Foothills Regional Emergency Medical & Trauma Advisory Council

Serving Boulder, Clear Creek, Gilpin, Grand, & Jefferson Counties

Regional Multiple Casualty Incident Plan

(MCI)

Updated
January 2025

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FRETAC Message

The Foothills Regional Emergency Medical & Trauma Advisory Council (FRETAC) provides this plan to the agencies, facilities, counties, and state agencies within the boundaries of our RETAC with the understanding that it is considered a "living document". Revisions of this plan are always on-going, and the plan will change as new information and data is obtained. Appendices to this plan are continually "in process" as events and data inspired standards are set.

The concept of this FRETAC Regional MCI Plan is that it is a document that it provides a foundational MCI plan focused on best practices and current principles and concepts that should be followed. For example, RAMP Triage should be used, and anything that slows the transport of patients is likely counterproductive. We no longer use choke points and tarps that slow patient transports. This MCI plan unifies the efforts throughout the FRETAC to better prepare for multiple patient (mass casualty and mass evacuation) incidents. These efforts will ultimately enhance the entire EMS system. This plan has been developed by pre-hospital, hospital-based, emergency management and public health professionals. This design ensures a plan that is a "top-down – bottoms-up" approach.

This plan is meant as a "systems" plan only and should NOT be interpreted as an Operational plan. This plan, along with the FRETAC Job Action Sheets should be used as templates to develop individual agency plans that work within our regional system.

The Foothills RETAC also acknowledges that resources around our state are changing very quickly, so the resource lists and other appendices will change.

The RETAC as an Agency Resource

Colorado Legislature mandated the development of regional medical systems. Under Senate Bill 00-180, which updated Colorado Revised Statute (CRS) 25-3.5-101 et seq., the "Colorado Emergency Medical and Trauma Services Act" (the Act) further defines the creation of the Regional Emergency Medical & Trauma Advisory Councils (RETACs).

Based on direction provided under the Act, the Foothills FRETAC was created through the Boards of County Commissioners in Boulder, Clear Creek, Gilpin, Grand and Jefferson Counties. The Commissioners from each county appoint regular members and possibly an alternate member to represent their interests on the FRETAC Board of Directors

This Plan has been approved by the Foothills Regional Emergency Medical and Trauma Advisory Council Board of Directors but will be continually updated as a living document.

Purpose

The Foothills Regional Emergency Medical and Trauma Advisory Council (FRETAC) was created to develop a comprehensive and regional, emergency medical and trauma care system.

Each Board of County Commissioners and Office of Emergency Management within our five counties will be given a copy of this plan for their review and use as appropriate for their county.

This FRETAC Regional MCI Plan establishes a basis for unified response to a Multiple Casualty or Mass Evacuation incident in our region. The region covers Boulder, Clear Creek, Gilpin, Grand, and Jefferson Counties. The FRETAC Board of Directors encourages all pre-hospital agencies, facilities, and county emergency managers to develop inter-operable MCI plans that include working agreements with neighboring agencies and facilities.

The intent of this plan is to provide fundamental concepts and best practices for MCI responses that can be utilized and incorporated into local plans. This plan is meant to provide a framework and a common means of operating so that these incident types can be quickly resolved and patients treated and transported as expeditiously as possible.

Successful management of any Mass Casualty or Mass Evacuation (with the use of the Regional MCI Plan) depends heavily upon cooperation and shared organization and planning among County Emergency Managers, healthcare professionals, administrators in facilities, prehospital agencies, and disaster related support agencies and government entities at all levels in the counties that comprise the FRETAC.

Administration and Support

The FRETAC MCI Committee is a standing committee of the Foothills RETAC. This committee shall work cooperatively with representatives from each county to link Local Emergency Planning with this Regional Plan

Plan Development and Maintenance

This Regional MCI Plan, along with the FRETAC Job Action Sheets (Appendix B) was originally written in 2004 through the FRETAC MCI Committee. The current plan of 2025 will be distributed via a wide range of outlets.

The FRETAC MCI Committee is responsible for triannual reviews of the MCI Plan. Other revisions can be made at any time that national, state, and federal standards change, upon approval of the committee and the FRETAC Board of Directors.

In essence the MCI Committee is operating on a three-year cycle where year one is plan revision, year two is plan updates and mini exercises to shop the plan with agencies, and year three is a full-scale exercise designed to test the plan.

Implementation

Revisions and/or amendments shall be acted upon by the FRETAC no longer than 60 days after all members have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the committee chair.

Definition Of Terms And Abbreviations

Alternate Care Facility (ACF): Location, preexisting or created, that serves to expand the capacity of a hospital to accommodate or care for patients when an incident overwhelms local hospital capacity. In an MCI, patients will be triaged and transported to the hospital not the ACF for definitive care.

Ambulance Staging: Designated parking area for patient transport vehicles. Operators and attendants will not leave their vehicles.

Colored Tags or Flagging: A color-coded identification system used to designate medical priority of patients during a MCI.

- Red (immediate)
- Yellow (delayed)
- Green (delayed)
- Black (deceased)

EMResource: Statewide hospital bed count availability system. MCI's need to be declared in this system and area hospitals will be 'pinged' and can update their bed counts and availability. Transportation Officers need to utilize this system or have a dispatch center or hospital manage it for them so they know how many patients can go to each hospital

EMS	Emergency Medical Services
EMResource	Web-based Hospital Divert and Capability Reporting System
EMTS	Emergency Medical and Trauma Services
ETA	Estimated Time of Arrival

Extraction: The process of moving patients out of the hot zone to the treatment and transport areas.

Extrication: The process of removing a patient from an entrapment.

Casualty Collection Point: Area designated or created by emergency officials for the congregation, triage, medical treatment, holding, and/or evacuation of casualties following aMCI.

Field Triage The process of rapidly categorizing a large number of patients, according to their severity of injury, in order to prioritize their extrication and/or extraction to the treatment area.
Various forms of triage are used to determine the severity of a patient's injuries and condition. Examples are:

- **RAMP Triage:** Triage method that involves the Rapid Assessment of Mental Status and Pulse and sorts patient into sick and not sick categories

- **START Triage:** An acronym for **S**imple **T**riage **a**nd **R**apid **T**reatment, and is defined as being a method that first responders use to effectively and efficiently evaluate all of the victims during a mass casualty incident

FRETAC Foothills Regional Emergency Medical and Trauma Advisory Council

HazMat Hazardous Material

IAP Incident Action Plan

IC Incident Commander

ICS Incident Command System

IMT Incident Management Team

Non-Patient Area An area dedicated to congregation, treatment, and care of patients with minor injuries. Designated as a separate area from Treatment due to the large number of potential patients and the special considerations they may need, such as: shelter, food and restroom facilities. Depending on the type of incident they may also be considered witness/suspects and require police presence.

Medical Control Physician direction over pre-hospital activities. Also includes written policies, procedures, and protocols for pre-hospital emergency medical care and transportation.

Mass Casualty Incident (MCI) An incident resulting from man- made or natural causes with associated illness or injury to a large number of people. The effect is that patient care cannot be provided immediately due to all, and resources must be managed.

MCI Response Varied level of resources dispatched to an incident dependent upon the nature of the incident, the number of patients, and their severity of injury.

MCI Trailer A mobile trailer provided by RETAC which contains large quantities of medical supplies that can be dispatched to a scene of an MCI.

Medical Ensures that Triage, Extraction, Treatment, Transportation, Non-patient Area, Medical Staging, and Morgue Team functions are performed; establishes positions as necessary.

MOU Memorandum of Understanding

MGS Medical Group Supervisor

NIMS National Incident Management System

Rescue In larger or more complex incidents Rescue will oversee the extraction and extrication of patients.

Staging Location where incident personnel and equipment are assigned to an immediately available status.

Treatment Area The designated area for the collection and treatment of patients.

- Red: an area where patients require immediate assistance
- Yellow: an area where patient injuries are serious (delayed) but not life-threatening
- Green: an area where patients with minor injuries are kept

Unique Identifier Number preprinted on a band, bracelet, or tag to assist in tracking patient throughout the incident from initial entry to final disposition.

Situations and Assumptions

Assumptions

The traditional definition of an MCI plan is: any incident that overwhelms the capacity of the system with the number and severity of victims. A more specific definition is: any time the presence of multiple patients at an incident affects the treatment of individual patients

Each Agency will define what constitutes a Multiple Casualty Incident for their jurisdiction. It is understood that an MCI is dependent upon the resources of the responding agency and what will constitute an MCI for one agency will not for another. Each agency must determine what number of patients will overwhelm their resources and plan accordingly. For the purposes of the plan written our suggested minimum number of patients for an MCI will be 10.

The following assumptions provide the basis for the execution of this plan:

- This plan assumes that you, the user, have an intimate working knowledge of emergency response in your County
- This plan assumes you are well versed in the complexities and capabilities of the various dispatch centers in your County
- This plan is meant to offer you basic frameworks and strategies for incident response, however it expects that incident command for any MCI will be highly functional and well-versed in managing complex incidents

- You, the user of this plan, have an operational understanding of NIMS, ICS, and response activities. The purpose of this plan is to provide a framework for response, but not to micromanage operations. As an example, this plan provides contact information on who to call to order medical helicopters, however you are expected to know how to land them and manage helicopter operations
- The priority of an MCI response is to streamline efforts to speed patient transition to definitive care centers
- Any action that delays the treatment or transport of patients should be modified or eliminated as long as it does not increase risk to responders
- Responders will use the Sick/Not Sick model for MCI triage. "Sick" (Immediate) patients will be classified as red. "Not Sick" (Delayed) will be classified as yellow or green. FRETAC recommends and supports the use of the RAMP Triage system.
- While FRETAC supports RAMP, it is recognized that all Triage systems produce similar results, resulting in red, yellow, green, and black patients. Therefore, when working with other agencies, it does not matter if different triage systems are used as patients will be sorted into immediate and delayed categories
- On scene treatment is dynamic, allowing alteration of treatment protocols to match available resources
- It is generally recognized that similar mechanisms of injury will have corresponding patterns of sick and not sick patients. This allows responders to quickly estimate the patient distribution based on total patient count. Using this assumption allows the first arriving officer to simply state the estimated total number of patients during the initial scene size up, rather than trying to determine the number of red, yellow, and non-patients on arrival. Assuming that approximately 20%- 50% of the patients on scene will be classified as immediate (red and some yellows), this will give a quick guide to the number of resources that will be immediately requested and establish the scope of the incident
- In large-scale MCIs patients will self-extricate and transport; this cannot be avoided. However, attempts must be made to triage and track all patients at the scene. There is also a law enforcement component to this issue, as these patients are witnesses to the event and may be needed for statements
- MCI responses may need to be adjusted to the configuration and geography of the incident. It may be necessary to create more than one treatment, loading, and transportation area. In these situations, Incident Commanders should consider creating as many divisions as necessary. Each division can be responsible for triaging and treating patients identified in their assigned geographical area. A single transportation group can support multiple divisions by managing the ambulance staging area and assigning ambulances to each division as requested
- A triage funnel point creates an unnecessary choke point, impeding patient care and will no longer be used.
  Deceased patients will not be moved, unless it is necessary to extract a live patient

Situations

This plan is to be activated upon the recognition of an MCI beyond what the individual agency capabilities/plans can manage (a suggested minimum of 10 patients is reasonable but will vary by agency capability). Therefore, it is also intended that this plan be utilized in conjunction with the tenets set forth in the National Incident Management System (NIMS), the Incident Command System (ICS), and in coordination with your County's Emergency Operations Plan.

Concept of Operations

Overview

In general, this plan is meant to outline the best practices as we know them today to assist regions or agencies on how to organize (ICS) and operate during an MCI. This plan assumes you have a good working knowledge of NIMS, ICS, and local plans, polices, and procedures.

Speed in the transport of patients to definitive care should be prioritized above all as this is the single most important component of survival. Everything is designed around this concept including but not limited to access and egress, triage, treatment, transport, not utilizing choke points and even alternate means of transport if absolutely necessary.

The basic concept of operations remains the same, do the most good for the most people that you can. Utilizing the principles and concepts outlined here, understanding how to work within the chaos of an MCI will allow you bring focus and control to the scene while rapidly transporting patients.

Response Plan

Dispatch

Dispatch centers and their capabilities vary greatly throughout the region. It is incumbent upon the reader of this plan to understand the capabilities and limitations of their dispatch centers prior to any MCI event.

We offer the following advice on utilizing dispatch centers during an event in order of need.

1. Use your dispatch center (via the normal ICS) as normal for all requests and resource ordering.
2. Go to a secondary dispatch center in your area that isn't involved in the call for ordering and resource needs
3. Utilize alternate means for resource ordering if needed (EOCs, HCCs, State, Feds, etc.)

Also because of the intricacies of emergency response various dispatch centers cannot automatically provide move ups, backfill, or automatic dispatching of resources both in and out of the counties. The request for resources, often, needs to be made by a person with specifics. For instance, a Battalion Chief may have to name request the agencies or Metro Task Forces they would like called.

The dispatch centers are linked to some degree and can be tasked to assist each other during an incident. For instance, the IC or Transportation Officer can request to have an unaffected dispatch center handle the EM System for the transportation officer or HRO.

Initial Report and Size Up

As with any fire or rescue response, the initial company is responsible to give an initial and size-up report. These reports give dispatch and all incoming units a "picture" of what the initial company is seeing.

Upon arrival the initial arriving personnel will broadcast the initial report over the radio, including the following in the report:

- Unit signature
- The location, or corrected location
- Initial basic impression

As soon as possible, the responders should give a size-up report including:

- Briefly describe an impression of the scene, including known hazards
- Cause of the incident if known
- Estimate total number of patients
- Establish the Command Designator and Command Post location
- Designate the Transportation Corridor (see Transportation Corridor)
- Initial actions and assignments
- Staging locations
- Additional resource requests

Progress Reports

Progress reports are suggested any time there is a change of the Incident Commander and roughly every 15 minutes.

The progress reports should include the following:

- Current estimated total patient count
- Update transportation corridor location as needed
- Numbers of triaged victims when known
- Number of patients remaining to be extracted
- Number of patients transported
- Progress of hazard mitigation
- Additional Resources needed

Tactical Benchmarks

- All patients triaged
- All patients extracted
- All immediate patients transported
- All patients transported
- Any tactical benchmarks appropriate for hazard mitigation

Initial Actions

The initial actions of the first arriving responders are critical to ensuring a successful outcome. Depending on the size and complexity of the incident, the initial units may be able to fill many roles or handle only a few assignments.

Critical Initial responder Actions

- Initial and size-up reports

- Establish and secure the transportation corridor
- Give assignments to incoming units.
- Begin Recon and Triage
- Perform a risk assessment and begin hazard mitigation for the purpose of reducing the immediate danger to patients, rescuers, or the public
- Designate a non-patient area and have all non-patients move to that location
- Begin extraction and treatment of patients as able.

Recon

A rapid reconnaissance of the entire MCI site is essential to establish the scope and scale of the incident. Depending on the size and complexity of the incident, this may require a Recon Group consisting of multiple teams. The overriding factor should be speed as opposed to specificity to ensure that the information reaches the IC in a timely manner.

Recon should identify the following:

- Equipment needs
- Levels of PPE that will be required. (Note: Differing levels may be required in different areas.)
- Estimate of the number and condition of patients involved.
- Hazards
- Cause of the incident
- Any physical barriers preventing easy access between areas in the hazard zone. If so, identify areas for multiple treatment and transportation areas.

Recon reports directly to Operations.

Scene security will be the responsibility of law enforcement, but Fire and EMS personnel must stay alert to potential security issues including but not limited to:

- Secondary Devices
- Crowd control
- Traffic control

The situation may cause delays of certain operations while law enforcement clears the hazard area. Clear and consistent communication between fire, EMS, and law enforcement is critical to maintain security.

Operational Zones

As a general rule establishing hazard zones without a known threat slows the incident response and therefore should not be done. However, if threat is known, hazard zones need to be established. If needed, initial responders will clearly establish hot, warm, and cold zones (only if there is safety reason such as Haz Mat or Active Shooter etc). The zones must be clearly communicated to all on-scene responders, including law enforcement. The operational zone locations should be broadcast over the main tactical channel to inform all incoming units even if coordination with law enforcement is handled face to face. Scenes should have clearly marked exclusion zones (outer perimeter) when possible. Larger sites may need to be secured by law enforcement.

Crowd Control

Care must be given to crowd control, but total exclusion of bystanders and volunteers may not be possible or practical. If exclusion is impossible or impractical, attempts should be made to moderate the risk to both bystanders and rescue personnel with the help of law enforcement.

Volunteers

MCI incidents may draw civilian volunteers with varying levels of skill and expertise. These volunteers can be helpful if utilized in a safe and organized way, but if they are ignored, they can hinder efforts and increase the risk to both themselves and personnel. Volunteers may be assigned appropriate tasks according to their self-claimed knowledge, skills, and abilities as long as the risks associated with these tasks are minimized. It may be difficult or impossible to verify the claims of expertise by volunteers and care should be taken to place them in supervised roles. It is important to remove or replace volunteers as resources become available.

Staging

Staging areas should be considered based on the size and complexity of the MCI.
There should be a separate Ambulance Staging area that is established for apparatus that will be used to transport patients from the scene to a facility. It is vital that you don't utilize patient transport apparatus for anything else. For example, an ambulance crew should not be assigned to a Rescue Task Force (RTF). In the Ambulance Staging area, personnel are not to leave their vehicles.

Transportation Corridor

The transportation corridor must be established early and clearly communicated by the first arriving units during the initial size-up. The exact street, entry point, exit point, and direction of flow must all be determined and communicated. Law enforcement should be directed to clear and protect the designated corridor; all other apparatus should keep this location clear. Large incidents may require law enforcement to extend the protected corridor all the way to the hospitals.

The first arriving unit is responsible for defining and determining a transportation corridor. The corridor must be maintained until law enforcement takes over the security of the corridor. If the initial company cannot commit a member, they will assign the task to another unit from the initial response.

The person or unit controlling the corridor should anticipate requirements for treatment and decontamination areas, and a patient loading area adjacent to the designated corridor.
All apparatus operators must keep the transportation corridor clear.

Treatment Area

The patient treatment area will be established in conjunction with the transportation corridor. It should be adjacent to the transportation corridor to facilitate communication, tracking, and patient transfer. If the treatment area and transportation corridor are unable to be co-located, they should be located as close as possible with a clear path between the two and their locations broadcast over the primary tactical radio channel.

The treatment area will be the responsibility of the Treatment group, typically, a senior ALS member appointed by Medical. (See Organizational chart).

Extracted patients will be delivered directly to the treatment area unless diverted to the transport corridor by Treatment. **A funnel point should not be utilized**.

Large incidents may necessitate large treatment areas with separate areas and staff for immediate patients. Multiple treatment areas with corresponding transportation corridors may be needed. Treatment needs to request enough staff to handle care for the expected number of patients.

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by Treatment in accordance with standing orders and/or direction from a hospital.

Casualty Collection Point (CCP)

When circumstances dictate that EMS resources must continue to treat patients, Medical should consider establishing a Casualty Collection Point (CCP). An CCP may be as simple as extended use of the treatment areas created at the incident or as complex as translocating patients to an Alternate Care Facility that has been opened to EMS. In some cases, local agencies and jurisdictions will predetermine where EMS might naturally establish an CCP. Ad-hoc CCP may be established wherever the IC can rally enough resources to effectively care for patients.

EMS may need to establish a CCP for any of the following reasons:

- Operating in a warm zone
- Transport cannot keep pace with Extraction

Triage

Triage will not be the responsibility of a single rescuer, rather it will be a collective and ongoing effort to constantly evaluate patients at every step in the MCI process. The Sick/Not Sick triage standard will be used to evaluate patients. RAMP triage should be utilized.

It is understood that all patients should be triaged. However, depending on the variables of the scene, triage may be accomplished by: a Triage team, Extraction teams, or after safely leaving the area.

Geographic triage allows a member to triage patients in their assigned area and prioritize those patients for extraction.

Non-patient Area

The Triage Teams at an MCI will direct ambulatory individuals to a designated area of refuge or Non-patient Area. These patients will be initially classified as non-patients. As soon as possible, a Non-patient Area Manager should be designated.

A large majority of the victims will be delayed (yellows and greens). As these non-patient areas become better established, more robust patient tracking should occur (See patient count and tracking section below) as time and staffing allow.

The Non- Patient Area Manager is responsible for the following:

- Find or create a proper Non-patient Screening Area if one does not already exist
- Liaison with law enforcement
- Medically evaluate all patients, upgrading patients to immediate or delayed as needed, and moving those patients to the treatment area(s)
- Provide basic medical care
- Contain patients as needed (share responsibility with law enforcement).
- Consider comfort needs such as restroom facilities, water, blankets, etc.
- Provide information as it becomes available to the non-patients
- Consider the need for emotional support including the victim advocates, chaplains, family members, or outside counseling support. Many of the non-patients may have been separated from friends or family members, and will experience even greater anxiety when dealing with the unknown
- Documentation
- Patient Tracking
- Victim Assistance and Family Reunification

Law enforcement is critical in establishing and maintaining the non-patient area. Law enforcement will likely want to interview and document non-patients for investigation purposes. Security in the non-patient area may be necessary.

Communications

A single tactical radio channel may be adequate for a small MCI. Large or complex MCIs may quickly overwhelm a single radio channel, hampering critical communication. The Incident Commander should forecast incidents and with the assistance of dispatch centers, may designate multiple radio channels for the incident. Possible radio channel assignments are:

Operations channel to include:

- Operations
- Recon
- Rescue (May need a separate channel)
- Hazard mitigation groups

Medical channel to include:

- Medical
- Triage
- Treatment
- Transportation

Rescue

Patient extraction from the hazard zone will be prioritized based on the patient's condition and difficulty of extraction. Rescue may direct extraction in smaller incidents. In larger incidents, Rescue will supervise Extraction as well as Extrication if needed.

Large or complex incidents may require the hazard zone to be divided into geographical divisions. Supervisors should be alert to recon their assigned area.

Geographical recon includes:

- Number of patients in their area.
- How many of those patients are Red, Yellow, and black.
- Extraction needs, including number of patients and complexity.
- Hazards inside their area.

Extraction

Extraction teams will be composed of one or more pairs of personnel and will report to Medical or Rescue, depending on incident size, for the purpose of patient removal and delivery to the patient treatment area.

Extrication

Disentanglement and technical rescue may be handled by extrication teams under the direction of Rescue. When trapped patients are located, the extrication teams will be sent to assist with the technical removal of those patients. Extrication teams must prioritize their operations to remove as many viable patients as possible in the shortest amount of time.

Decontamination

Any MCI, natural or intentional, may include the release of hazardous materials (haz-mat). Rescuers will need to evaluate the potential need for a haz-mat response and decontamination procedures. If a haz-mat release is known or suspected, a haz-mat response should be requested if not already dispatched.

Primary tasks of the initial responders include: wear the appropriate level of PPE, consider a larger evacuation zone, and start emergency decontamination procedures.

Treatment and/or transport of any patient cannot occur until the patient has gone through emergency decontamination.

It may be difficult to determine in the field if a patient is completely decontaminated, therefore patient contact should be limited to essential procedures in the field and during transport.
Tyvek® suits should be used for patients after gross decontamination when their clothing has been discarded.

Patient Sheltering

Every attempt should be made to provide shelter for the patients in the patient treatment and non- patient areas. The shelter should provide protection from the hazards, weather, media, and the public.

Shelters of opportunity, or existing buildings, should be considered first. Priority will be given to structures with bathroom facilities, running water, and buildings with access that can be easily controlled. If no existing buildings are easily accessible or adjacent to the transportation corridor, then temporary shelters may be used.

Possible temporary shelters include:

- Tents from Decon Units
- Public transportation bus

When choosing a shelter, the possibility for an expanding incident needs to be considered, ensuring patients are not placed into an existing or future hazard zone.

Field Treatment

Standing Orders for Patient treatment during an MCI

MCI Standing Orders should be considered during an MCI. It is understood that communications may be difficult or impossible and it may not be possible to consult medical control prior to providing patient care. MCI standing orders authorize EMS personnel to act pursuant to these orders while on or off duty.

In general, personnel will treat “Red/Immediate” patient’s first, “Yellow or Green/Delayed” patients Second and “Black” patients only after assuring that all patients from the immediate and delayed categories are stabilized. Depending on the acuity and number of patients, it may be necessary to transport ALS patients in BLS units without the oversight of ALS personnel.

Individual Patient Care Reports (PCRs) are not recommended during an MCI. In addition, no permission is required to “cease efforts”. Patient tracking should be considered and attempted as long as it does not slow patient transport

If neither a primary nor back up Hospital is able to help coordinate patient destination, Transport shall notify the receiving hospital of patient numbers and triage status prior to patient transport if possible. Individual transporting units may not routinely communicate with hospitals unless directed to do so.

Patient Count and Tracking

Patient count and tracking are important aspects of an MCI, especially when the incident is large and complex. Every reasonable effort will be made to count and track every patient that is cared for at an incident. The level of tracking may have to be scaled to an individual incident. Factors such as environment, severity of injuries, hazards, and number of patients will dictate the level of tracking. At no time will these activities be priorities above patient care and transport.

Patient count and tracking will be the responsibility of Transportation in coordination with Treatment and the transporting units. Transportation will attempt to keep track of the number of Immediate and delayed patients as they are transported.

Because not every agency utilizes the same triage method, patient tracking will be dependent on the State's tracking system if available, or each agency attaching their own tracking system.

In the initial chaos of a large-scale MCI, ambulances and LEOs may be transporting from many locations. If they transport a patient they should attempt to take and record basic information.

- An example would be recording information such as patient 1 John Doe found in east side parking lot and is an immediate. Patient 2 is Ryan Reynolds DOB is 01-01-01 found in the east side parking lot and is an immediate

A good practice will be for each transporting unit to get what information they can about their patients and where they were found/located. As the event goes on and becomes more organized tracking may start to occur at the triage locations and patients will begin to have a unique identifier, such as a wrist band, already attached when the transport unit picks them up. This unique identifier should be noted by both triage person and the transporting unit.

Documentation

Patient Care Reports (PCR)

Patient documentation is important; however, documentation should never delay patient care or transport. Individual PCRs should be attempted at every incident, however, as an incident grows in size and complexity, it may not be possible to complete PCRs. Incidents may have segments where PCRs may be completed and other segments where circumstances prevent completion of PCRs.

As a rule of thumb, as much information about each patient should be collected and documented as is possible without sacrificing speed and efficiency.

Unique number with transporting agency

When a patient is received by a transporting unit, personnel will document the unique identifier if there is one attached to the patient. If a unique identifier has not been assigned to the patient, then the transporting unit's personnel will attempt to do so. Every effort will be made to give a copy of the unique identifier to Transport. See section above.

Transportation

Transportation will assign patients to transporting units as those resources arrive. Constant communication between Transportation and Treatment is important to ensure that patients are ready to be transported.

The preferred method of transport is an ambulance. Larger incidents may require non-traditional assets. If non-traditional assets without emergency signal devices are used, consideration should be given to using law enforcement escorts to aid during travel. Containing bio-hazardous material in non-traditional assets may be difficult, but tarps, plastic, or other resources should be used to limit the spread of this material.

Law Enforcement

Law enforcement has a huge role in any MCI incident and their piece is critical. At the scene, outside of their traditional investigatory, criminal, and evacuation roles, they are responsible for scene security, security of responders and victims, controlling access, and managing the access and egress corridor.

Additionally, law enforcement should be sending officers to all the hospitals to attempt to identify and track patients that show up and those that arrive by ambulance. As mentioned in the initial chaos of an MCI identifying and tracking patients can be difficult. It will be very helpful to have an officer at each hospital tracking patients as they arrive and doing what they can to identify them and/or at least noting with whom they arrived and from where at the scene they came from. For instance, if an unconscious patient came from the CCP on the north side of the incident this would at least help with patient tracking and with the investigation and reunification needs that are sure to follow.

Lastly, the assigned police officer should be tying in with the hospital resource officer and helping to coordinate activities at the hospital.

Job Assignments

Medical

The role of Medical Group Supervisor should be assigned to a senior ALS member, ideally a supervisor or highly experienced paramedic. In cases where the dynamics of the emergency require earlier assignment of a Medical Group Supervisor, on-scene Medics can be assigned to this position.

Medical is responsible for the following tasks

- Transportation
- Treatment
- Triage
- Non-patient management

Medical may handle most or all the responsibilities in smaller incidents. Larger or complex incidents will require Medical to be proactive in forecasting the incident and begin assigning roles as soon as possible. Circumstances may dictate a large number of ALS and BLS personnel whereby:

- ALS personnel need to be prioritized to treatment due to a high patient count
- Patient removal from the hazard zone will require a large number of BLS personnel and/or complex coordination.

Treatment

Medical may designate a member to be Treatment. (Note: Smaller incidents may allow Medical to retain this role). Treatment is responsible for the following:

- Receiving patients from Extraction
- Supervising treatment of patients
- Managing Treatment Personnel
- Coordinating with Transportation
- Prioritizing patients for transport

The level of treatment performed in the treatment area may vary according to the situation, but rapid patient stabilization will be the priority. The level of care will be determined by the Treatment Team Leader.

Treatment, with input from Transportation, may elect to have patients delivered directly to the transportation corridor for transport.

Treatment should request adequate personnel and resources to care for the expected number of patients.

Transportation

Transportation should be designated early by Medical. Smaller incidents may allow Medical to retain this role. Transportation should be a senior ALS member capable of performing a wide range of duties including:

- Communication with hospitals and Medical Control
- Keeping a total patient count of all transported patients (may be delegated to one or more Aides)
- Coordination with Treatment
- Coordination with law enforcement to clear the transportation corridor
- Liaison with transportation resources
- Maintain adequate transportation resources
- Initiate tracking if unique identifier not already assigned

Incidents that require multiple transportation corridors must have multiple personnel assigned to Transport. They may act independently of each other. Transportation may contact the hospital independently for patient destinations and be responsible for patient count and tracking.

Rescue

Rescue shall be considered when:

- ALS staffing needs to be prioritized to patient treatment and transport.
- Any part of patient removal from the hazard zone will require a large amount of BLS resources or skills.

Rescue may oversee triage and extraction of all patients from the hot zone into the patient treatment areas.

Technical Rescue Teams will report to Rescue to serve as technical advisors and participate in extrication as needed.

Hospital Resource Officer

A Hospital Resource Officer (HRO) should be sent to each of the affected hospitals during a large MCI. The HRO should be a person with good knowledge of hospitals, EMS, and ICS. Their job will be to liaise with the hospital command staff and the incident command and provide support.

Often, each hospital becomes its own MCI as patients self- transport or get transported by EMS. It can be helpful for an HRO to work with the hospital and call in outside resources (from farther away) to come and transport delayed patients to farther away locations.

Additionally, HROs can help with patient tracking and identification and provide real-time updates on the bed count / ability of the hospital to handle more patients. If needed HROs can request further response to the hospitals to assist with triage and treatment that might need to occur in such places as the parking lot.

FRETAC MCI Job Action Sheets (See Appendix B)

Provides standardized guidance on job roles and checklists for those functioning in important supervisory roles. Examples include Medical Group Supervisor, Triage, Treatment, and Transport, etc.

Types of Multiple Casualty Events

The classification of the incident shall be determined by the IC based upon the needs of the scene and available resources.

Resources for care and transportation of patients/victims may be requested and posted on the EMResource site.

Other (usually non-medical) resources may be requested per local protocol.

- **LOCAL:** Required resources available to the agency or immediately available through normal mutual aid.
- **REGIONAL:** Required resources exceed those immediately available locally.
- **STATEWIDE:** When regional resources are overwhelmed, a statewide incident may be declared. Statewide mutual aid or a county disaster declaration must be activated through the County Emergency Management System.
- **FEDERAL:** Activation of Federal resources requires a State declaration by the Colorado Office of Emergency Management and the Governor's office.

Incident Priorities

- Healthcare Provider / Rescuer safety, accountability, and welfare
- Life Safety
- Incident Stabilization
- Conservation of Property and Evidence

Critical Incident Stress Management

CISM team or peer support should be activated through local agencies or the State EMTS section (path4EMS).

Organization and Assignment of Responsibilities

Local Emergency Plans

It is recognized that some localities and each county have a local emergency operations plan.

This Regional MCI Plan shall be transparent to and support any local jurisdictional plan.

The FRETAC MCI Committee will provide assistance (upon request) to Counties/Agencies/Emergency Managers in preparation and maintenance of their MCI plan.

Activating the Operational MCI Plan

The agency, which is the Authority Having Jurisdiction (AHJ) can activate their MCI Plan from the scene.

Once the MCI Plan is activated, the Communications Center will make appropriate notifications via EMResource..

Responsibilities

Hospitals and Healthcare Facilities

Facilities that are activated or alerted under the MCI Plan shall provide, through EMResource, confirmation or adjusted information on the numbers of patients they can accommodate in the three START Triage categories:

- Red: Immediate
- Yellow: Delayed
- Green: Non-patients
- Black: Deceased/Not revivable

Facilities shall activate their own MCI plans for additional staffing based on anticipated patient counts from the scene

Note, facilities do not use RAMP and may recategorize with yellow. However, they are aware that agencies will transport utilizing the immediate and delayed naming convention. Nothing changes in terms of priority however, and the sickest patients get seen first.

Office of Emergency Management

Emergency Managers should be notified of an MCI event through their dispatch centers.

Emergency Management will activate their Emergency Operations Center (EOC) if deemed necessary to support the Incident Commanders in the field.

Acquisition of resources that are needed by the incident beyond the capability of the local response agency and the communications center will fall to the Office of Emergency Management (OEM) and/or the EOC.

A County-to-County resource request will be coordinated by the EOC.

Additional requests will funnel through the State Office of Emergency Management.

There may also be a coordinated request made through the local health department to the State Health Department for additional resources.

Typically, a designated individual will respond to the EOC help coordinate those requests as a representative for ESF8.

Along with the direct coordination between agencies, the use of EMResource and WebEOC in an MCI event is critical and is used by many OEMs to help with resource coordination.

Lastly, many OEMs will request a hospital liaison to the EOC to assist with resource and patient tracking.

Public Health

Public Health representatives are typically the lead for Emergency Support Function (ESF) 8 to provide a coordinated response to health and medical care needs during and following an emergency or disaster incident.

ESF 8 supports the overall health and medical response through the EOC.

For emergency and disaster incidents requiring mutual-aid and local, state or federal assistance, public health will work with counterparts from such entities to seek, plan, and direct use of those assets.

When an incident is focused in scope to a specific type of a response, such as a mass casualty, the position and functions of ESF 8 will be assumed by appropriate personnel with expertise pertinent to the incident.

Medical Direction/Protocols

Established medical direction will be maintained by each agency's provider, even outside of the local agency's jurisdiction.

Patient care shall be rendered in accordance with the established prehospital care protocols of each responding agency.

Fatalities and Mass Fatalities Incidents

It is critical that the Coroner's Office be notified as early as possible in any mass fatality situation.

Fatalities and any incident debris need to be left in place to assist the Coroner in identifying victims.

The Coroner and Law Enforcement shall be responsible for scene and evidence security.

Activation of your County's mass fatality plan should occur; typically done via the OEM

Direction and Control

Technical Rescue Operations/Specialized Resources

When needs exceed regional resources, additional assistance is available through the local EOC.

Hazardous Materials

A Hazmat activation and notification plan should exist locally for incidents involving hazardous materials.

Patients exposed to hazardous materials shall not be transported unless decontaminated.

All healthcare facilities are encouraged to have basic decontamination capabilities to treat patients exposed to hazardous materials.

Patient self-transport should be anticipated by the facilities. Isolation and decontamination should be set up and available.

Decontamination shall be conducted according to accepted national guidelines established by DOT, OSHA, EPA, NFPA and any local hazardous material response plans.

Whole Blood- place holder

MCI FIELD OPS GUIDE

Objectives

- Do the most good for the most amount of people
- Speed is a priority- patients need definitive care; don't forsake speed for scene organization, your goal is to transport patients as quickly as possible
- Establish an evacuation corridor early and protect it
- Reduce choke points
- Treat
- Transport
- Coordinate

Tactical Benchmarks

- All patients extracted
- All patients triaged
- All red patients transported
- All patients transported/clear of incident
- Any tactical benchmarks appropriate for hazard mitigation

Key Points

- Fill vital roles: Operations, Medical, Triage, Transport, Treatment, Rescue, Recon, and Hazard Mitigation if needed.
- You will have to name request most of the resources you want (see PSAPs page)
- Use the EM system (hospital bed availability)
    - Have a dispatch center do this for you
    - Have a hospital do this for you
    - Do it yourself
- Transportation officer and egress corridor are two of the most important pieces you will need
    - Use law enforcement to secure egress corridors
- Move up units to backfill the system as needed

Ambulances needed Calculation

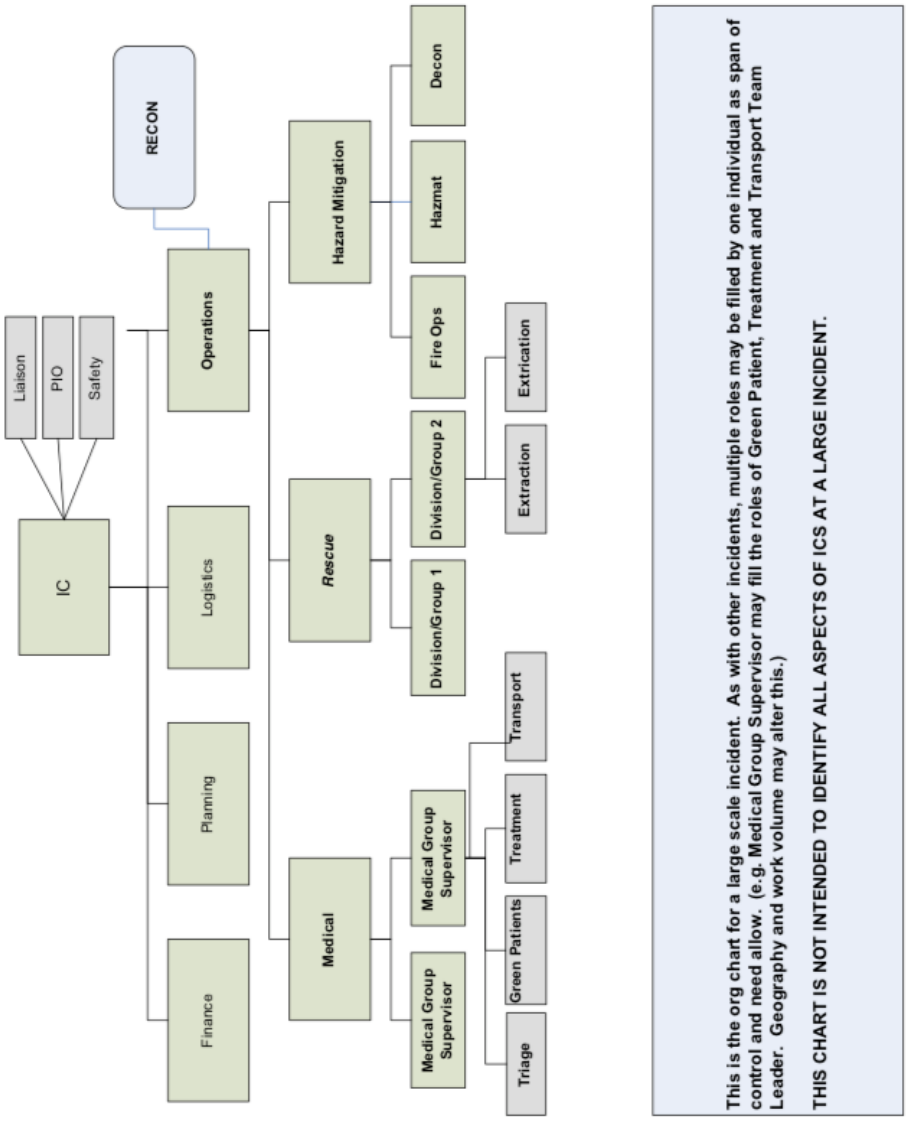
Required ambulances = number of immediate patients divided by two, plus one

- Example: ten immediate patients will require 6 ambulances

EMResource (hospital bed counts and declaration of MCI)

- Follow agency or county protocol for activating EMResource
- Please have a plan to activate it in multiple ways
- If you're requesting a bed count from a facility consider following up on the status of the MCI.

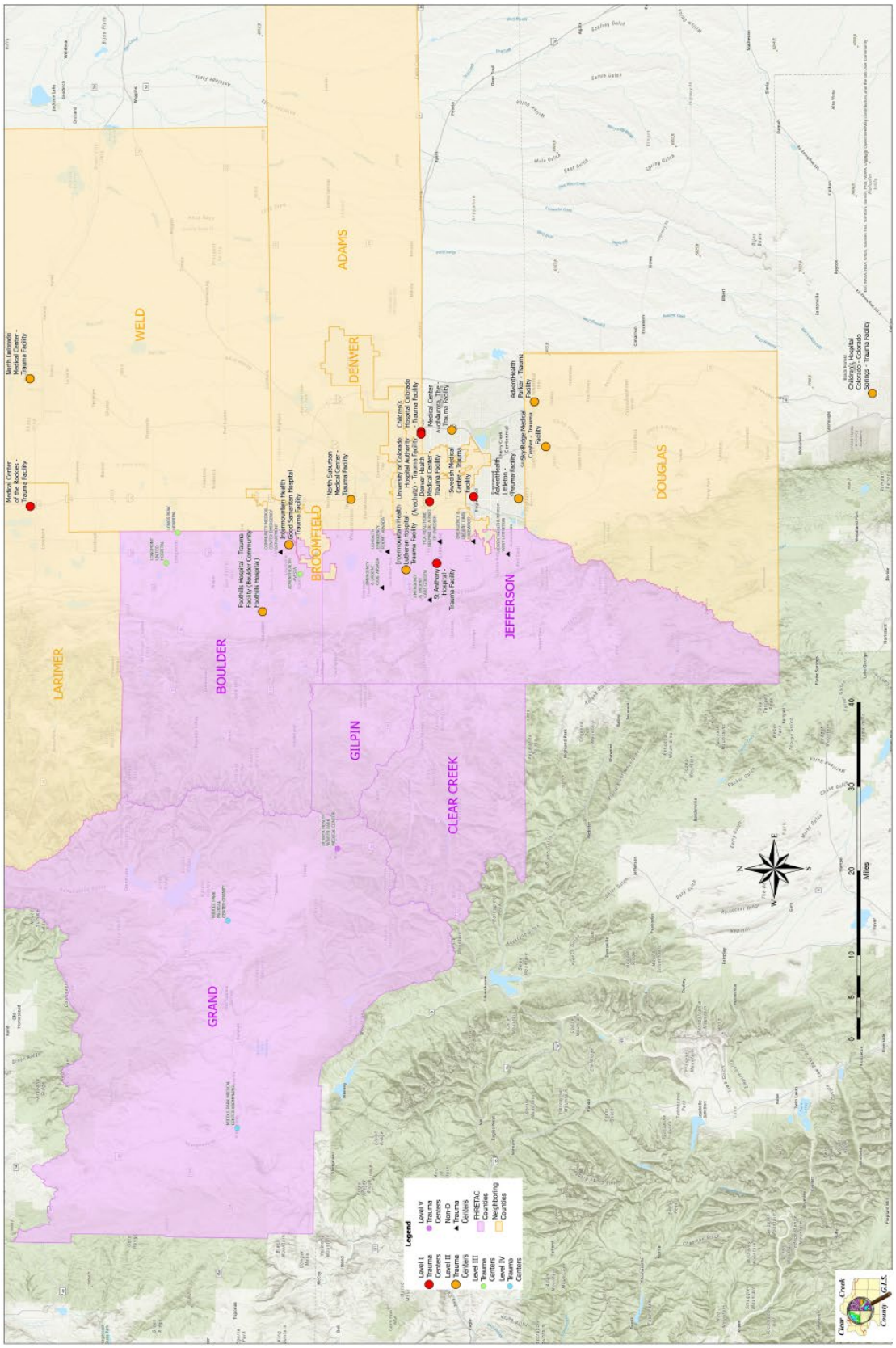
Sample ICS Organizational Chart For MCI



PSAP and Communication Center Contact List

Adams County Communication Center (ADCOM)	Joel Estes	303-289-2235	Adams County (Excluding Federal Heights, Thornton, Westminster, Aurora, Arvada)
Boulder County Communications	Steve Sibermann	303-441-1732	Boulder County, Erie, City of Boulder, City of Longmont, CU-Boulder
City of Thornton Emergency Communications Center	Ashley Morgan	720-977-5151	City of Thornton
Denver 911 Communication Center	W. Andrew Dameron	720-913-2025	City and County of Denver
Federal Heights Police Department	Chris Lyman	303-428-8833	City of Federal Heights (Fire & Police)
Gilpin County	Lyssa Gray	303-528-5500	Gilpin County (Excluding the City of Black Hawk)
Jeffcom	Jeff Streeter	303-980-7300	Jefferson County (Excluding Westminster), All of City of Arvada, Clear Creek County
Grand County Communications	Ashley Macchione	970-725-3311	Grand County
Longmont Emergency Communications	Kristine Mason	303-651-8501	City of Longmont
Loveland Emergency Communications	Becky Kamoske	970-962-2204	City of Loveland and SE Larimer County
Park County Communications	Maria Mitchell	719-836-4115	Park County
South Metro Emergency Communications	Tyler March	720-989-2653	SMFR, West Douglas County, Bennett, Byers, Deer Trail, Sable Altura, Strasburg
Westminster Police and Fire	Lara Mitchell	303-658-4364	City of Westminster

Foothills RETAC Map with Regional Hospitals Noted



Helicopter Use

Helicopters can be an important aspect of an MCI response due to their ability to transport complex patients to specific hospitals farther away. For instance, they can go farther away to lessen the impact on local hospitals, or they can take specific patients to specialized hospitals (i.e. burns, pediatrics, level I trauma etc.).

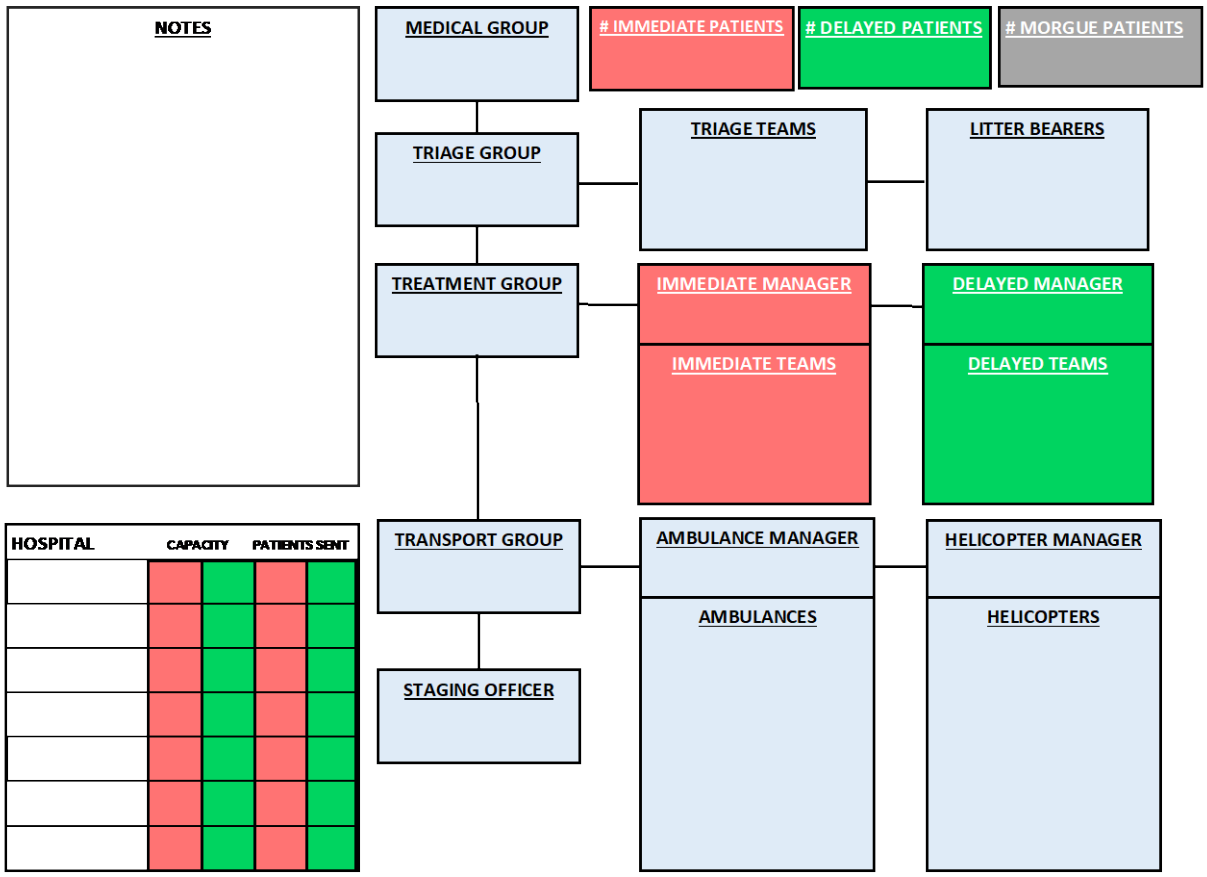
Order air resources as per protocol

Hospital Contact Information

Facility	Biophone #
AdventHealth Avista	303-673-1118
Banner North Colorado Medical Center	970-810-4888
Boulder Community Hospital	303-415-7103
Children's Hospital Colorado	303-363-4778
CommonSpirit Longmont United Hospital	303-772-6704
CommonSpirit St. Anthony Hospital	720-321-4220
Denver Health Medical Center	303-436-6307
Denver Health Winter Park Medical Center	970-726-4299
Good Samaritan Medical Center	303-689-5911
Intermountain Health Lutheran Hospital	303-265-2321
Middle Park Medical Center Granby	970-887-5811 (Charge Nurse)
Swedish Medical Center	303-761-8721
UCHealth Broomfield Hospital	303-464-4513
UCHealth Longs Peak Hospital	720-718-1220
UCHealth Med Center of the Rockies	970-624-1630
UCHealth University Hospital	720-848-5120
HCA HealthOne Mountain Ridge (North Suburban Medical Center)	303-450-3363

Appendix A

MCI Transport Form



APPENDIX B

Job Action Sheets

Medical Group Supervisor

- ○ Consider Hemorrhage Runner/ Recon team
- ○ **Establish Ambulance Corridor**
- ○ **Ensure EM Systems has been activated**
- ○ Designate Triage Group Supervisor
- ○ Designate Treatment Group Supervisor
- ○ Designate Transport Group Supervisor
  - ○ Consider Air Transport Group
- ○ Establish Comms plan with Group Supervisors
  - ○ Tac Channels

Triage Group Supervisor

- Inform Medical Branch Supervisor of resource needs
- Implement Triage Process
    - Assign multiple teams (if necessary)
- Establish litter bearer teams to begin removing critical patients
- Coordinate movement of patients from Triage Area to Casualty Collection (CCP) or Ambulance Transport Point (ATP)
- Maintain accurate casualty count
- **Notify Medical Branch Supervisor once Triage completed**
- Establish area for contaminated casualties (if necessary)

Treatment Group Supervisor

- Establish Immediate & Delayed Treatment Areas
    - Consider area for contaminated patients
- Coordinate movement of patients from Triage to Casualty Collection Point (CCP), Ambulance Transport Point (ATP), or appropriate treatment area
- Establish Tac Channel with Transport Group Supervisor
- Ensure continuous patient monitoring and re-triage
- Assign medic to determine transport order of patients by severity
- Established Morgue area

Transport Group Supervisor

- **Establish Communications with hospitals**
  - **EM Systems**
  - **Consider direct contact via phone**
- Designate Ambulance Staging Area(s)
- Transport patients in order of priority determined by Treatment Group
- Assure accurate destination of transports is recorded
- Request additional Ambulances as needed
- **Consider requesting alternative transport options**
  - Air, Bus, Police Car
- Coordinate any Air Transports with Air Transport Supervisor
- **Notify Medical Brach Supervisor when all Critical Patients off scene**
  - **60 Minute Goal**
- **Notify Medical Branch Supervisor when all Patients off scene**