



Mass Casualty Incident Management Guideline

**Planning, Responding, and Reviewing
MCI Events**

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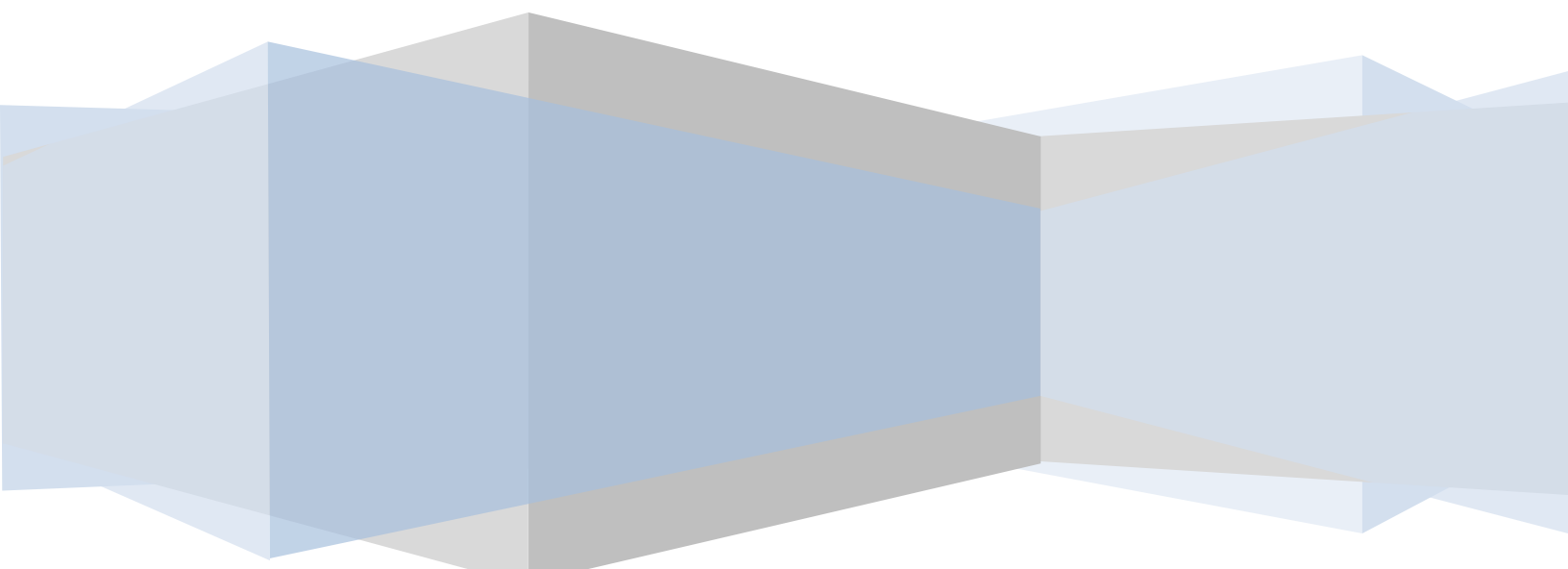


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INTRODUCTION

The Mass Casualty Incident (MCI) Management Guideline is designed to provide Harris County Emergency Corps (HCEC) EMS providers with a template for planning for, responding to, and reviewing the agency's performance after an MCI. The following guidelines are meant to serve as the medical framework for an MCI, which by definition, is outside the typical scope of daily operations.

OBJECTIVES DURING AN MCI

1. To provide safe, effective, and efficient care for as many patients as possible with available resources.
2. To integrate the principles of the National Incident Management System (NIMS).
3. To efficiently communicate within HCEC, as well as coordinate with local, regional, and federal resources.

KEY RESPONSIBILITIES

1. All medical personnel will be responsible for adhering to guidelines outlined in this document. Unless otherwise described herein, patient care is to be directed by the HCEC Standing Orders & Emergency Medical Guidelines. All personnel should wear safety vests to aid in rapid identification.
2. The **Incident Commander** shall be responsible for the management of an MCI and will follow management guidelines consistent with the NIMS.
3. The **HCEC Communications Center** shall assign a **Communications Incident Supervisor** who will oversee communications with assigned units, mutual aid companies, and the **Incident Commander**.

DEFINITIONS

- **Advanced Life Support (ALS)** – The level of care provided by an Advanced EMT/EMT-Intermediate or an EMT-Paramedic who is credentialed and performs advanced procedures within the HCEC system.
- **Basic Life Support (BLS)** – The level of medical care provided by an EMT-Basic who is credentialed within the HCEC system.
- **Casualty Collection Point** – The area(s) to which patients are moved to facilitate triage, treatment, or transport in the case of the patients spread out over a large area or separated by geography.
- **Catastrophic Medical Operations Center (CMOC)** – A regional entity typically located at the Houston Office of Emergency Management tasked with assisting area EMS agencies, healthcare facilities and those with access and functional needs with the coordination of patient movement, asset organization, patient tracking, public health issues, and coordination of mass casualty and fatality issues when activated.
- **Communications Center** – The Harris County Emergency Corps Communications Center.
- **Emergency Operations Center (EOC)** – The HCEC central command and control facility responsible for gathering information and making decisions during a disaster.
- **EMResource** – The regional web-based program utilized by the CMOC, EMS agencies, and healthcare facilities to report current status and asset capabilities, as well as provide notifications of evolving incidents.
- **EMTrack** – The regional web-based patient tracking system that allows responders on the scene of an incident, healthcare facilities, and other agencies to track the movement of patients throughout the healthcare system.
- **JumpSTART Triage** – A method of triage used to assign the priority of care and transport for patients ≤ 8 years of age.
- **Level 1 MCI** – An MCI involving 10-19 patients who may require transport and who have a substantial priority level (yellow or red) or require decontamination. Local mutual aid will likely be required.
- **Level 2 MCI** – An MCI involving 20-49 patients who may require transport and who have a substantial priority level (yellow or red) or require decontamination. Local mutual aid will be required.
- **Level 3 MCI** – An MCI involving ≥ 50 patients who may require transport and who have a substantial priority level (yellow/red) or require decontamination. This level of MCI will require activation of regional and/or multi-jurisdictional mutual aid. It also requires the establishment of field medical triage, treatment, and transport groups.

- **Level 1 Staging** – Units staged in their direction of travel, uncommitted to the event, and ready for response approximately 1-2 blocks from the scene.
- **Level 2 Staging** – A formal staging area where units and personnel report and are directed by operations/command personnel.
- **Mass Casualty Incident (MCI)** – An incident which overwhelms local EMS resources and is likely to utilize mutual aid or regional assets to provide appropriate management.
- **Multiple Patient Vehicle (MPV) or AMBUS** – A vehicle designed to carry multiple (20 littered or 30 seated) patients from an MCI or healthcare facility.
- **Office of Emergency Communications (OEC)** – The communications division of the Houston Fire Department responsible for dispatch and allocation of resources in the City of Houston.
- **Office of Emergency Management (OEM)** – A government division tasked with coordinating disaster planning and emergency response. Houston OEM (713-884-4408) has primary responsibility for event occurring within the City of Houston limits, while the Harris County Office of Homeland Security and Emergency Management (OHSEM, 713-881-3300) manages unincorporated areas of Harris County.
- **START Triage** – A method of triage to assign the priority of care and transport for patients >8 years of age.
- **Triage Area** – The area in which patients are found or directed to for further assessment. In large incidents that are separated by geography or distance, there may be multiple triage areas or casualty collections points.
- **Treatment Area** – The area in which patients receive care not provided immediately upon triage.
- **Transport Area** – The area utilized by EMS for loading and transporting patients to area hospitals, as well as tracking the destination facilities of those patients.

INITIAL OPERATIONS

FIRST ARRIVING UNIT

The **In-Charge Paramedic** should:

- Establish communications with the **Communications Center**.
- Assume the initial role of **Incident Commander** until relieved. The **Incident Commander** should *not* have direct patient care responsibilities.
 - If **Incident Command** has already been established by, or is transferred to, a First Responder Organization, assume the role of **Medical Branch Director**.
- Determine and communicate with the **Communications Center** the following:
 - Confirmed location.
 - Overall assessment (i.e. commuter bus on its side) and scene size-up.
 - DECLARE AN MCI and implement the Incident Command System.
 - State estimated number of patients and triage categories as well as MCI Level:

Level	1	2	3
Number of RED/YELLOW patients	10-19	20-49	≥50
 - Known hazards.
 - Anticipated need for additional units.
 - Recommended ingress and egress routes.
 - Staging instructions.
 - Need for scene security and perimeter establishment.
- If contamination is suspected, notify the **Communications Center**, isolate the area, and establish a decontamination area.

The **Attendant** should:

- Assess for scene hazards.
- Establish the **Triage Group**.
- Globally sort and initiate scene triage *using ribbons*.
 - Use START/JumpSTART triage guidelines (*see Attachment 2*).

SECOND ARRIVING UNIT

The **In-Charge Paramedic** should:

- Establish the **Treatment Group**.
 - When available, an **EMS Supervisor/Medical Director** may assume the role of the **Treatment Group Supervisor**.
- Secondary triage is performed once a patient initially arrives in the **Treatment Group**.
- Patients are assigned regional disaster triage tags with a unique identifier when placed in this group.
- Select an area large enough to sort patients into **Immediate**, **Delayed**, or **Minor** categories.
- Select an area close to ingress/egress routes, whenever possible.
- Obtain colored tarps or flags representing the designated treatment areas from the **EMS Supervisor** vehicle and deploy to identify each treatment area visually.

The **Attendant** should:

- Gather patient transport equipment and assist with patient triage or initiate transfer of patients to the treatment area.
- Establish **Litter Teams** of first responders, law enforcement, and/or citizens to help transfer patients to the treatment area.
 - MegaMovers or other transport litters may be helpful when stretchers are unavailable.
 - Consider golf carts, luggage carriers, wheelchairs, and non-traditional transport tools as the situation dictates.

THIRD ARRIVING UNIT

The **In-Charge Paramedic** should:

- Establish the **Transportation Group**.
 - If an **EMS Supervisor** assumes this role, the paramedic may assist with **Treatment or Triage Groups**.

The **Attendant** should:

- Assist with **Treatment or Triage Groups**.

INCIDENT COMMANDER

The **Incident Commander** is responsible for all operations on scene. Initially the role is filled by the first arriving unit's In-Charge Paramedic, but should be transitioned to a fire department official when an incident is not strictly medical.

Radio Call Sign: "**Command**"

- Don identification vest and obtain equipment.
- Determine safety needs, including decontamination and possibility of secondary devices (explosives designed to explode after a primary explosion, intended to cause casualties among responders).
- Assign a **Medical Branch Director**.
- Assist the **Medical Branch Director** in assigning the following:
 - **Triage Group Supervisor**
 - **Treatment Group Supervisor**
 - **Transportation Group Supervisor**
- Request tactical radio channel(s). EMS operations alone may need multiple channels, including:
 - Triage/Treatment channel
 - Transport/Staging channel
- Request additional resources as needed (e.g. hazmat, bomb squad, law enforcement, Houston or Harris County OEM).

MEDICAL BRANCH DIRECTOR

The **Medical Branch Director** when possible should be an **EMS Administrator** and will be responsible for all medical operations on scene.

Radio Call Sign: “**Medical**”

- Don identification vest and obtain equipment.
- In coordination with the **Incident Commander**, designate the following:
 - **Medical Branch Assistant**, if necessary
 - **Triage Group Supervisor**
 - **Treatment Group Supervisor**
 - **Transportation Group Supervisor**
- Obtain number of patients.
- Determine and request resource needs.
 - **Triage Group** – 1 EMS provider for every 10 ambulatory patients.
 - **Treatment Group** – a minimum of 4 ALS personnel and 6 BLS personnel.
 - **Transportation Group** – a minimum of one EMS provider.
 - Transportation units –
 - Immediate (**RED**) or Delayed (**YELLOW**): 1 ambulance for every 2 stretcher patients
 - Minor (**GREEN**): 1 ambulance for 5 patients, 1 MPV/AMBUS for 20 littered or 30 seated patients (6 EMS providers), 1 Metro bus for 40 patients (4 EMS providers).
 - Receiving hospital options.
 - Other resources (e.g. CMOC, Houston or Harris County OEM, EMTF).
- Confirm with **Communications Center** that an incident has been created within EMResource and EMTrack.

GROUP OPERATIONS

TRIAGE GROUP

Initiated by the first arriving unit's attendant and led by the **Triage Group Supervisor**.

Radio Call Sign: "**Triage**"

- Don identification vest and obtain equipment.
- Assess for scene hazards.
- Identify **Triage Group** members and implement triage process.
- Initiate START/JumpSTART triage (*see Attachment 2*) utilizing triage ribbons or tape.
 1. Globally sort: assess those who can walk 3rd; those who can wave (purposeful movement), 2nd; those who are still (obvious life threat), 1st.
 2. Verbally direct all patients who can walk to a designated area and initially triage them as **Minor – GREEN**.
 3. Relay ambulatory and non-ambulatory counts to the **Medical Branch Director**.
 4. Triage all remaining patients where they are found (if possible) into the following categories:
 - **Immediate - RED**
 - **Delayed - YELLOW**
 - **Minor - GREEN**
 - **Deceased - BLACK**
- Perform *limited* lifesaving interventions (major hemorrhage control, open airway, etc.)
- Relay number of patients and priorities to **Medical Branch Director** (e.g. 2-red, 3-yellow, 4-green).
- Ensure **Litter Teams** of first responders, law enforcement, and/or citizens have been established (typically by the second arriving unit's attendant) to help transport patients to the treatment area.
- Move **RED**, **YELLOW**, and remaining **GREEN** patients to the treatment area.
- Coordinate with the **Treatment Group Supervisor** to assure patients are being delivered to the correct treatment area.

Hot Zone Triage – Contaminated Patients

- Using the public address (PA) system (if available), providers shall instruct all ambulatory patients to move to the gross decontamination area.
- For non-ambulatory patients, providers wearing appropriate PPE will:
 1. Mark *responsive* patients with 2 feet of **ORANGE** ribbon tied to the right wrist.
 2. Mark *unresponsive* patients with 2 feet of **BLUE** ribbon tied to the right wrist.
 3. Move the *responsive* (**ORANGE**) patients to the decontamination area before the *unresponsive* (**BLUE**) patients.

Post-Triage Activities

- When all **RED/YELLOW** patients are transported from the **Treatment Group**, reconfirm all **BLACK** tagged patients are deceased and secure a regional disaster triage tag to the patient. If a pulse or signs of life are present, re-triage as **RED** and move immediately to the **Treatment Group**.
- Report to the **Medical Branch Director** for reassignment when triage is complete.

TREATMENT GROUP

Usually initiated by the second arriving unit's In-Charge Paramedic, or **Medical Director** or **EMS Supervisor**, when available. Led by the **Treatment Group Supervisor**.

Radio Call Sign: "**Treatment**"

- Don identification vest and obtain equipment.
- Consult with the **Medical Branch Director** to determine location of the treatment area.
- Re-triage patients upon arrival and assign a regional disaster triage tag with a unique identifier. Remove the colored ribbon.
- Place patients into 1 of 3 separate units: **RED**, **YELLOW**, and **GREEN**.
 - Designate a **Treatment Manager** for each unit.
 - Designate an area large enough to allow for sorting into treatment units.
 - Use colored tarps or flags to identify the treatment areas visually.
 - Consider setting up the **GREEN** treatment area a distance from the other treatment areas to prevent ambulatory patients from entering other areas.
- Assign a minimum of 4 ALS personnel and 6 BLS personnel to the treatment area:
 - **RED**: 2 ALS personnel and 2 BLS personnel per 4 patients.
 - **YELLOW**: 2 ALS personnel and 2 BLS personnel per 10 patients.
 - **GREEN**: 2 BLS personnel per 20 patients.
- Provide care to salvageable patients. Re-triage as often as possible.
 - Move patients to the correct colored unit if their condition changes.
 - The treatment area that a patient occupies is the *primary* indicator of that patient's triage category; the color of the ribbon or regional disaster triage tag is *secondary*.
- Establish communications and coordinate with **Transportation Group Supervisor**; prioritize patients for transport.
- Request medical supplies or personnel through the **Medical Branch Director**.
- Update the **Medical Branch Director** periodically on the number of patients per category.
- Ensure appropriate patient documentation on regional disaster triage tags.

TRANSPORTATION GROUP

Usually initiated by the third arriving unit's In-Charge Paramedic and led by the **Transportation Group Supervisor**.

Radio Call Sign: "**Transportation**"

- Don identification vest and obtain equipment.
- Obtain a number of patients from the **Medical Branch Director** and determine the need for additional transport units.
- Identify a safe, efficient loading area adjacent to the treatment area. Secure ingress and egress routes and inform the **Medical Branch Director** and **Staging Officer** (if present).
- Confirm with the **Medical Branch Director** that **Communications Center** has established an incident within EMResource and EMTrack.
- Contact the **Communications Center** to review EMResource for hospital available bed counts/acuity levels. Maintain a status board of receiving hospitals (*see Attachment 6*).
- Request personnel and units through the **Medical Branch Director**.
- Work with the **Treatment Group Supervisor** to move patients off the scene utilizing available resources.
 - Assign patients to transport vehicles.
 - Assign transport vehicles a hospital destination.
 - The **Transport Group Supervisor** must be advised of an intended release of a unit from the scene *prior* to the departure. This prevents units from arriving at destinations without notification.
- Log each transported patient's unique identifier number and their destination facility.
 - This information should be placed in EMTrack prior to departure. Utilize scanners if available.
- Coordinate requests for air ambulance transportation as needed.
- Assign the following positions as available: **Staging Officer, Transportation Group Communicator, Hospital Status Board Recorder, and Patient Tracking Recorder**.
- Maintain security and safety in the patient loading area.
- Ensure appropriate patient documentation on regional disaster triage tags.

Patient Assignment

- Non-ambulatory patients:
 - Each ambulance can accommodate 2 stretcher patients.
- Ambulatory patients:
 - Each ambulance can accommodate up to 5 ambulatory patients.
 - The MPV/AMBUS can accommodate 20 littered or 30 seated patients and are staffed with 6 EMS personnel.
 - A Metro bus can accommodate up to 40 seated patients.
 - The ratio of EMS personnel per bus patients should be at least 1:10.
 - If available, **Minor - GREEN** patients should be loaded and transported as soon as possible, regardless of the number of remaining critical patients.
- Destination capability suggestion:
 - **Minor - GREEN** patients can be sent to any hospital.

Type of Hospital	Immediate - RED	Delayed - YELLOW
Level I Trauma Center	10	15
Level III Trauma Center	5	5
Non-Trauma Center	3	5

Staging

The **Transportation Group Supervisor** may appoint a **Staging Officer** to direct the flow of incoming units.

Radio Call Sign: “**Staging**”

- The **Staging Officer** should identify which level staging is required.
 - *Level I Staging* – Park in the direction of travel, in close proximity to the scene but remain uncommitted until assigned by the **Transportation Group Supervisor** (or **Medical Branch Director** if transport leader not designated).
 - *Level II Staging* – Report to a designated area or location and await assignment.
- If no special instructions are given with regards to staging, additional arriving units should report “On Scene” and Level I stage while awaiting further instructions.
- If requested to the scene, additional arriving units should leave the keys in the ignition, and report to the **Transportation Group Supervisor** with patient treatment equipment and stretcher.
- All vehicles should be parked in a way that allows ingress/egress from the scene.

Transport Group Communicator

- Maintain continuous contact with **Communications Center** or CMOC (if activated).
 - Confirm that an incident has been created in both EMTrack and EMResource.
 - Receive hospital status updates and refer them to the **Hospital Status Board Recorder**.
 - Notify of each transport (unit, destination, number of patients).
- Notify the **Transportation Group Supervisor** before each unit departs.
- Based on input from the **Transportation Group Supervisor** and the **Hospital Status Board Recorder**, units may be re-directed to alternate destinations.

Hospital Status Board Recorder

- Continuously update the hospital status board (*see Attachment 6*).
 - Review hospital bed availability information from EMResource.
 - Record each transport count and destination.
- Continually inform the **Transportation Group Supervisor** of hospital statuses.

Patient Tracking Recorder

- Utilize EMTrack to:
 - Maintain a record of all patients tied to their unique number found on the regional disaster triage tags.
 - Record required demographics, chief complaint, acuity, destination, and transporting unit.
 - Collect Transportation Receipts from the regional disaster triage tags.
 - Electronically advise hospitals of incoming patient transports.
- If EMTrack is unavailable:
 - Maintain a written account of the transportation destination for each patient (*see Attachment 7*). This should include:
 - Priority Color (**RED**, **YELLOW**, or **GREEN**)
 - Regional disaster triage tag number
 - Name
 - Gender
 - Age
 - Unit transporting
 - Hospital destination
 - Collect Transportation Receipts from the regional disaster triage tags.
 - Notify receiving hospitals of incoming patient transports as available through the **Transport Group Communicator**.

COMMUNICATIONS CENTER

- Identify a **Communications Incident Supervisor** to oversee MCI communications.
- Develop incident in CAD (if not already done), detailing information provided by the first arriving unit. Note the Level of MCI.

Level	1	2	3
Number of RED/YELLOW patients	10-19	20-49	≥50

- ALL CALL on all radio frequencies: “Attention all units – [Unit ID] has activated a Level “x” Mass Casualty Incident for a [type of incident] at [location and key map]. Standby for assignments.”
- Assign a tactical radio channel.
- Send an HCEC Admin group page. Ensure the **Medical Director** has *acknowledged* the incident; if not, contact the **Medical Director** (281-886-8182).
- Dispatch ambulances as requested.
 - When more than 3 HCEC ambulances are required, request mutual aid. Initially request 1 ambulance from each surrounding agency with a mutual aid agreement.
 - Staging: If no instructions from the **Incident Commander** are given, arriving units should report “On Scene,” Level I stage, and await further instructions.
- Request creation of an incident within EMResource (notifies area hospitals and requests bed availabilities) *and* EMTrack (allows digital patient tracking).
 - Contact the **SETRAC Duty Officer** (281-822-4444) and request *both*.
 - Advise the **Medical Branch Director** when the incident has been created.
- Maintain continuous contact with the **Transport Group Communicator**.
 - This may require a separate tactical channel.
 - If requested, provide hospital availability information from EMResource.
 - Receive and record each ambulance transport (unit, destination, number of patients).
 - If directed, notify hospitals of incoming patient transports.
- If the MCI is large/complex enough to require CMOC activation, the **Medical Branch Director** may advise to contact the on-call **Houston OEM Duty Officer** (713-884-4408) regarding CMOC activation. Provide the CMOC representative with the **Medical Branch Director’s** contact information.

MEDICAL DIRECTOR SPECIAL AUTHORIZATIONS

RAPID EXTRICATION

The **Medical Director** authorizes that if there is an immediate danger to life and health to the patients or responders in the triage area/scene (explosion, fire, inhalation risk, etc.), it is not necessary for patients to be immobilized before rapid extrication from the scene.

TRANSPORTATION GUIDELINES

The **Medical Director** may authorize the following deviations to the HCEC Standing Orders & Emergency Medical Guidelines for the duration of a Mass Casualty Incident:

- **Transportation Group Supervisor** may direct patients who meet criteria for trauma center transport to *any* level trauma center.
- Ambulances will transport all patients in emergency mode (lights and sirens). MPV units are licensed ambulances and may use their emergency equipment for transport.
 - Civilian buses will obey all traffic laws and should not have an emergency police escort.
- After delivering patients to a hospital, the ambulance will immediately return to the MCI staging area in emergency mode (lights and sirens), unless otherwise advised. Full patient records may be completed and delivered to hospitals once released from the MCI.
- When helicopters transport patients from an MCI during a declared disaster, they should consider transporting non-critical patients to hospitals out of the local area. The **Transportation Group Supervisor** should, in conjunction with the **Communication Center**, direct helicopters to transport patients to other hospitals, including distant trauma centers around the South Texas Area.
- During an MCI, the HCEC Patient Care Report shall be utilized for all patient records. The regional disaster triage tag is *not* a sufficient final patient record. If time does not allow personnel to complete all patient records before returning to the scene, personnel will complete them at the termination of the MCI or prior to being relieved of duty.

CATASTROPHIC MEDICAL OPERATIONS CENTER (CMOC)

DESCRIPTION

CMOC is a regional entity under the coordination of the Regional Hospital Preparedness Coalition and typically housed in the Houston Office of Emergency Management. It is staffed by regional hospital personnel, public health department personnel, access and functional needs advocates, an EMS transportation coordinator, and a medical operations chief. Its purpose is to assist area EMS agencies, hospitals, nursing facilities, and access and functional needs individuals in the community with coordination of patient movement, asset organization, patient tracking, public health issues, regional patient tracking, and coordination of mass casualty and mass fatality issues.

GENERAL CAPABILITIES

CMOC has traditionally played a distinct role in patient tracking and relocation during evacuations whether due to an impending natural disaster (hurricane) or due to a compromised healthcare facility. During MCIs and natural/biological/radiological disasters, CMOC can facilitate the expansion of surge capacity in the region, determine bed availability, coordinate patient assignments, and assist with load-balanced patient distribution to healthcare facilities in the region.

REASONS TO ACTIVATE CMOC DURING AN MCI

- Any Level 3 MCI or an incident with contamination.
- Due to a large number of patients, a coordinated effort is required to redistribute patients in hospitals to healthcare facilities outside of greater Houston.
- To coordinate the request for and response of multiple mutual-aid ambulances for transport of patients.
- To provide a regional entity to coordinate patient transportation, surge capacity, resource requests, and activation of EMTF resources.

HOW TO ACTIVATE CMOC

The **Medical Branch Director** in conjunction with the **Medical Director** or his designee and the **Incident Commander** may activate CMOC if the above criteria are met or if the incident would benefit from their activation. The **Medical Branch Director** should notify the **Communications Center** to contact the on-call **Houston OEM Duty Officer** regarding CMOC activation (713-884-4408). When the CMOC representative calls, they will expect a brief report regarding the nature of the incident, whether decontamination is required, the number of casualties, and the role CMOC should play.

SPECIAL CONSIDERATIONS IN MANAGEMENT OF MCI

AIRPORT AND MASS TRANSIT

- All mass transit incidents will require a federal investigation. If equipment is available and the time and patients' conditions permit, use flags to mark the locations of patients and/or body parts. In general, body parts should not be moved. This is an NTSB requirement for all mass transit accidents.
- Consider requesting luggage carriers to move patients after initial triage from the triage area to the treatment area.

CORRECTIONAL FACILITIES

- For incidents occurring at Pam Lychner State Jail, ambulances should stage at the HCSO firearms range complex.
- During transport to a hospital facility, all units must have a law enforcement (LE) escort.
 - In case of several units leaving at the same time, a lead LE unit and a follow LE unit is acceptable.

ACTIVE SHOOTER

- Work with law enforcement to gather information and assign a casualty collection point.
- If authorized by prior agreement, establish a Rescue Task Force (2 EMS providers and ≥ 2 law enforcement officers) to enter the inner perimeter, rapidly assess casualties, report counts to the **Triage Group Supervisor**, and evacuate casualties.

MEDICAL SURGE

In an extensive MCI, the **Treatment Group** may be active for hours or days. If it is projected that an event will last longer than a day, consider activating CMOC and request the Mobile Medical Unit (MMU) from the Emergency Medical Task Force (SETRAC resource). The MMU is an inflatable field hospital that can protect responders and patients from the elements.

MINOR (GREEN) PATIENTS

- When setting up the treatment areas, the **Treatment Group** should consider placing the **Minor (Green)** treatment area away from the other areas. This area should not be so far away, however, that the **Medical Branch Director** and **Treatment and Transport Group Supervisors** cannot see and manage it.
- Medics who are attending **Minor (Green)** patients on a bus should ensure that all patients on their bus have their regional disaster triage tags filled out completely prior to arrival at the hospital, and that a separate register of patients on each bus (numbers and destinations) is documented and returned to the **Transport Group Supervisor**.

FATALITY MANAGEMENT

In general, personnel shall leave the deceased where they lie, unless it is necessary to move a deceased body to gain access to a live patient. There will not be a morgue area, unless established by the **Medical Examiner**. Persons who die in the **Treatment Area** before transport shall be moved to the black tarp.

MUTUAL AID

- EMS mutual aid units will be used as necessary. Mutual aid units may be dispatched to emergency calls in the HCEC service area if HCEC units are otherwise committed to the MCI scene.
- When requested, mutual aid units will be directed to move from the staging area to the transportation area, load patients, transport the patients to the hospital they are assigned to, unload the patients, and return directly to the MCI, unless otherwise instructed.

VOLUNTEER RESOURCES

- American Red Cross (866-526-8300), CERT Personnel (via OEM), and others may be utilized as needed. They should be referred to regional coordinating agencies (including SETRAC, OEM) or sent to a volunteer staging area as directed by a member of the HCEC administration to be selected by the **Incident Commander**.
- Volunteer IDs will be confirmed. If no ID is available, they will be required to log in with presentation of a governmental ID and preferably given no treatment roles.

PUBLIC INFORMATION DISSEMINATION

The **Public Information Officer (PIO)** should be the only person providing information to the media or requesting parties not directly involved in the incident. The **PIO** will be activated through the HCEC Admin page and must develop a media strategy. Large, extended events may necessitate the use of a joint information system. The **PIO** should provide information regarding a staging area for relatives of patients and may support those families in handling media requests. In a mass fatality incident, a Family Assistance Center may be established via the appropriate OEM for families of deceased or those unaccounted for.

CRITICAL INCIDENT STRESS MANAGEMENT (CISM)

CISM is the peer-based response team that is available to assist responders with the psychological aspects following a significant event. The **Executive Director** will activate this resource.

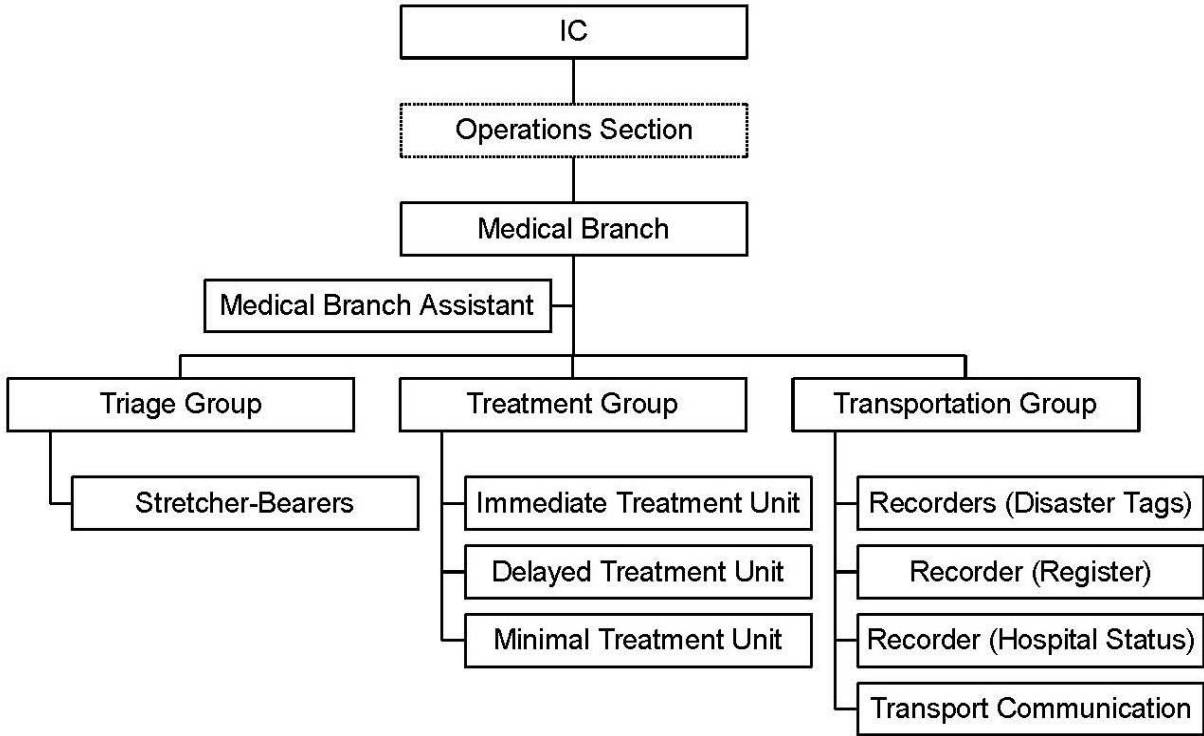
FINANCIAL PLANNING

Proper record keeping should be established by a member of the HCEC administration to be selected by the **Executive Director**, in accordance with HCEC Policy, to include: timekeeping, cost accounting, compensation and claims, purchasing, and recovery records.

ATTACHMENTS

ATTACHMENT 1: INCIDENT MANAGEMENT ORGANIZATIONAL CHART

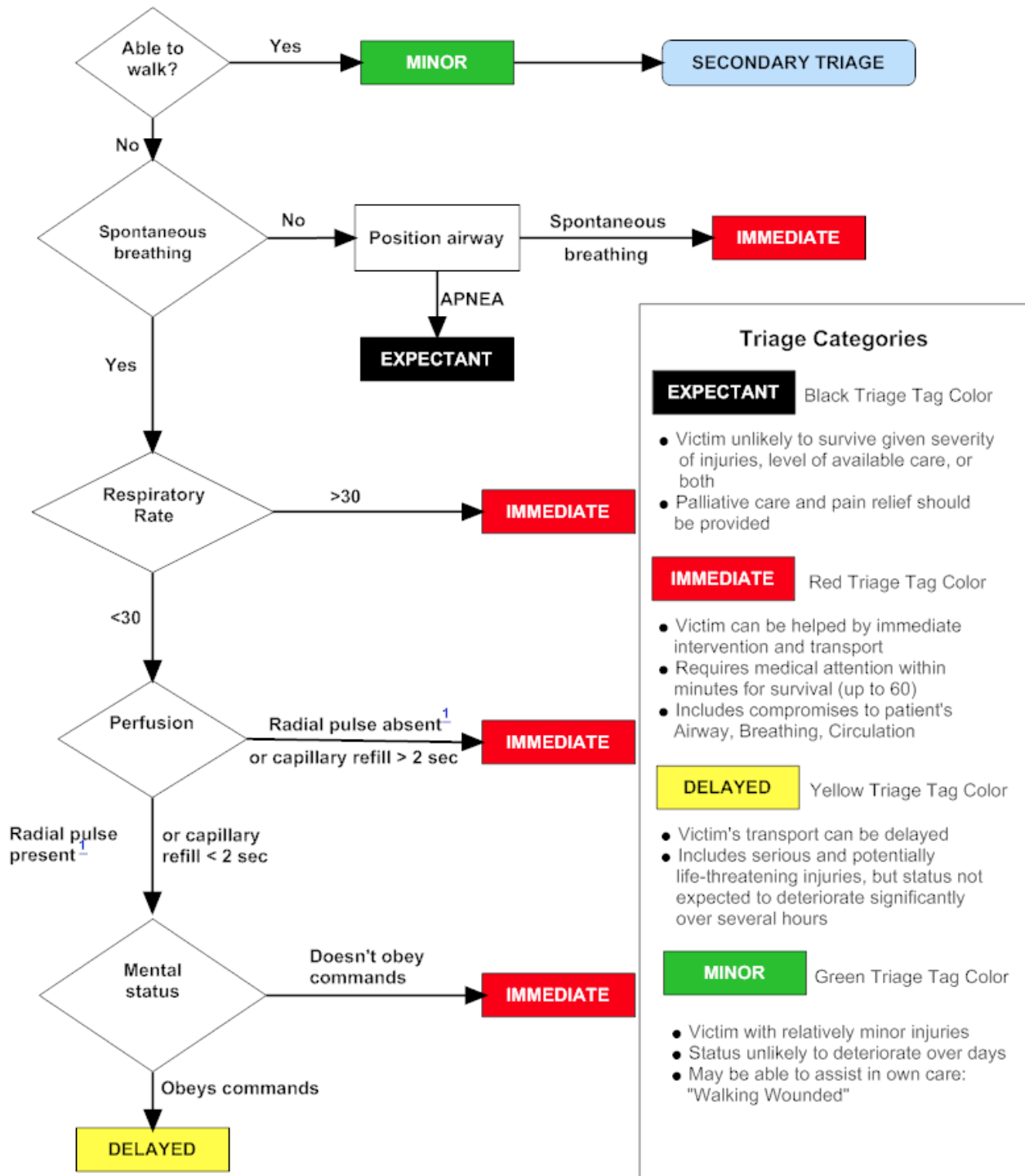
Incident Management -- Medical Branch



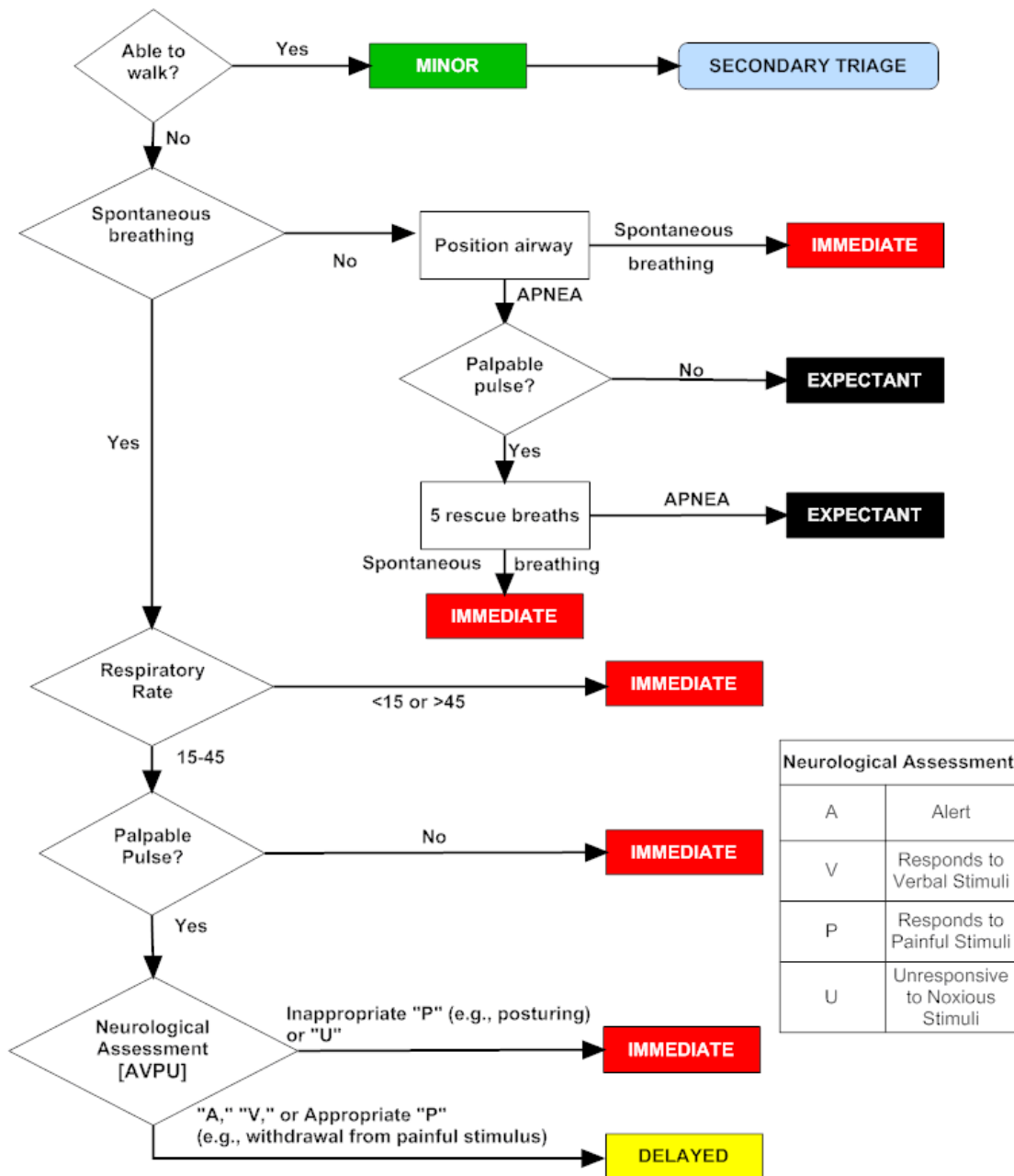
ATTACHMENT 2: TRIAGE GUIDELINES

START (Adult Triage)

Globally sort: assess those who can walk 3rd; those who can wave (purposeful movement), 2nd; those who are still (obvious life threat), 1st. Instruct ambulatory patients to walk to an out of the way area for later assessment.



JumpSTART (Pediatric Triage)



Triage Pearls

- Quickly obtain an accurate scene size-up.
- Be systematic: start where you stand.
- Provide *limited* BLS to salvageable patients (hemorrhage control, open airway, etc.).
- **Litter Teams** move all **Immediate (RED)** patients first.
- Black tagged/Expectant patients should be left in place.
- Patients who have potentially life threatening injuries outside of the START criteria (e.g. 3° burns >40% BSA) may be upgraded to an **Immediate (RED)** category.

ATTACHMENT 3: EMS REGIONAL DISASTER TRIAGE TAG GUIDELINES

Treatment Group Responsibilities

1. Place the regional disaster triage tag on the patient with the following location preference: NECK > RIGHT WRIST > LEFT WRIST > RIGHT ANKLE > LEFT ANKLE.
2. Tear off and dispose of “CONTAMINATED” strip if the patient is not contaminated or after proper decontamination.
3. Tear off and dispose of the acuity level(s) not applying to the patient.
4. Tear off half of the acuity level applying to the patient for **Treatment Group** tracking.
5. Document the patient’s name, age, sex.
6. Record chief complaint, mechanism of injury, and injuries found.
7. Document any emergent treatments provided on reverse (e.g. tourniquet, OPA, NPA).

Transportation Group Responsibilities

1. The Personal Property Receipt should be completed with the patient’s name and placed in the patient’s belongings bag.
2. Complete the Transportation Receipt.
 - a. Record the destination facility unit transporting (e.g. HCEC M91), chief complaint, time transported, and triage acuity.
 - b. On the reverse, complete patient age, gender, and name.
 - c. Remove the Transportation Receipt; the **Patient Tracking Recorder(s)** should ensure data entry into EMTrack and maintain redundant patient tracking records.

Transporting Ambulance Responsibilities

1. Record findings, vitals, and treatment on the regional disaster triage tag.
2. Complete the Ambulance Receipt.
 - a. Record the destination facility and patient name.
 - b. Remove the Ambulance Receipt for your records.
3. Complete any unfilled fields as appropriate.
4. Complete a full EMS patient care record on all patients once incident has concluded.

Sample Regional Disaster Triage Tag

TRANSPORTATION RECEIPT Tag Number **4869**
 E10004869

Destination _____ Via _____
 Chief Complaint _____ Time **1 2 3**

TRIAS TAG E10004869

Age _____ First _____ M _____
 Last _____
 Address _____
 City _____ St _____ Zip _____
 Phone _____ Religious Pref _____

Contaminated

Blunt Injury **AFN**

Burn Trauma Burn
 C-Spine Cardiac
 Crushing Fracture
 Laceration Penetrating Injury
 Other _____

Mechanism of Injury _____

Vitals	Time	B/P	Pulse	Respiration

TRANSPORTATION RECEIPT For Use by Transportation Recorder Only
 DAG-05764

Age _____
 First _____ M _____
 Last _____

Tourniquet Applied Time _____
 Airway Management OPA NPA

GCS Tx In:	E:	M:	V:	Time:
GCS Tx Out:	E:	M:	V:	Time:

Known Allergies: _____

Treatment Administered/Comments: _____

ID	Time	Drug Solution	Dose

S L U D G E M
 Suction, Laceration, Ulceration, Debridement, GI Distress, Emesis, Miosis

Injector Type: _____
 Injector Type: _____

Primary Decon Secondary Decon **RESOLUTION**

START triage system Initial Ribbon Triage **1 2 3**

MINOR Move the Walking Wounded

R RESPIRATIONS <input type="checkbox"/> Yes <input type="checkbox"/> No	P PERFUSION <input type="checkbox"/> - 2 Sec. <input type="checkbox"/> + 2 Sec.	M MENTAL STATUS <input type="checkbox"/> Can Do <input type="checkbox"/> Can't Do
--	--	--

IMMEDIATE Respirations - Over 30
IMMEDIATE Perfusion - Cap. Refl. Over 2 sec. or Radial Pulse Absent
IMMEDIATE Mental Status - Unable to Follow Simple Commands
DELAYED All Others
MORGUE No Respirations After Head Tilt

MORGUE Pulseless/ Non-Breathing 0	MORGUE Pulseless/ Non-Breathing 0
IMMEDIATE Life Threatening Injury 1	IMMEDIATE Life Threatening Injury 1
DELAYED Serious Non Life Threatening 2	DELAYED Serious Non Life Threatening 2
MINOR Walking Wounded 3	MINOR Walking Wounded 3

EVIDENCE CONTAMINATED E10004869

ATTACHMENT 4: MASS CASUALTY INCIDENT SUPPLIES

All Vehicles

- MCI Management Guideline.
- Triage pouch containing rolls of ribbon in the following colors:
 - RED, YELLOW, GREEN, BLACK.

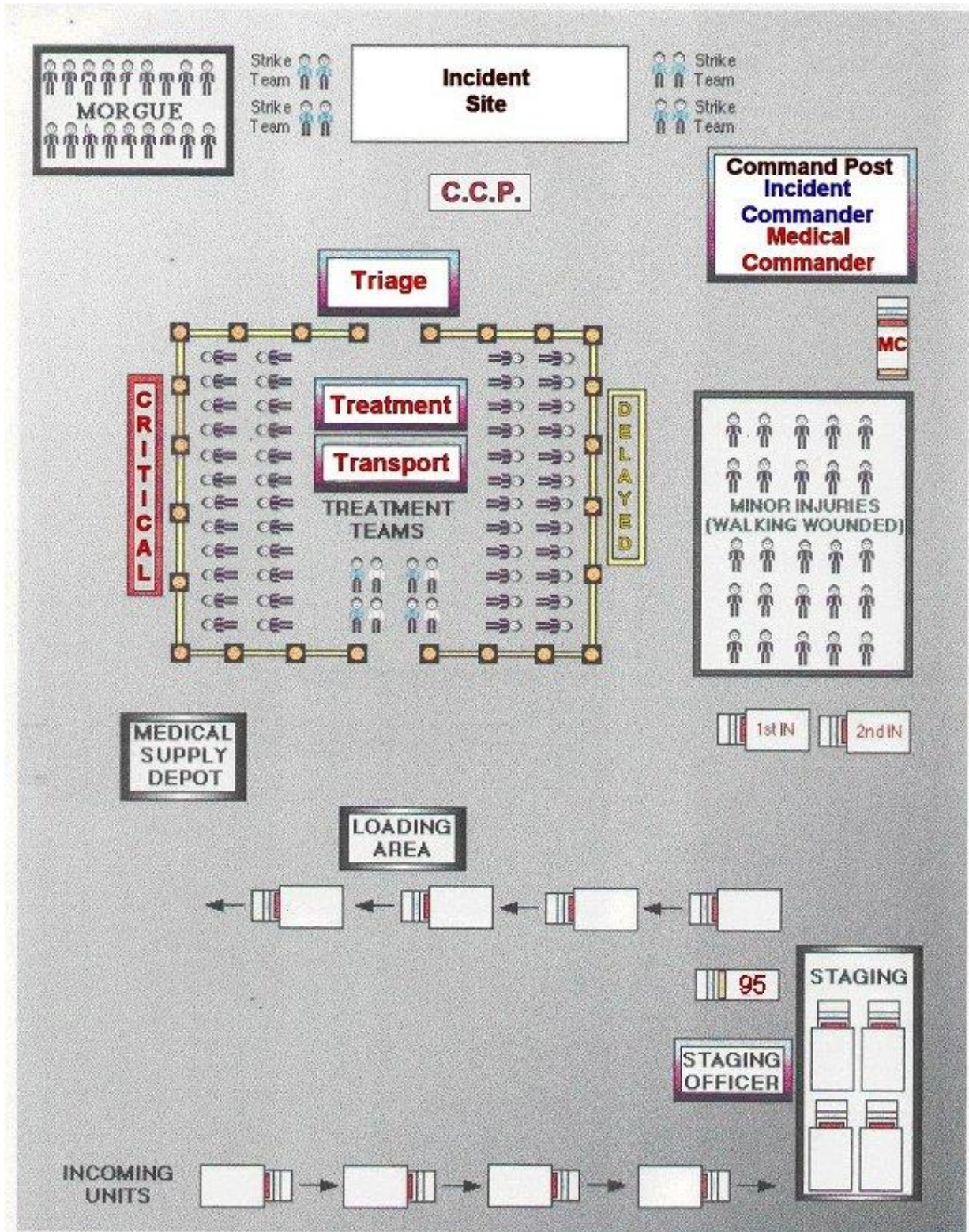
EMS Supervisor Vehicles

- 100 regional disaster triage tags
- Supply of necessary forms
- MCI management vests
- Flags and tarps in the following colors:
 - RED, YELLOW, GREEN, BLACK
- Clipboards, notepads, ballpoint pens
- Computer with access to EMResource and EMTrack
- WMD kit (if available)
- Survey flags or similar for location identification

Mobile Medical Command Vehicles (Medical Director/EMS Director/VP Clinical Services/Events Director)

- 100 regional disaster triage tags
- MCI command board

ATTACHMENT 5: SAMPLE INCIDENT MANAGEMENT DIAGRAM



ATTACHMENT 6: HOSPITAL STATUS BOARD

Bed Availability Worksheet

www.TriageTags.com



Hospital Name	Available Beds	Used Beds
SPECIALTY PTC <input type="checkbox"/> PMC <input type="checkbox"/> Trauma Level 1 <input type="checkbox"/> Burn <input type="checkbox"/> Helipad <input type="checkbox"/>	IMMEDIATE Available Beds for Critical Patients	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
	DELAYED Available Beds for Non-Critical Patients	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26
	MINOR Available Beds for Walking Wounded Patients	1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26

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www.TriageTags.com



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ATTACHMENT 8: EMERGENCY CONTACTS

Emergency Resource	Number
American Red Cross (ARC)	866-526-8300
Catastrophic Medical Operations Center (CMOC)	713-884-4408
Dr. Cameron Decker, HCEC Medical Director	281-886-8182
Harris County Emergency Corps (HCEC)	281-847-5544
Harris County Fire Marshal's Office (HCFMO)	800-590-0005
Harris County Hazardous Materials (HAZMAT)	800-590-0005
Harris County Medical Examiner	713-796-9292
Harris County Office of Homeland Security & Emergency Management (Harris County OHSEM)	713-881-3300
Houston METRO Police	713-224-2677
Houston Office of Emergency Management (Houston OEM)	713-884-4408
National Transportation Safety Board (NTSB)	202-314-6290
SouthEast Texas Regional Advisory Council (SETRAC)	281-822-4444

Hospital	Address	Phone
Ben Taub	1504 Taub Loop	713-873-2446
Conroe Regional Medical Center	504 Medical Center Blvd	936-538-7906
Cypress Fairbanks	10655 Steepletop Dr	281-897-3150
Houston Northwest	710 Cypress Creek Pkwy	281-440-2149
Kingwood	22999 US-59	281-348-8560
Lyndon B. Johnson (LBJ)	5656 Kelly St	713-566-9562
Memorial Hermann Greater Heights	1635 North West Loop	713-867-3335
Memorial Hermann Med Center	6411 Fannin St	713-704-3174
Memorial Hermann Memorial City	921 Gessner	713-242-3070
Memorial Hermann Northeast	18951 N Memorial Dr	281-540-7999
Memorial Hermann Southwest	7600 Beechnut	713-456-5768
Memorial Hermann Woodlands	9250 Pinecroft Dr	281-364-2525
Methodist Med Center	6565 Fannin St	713-441-1016
Methodist Sugarland	16655 Southwest Frwy	281-274-7121
Methodist Willowbrook	18220 State Highway 249	281-737-4610
St. Joseph	1919 LaBranch	713-757-7557
St. Luke's Health Med Center	6720 Bertner	832-355-2121
St. Luke's Health Sugarland	1317 Lake Pointe Pkwy	281-637-7700
Texas Children's Med Center	6621 Fannin	832-824-5454
VA Medical Center	2002 Holcomb	713-794-7440