

**GUIDANCE FOR DEVELOPING
COMMUNICATIONS PROTOCOLS FOR
CALIFORNIA-NEVADA MASS CASUALTY
INCIDENT PATENT TRANSPORTATION**

TAO EMERGENCY MANAGEMENT CONSULTING

JUNE 15, 2005

ACKNOWLEDGEMENT

TAO Emergency Management Consulting produced this document under the direction of the California/Nevada Border County Medical Health Disaster Coordination Committee. This project was funded through a CDC Regional Partnership Bioterrorism preparedness Project Grant, through the California State Department of Health Services. The purpose was to prepare for a California/Nevada border mass casualty incident. The contract was managed through the El Dorado County Health Department with TAO Emergency Management Consulting per contract #417-PHD0205. Any questions about the contents of this document should be directed to Margaret Williams, Health Program Manager, El Dorado County Public Health Department, Public Health Preparedness Division, (530) 621-6243 or e-mail at: mwilliams@co.el-dorado.ca.us.

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INTRODUCTION

The purpose of this document is to provide a coordination guide for development of critical communications protocols between key stakeholders (defined in the MOU Guide) who are involved in California-Nevada Mass-Casualty Incident (**MCI**) patient dispersal. The primary focus is on Mutual Aid Region IV in California. This is not a tool to be used during an MCI, but rather as a road map to develop such tools through a proscribed process before an MCI occurs.

This guide takes into consideration the responsibility of the Incident Commander (**IC**) at the scene of the MCI. The IC typically makes the final decisions on movement of victims to hospitals. This guidance addresses topic areas of coordination that are relevant to that decision making process between the IC, the pre-hospital Emergency Medical Services (**EMS**) and the health care facilities (**HCF**). Areas of coordination may include:

- Alert notifications of healthcare systems and responsible stakeholders
- Operational communication protocols to ensure appropriate, timely and consistent information sharing
- Transport times and service zones
- Use of Casualty Collection Points
- Communication participant charts

BASIC ASSUMPTIONS

The following assumptions need to be agreed upon by all relevant partners prior to setting communications protocols. This can be done, as described in earlier reports, most easily through letters of intent, followed by letters of agreement.

1. All field operations will use the Incident Command System (**ICS**) (as required by the Standardized Emergency Management System in California, and the National Incident Management System).
2. All pre-hospital assessments will use **START** (for adults and youths) and **JumpSTART** (for pediatric patients) for triage at the scene.
3. Altered Standards of Care will be discussed and agreed upon prior to and during the event (See Reference 1).
4. All communications with healthcare personnel will be conducted in Plain Text, without the use of 10-Code.

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5. All control hospitals and receiving healthcare facilities will be contacted for acceptance of patients prior to transport, to ensure appropriateness of the selection and availability of resources to serve the patient.
6. All parties involved in the patient transport will complete the circle of communications to ensure the patients arrived at the designated facility(ies) as directed.
7. All parties understand that it is unlikely that an MCI in itself will lead to the declaration of a Local Emergency by local government, but the events that created the MCI may be cause for a declaration of a Local Emergency. Since regional and statewide mutual aid is not activated (in California) until a Local Emergency is declared, ICs may have to depend, at least initially, on other agreements for expanded EMS support.

ALERT NOTIFICATIONS

In order to ensure the patient management system is appropriately alerted of a MCI of interest in the “Region,” the Incident Commander should be aware of the selections of healthcare facilities in the “Region,” and their standard capabilities, as well as their current capacities. This can be achieved by contacting the Dispatch Center for the first responder jurisdiction, which then would contact the control hospital dispatch center for that “service area”. A map of the area with identified trauma facilities, along with a table below with current contact numbers (See Attachment 1) can be of great value. It will aid dispatchers, disaster control facility hospitals in the Region, and first responders who may serve as ICs. These guide documents must be tracked and updated frequently to ensure all key stakeholders have the latest information. It is recommended that this be done no less than once a month, every month, once these guides are in place. Considerations for notification for a regional MCI response are provided from Reference 2 as Attachment 2.

OPERATIONAL COMMUNICATION PROTOCOLS

Pre-determined operational communications protocols help to ensure appropriate, timely and consistent information sharing. All parties in the loop of patient movement and treatment should agree on what elements of information are most critical, when to provide them, and to which parties. At a minimum, critical decisions require information concerning:

- Patient status and needs (via field triage)
- Numbers of patients to be transported
- Hospital/treatment facility capabilities and current capacity (staffing, space, equipment and supplies, pharmaceuticals, etc.)
- Safest routes of travel (e.g., weather, road conditions, security issues, other hazards like fire or hazardous materials releases)

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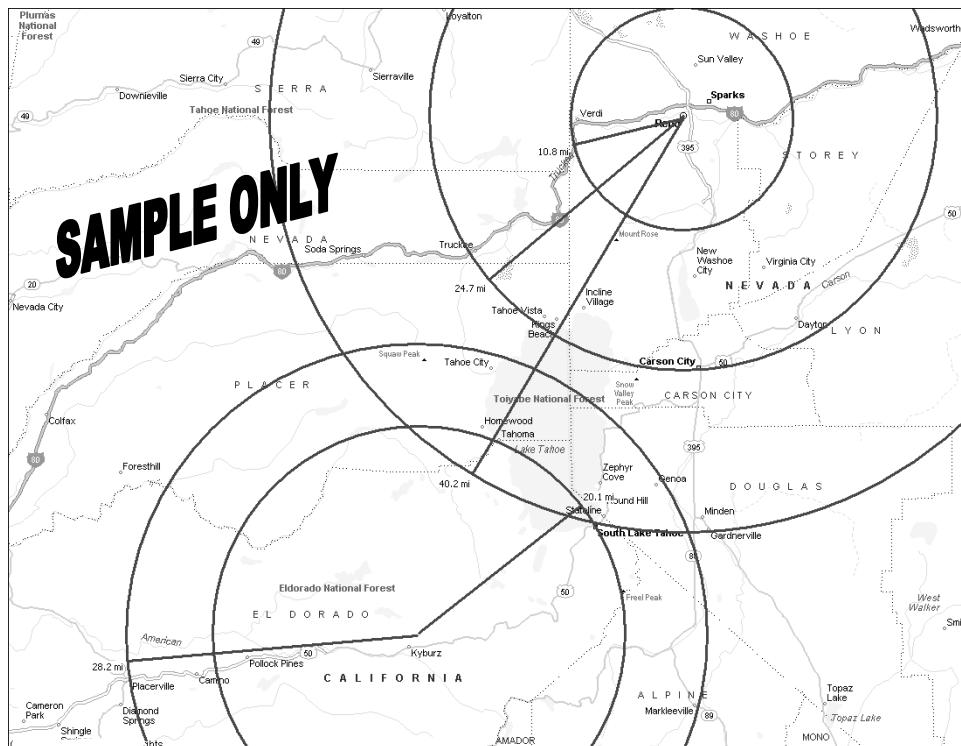
- Travel time/ETA
- Ambulance capability (BLS/ALS) for ground transport, and helicopter support (Life Flight, CHP, National Guard, etc.)
- Secondary communications if primary methods fail (especially in the foothills and mountain terrain)

This information should be provided, along with any other data considered critical for improving patient outcomes, in a checklist format between all parties during the communication process (See a sample as Attachment 3).

TRANSPORT TIMES AND SERVICE ZONES

All parties involved in decisions about an MCI patient transport should have access to guides showing likely transport times by road and by air to hospitals/treatment facilities in the “Region.” These can be prepared in zones that allow the IC to estimate the closest travel times by land and by air. These zone maps would show likely distances from *areas of concern* (likely MCI sites based on history, lessons learned, and projected scenarios) and/or from urban area to urban area. These areas of concern would also include indications of sites of pre-designated Casualty Collection Points (CCP) in the participating jurisdictions. A sample design for such a map might look something like Map 1, below.

MAP 1



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agreements are in place for MCIs prior to the event. If not, the decision will be with the IC to work the best solution for the patient in a timely manner. This may lead to considerable efforts to resolve these issues after the event, perhaps even more than would have been required to form agreements before the fact. Until such agreements are in place, policies set in LOIs and LOAs for pre-hospital care and transport can give the necessary leeway ICs need to provide the best health outcomes for the MCI patients.

CASUALTY COLLECTION POINTS

It is a standard concept of operation to use casualty collection points to concentrate the triage, treatment and transportation of numerous patients. This process may involve pre-designated CCPs for anticipated large-scale events in the “Region,” (e.g., catastrophic earthquakes, fires, floods, dam failures, hazardous materials releases, terrorist attacks, etc.). These are chosen to ensure the likelihood that some will remain viable from the impacts of the most likely hazards. These should be mapped and made available to all transporting agencies as well as first responders in the “Region.”

In the case of transportation accidents, or in fast moving events that don’t allow for establishing a pre-designated CCP, the IC may designate an ad hoc CCP. If the CCP will be support by ground transportation it should be sited close to the best transportation route having no travel impediments. If air support is going to be used, the IC will work with the incoming pilots to establish a landing zone (LZ) that is as free of as many interfering trees, power lines, and structures as is possible.

It is crucial that no matter which CCP is used that the sites be communicated quickly and clearly with all parties, including the receiving hospitals. Public Health officials need to know if these sites are going to be in use during a long-term response to a larger ongoing event. In this way, Public Health can coordinate with local emergency services to establish additional medical assistance for the CCP sites, including EMS, nurses and even physicians (e.g., a CCP used as a remote treatment site for victims evacuating to rural areas after a terrorist chemical attack on a large city).

CHARTING COMMUNICATIONS

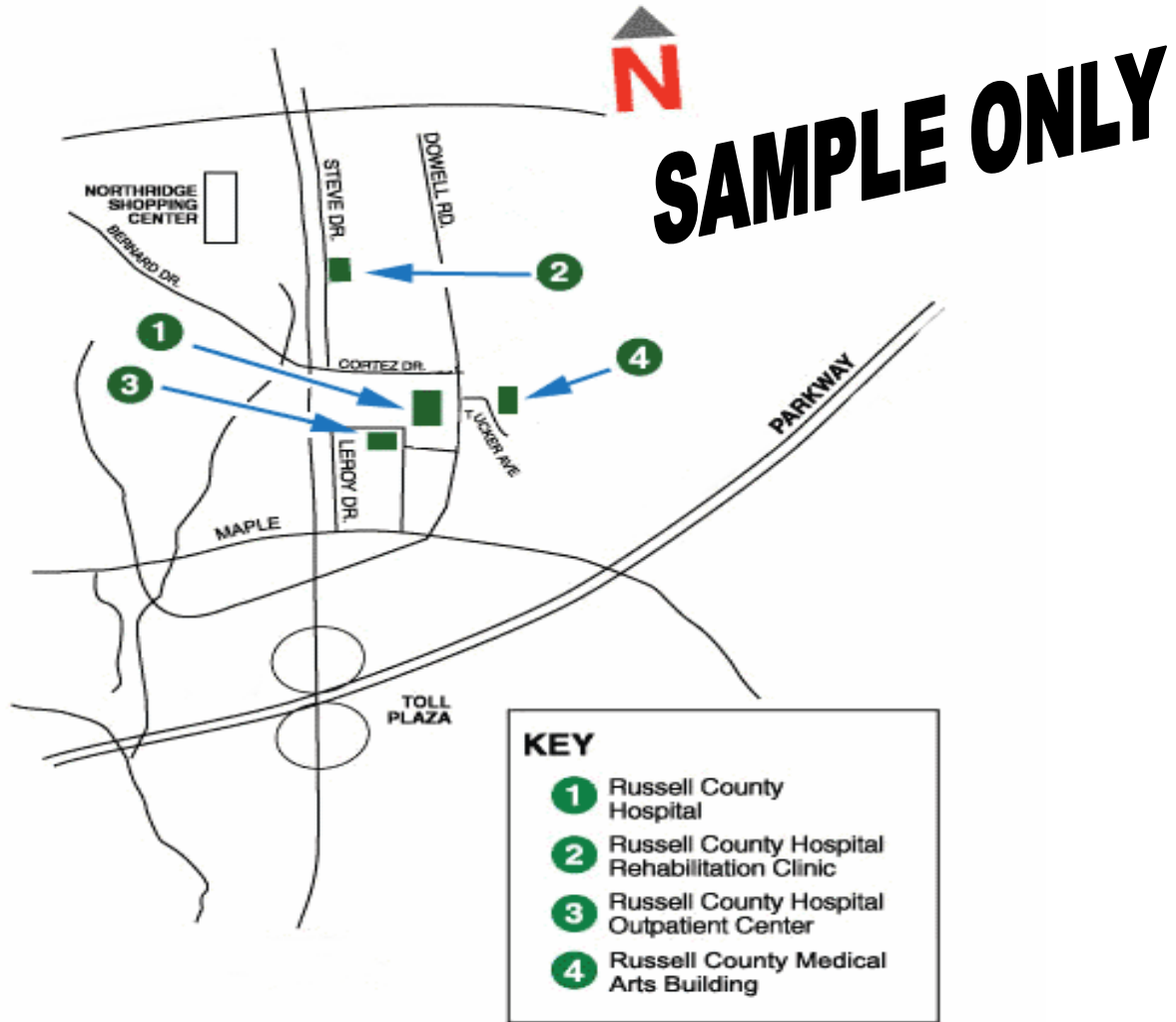
The stakeholders should agree to use charts that describe the MCI communication links in the “Region.” These charts act as a visual agreement as to who communicates with whom. This starts from initial alerting and notifications and extends through coordination and decision-making, to transport tracking and reporting, and finally to assessment of the quality of the process in the after action reports as required in larger events. Several examples of MCI communications charts are provided in Attachment 4.

REFERENCES

1. Bioterrorism and Other Public Health Emergencies:
Altered Standards of Care in Mass Casualty Events
AHRQ Publication No. 05-0043
Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
April 2005
2. Regional Mass Casualty Incident Plan
Northeast Colorado All-Hazards Region
December 1, 2003

ATTACHMENTS

**ATTACHMENT 1
REGIONAL TRAUMA CENTERS AND HOSPITALS
COMMUNICATIONS TOOL**



FACILITY	CONTACT #S	CAPABILITY
Russell County Hospital	555-222-3331, Med-Rad Phone 23, L-Med Radio,	All major traumas, burn center, pediatrics, decon center
Russell County Hospital Rehab Clinic	555-222-3322, Med-Rad Phone 24, L-Med Radio,	Major trauma, ventilators
Russell County Hospital Outpatient Center	555-222-3301, Med-Rad Phone 25, L-Med Radio,	Basic medicine, isolation ward, ventilators,
Russell County Medical Arts Building	555-222-3300, 555-222-1856	2 operating theatres, x-ray, general medicine, 6 beds

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ATTACHMENT 2 MCI NOTIFICATION ACTION CONSIDERATIONS

Case examples have shown repeated pitfalls from initially underestimating the size of MCIs. These delays have created catastrophic situations and shown that it is better to cancel resources than to request them too late.

Upon notification from an Incident Commander, or by approved local protocol or SOP, the dispatch center should:

1. Initiate notifications based on pre-determined lists. Notifications may include, but not be limited to:
 - Hospitals (receiving, control and specialty care)
 - Neighboring jurisdictions via communications centers
 - Mutual aid response agencies
 - Technical specialists
 - Other entities based on incident type, magnitude and other considerations
2. Avoid making assumptions about severity/complexity of the field situation
3. Respond positively to initially large requests for resources, but never go beyond requesting authority defined by protocol
4. Tend to order/initiate more resources rather than conserving immediately deployable (less than 1 hour) resources, regardless of personal preference, time of day, or multiple simultaneous MCIs
5. Initiate field unit roll calls if necessary to confirm status of field units
6. Initiate mutual aid requests early, and based on pre-determined protocols
7. Consider alternatives if, for some reason, the dispatch center were to become inoperative

SOURCE: Regional Mass Casualty Incident Plan
Northeast Colorado All-Hazards Region
December 1, 2003

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ATTACHMENT 3 CRITICAL MCI INFORMATION CHECKLIST

Patient status and needs at the scene or CCP (via field triage): (list numbers)

Immediate
 Delayed
 Minor
 Deceased

Numbers of patients needed to be transported to _____ Hospital/Clinic:

Immediate
 Delayed
 Minor

_____ Hospital/treatment facility's capabilities and current capacity (staffing, space, equipment and supplies, pharmaceuticals, etc.)

Can receive:

Immediate Ventilators available Isolation wards available
 Delayed
 Minor

Safest routes of travel: By Ground: _____
By Air: _____

SAMPLE ONLY

Travel time/ETA to hospital/clinic: By Ground: _____
By Air: _____

Ambulance capability (BLS/ALS) for ground transport, and helicopter support (Life Flight, CHP, National Guard, etc.)

Secondary communications if primary methods fail (especially in the foothills and mountain terrain):

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ATTACHMENT 4 MCI COMMUNICATIONS CHART

NOTES:

These tables are provided more as a basis for planning discussion rather than a specific recommendation on how to connect various entities within a given MCI response system.

It is useful to initiate notifications to higher levels while simultaneously notifying organizations at lateral levels within the system. However, one should not be done without the other.

At the regional EOC level, communications silence from a given geographic area should be assumed to mean that that area has undergone catastrophic impact and is not in a position to establish communications with regional EOCs.

Notification Table showing communications WITHIN affected area

	FIELD	HOSPITAL	CLINIC	DISPATCH CENTER	LOCAL GOV'T EOC
HOSPITAL	Y	Y	N	?	Y
CLINIC	N	N	?	N	Y
DISPATCH CENTERS	Y	?	?	?	Y
LOCAL GOV'T EOC	Y	Y	Y	Y	-

"Y" = Yes, communications should be established between these two entities

"N" = No, communications should not be established between these two entities

"?" = Communications should be decided at the local & regional level

"-" = Null value

SAMPLE ONLY

Notification Table showing communications between affected area and OUTSIDE areas

	FIELD	HOSPITAL	CLINIC	DISPATCH CENTER	LOCAL GOV'T EOC
REGIONAL HOSPITALS	N	N	N	N	Y
(REGIONAL CLINICS)	N	N	Y	N	Y
(REGIONAL DISPATCH CENTERS**)	N	N	N	Y	Y
(REGIONAL GOV'T EOCs)	N	N	N	Y	Y

Organizations in parentheses are in areas away from impacted areas

** This includes both public (government) and private (provider) dispatch centers

SOURCE: Regional Mass Casualty Incident Plan
Northeast Colorado All-Hazards Region
December 1, 2003