members

ST/ TF Leader- Vehicle

- Equipment and supplies to meet minimum vehicle standards as defined under 19a-179-18 of the Connecticut Emergency Medical Services regulations
- Personal go-pack to accommodate up to 12-hour deployment
- Current statewide map book / GPS
- Fuel and supply purchasing resources (credit cards, cash)
- Communications equipment capable of communicating with the team en route and at the incident
- Cell phone, batteries and charger
- SMART Triage Command Pack
- 2 Helmets
- 2 pairs work gloves
- 2 Flashlights
- Appropriate ICS Forms
- 100 Patient Care Reports (PCRs)
- UHF Portable Radio equipped to operate on all 10 CMED UHF Channels and all CTCSS tones used in the State of Connecticut, as well as all 5 State On Scene Tactical Communications Channels (STOCS), with appropriate CTCSS tone

*NOTE: When assembling the team and the vehicles, the ST / TF Leader shall ensure that there are extra batteries, bulbs, chargers, etc. as needed for all equipment.*

### *h. Operational Communications*

There are three distinct operational communications needs for ST/TF:

- Communications to the designated CMED
- Communications in-transit

- Communications at the scene

In order to ensure smooth operations, a common communications system is required for public health and emergency medical care. The UHF radio system employed throughout the state by the various CMED centers is the ideal base to establish the communications services needed to implement this plan.

1. Mobilization shall take place on the UHF CMED radio system

2. ST/TF's shall maintain contact on the CMED UHF Radio System with their home DEMHS/DPH-designated CMED up until the time they transit into the affected region. At that time they shall use the CMED UHF radio system to communicate with the designated regional CMED in the affected area

3. ST/TF's and their component units (if resources are split) shall fall under the operational control of the designated CMED in the affected area. In effect the designated CMED becomes the dispatch center for all ST/TF's mobilized to assist that region

4. Channel assignment shall be determined by the designated CMED in the affected area

5. Where the DEMHS/DPH region has more than one CMED, the channel assignments shall be made by the CMED serving the municipality where the incident is located. This assignment must be relayed to the designated CMED for dissemination to all incoming units

6. The establishment of a direct radio link between all CMED's is critical. Either the MEDNET system using 155.340, or the Connecticut MEDSAT system, shall be used to provide direct CMED- to-CMED communications

7. Notification to the designated CMED can take place directly from the incident on the CMED radio network, or through the municipality's local dispatch center

8. State, Regional or Local EOC, State DPH, or local health department command centers may use a pre-designated, mutually acceptable communications system

9. All communications concerning patient care, numbers of patients and the determination of their destinations, shall be conducted on the UHF CMED radio networks. Each CMED shall be required to ensure that it has in place sufficient infrastructure to facilitate these communications

10. Tactical communications channels shall be identified by Incident Command and provided to ST/FT's upon their arrival at staging area

### *i. Demobilization*

Planning for demobilization is the responsibility of the local, regional or state command authority that requested the activation to ensure that an orderly, safe, and cost-effective movement of demobilized personnel and equipment from the incident scene is accomplished.

- At no time should an ST/TF crew member leave without receiving departure instructions from their ST/TF Leader
- All EMS Mobilization personnel shall receive a debriefing from the EMS Mobilization Team Leader prior to departure from the incident
- EMS Mobilization Team Leaders shall obtain necessary supplies to assure that the ambulances leave in a "state of readiness" whenever possible
- If unable to replace lost, used or damaged equipment, the EMS Mobilization Team Leader shall notify the command authority prior to leaving the incident
- The EMS Mobilization Team Leader shall return all radios and equipment on loan for the incident
- Timekeeping records shall be recorded and shall be submitted to the appropriate personnel at the incident prior to departure
- ST/TF vehicles shall be inspected for safety by the Ground Support Unit (when available) prior to departure from the Incident
- Local Incident Command shall be responsible for any required decontamination of equipment and personnel
- Local Incident Command shall notify the designated primary CMED of ambulance release time, travel route, and estimated time of arrival back at home base

## PRINCIPLES OF CARE

### *a. Guidelines for Delivery of Pre-Hospital Care*

*During a response into another Connecticut region, EMS personnel acting as part of an EMS Mobilization ST/TF may deliver care according to the following guidelines:*

- A **Paramedic** may utilize the skills and interventions for which s/he is trained and authorized according to the policies and procedures established by his/her local sponsor hospital

- **EMT-Intermediate** may utilize the skills and interventions for which s/he is trained and authorized according to the policies and procedures established by his/her local sponsor hospital

- **EMT-Basic/ MRT** personnel functioning as members of an EMS Mobilization out of their local jurisdiction are authorized to perform any skills in the Connecticut State BLS Guidelines, and any extended skills and interventions for which they are trained and authorized by their local sponsor hospital

- If the ***ST/TF Leader*** provides any medical care during the incident, s/he will utilize the skills and interventions for which s/he is trained and authorized according to the policies and procedures established by his/her accrediting local sponsor hospital

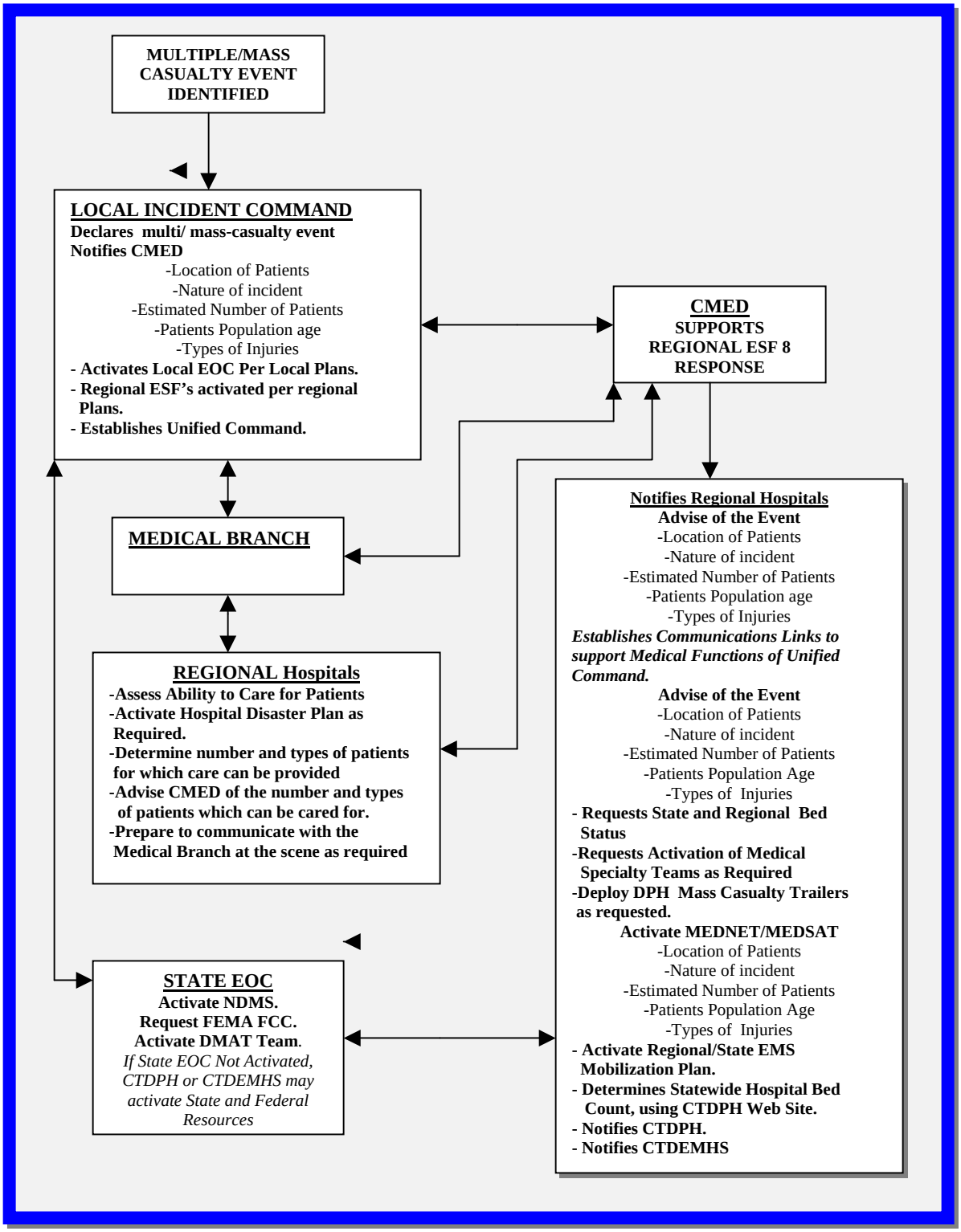
*EMS personnel may not exceed their scope of practice, or utilize medical skills and interventions they are not authorized to use by their local sponsor hospital, regardless of directions or instructions they may receive from any authority while participating in an activation of the EMS Mobilization Plan, unless specifically authorized by the CT Department of Public Health to meet the immediate needs of the incident.*

### *b. Guidelines for Triage*

- The principles of the SMART Incident Command System shall be the standard for triage and treatment used by all parties participating in a field or hospital emergency department response to a mass casualty incident in the DEMHS/DPH regions. All victims shall be tagged prior to transport using the SMART tagging system authorized by the CT Department of Public Health.

- The circumstances regarding how a person was injured, such as in instances of an explosion or coincident with a structural collapse, mandate strict adherence to trauma protocols requiring the immediate evaluation of the patient for hemorrhage and/or multi-system trauma to ensure rapid assessment, treatment and transport of these patients.

# *EVENT ALGORITHM*



# Annex B
# To the CT Forward Movement of Patients Plan

The State of Connecticut Protocol
For the Pre-Hospital Management
Of
Multiple Burn Victims

(The CT Burn Protocol)

The CT Department of Public Health

The CT Department of Emergency Management and Homeland Security

The Capitol Region Metropolitan Medical Response System

**TABLE OF CONTENTS**


| | |
|---|---|
| **INTRODUCTION** | **page 49** |
| **PURPOSE AND SCOPE** | **page 49** |
| **ASSUMPTIONS** | **page 50** |
| **CONCEPT OF OPERATIONS** | **Page 51** |
| **STRATEGIES AND ACTIONS** | **page 51** |
| **LOCAL ACTION PLAN** | **page 52** |
| **a. Coordination of Forward Movement of Patients** | **page 52** |
| **b. Coordination of Medical Services and Mass Care** | **page 54** |
| **TRANSPORTATION OPTIONS** | **page 55** |
| **INCIDENT COMMAND** | **page 55** |
| **PRINCIPLES OF CARE** | **page 57** |
| **a. Guidelines For Triage** | **page 57** |
| **b. Burn Event Algorithms** | **page 58** |
| **c. Guidelines For Medical Stabilization** | **page 61** |

## INTRODUCTION

The purpose of the State of Connecticut Protocol for the Pre-Hospital Management of Multiple Burn Victims (The CT Burn Protocol) is to create a practical and locally deployable incident management system, developed to be consistent with medically acceptable standards of care, that ensures accurate triage and medical stabilization in the field prior to and during the transport of an individual or of a large number of severely burned patients to their appropriate final destination.

## PURPOSE AND SCOPE

A *burn* is, by definition, a 'trauma' to the skin. In a "pure" burn injury, an immediate threat to life is rarely present, and burn management protocols must recognize that severe burns are uncommon. Therefore, it is important to distinguish the trauma resulting from a burn and the trauma resulting from a blunt or penetrating type of injury, as these other forms of injury may prove to be life threatening, especially hemorrhage.

The circumstances regarding how a person was burned, such as in an explosion, or coincident with a structural collapse, mandate the immediate evaluation of the patient for crush injuries or hemorrhage. In those cases, these other medical injuries take precedence in the triage process, and the burn injury becomes a secondary concern.

Triage performed in the field, at non-burn centers or at low-volume trauma centers, is prone to inaccurate evaluations of the extent, depth and total body surface area burned. Some estimates indicate that up to 90% of initial triage assessments of burn victims are later proven incorrect. It is important to note that the pathophysiology of burn injury and burn shock has a time course permissive of transport.

Simply put, *"burn victims travel well"* and are commonly sent by airplane to distant locales, especially in the Northwest region of the United States.

The acute shortage of critical care burn beds is a national phenomenon[1]. There is only one specialized burn center in Connecticut. The maximum number of critical care burn beds in Connecticut, without implementing surge capacity protocols, is eight (8) beds. At any given moment, Connecticut's burn bed capacity can easily be exceeded by a single event with numerous patients, or by simultaneous events with as few as one patient each.

Even moderate burn injuries often require at least a 2-month hospital stay, a condition for which most acute care facilities are neither adequately equipped nor sufficiently staffed.

[1]*Barillo DJ, Jordan MH, Jocz RJ et al. Tracking the Daily Availabilty of Burn Beds for National Emergencies. J Burn Care Rehabil 2005;26:174-182*

## ASSUMPTIONS

1. The State of Connecticut assumes that the resources of the US Department of Health and Human Services (DHHS), including the National Disaster Medical System (NDMS), are not available immediately following a multi-casualty occurrence. DHHS assets must be considered a secondary resource for transportation of patients to definitive care outside of Connecticut during the first hours of a multi-casualty burn incident.

2. Therefore, for the first 96 hours of an incident, the Connecticut system of response relies on existing transportation resources and mutual aid agreements developed through the five designated emergency preparedness regions established in 2005 by the CT Department of Emergency Management and Homeland Security (DEMHS).

3. Efficient and accurate medical triage by knowledgeable health professionals is integral to the achievement of best outcomes.

4. Sophisticated resources for the expert management of burn patients are found in burn centers.

5. Burn center expertise in the interdisciplinary needs of these victims warrants the development of a pragmatic protocol for the primary triage of these victims that includes on-scene or near-scene medical stabilization prior to transport to recognized burn centers.

6. The incident and the number of casualties may be of such a magnitude that local communities require assistance from other regions, from the State of Connecticut, and from applicable federal agencies in order to successfully manage and transport such casualties.

7. A Unified Command System (UCS) involving local, state, and possibly federal and military decision makers has been established.

8. The Coordinated Medical Emergency Direction (CMED) in whose jurisdiction the incident is located is the primary agency responsible for all patient transportation requirements within or out of the incident site.

9. The National Disaster Medical System has been alerted through the CRMMRS, the CT Department of Public Health, or the CT Office of Emergency Management. The responsible agency shall notify NDMS as early in the event as possible of the potential need for federal assistance.

10. There is no contraindication (such as a disease vector) that would preclude moving patients from the area to burn care centers away from the region.

## OPERATIONAL CONCEPTS

### a. Stages of Severity

These concepts of operation are based upon the assumption that fully 75% of all burn beds available nationally are occupied at any given time[1]. Therefore, the Incident Command System must alter command decisions based on the receipt of accurate and timely information on regional and national burn bed availability, and on access to a variety of transportation resources.

This plan has been developed to manage three stages of severity of a multi-casualty event involving burn victims. The level of severity is determined by the local Incident Command System after assessing the number of patients and the local resources available to manage these casualties. The stages of severity are defined as follows:

**Stage I:** Developing Public Health Crisis (2-8 burn patients)

**Stage II:** Public Health Disaster (9-15 burn patients)

**Stage III:** Catastrophic Public Health Event (16+ burn patients)

## STRATEGIES AND ACTIONS

Each stage of severity requires a different strategic response. This response is implemented through a general action plan suitable for each stage. The following is a list of strategies and general actions for each stage of severity:

**Stage I: Burn-Related Casualty Incident (Local Response)**

**Strategy:** Assess needs and establish command

**General Action:** Needs assessed, command established, local protocols activated. Care and treatment provided by local/regional healthcare facilities. Local Incident Command or CMED may request the activation of the CT Burn Protocol

**Stage II: Public Health Disaster (Regional Response)**

**Strategy:** Activate regional resources and establish Regional Coordination Center (RCC) if called for in the regional response plan

**General Action:** Unified Command established at Medical Operations sites. Augment local resources with regional and state assets through regional resource management plan. CT Burn Protocol activated

**Stage III: Catastrophic Public Health Event (National Response)**

**Strategy:** Utilize all available federal and state resources

**General Action:** Unified Command requests federal response and integrates federal resources into regional structure

## LOCAL ACTION PLAN FOR FORWARD MOVEMENT

The CT Burn Protocol establishes a system to provide for on-scene or near-scene triage, on-scene medical stabilization, and transport of patients to appropriate burn centers. In the event of a burn-related multi-casualty incident located within the State of Connecticut, local and regional multi-casualty protocols shall be placed into operation as requested by local incident command. Steps shall include:

- The local Incident Command shall make an appraisal of numbers and types of casualties, and shall advise Coordinated Medical Emergency Direction (CMED) that an activation of the regional resource management plan is required to meet the emergency, and shall advise appropriate agencies in accordance with the regional plan of the regional resources required to meet the emergency.
- The Regional Emergency Planning Team (REPT) in each DEMHS region, as authorized by DEMHS, shall have determined in advance that, upon the activation of the CT Forward Movement of Patients Plan or any of its annexes, one Coordinated Medical Emergency Dispatch (CMED) in each planning region shall be designated as the primary regional CMED, with responsibility for the overall coordination and management of patient transport throughout the duration of the incident.
- A Regional Coordination Center (RCC), if required by the regional response plan, shall be opened and staffed with the appropriate regional Emergency Support Functions.
- In the early stages of any single or multi-casualty burn emergency, burn patients initially shall receive care at local health care facilities utilizing the normal operating procedures of those facilities, and following local emergency care protocols.
- The *State of Connecticut Protocol for the Pre-Hospital Management of Multiple Burn Victims* may be activated by the local Incident Command, by the local Emergency Manager, by the primary CMED, or by the sub-state Regional Coordination Center (RCC) as required to support the local and regional response.

## A. COORDINATION OF PATIENT TRANSPORT

- Responding medical personnel, staff from the local EOC's, personnel at hospitals and other local and regional treatment facilities, and incident commanders at the scene, shall interact with the designated primary regional CMED to coordinate the transportation of patients to regional hospitals or

alternative treatment sites or, if the NDMS is activated, to the designated NDMS patient collection area(s).

- The designated primary CMED shall coordinate the transport of patients throughout the incident utilizing available local, regional and state EMS resources.

- CMED shall coordinate local, regional and State EMS resources with the CTDPH Office of Emergency Medical Services (OEMS), and with the assets of the National Disaster Medical System if the NDMS has been activated.

- CMED shall monitor the status of individual hospitals and other healthcare facilities in its jurisdiction. The designated primary regional CMED shall alert the regional hospitals that a multi-casualty burn incident is evolving.

- The designated primary regional CMED shall activate the MEDNET System (155.340Mhz, PL 203.5) and shall contact the State MEDNET relay center, KX Colchester, to share the notification with the remaining CMED's.

- The designated primary regional CMED's in the remaining DEMHS regions shall determine the status of individual hospitals in their jurisdictions, and shall report that information on a regular basis to the primary regional CMED managing transport assets for the incident.

- Upon the request of the designated primary regional CMED, a sub-state Regional Coordination Center (RCC) set up in accordance with the regional emergency operations plan (REOP) shall coordinate the deployment of regional and state resources in support of the EMS mission to transport and transfer patients. Transportation resources may include air ambulances, buses, and other resources as required by the severity of the incident.

- The designated primary regional CMED shall initiate a burn bed availability call-down through the Bridgeport Hospital Burn Center. The following sequence shall be followed to communicate with the Bridgeport Hospital Burn Center:

**Call the Bridgeport Hospital Page Operator at 203-384-3311**

The Page Operator shall contact the "On-Call" Surgical Critical Care Attending Physician.

1. The Surgical Critical Care Attending shall contact the designated primary regional CMED to confirm the request for assistance.

2. The Surgical Critical Care Attending then shall alert the Burn Center's "Burn Specialty Team", initiate the Regional Burn Bed Census process and:

- In a Stage 1 event, report the results to the designated primary regional CMED, and to the CTDPH, CTDEMHS and the State EOC
- In a Stage 2 or a Stage 3 event, The Surgical Critical Care Attending shall receive updates on the status of the Regional Burn Bed Census every hour and shall communicate that information to the designated primary regional CMED and to CTDPH, CTDEMHS and the State EOC

3. During the event, all patient transportation requests from hospitals shall be forwarded to the designated primary regional CMED for resource allocation
    - Inter-facility movement of appropriate, non-contaminated burn patients shall be accomplished utilizing Advanced and Basic Life Support units assigned to the incident, or through the use of other transport resources identified by the designated primary regional CMED.

4. The CT Department of Emergency Management and Homeland Security (DEMHS) shall make the decision to request the activation of the NDMS based on specific incident data, and on actual or anticipated expectation of depletion of regional and state resources.

5. Activation of the NDMS is accomplished by notifying the NDMS Regional Emergency Coordinators of the incident, and advising of the need for federal assistance. The request for assistance should include a detailed statement of specific resources required.
    - If activated, the NDMS shall coordinate the transport of patients to healthcare facilities outside of the state, or to designated NDMS patient collection areas.
    - Patients transported to hospitals beyond the region or state by the NDMS shall be tracked through their triage tags.

**B. COORDINATION OF MEDICAL SERVICES**

Initially, local incident command shall assume responsibility for coordination of medical services, including:

1. On-scene safety of first responders
2. Triage and on-scene safety of victims
3. Activation of appropriate decontamination procedures

When the local Incident Command System anticipates that local resources for management of the medical emergency may be overwhelmed, then the Incident Command may request the activation of the sub-state regional resource allocation system. The regional system shall deploy regional response resources including medical care providers. Medical services may include triage, transportation, decontamination, on-scene medical treatment, and mass care.

Additional oversight and coordination responsibilities of the regional resource allocation system may include:

1. Activation of the regional plan for the transfer of victims to appropriate medical sites using appropriate medical evacuation systems to ensure patient safety
2. Coordination of the expansion of the healthcare system to meet the needs of the region
3. Coordination of the use of trauma, burn, ICU and other specialized care facilities
4. Facilitation of credentialing and distribution of medical staff to ensure adequate medical services at all participating facilities
5. Implementation of regional plans to activate alternative treatment and patient sheltering sites, and assurance of adequate staffing to complete the mission at those locations

## C. TRANSPORTATION OPTIONS

To accommodate the transport of severely burned patients, all modes of transportation may be utilized. Access to these transportation options is available through the activation of the *State of Connecticut Protocol for the Pre-Hospital Management of Multiple Burn Victims* and through the activation of the regional Emergency Services Function 1 (ESF 1: Transportation). This activation may include the deployment of any commercial and state-owned buses, fixed and rotor wing aircraft (military and commercial), and commercial and private automobiles and trucks.

## D. INCIDENT COMMAND

### Stage I Incident (Local Response)

- Local Incident Command shall be established according to the Incident Command System (ICS) as promulgated in the National Incident Management System (NIMS).

- It is recommended that a unified command system (UCS) be established early in a burn casualty incident to allow for input from local and regional health providers and from responding state agencies.

- The Incident Commander or designee shall notify CMED of the type of incident and estimated numbers and types of patients. In addition, the appropriate official may:
    a) Request additional EMS, fire and police assistance as needed
    b) Request activation of the regional resource allocation system

- EMS personnel arriving at the scene shall report immediately to the local Incident Commander or, if designated, to the Operations Chief or, if designated, to subordinate officers in the Incident Command System

managing EMS operations, or to other subordinate ICS officers as directed by the Incident Commander.

**Stage II Incident (Regional Response)**

If local Incident Command declares a burn-related multi-casualty incident and requests additional resources, the following shall occur:

- The sub-state regional resource allocation system shall be established and shall be activated. A Regional Coordination Center (RCC) may be opened and staffed with the appropriate regional Emergency Support Functions

- When activated, the RCC assumes responsibility for the acquisition, deployment and coordination of regional medical personnel and other assets responding to the event.

- The designated primary regional CMED shall establish reliable communications with local Incident Command, with the Local Emergency Operations Center if activated, and with the RCC if activated.

- The designated primary regional CMED shall establish communications with LifeStar Air Operations at 800-437-4378

- The designated primary regional CMED shall alert all hospitals and EMS Services in its jurisdiction, all other CT CMED's, the CT Department of Emergency Management and Homeland Security, and the CT Department of Public Health

- The National Disaster Medical System (NDMS) may be notified of the incident by the CT Department of Emergency Management and Homeland Security, by the CT Department of Public Health, or by the Capitol Region Metropolitan Medical Response System. Notification is accomplished by notifying the NDMS Regional Emergency Coordinators. This notification is essential to allow NDMS personnel adequate time to initiate their internal notification system.

**Stage III Incident (Catastrophic Event with National Response)**

- In consultation with local Incident Command, or with the Regional Coordination Center if activated, and with CT Department of Public Health, The CT Department of Emergency Management and Homeland Security shall determine the need to request activation of the National Disaster Medical System (NDMS), and to request federal response teams to assist in managing the incident.

- The State EOC shall request the activation of the National Disaster Medical System (NDMS) by notifying the NDMS Regional Emergency Coordinators. The notification shall include a specific inventory of equipment and personnel being requested from the NDMS for the management of the incident.
- Once on-scene, designated personnel from the NDMS shall be responsible for the coordination of forward movement of patients out of the state utilizing the National Disaster Medical System.
- The NDMS representatives shall provide the following functions:
    a) Organization of transportation assets
    b) Notification to NDMS-designated receiving hospitals
    c) Organization of personnel to staff transport assets in forward movement
    d) Organization and management of supplies required for forward movement
    e) Coordination with local airports for landing and staging areas

## PRINCIPLES OF CARE

The principles of Advanced Burn Life Support (ABLS) are an extension of Advanced Trauma Life Support (ATLS) and shall be the standard for triage used by all parties participating in a field or hospital response to a burn-related multi-casualty incident in the State of Connecticut.

### Clinical Guidelines for On-Scene Burn Triage

*The clinical guidelines for on-scene triage and pre-treatment evaluation of burn patients are predicated upon the principles of burn management recommended by the American Burn Association and taught in the ABLS certification program. Included are the following categories of injury:*

1. **Burn trauma deemed isolated and less than 20% body surface (no other injuries and no respiratory compromise)**
    a. *Recommendation: Refer to local hospital*

2. **Burn trauma deemed isolated and greater than 30% (and GCS 15)**
    a. *Recommendation: Transport by air to distant burn center*

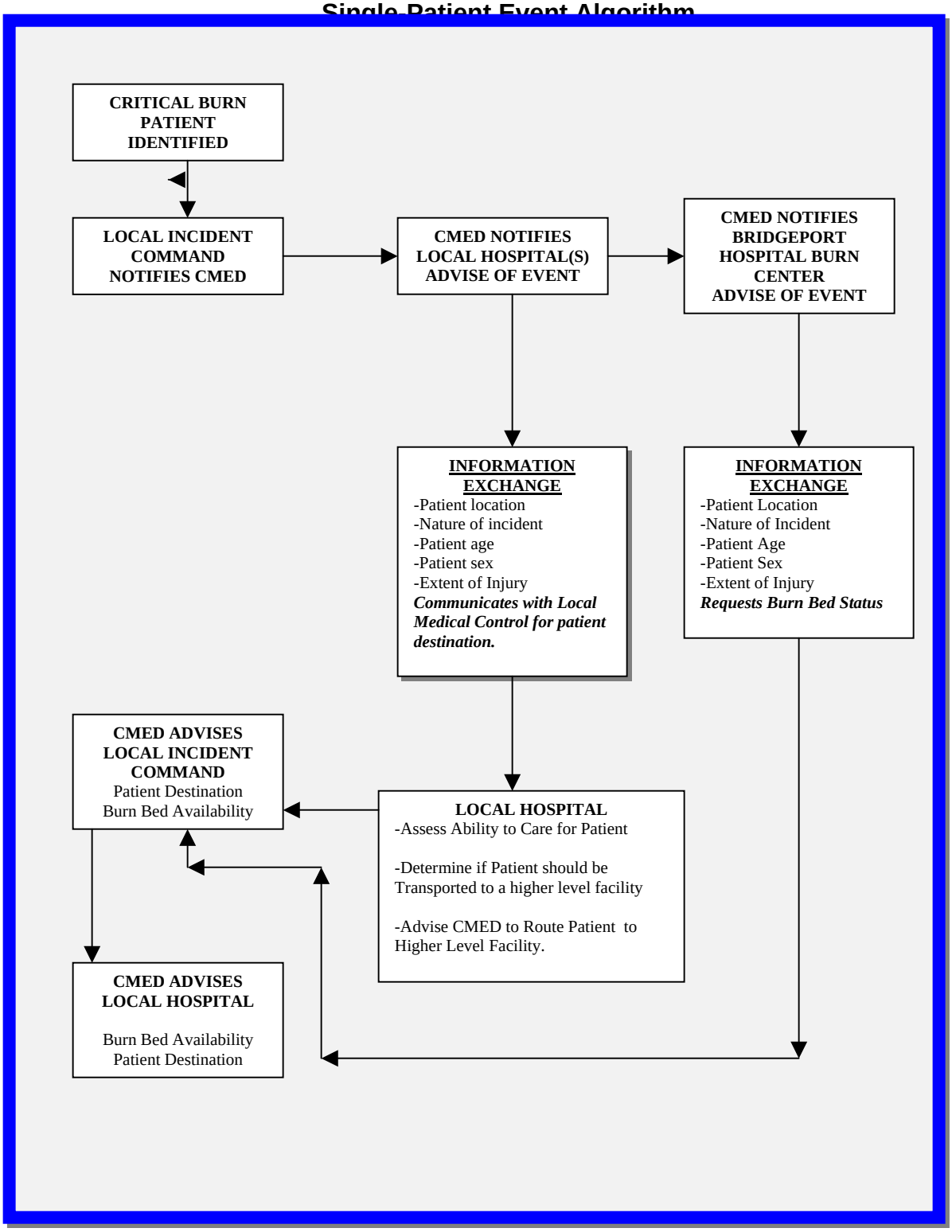
3. **Child less than 12, with above same criteria**
    a. *Recommendation: Refer to pediatric burn center if available, or to nearest PICU if necessary*

4. **Burn trauma with expectation of internal hemorrhage**
    a. *Recommendation: Refer to trauma center*

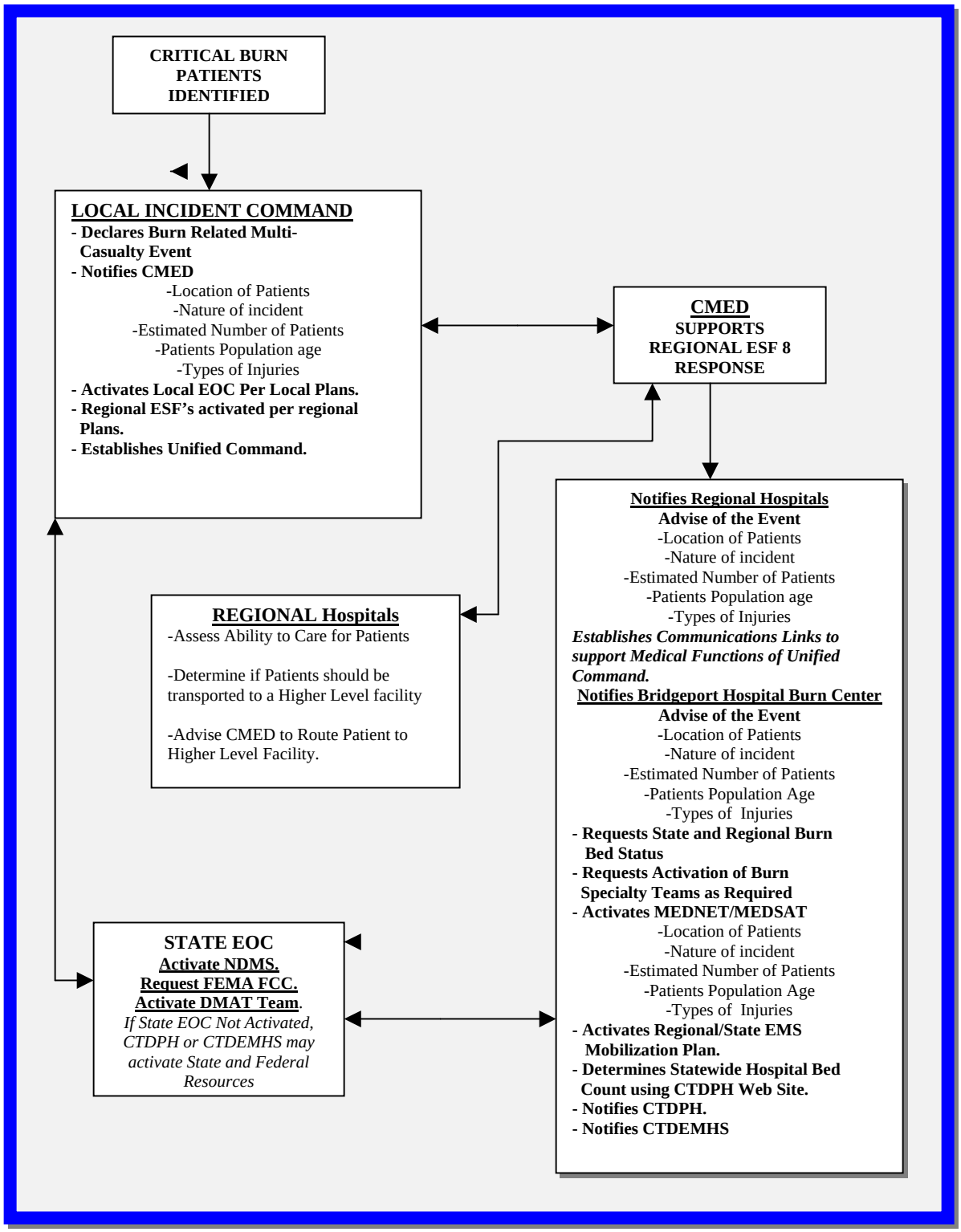
5. **Burn trauma deemed isolated and greater than 40% in presence of respiratory distress, stridor, or loss of consciousness**
    a. Recommendation: Priority referral to trauma center

## *ANNEX A. BURN EVENT ALGORITHMS*
## *STAGE 1*

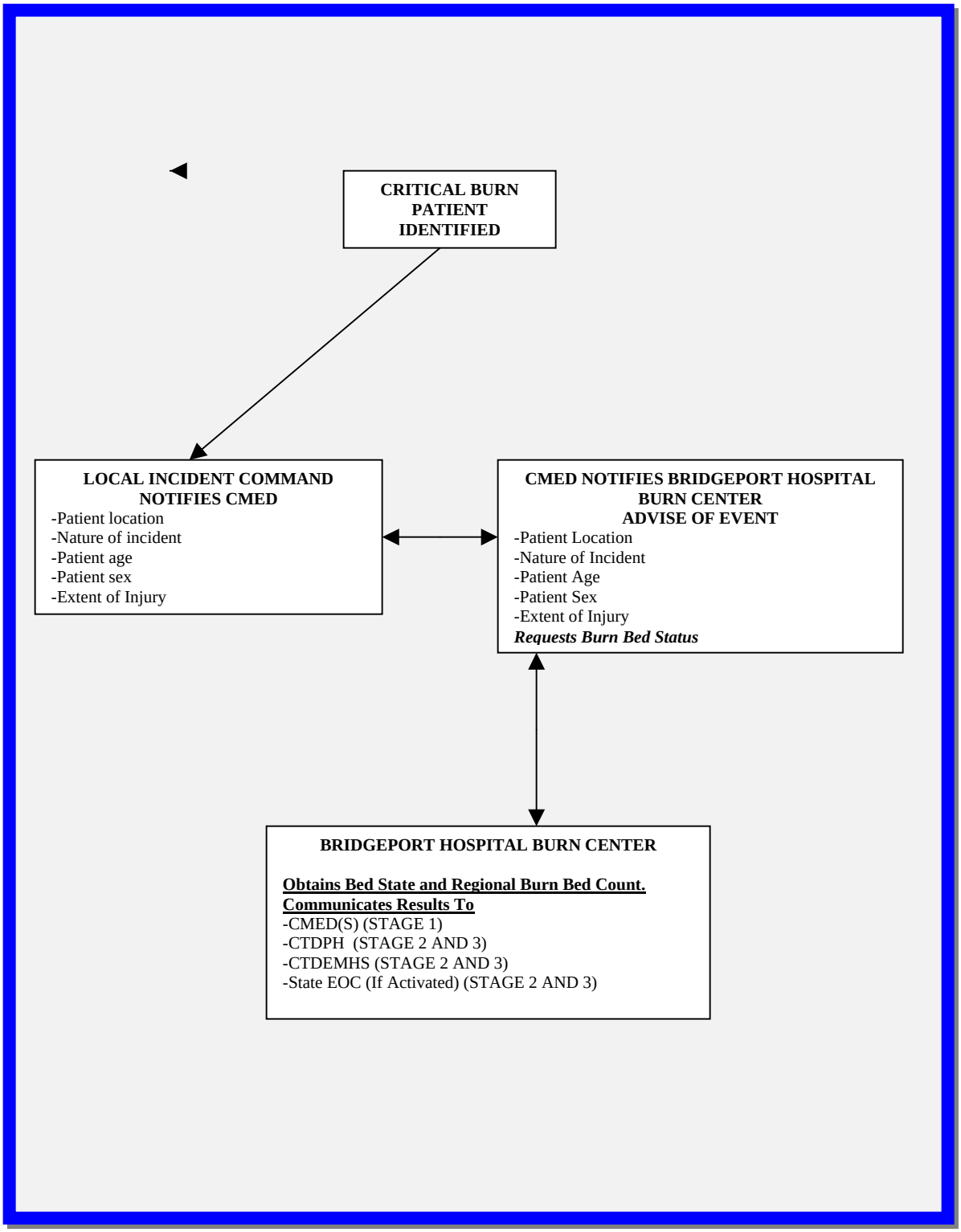
**Single-Patient Event Algorithm**



# Multi-Patient Event Algorithm
## STAGE 2 and STAGE 3



## *Activation of Burn Center Call-Down Procedures*



## CLINICAL GUIDELINES FOR ON-SCENE MEDICAL STABILIZATION

These guidelines are intended to inform the decision-making process regarding the on-scene medical management of burn victims from the first moments of an incident up to 96 hours due to circumstances preventing the transport of the victims to appropriate burn centers.

### 5 Principles of On-Scene Patient Management

1. Establish and Protect Airway
2. Prevent Infection
3. Apply Dressings as Needed
4. Control Pain
5. Transport to Appropriate Facility ASAP

### 10 Steps for On-Scene Management by Responders

1. Protect yourself
2. Put Out the Fire:
    i. Water on burns
    ii. Dry quickly to prevent hypothermia
3. Assess and Expose:
    i. Neurological assessment: Conscious? Unconscious?
    ii. Expose and examine for extent of burns
4. Remove jewelry but not adhering clothing
5. Start IV's:
    i. 2 large-bore for big burns
    ii. Burns = ↑ vascular permeability = ↓ cardiac output up to 12 hours
6. Give Fluids:
    i. Wide open if in the field
    ii. Otherwise, 2-4 cc/kg per % burned in adults, 3-4cc/kg per % burned in children, half in first 8 hours
7. Estimate Severity: Rule of 9's
8. Control the Pain:
    i. Morphine sulfate 5-10 mg/kg IV titrated for pain in adults
    ii. Morphine sulfate 0.05 mg/kg IV children
9. Protect Against Hypothermia:
    i. Dry or Water Jel dressings on any burn > 10% BSA...no exceptions
    ii. Elevate Body Parts: 30%
10. Consider Patient Psychology:
    i. Be honest
    *ii.* Consider anxiolytics (diazepam, midazolam)

### Components of a Burn Victim Travel Pack

The State of Connecticut Protocol for the Pre-Hospital Management of Multiple Burn Victims includes a description of the personnel and equipment required to accompany burn victims as they are transported by air to distant burn treatment facilities. The components of a "Burn Victim Travel Pack" are listed in order of priority from the ideal to the most basic reflecting that, under extreme circumstances involving multiple burn casualties, it may be impossible to assemble the ideal travel pack:

**1. Staffing Guidelines for Burn Victim Transport**

a. 2 medical personnel for 1 victim
b. 3 medical personnel for 2 victims

**2. Qualifications of Transport Personnel**

a. Flight-experienced burn unit medical personnel on helicopter en route or, if unavailable:
b. Flight-experienced trauma center personnel on helicopter en route or, if unavailable:
c. Paramedic on helicopter en route or, if unavailable:
d. EMT on helicopter en route (requires CT PHERA activation) or, if unavailable:
e. RN on helicopter en route or, if unavailable:
f. PA on helicopter en route or, if unavailable:
g. Licensed physician on helicopter en route

**3. Minimal Transport Equipment Requirements**

a. 100% O2 by face mask and bag valve mask
b. Cricothyroidotomy kit
c. I.V. Lactated Ringers or Saline (estimated at 6 liters per patient)
d. Warming blankets
e. Morphine IV formulation in sufficient quantities to suppress pain