WISCONSIN DEPARTMENT of HEALTH SERVICES

Division of Public Health

Wisconsin Emergency Medical Services Mass Casualty Incident Response Planning Guide

State of Wisconsin EMS Section

Emergency Medical Services Advisory Board

System Management and Development Subcommittee

Revised 2023

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EMS Mass Casualty Incident Response Plan Guide Template

The purpose of this template is to assist Emergency Medical Service (EMS) providers with development of a new or revised response plan to address management of a mass casualty incident (MCI) during the preliminary stages when first on scene, utilizing the principles of the Incident Command System (ICS). Per Wis. Admin. Code § DHS 110.35(2)(e)9 (**See Attachment F**) EMS agencies in Wisconsin are required to have and submit a mass casualty incident (MCI) plan. This template should be used in conjunction with other relevant information available from entities specializing in MCIs such as the Federal Emergency Management Agency (FEMA), local emergency management, Mutual Aid Box Alarm System (MABAS), regional Healthcare Emergency Readiness Coalitions (HERC) and Regional Trauma Advisory Councils (RTACs) (**See Attachment C**). Further resources are available, (**See Attachment I**).

Definition of a mass/multiple patient incident (MCI)

An MCI is an incident with multiple patients which may overwhelm the resources of the initial responding agencies.

Notification of incident

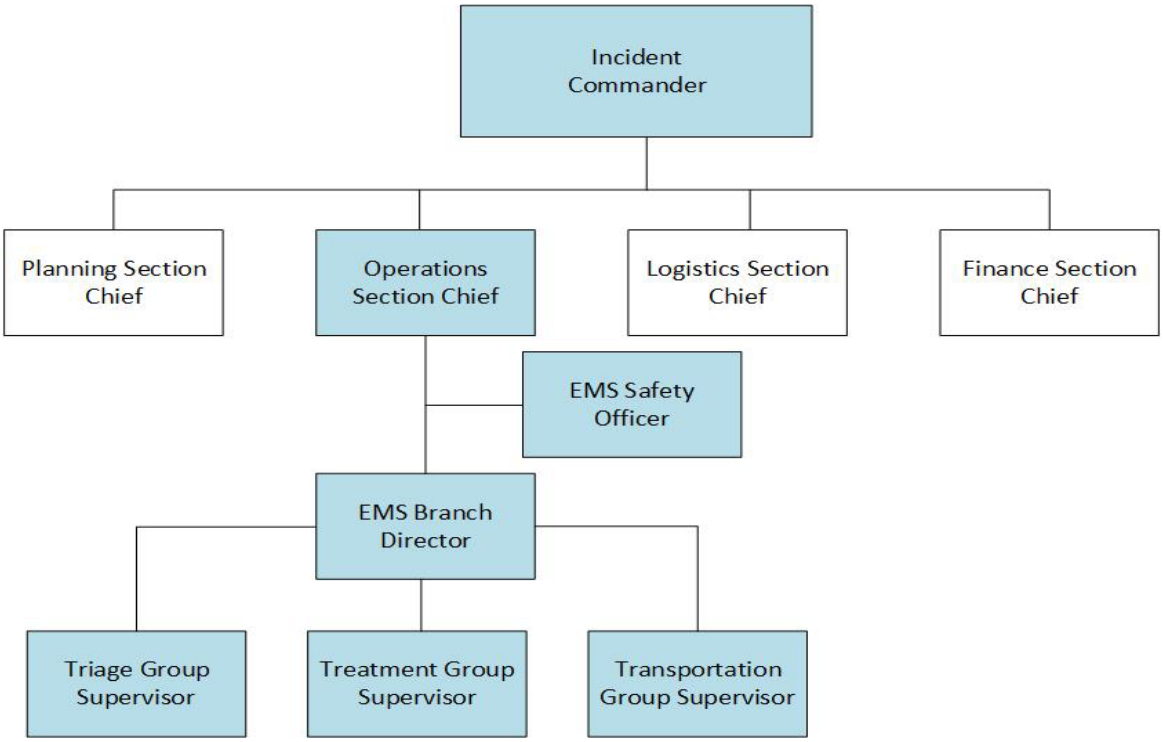
- The 911/public safety answering point (PSAP) is advised that an incident has occurred.
- The PSAP dispatches the public safety agency(ies) necessary to respond to the incident.
- The PSAP provides updates to responding agencies, as available.
- The initial arriving agency evaluates the scene and establishes on-scene Incident Command (IC). (See Attachment A).
- The on-scene IC/responders recognize that current resources may be insufficient.
- The on-scene IC requests additional response resources, including individuals to staff IC positions.
- IC may initiate a Unified Command (UC) depending on size and needs of the incident.
- IC determines the needs and notifies the primary receiving facility of the estimated number of patients involved. This is to allow for the facility and respective health care system to initiate appropriate response plans.

Incident command system

- Incident Commander (IC) or Unified Command (UC) is in charge of the incident.
- The Operations Section Chief manages the operations of the incident. The Operations Section Chief receives direction from the IC.
- The EMS Safety Officer monitors incident operations and advises the EMS Branch Director or IC/UC on all matters relating to operational safety, including the health and safety of incident personnel. This may be part of the role of general incident safety officer but it is important that EMS specific aspects of safety are included (for example, clinical personal protective equipment).
- The EMS Branch Director is responsible for the Emergency Medical Operations during the incident. Depending on the size of the incident and available personnel, the EMS Branch Director may further delegate and assign duties to the Triage Group Supervisor, the Treatment Group Supervisor, and the Transportation Group Supervisor. The EMS Branch Director receives direction from the Operations Section Chief.

- The Triage Group Supervisor is responsible for initiating and directing the Triage Group which is responsible for the rapid assessment and categorization of all patients. The Triage Group Supervisor receives direction from the EMS Branch Director.
- The Treatment Group Supervisor is responsible for initiating and directing the Treatment Group, which will provide on-scene treatment of patients. The Treatment Group Supervisor receives direction from the EMS Branch Director.
- The Transportation Group Supervisor is responsible for assigning transport destination for all patients and ensuring that all patients are transported to the appropriate facility. The Transportation Group Supervisor receives direction from the EMS Branch Director.

Incident command structure



Initial actions for the incident commander

Refer to the First in Checklist, **see Attachment A.**

The checklist presents the initial tasks that an IC may need to perform during the first minutes of an MCI. For the safety of all responders, persons assuming IC ideally should have a working knowledge of the unique aspects of the various incidents that result in a mass casualty incident, such as hazardous materials, chemical attack, mass shooter, building collapse, and others.

EMS branch operations

Refer to the Duties and Responsibilities checklist for each position. Refer to Triage Information.

Hospital-EMS communication

It is essential that, once initial responding units recognize an incident as an MCI, communication with the primary receiving facility should be established. It is important that the facilities have adequate time to enact their internal surge plans and have staff ready to treat incoming patients. The primary receiving facility may

initiate an alert via EMResource (**See Attachment E**) with other facilities in the region that may be impacted by the MCI.

EMS (via the Incident Command structure) and receiving facilities should agree on a method for ongoing communication during an incident. This could include EMResource alert updates, exchange of direct phone numbers or use of local radio system.

Components of ongoing communication

- The primary receiving facility will gather MCI bed capacity information from other facilities in the region. This information should then be communicated to the scene IC.
- The EMS Branch/IC should provide updates to the primary receiving facility on the number and triage category of patients as the incident evolves.
- The primary receiving facility should communicate with IC on the types and number of patients they are capable of receiving, as well as other receiving facilities available for patients.
- IC Structure should provide updates to the primary receiving facility when incident milestones are met, such as initial triage completed, all known patients transported, active threats mitigated (active shooter in custody, hazardous material release contained, etc.). This will assist facilities in their mobilization/demobilization planning of the current event.
- The primary receiving facility should provide updates to IC and via EMResource if facilities' MCI capacities change due to self-presenting patients, arrival of additional staff, and/or concurrent incidents.
- The primary receiving facility will serve as a resource to EMS for medical consultation to determine the most appropriate patient destinations.

Destination, determination and considerations

Primary Receiving facility MCI capacity (**See Attachment D**)

Primary Receiving Facilities MCI bed capacities obtained during an incident should be utilized to guide patient destination decisions but should not be taken as absolutes. Efforts should be made to distribute patients to multiple facilities within the region, and not to overwhelm one facility. However, facilities may receive more patients than indicated as their MCI capacity changes.

Transportation factors:

- Utilize helicopter EMS preferentially to transport critical patients to facilities that may be farther away from the scene.
- Consider the home site of transportation resources. Ambulances transporting to facilities in their primary service area may be able to re-stock more efficiently or may have extra equipment to offer at the treatment sector.

Patient triage (See Triage information)

Multiple methods and algorithms exist to provide the framework for initial rapid triage of victims of an incident. Currently, the recommendation is to utilize a triage algorithm meeting the Model Uniform Core Criteria (MUCC) for MCIs. SALT (Sort, Assess, Lifesaving Interventions, Treatment and/or Transport) Triage is an evidence-based system and is MUCC compliant. It is endorsed by the State of Wisconsin EMS Advisory Board, Physician Advisory Committee, and State Trauma Advisory Council.

As the incident evolves, additional clinical considerations need to be accounted for. The prioritization process is dynamic and may be altered by changes in patient condition, changes in available resources and scene safety.

Reassessment and re-triage of patient condition should occur at each stage of the treatment and transportation process. In general, treatment and/or transport should be provided for **immediate** patients first, then **delayed**, then **minimal**. Additional prioritization should be done utilizing EMS clinical judgment.

Patient tracking **(See example form – Attachment H)**

Each EMS service or region should have a plan in place for patient tracking during an MCI event. It is imperative that there is a record of how every patient is transported from scene and the destination of each patient by any identified means. Ideally, the name of each patient and a unique identifier, such as triage tag number, and triage category is documented for each patient. Tracking can be performed on paper or via electronic method, such as EMTrack. The benefit to using EMTrack is that all users can monitor forward movement of patients in real-time as the incident evolves. EMTrack allows field IC, destination facilities, family reunification centers, and emergency management staff to monitor patient flow, which can assist with resource deployment decisions. Destination facilities will receive a real-time incoming patient notification with an estimated time of arrival once transport is initiated on the patient tracking encounter. Please see the EMTrack Checklist on the EMTrack webpage for a checklist for setting up EMTrack.

Transport units

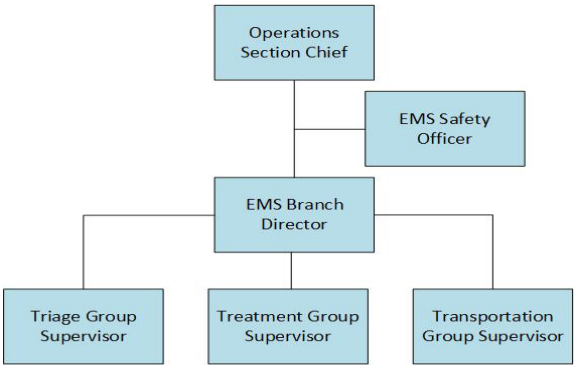
- Efficient use of transport assets may include mixing triage categories of patients and using alternate forms of transport.
- If patients are directly related and all require transport, it is ideal to keep family together, especially with pediatric patients. If keeping a family together is not possible, ensure tracking is accurate and as up to date as possible, to facilitate reunification.
- Transporting EMS units should communicate with receiving facilities using defined methods and formats identified with the current MCI.
- In some cases, the Transportation Group Supervisor may provide patient reports or updates directly to the receiving facility. If the Transportation Group Supervisor gives report to the receiving facility, the transporting EMS units should only communicate changes in patient status or as requested from the receiving facility to avoid unnecessary use of the communication system.
- Prior to departure from the scene, transporting EMS units should confirm with the Transportation Group Supervisor if they should return to Incident Staging, EMS Transportation Area, another location, or return to normal service after completing transport to the facility.

Recovery

- Each service is to assess the need for staff rehabilitation, rotation, and replacement.
- Ambulance supplies and equipment are to be restocked and rehabilitated according to usual pre-incident standards before returning the ambulance to active status.
- If the incident involves an infectious or hazardous items, ambulances and other vehicles along with personnel should be appropriately decontaminated before returned to service
    - Each service should assess the need for Critical Incident Stress Management or other incident debriefing resources.
    - All actions and care should be documented and required reports submitted, for example Wisconsin Ambulance Run Data System (WARDS) Elite.
    - All agencies should complete agency-specific after-action reports and participate in incident and regional after-action reports and analyses.

EMS branch operations positions duties and responsibilities checklists

EMS BRANCH DIRECTOR



Possible equipment and supplies you may need available:

- ❑ EMS branch director vest
- ❑ Communications equipment
- ❑ Clipboard
- ❑ Flashlight
- ❑ Paper
- ❑ Pens/pencils
- ❑ Highlighter
- ❑ Personal protective equipment

Initial duties and responsibilities:

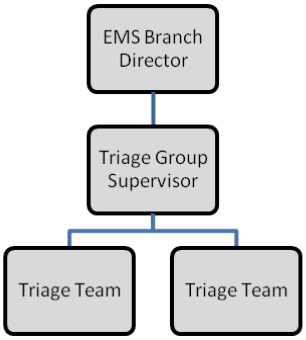
- ❑ Size-up incident area (including scene safety)
- ❑ Put on the EMS Branch Director vest (if provided)
- ❑ Communicate with EMS Safety Officer (if assigned)
- ❑ Read through this Duties and Responsibilities checklist
- ❑ Remain in contact with the Operations Section Chief
- ❑ Supervise personnel assigned to EMS Branch
- ❑ Ensure safety of EMS responders and others under your command
- ❑ Assign and direct Triage, Treatment, Transportation Supervisors
- ❑ Determine treatment and transport areas, including air medical landing zone
- ❑ Request patient count, including the number of pediatric patients, by triage code from Triage Group Supervisor. Information is then relayed to the transportation supervisor. Notify closest/medical control hospital with total patient count by category and obtain information regarding hospital capacity to accept patients.
- ❑ Using information from Triage Group Supervisor, estimate number of transport units needed and request from Operations Section Chief
- ❑ Request non-EMS transportation resources for injured from Operations Section Chief, if needed

Extended duties and responsibilities:

- ❑ Request additional medical supplies as needed. Consider mass casualty trailer, if available
- ❑ Request additional ambulances, if needed
- ❑ Estimate and request additional personnel from Operations Section Chief, indicate type and function needed
- ❑ Request status updates, as necessary, from Triage, Treatment and Transportation Supervisors
- ❑ Provide updates to the Operations Section Chief
- ❑ Request Medical Examiner or Coroner and communicate need for temporary morgue, if needed

- ❑ Monitor EMS personnel for rehabilitation and replacement needs
- ❑ Report to Operations Section Chief when each assignment/task is completed

TRIAGE GROUP SUPERVISOR



Possible equipment and supplies you may need available:

- ❑ Triage group supervisor vest
- ❑ Communications equipment
- ❑ Clipboard
- ❑ Paper
- ❑ Pens
- ❑ Pencils
- ❑ Highlighter
- ❑ Flashlight
- ❑ Bull horn
- ❑ Patient triage tags/marking system
- ❑ Triage area identification markers
- ❑ Personal protective equipment

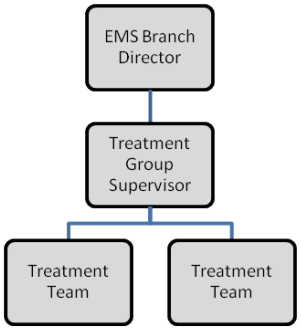
Initial duties and responsibilities:

- ❑ Size-up incident area (including scene safety)
- ❑ Put on the Triage Group Supervisor vest
- ❑ Read through this duties and responsibilities checklist
- ❑ Remain in contact with the EMS Branch Director
- ❑ Establish contact with Treatment Group Supervisor
- ❑ Supervise personnel assigned to the triage group
- ❑ Ensure safety of all members of triage teams and others under your command
- ❑ Assign staff, select and mark GREEN collection area and announce that anyone who is able to walk is to get up and move to the GREEN collection area
- ❑ Estimate patient count, including the number of pediatric patients, by triage category and report numbers to EMS Branch Manager
- ❑ Assemble and direct triage teams
  a. Each patient triaged using a triage system
  b. Triage identification is to be placed visibly
  c. Triage teams report patient count to Triage Group Supervisor
  d. Re-triage as necessary

Extended duties and responsibilities:

- ❑ Establish system to move patients from triage to treatment area, deceased patients should not be moved
- ❑ Request adequate personnel to provide triage and movement of all patients
- ❑ Monitor the supply of patient triage supplies and tags/marking system
- ❑ Provide updates when requested to EMS Branch Director
- ❑ Monitor personnel for rehabilitation and replacement needs
- ❑ Report to EMS Branch Director when triage duties are completed

TREATMENT GROUP SUPERVISOR



Possible equipment and supplies you may need available:

- ❑ Treatment group supervisor vest
- ❑ Communications equipment
- ❑ Clipboard
- ❑ Paper
- ❑ Pens/pencils
- ❑ Highlighter
- ❑ Flashlight
- ❑ Tarps
- ❑ Barricade Tape
- ❑ Traffic cones
- ❑ Patient care equipment and supplies
- ❑ Personal protective equipment

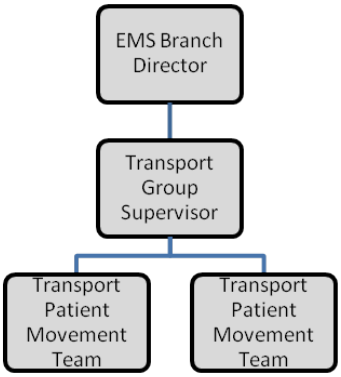
Initial duties and responsibilities:

- ❑ Size-up incident area (including scene safety)
- ❑ Put on the Treatment Group Supervisor vest
- ❑ Read through this Duties and Responsibilities checklist
- ❑ Supervise personnel assigned to treatment group
- ❑ Ensure safety of all members of Treatment Teams and others under your command
- ❑ Select and mark treatment areas, maintain 3 ft between patients. Advise EMS Branch Director of treatment area locations
- ❑ Assign treatment team leaders to each area if personnel allow
- ❑ Ensure completion of triage tags and re-triage of patients as needed

Extended duties and responsibilities:

- ❑ Request adequate personnel to provide treatment of all patients
- ❑ Monitor supply of patient treatment equipment and supplies. Request additional equipment and supplies, as needed, from EMS Branch Director.
- ❑ Establish an area for incoming medical supplies
- ❑ Prioritize patients for movement to transport Area. Direct patient movement from treatment area to transport area.
- ❑ Keep Transportation Group Supervisor and EMS Branch Director informed of number and category of patients in treatment area
- ❑ Provide updates when requested to EMS Branch Director
- ❑ Monitor personnel for rehabilitation and replacement needs
- ❑ Report to EMS Branch Director when treatment duties are completed

TRANSPORTATION GROUP SUPERVISOR



Possible equipment and supplies you may need available:

- ❑ Transportation group supervisor vest
- ❑ Communications equipment
- ❑ Clipboard
- ❑ Paper
- ❑ Pens/pencils
- ❑ Patient routing worksheet
- ❑ Flashlight
- ❑ Large envelope
- ❑ Highlighter
- ❑ Traffic cones
- ❑ Personal protective equipment

Initial duties and responsibilities:

- ❑ Size-up incident area (including scene safety)
- ❑ Put on the Transportation Group Supervisor vest
- ❑ Read through this duties and responsibilities checklist
- ❑ Ensure safety of members of transport patient movement teams and others under your command
- ❑ Establish ambulance staging in a safe area. Avoid the backing of transport units.
- ❑ Assemble and stage transport patient movement teams
- ❑ Assign crew to manage landing zone, if air transport is to be used
- ❑ Request hospital capability information from EMS Branch Director and record information on the patient routing worksheet
- ❑ Direct transport patient movement teams in moving patients from treatment area to transport area

Extended duties and responsibilities:

- ❑ Request adequate personnel to provide movement and transportation of patients
- ❑ Request transport units from EMS Branch Director, as needed
- ❑ Direct movement of transport vehicles in transport area**. One member of the transport unit must remain with the vehicle**
- ❑ Direct removal of patient care equipment and supplies from transport units, if needed. Stockpile for delivery to patient treatment area.
- ❑ Direct movement of patients from the transport area to the transport vehicles. The ambulance stretchers must be matched to their home vehicles for transport safety.
- ❑ Direct transport units to designated hospitals based on capabilities

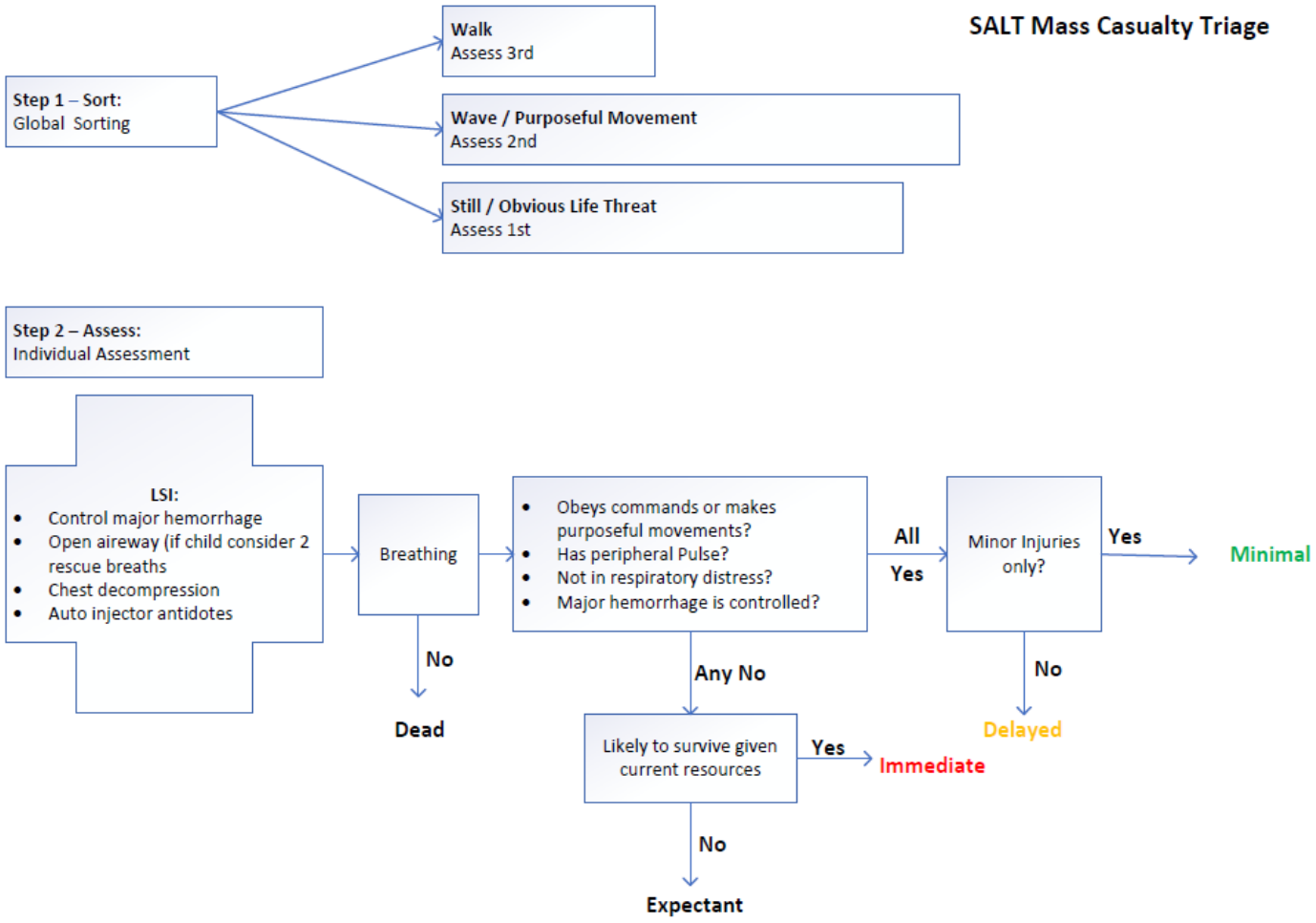
Extended Duties and Responsibilities

- ❑ Record the transportation of all patients using a patient routing worksheet or program (EMtrack) including the triage or patient identification number

- When patient transport starts relay to the receiving facilities the number of victims by treatment priority category (triage tag color) and estimated time of arrival. Provide a **brief** report with minimum required information.
- Transport unit personnel should minimize radio communication during patient transport unless emergency medical control intervention is needed
- Advise transport unit personnel to contact incident command after patient transport has been completed for further directions
- Provide updates when requested to EMS Branch Director
- Monitor personnel for rehabilitation and replacement needs
- Notify facilities and EMS Branch Director when all patients have been transported
- Report to EMS Branch Director when transport duties are completed

Triage Information

SALT (Sort, Assess, Life-saving Intervention, Treatment and/or Transport) TRIAGE



Attachments and sample forms

Attachment A: First-in checklist for EMS MCI response

Checklist	Tasks
Arrival	Park vehicle and position yourself and other responders upwind and upgrade and at a safe distance.
First- in Report	1. Identify yourself and your unit via radio. 2. Give the "First in Report" via radio to include the following information: 3. Description and exact location of the incident 4. Potential Hazards present Chemical Release/Hazardous Materials Type or types of structures/vehicles involved Presence of fire, spilled liquids, vapor leaks, or other hazards Active Shooter Suspect intentional or terrorist incident 5. Estimated number and severity of injuries or casualties 6. Need for evacuation of public
Establish Command	1. If first agency to arrive, state that you are assuming command by identifying yourself and naming command, 2. Give exact location of command post 3. Request additional resources needed immediately (bomb squad, hazmat unit, search and rescue, medical teams, ambulances, law enforcement, traffic control, etc.) 4. Identify route of approach for other responders (wind direction, etc.) 5. Identify staging area location 6. Request initial notification of closest or designated facility, including estimate number of patients, and radio channel/phone number for communication between scene and hospital
Incident Assessment	1. Determine safety hazards 2. Stay out of hot zone of incident (active fire, active shooter, chemical release, etc.) 3. Determine need for immediate evacuation of victim prior to triage or assessment 4. Do not allow any other responders or bystanders to enter the hot zone area 5. Ensure responders injury/illness are immediately treated 6. Estimate the scope and magnitude of the incident ▪ How many injuries? ▪ Severity of injuries? ▪ Nature of injuries – burns, trauma, chemical exposure, etc. ▪ Entrapment of victims

Checklist	Tasks
	▪ Imminent dangers – further chemical release, structural collapse, explosion, secondary devices, active shooter, etc. 7. Determine immediate priorities. 8. Establish staging area, ensure staging area is in a safe location 9. Designate radio frequencies for use on scene. 10. Request the communication center to notify all responding units of designated radio frequencies/communication plan ▪ Consider if units arriving at staging should make radio or face-to-face contact with staging officer 11. Designate staging officer
Initial Actions	The first EMS crew is to begin the process of triage and patient care activities as appropriate for the circumstances once area deemed safe to enter

Attachment B: Pediatric addendum to the Wisconsin emergency medical services mass casualty incident response plan

Introduction

Children are more vulnerable in emergencies, such as MCI events and disasters for the following reasons:

- They breathe in more air for their size than adults and absorb harmful materials from the air more readily.
- When there are toxins or pollutants in the air, the particles fall towards the ground. Since children are smaller than adults and are breathing in and out closer to the ground, they breathe in heavier concentrations. They may not be able to communicate their symptoms or feelings.
- They are emotionally and developmentally immature and more likely to place themselves into danger and unwilling to cooperate with assistance to safety.
- They need medicines, and specifically designed equipment for emergency situations that are different from adults.

It is important for each EMS agency to make a plan to meet the needs of children that may be impacted by an MCI event or disaster. The prehospital pediatric readiness checklist, includes a recommendation that each EMS agency's plans and exercises for disasters or mass casualty incidents include,

Care of pediatric patients, such as, but not limited to:

- Pediatric mental health first aid
- Pediatric disaster triage
- Pediatric dosing of medications used as antidotes
- Pediatric mass transport
- Tracking of unaccompanied children
- Family reunification

The resources in this pediatric addendum to the Wisconsin emergency medical service mass casualty incident response plan guide are designed to help your EMS agency meet the prehospital pediatric readiness checklist recommendations.

Mental health first aid

- Psychological first aid for disaster survivors: This resource includes just in time tips for providing psychological first aid and communicating with disaster survivors.
- Psychological first aid field operations guide: This resource is an in-depth resource guide to for responding to disaster or terrorism events using psychosocial first aid.

Pediatric disaster triage

- JumpSTART pediatric triage algorithm: This resource is a PDF copy of the JumpSTART pediatric triage algorithm.
- SALT mass casualty triage algorithm: This resource is a PDF copy of the SALT mass casualty triage algorithm.
- Disaster triage game: This resource is an interactive game to practice triaging pediatric patients in mass casualty incidents and disasters.
- JumpSTART triage training scenarios: This is a resource to assist with drills and exercises that involve mass casualty incident (MCI) triage and the use of START and JumpSTART triage methods.

- School bus roll over scenario: This scenario will prepare learners to actively triage pediatric patients, using a school bus roll over scenario.
- House fire scenario: This scenario will prepare learners to actively triage pediatric patients, using a house fire scenario.
- School shooting simulation: This scenario will prepare learners to actively triage pediatric patients, using a school shooting scenario.

Pediatric dosing of medications used as antidotes

- National association of state EMS officials model clinical guidelines (toxins and environmental section pgs. 252 – 336): This resource was developed to provide guidance for treating environmental exposure, overdose, poisonings, and exposures to toxins and includes pediatric dosing of medications used as antidotes.

Pediatric mass transport

- Small children don't always travel securely in a large city bus the way adults can. Talk to a local daycare and arrange to use their vehicles, with smaller seats and car seats, in case you need to transport several small children. Arrange to add some car seats to your local stockpile. Have these plans in place ahead of time, with written agreements with the daycare or preschool.
- If patients are directly related and all need transport it is imperative to either keep family together, especially with children or ensure tracking is as concise as possible.
- Ensure that children who are dependent on assistive technology (wheelchairs, ventilators, hearing aids, etc.) are transported with their devices or "go bag."

Tracking of unaccompanied children

- National center for missing and exploited children (NCMEC): This data collection tool is focused on collecting basic information of children who have been separated from their families as a result of a disaster. Individuals can provide basic information and photos concerning a located child whose parents are missing. Once registration information is submitted, NCMEC will cross-reference it against any potential phone calls from a child's parents who may be searching for their child.
- EMTrack: EMTrack is the recommended resource to facilitate patient tracking. To facilitate tracking, and later reunification, of unaccompanied children it is especially helpful to take pictures and document estimated age and date of birth.

Family reunification

- AAP reunification toolkit: The American Academy of Pediatrics has developed a toolkit to provide planning assistance and useful information for starting reunification in the pre-hospital.
- Western region homeland security advisory council family reunification plan activation checklist: This Family Reunification Plan (FRP) Template can be used as the basis for developing a detailed Family Reunification Plan.
- ASPR TRACIE Topic collection: family reunification and support: This website is a collection of resources collected by ASPR TRACIE related to family reunification best practices and recommendations.

Additional pediatric resources

- Prehospital pediatric readiness EMS agency checklist: This resource can be used to learn if your EMS agency is ready to care for children as recommended in the Pediatric Readiness in Emergency Medical Services Systems Joint Policy Statement.

- Wisconsin Emergency Medical Services for Children: This website has resources and information from the Wisconsin Emergency Medical Services for Children (WI EMSC) Program, including pediatric reference cards, pediatric comfort kits and pediatric education.
- EMSC innovation and improvement center: The EMSC Innovation and Improvement Center provides technical assistance to EMS agencies and hospitals to optimize outcomes for children across the emergency care continuum.
- Pediatric Assessment Triangle: This brief video introduces the pediatric assessment triangle is a tool for medical professionals to rapidly assess a child and determine if rapid transport or emergency treatment is needed.
- Pediatric emergency pre-hospital reference guide: This resource is an order form for the pediatric emergency pre-hospital reference guide designed by Wisconsin EMS for children (Wi EMSC). This reference guide includes pediatric medication dosing, normal vital signs, equipment estimates, pediatric pain scales and pediatric glasgow coma scale (GCS). Below is an excerpt from the Wisconsin EMS for children (Wi EMSC) pediatric emergency pre-hospital reference guide.

Weight, Normal Vital Signs and Equipment Estimates

Broselow® Color	Weight (kg)	Reference Age	Heart Rate	Respiratory Rate	BP – Systolic (mm Hg)	Laryngoscope Blade	ETT (cuffed)	LMA	King
Gray	3-5 kg	<3 months	100-165	40-60	60-80	1 Miller	3	1	0
Pink	6-7 kg	3-5 months	120-185	40-60	65-95	1 Miller	3	1	0
Red	8-9 kg	6-11 months	120-170	25-40	65-105	1 Miller	3	1.5	1
Purple	10-11 kg	12-24 months	110-170	20-30	70-110	1 Miller	3.5	2	1
Yellow	12-14 kg	2 years	75-150	20-30	75-110	2 Miller	4	2	2
White	15-18 kg	3-4 years	65-135	20-30	80-110	2 Miller/Mac	4.5	2	2
Blue	19-23 kg	5-6 years	60-130	12-25	90-115	2 Miller/Mac	5	2.5	2.5
Orange	24-29 kg	7-9 years	60-120	12-25	90-115	2 Miller/Mac	6	2.5	2.5
Green	30-36 kg	10-11 years	60-120	12-18	95-130	3 Miller/Mac	6.5	3-4	2.5-4

Attachment C: Healthcare Emergency Readiness Coalition (HERC) and Regional Trauma Advisory Council (RTAC)

The HERC and RTAC are both regional multidisciplinary committees that serve to connect the various stakeholders involved in MCI response.

The HERCs key member disciplines include hospitals, EMS, trauma, public health and emergency management. In addition, the HERC members include other partners, such as, long-term care, clinics, Tribal organizations, and community organizations. These partners collaborate for the common goal of making their communities safer, healthier, and more resilient.

The RTACs are an organized group of health care entities, EMS and others who are interested in organizing and improving trauma care in a specified region of Wisconsin. The purpose of an RTAC is to develop, implement, and monitor a regional trauma system plan to facilitate trauma system networking within a region.

Both serve a venue to bring EMS and other response partners together to plan for MCI events, review responses, build relationships, and share information. In addition, both have a state level component to allow for inter-region and statewide collaboration.

Pre-planning, community relations (Red Cross, CERT, etc.)

It is important to establish communication, develop relationships, and participate in joint training with agencies that may co-respond to an MCI or support efforts of those responders. Considerations for which agencies or groups to involve and details of pre-planning efforts is specific to each agency. The information below is intended to be a general reference.

Co-responders may include law enforcement, fire department, other EMS agencies, county or regional emergency management, community emergency response team (CERT), and mass transit.

- Consider each agency's ability to respond to an MCI and what resources or specialty services they can provide.
  For example, hazardous materials, search and rescue, manpower, equipment, supplies, etc.
- Consider the role another agency may serve in ICS and operations.
- Consider need for rest and rehabilitation for each co-responding agency.
- EMS services' MCI plans, both general and hazard specific, should be developed in conjunction with community partners, including but not limited to law enforcement, fire department, and jurisdictional emergency management.

Deployment of Response Resources

- EMS services should consider developing deployable caches of supplies for response to MCI, such as, tourniquets, wound packing, patient movement supplies (backboards, mega-mover, etc.), triage and tracking tags.
- MCI caches should ideally be pre-deployed to known mass gathering events.

Agencies or groups that may provide support for response efforts include communications groups, charitable organizations, and local businesses.

- Consider the role of amateur radio groups for communication.
- Consider the role of charitable organizations like the Red Cross or Salvation Army for victim services or canteen or other support.
- Consider restaurants or convenience stores for food and beverage, construction or tow services for rescue and scene management, etc.

Planned mutual aid

It is highly recommended that EMS agencies pre-develop plans for resources that could be requested based on the incident size and location. The Mutual Aid Box Alarm System (MABAS) is a fire-based example of such a system using the life safety cards.

Considerations in plan development

- Requesting additional EMS units and resources in a manner that allows other area EMS needs to continue to be met
- Balancing needs for transportation from incident to hospital and from initial facilities to tertiary facilities
- Early notification of air medical assets
- Early mobilization of MCI response caches
- Notification and access of alternative transport assets, such as, buses
- Early notifications to supporting agencies and personnel, such as, emergency management and EMS medical director

Attachment D: Considerations for facility destination

The following guidelines should be considered when transporting patients with specialized needs and situations, though it is recognized that every MCI has unique challenges and may not allow for ideal patient distribution to destinations.

Facility capability and specialization:

- Patient with most immediate need of trauma care should be prioritized for transport to closest level 1 or level 2 trauma center, please refer to trauma triage guidelines.
- In general, level 3 trauma centers have general and orthopedic surgery, and may have other subspecialities such as neurosurgery. IC should request available resources and capabilities from the level 3 trauma centers to help guide decisions.
- Level 4 trauma centers can provide stabilization and advance trauma life support to patients. IC should request available resources and capabilities from level 4 trauma centers to help guide decisions.
- Preferentially transport pregnant patients to facilities with labor and delivery services.
- Preferentially transport pediatric patients to facilities with inpatient pediatric capability (**See Attachment B**).
- Utilize the State Emergency Operations Plan (EOP) Medical Surge Annex for information on specialty surge capabilities. https://www.dhs.wisconsin.gov/publications/p01119-17.pdf

Attachment E: EMResource

EMResource is a computer and mobile application tool that optimizes communication between dispatch centers, emergency management services and destination health care facilities. The system provides real-time updates of daily health care capabilities on a local, regional, and statewide level.

During an MCI, the EMResource system can be used to alert health care partners of the event and request facilities to report immediate bed availability and patient triage counts. Hospitals should monitor the event closely and update their bed counts throughout the duration of the incident.

Data entered and displayed in EMResource are not for public consumption and are only for official use. EMResource is a commercial software product of Juvare, with both web-based and mobile applications. Wisconsin DHS provides EMResource at no cost, and encourages EMS agencies, dispatch centers, and first responders to have access to the system and sign up to receive notifications in their jurisdictions.

Attachment F: Related regulatory information

Wis. Admin. Code § DHS 110.35

Licensing and application requirements:

To apply for a license as an ambulance service provider, a non-transporting emergency medical service provider, or an emergency medical responder service provider, a person shall do all of the following:
(1) Feasibility study. Complete a feasibility study and submit it to the department for approval. First responder service providers are not required to do a feasibility study.
(2) Application and operational plan. Upon the department's approval of the feasibility study required under sub. (1), complete and submit an application and an operational plan to the department in the manner specified by the department. The operational plan and its addendums shall include all of the following:
(a) Signed patient care protocols approved by the service medical director.
(b) A formulary list of medications the emergency medical service provider will use.
(c) A list of the advanced skills and procedures the applicant intends to use to provide services within the Wisconsin scope of practice of the level of care for which licensure is sought.
(d) Proof of professional liability or medical malpractice insurance, and, if the emergency medical service provider is an ambulance service provider, proof of vehicle insurance.
(e) Operational policies for all of the following:
1. Response cancellation, describing how the emergency medical service provider will handle a cancellation of a response while enroute to the scene.
2. Use of lights and sirens in responding to a call.
3. Dispatch and response, describing how EMS professionals are dispatched and how the emergency medical service provider acknowledges to the dispatcher that it is responding.
4. Refusal of care, describing the procedure for accepting a refusal of care from a patient.
5. Destination determination, describing how the transport destination of the patient is determined if the provider is an ambulance service provider.
6. Emergency vehicle operation and driver safety training.
7. Controlled substances and how the service provider will obtain, store, secure, exchange, and account for any and all controlled substances used to provide patient care.
8. Continuous quality assurance and improvement program describing the components of the program, including how patient care and documentation will be reviewed, by whom, and how the results will be shared with practitioners and incorporated into continuing education.
9. Multiple patient incidents describing how the service will handle the response to the incident including triage, care, transportation and patient tracking.
(f) Written letters or other documentation of endorsement from the local hospital and government within the proposed primary service area, if the application is for licensure as a 9-1-1 ambulance service provider or non-transporting emergency medical service provider, whether the application is for initial licensure or a service level upgrade.
(g) When a service provider is required to submit an update to its operational plan, the update to the operational plan must be submitted on the form or in the manner approved by the department indicating:
1. The section of the operational plan being updated or revised.
2. Description detailing the change and intended impact on the service.
3. Approval of the update or revision by the service director and when involving patient care or patient care equipment, the service medical director.
4. Other information as determined by the department.

Wis. Admin. Code § DHS 110.44

Special Events:

A licensed ambulance service provider or non-transporting emergency medical service provider shall obtain department approval before providing emergency medical services for special events outside its primary service area or that will require the provider to exceed its normal staffing and equipment levels within its primary service area. Events that occur on a regular basis may be included in the service operational plan and an update submitted in lieu of a complete plan. To obtain department approval, the ambulance service provider or emergency medical service provider shall submit all of the following to the department not less than 10 business days before the event:

(1) Name of the ambulance service provider or non-transporting emergency medical service provider requesting approval.

(2) Contact information for the event manager, including how to contact the ambulance service provider during the event.

(3) Locations, dates, and times of the event.

(4) Name, address, phone numbers, and e-mail addresses for each service medical director who will oversee the medical services at the event.

(5) Name and contact information for the medical control facility.

(6) The types of EMS services that will be provided.

(7) The level of EMS service that will be provided.

(8) The number of ambulances dedicated to the event including ambulance staffing configurations and types.

(9) Whether the service will be "dedicated services" or "as available" based on resources.

(9m) Whether the special event coverage is for participants, spectators, or both.

(10) Description of on-site communications between the event manager, event staff, dispatch, and 9-1-1 dispatch.

(11) Explanation of how medical consultation will be contacted or if on-site medical consultation will be used.

(12) Any special patient care protocols for use at the event.

(13) Explanation of how EMS professionals will be notified and requested during the event.

(14) Explanation of how the ambulance service provider will integrate with the 9-1-1 system.

(15) Explanation of how a 9-1-1 request that is generated within the event by a participant or spectator will be handled.

(16) Identification of the service provider that will respond to a 9-1-1 call initiated from within the event.

(17) If the event occurs outside the primary service area of the ambulance service provider or non-transporting emergency medical service, documentation that the ambulance service provider for the primary service area in which the event is located has been notified at least 10 business days prior to the event or documentation that the ambulance service provider for the primary service area in which the event is located has approved the ambulance service provider or non-transporting emergency medical service requesting special event approval to provide event coverage within its primary service area.

(18) Written assurance that adequate resources will be available.

(19) Written acknowledgement that the ambulance service provider requesting special event approval assumes all liability for ambulance coverage and response during the event.

(20) Copies of any agreement or contract for providing emergency medical services for the event.

Note: When submitting copies of the contracts or agreements the service may redact any compensation information.

(20g) Written acknowledgement that the special event coverage will not interfere with its responsibility to provide 9-1-1 emergency response within its primary service area, if the ambulance service provider or non-transporting emergency medical service provider is also licensed as a 9-1-1 provider.

(20r) If the special event coverage is for spectators and participants or both and more than 5000 people total are anticipated to be in attendance, a mass casualty plan including all of the following:

(a) Name and contact information of the ambulance service provider or public safety agency that shall be the lead agency in the event of a mass casualty incident.

(b) A copy of the triage protocol to be used in the mass casualty incident.

(c) A copy of the destination determination policy to be used in a mass casualty incident.

(d) A list of destination hospitals including contact information.

(e) Copies of any mutual aid agreements specific to the event.

(f) A list of any specialty resources prepositioned for the event.

(g) Patient tracking method to be used.

(h) Written acknowledgement that the ambulance service has identified potential staging areas and landing zones near the event.

(i) Written acknowledgement that the ambulance service provider or non-transporting emergency medical service provider has notified area hospitals of the date of the event.

Attachment G: EMS AGENCY & FIRE RESOURCE/TRANSPORT LIST

PROVIDER	RESOURCES

AIR MEDICAL TRANSPORT RESOURCES

NAME	CONTACT NUMBER

HOSPITAL RESOURCE LIST

HOSPITAL NAME	CONTACT & NUMBER

LAW ENFORCEMENT RESOURCE LIST

NAME	CONTACT NUMBER

Attachment H: Patient tracking form (example)

1. Incident Name & Number	**2. Operational Period:** DATE: FROM: _____ TO: _____ TIME: FROM: _____ TO: _____
3. Area (Triage or Specific Treatment Area)	

Field Tag Number	**Medical Record Number**	**Name** (Last name, First name)	**Sex** (M/F)	**DOB / Age**	**Triage Category** Immediate Delayed Minor Expectant DECEASED	**Disposition Transport** (E) EMS Transport: [Service, Unit ID] (P) Private Vehicle (B) Bus (U) Unknown	**Disposition Location** Hospital Name

Attachment I: Other response and planning resources

FEMA: https://training.fema.gov/nims/

Wisconsin DHS EMS Section: https://www.dhs.wisconsin.gov/ems/index.htm

Wisconsin EMTrack: https://www.dhs.wisconsin.gov/preparedness/systems/emtrack.htm

Wisconsin EMResource: https://www.dhs.wisconsin.gov/preparedness/systems/emresource.htm

Wisconsin EMS for Children: https://www.chawisconsin.org/initiatives/emergency-care/emergency-medical-services-for-children/

Wisconsin Air Medical: http://wiamc.org/programs