Region X

MULTIPLE PATIENT MANAGEMENT PLAN

September 1, 2012
Amended March 1, 2013

Table of Contents

ENDORSEMENTS

This plan has the endorsement of each of the MABAS Divisions covered within the plan, the Medical Directors of each of the EMS Systems located within the boundaries of this plan and the Disaster Management Services Committee of Region X. The plan has been approved by the Region X Trauma / EMS Advisory Committee as well as the Illinois Department of Public Health.

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INTRODUCTION

The purpose of this plan is to enable Fire/EMS agencies and Region X hospitals to respond effectively and efficiently to multiple patient incidents so as not to tax the resources of any single pre-hospital provider or healthcare facility and to provide optimal patient care. This plan is intended to supplement each participant's individual mass casualty or disaster plan.

ASSUMPTIONS:

- The fundamental principles of risk assessment and risk management are essential to responder safety.
- Multiple patient incidents will occur in Region X.
- Given the population of Region X, responders and receivers should expect patient diversity in an incident, to include (at a minimum): age, gender, and special needs.
- This goal of this plan is to promote proper patient destination in the best interest of patient outcome.
- This plan is motivated by the essential priorities of fire/EMS service response to a multiple patient incident.
- The most probable multiple patient incidents will involve less than five patients.
- The influx of multiple patients from the same incident may create unique challenges for both hospitals and field providers.
- Given the challenges of simultaneously caring for multiple patients, altered standards of care may be temporarily required.
- Communication challenges will occur during multiple patient incidents.
- Patient conditions may change en route to the hospital and following initial communications with hospital(s).
- Alterations to modes of transportation or traditional transportation practices may be required, such as more than one patient per ambulance and/or the use of buses or vans to transport patients to regional healthcare facilities.
- Typical transportation routes may be affected by adverse weather conditions, debris or road closures which may impact hospital destinations.
- EMS personnel and hospital-based Emergency Communications Radio Nurses (ECRNs) are well versed in the trauma classification system as outlined by the Illinois Department of Public Health and inherent to the Region X Standing Operating Procedures.

This plan assigns specific responsibilities to EMS providers and hospitals to coordinate resources and activities when an incident involves multiple patients. The plan outlines:

1. An approach that is scalable to the size, nature, geographic specifics, and speed of the event;
2. A classification system which promotes an orderly disbursement of patients to local/ regional hospitals;
3. A uniform operational guideline for handling multiple victim incidents within the structure of the Incident Command System;

4. A communications network linking responding Fire/EMS agencies to receiving hospitals and Region X Resource Hospitals;
5. Responsibilities of responding EMS providers;
6. Responsibilities of hospitals closest to a Small Scale multiple patient incident;

7. Responsibilities of the Resource Hospitals who shall serve as Hospital Command to assist with transportation management, including, but not limited to, managing logistics, obtaining hospital resource availability, and communicating such information to scene personnel when the number of ill or injured persons exceeds the routine disbursement of patients in Medium and Large Scale incidents; and
8. Basic guidelines for the management of an emergent evacuation of a healthcare facility.

Hospitals and Fire/EMS providers in Region X are responsible for functioning as a unified entity in the event of a multiple patient incident. This plan enables all participants to collectively serve their communities and patients with efficiency and competence.

Every agency participating in this plan shall routinely conduct post-action reviews of all training exercises and plan activations to identify areas of improvement and to amend procedures as necessary. A form to facilitate such review is contained within the plan.

Local government is recognized as the first line of official public response for emergency management activity. In addition to local resources used during a multiple patient incident, county, state, and federal emergency management agencies may be relied upon for support when damage, illness or injury is unusually widespread or severe. Private ambulance providers affiliated with Region X are considered valuable members of the EMS community and as such may be called upon as needed. The Private Provider Emergency Response System (PPERS) has been established in Illinois and may be activated to assist Illinois' Mutual Aid Box Alarm System (MABAS) during incidents involving large numbers of victims. Protocols for activating these agencies reside in the emergency operations plans of local governments, MABAS, and Resource Hospitals.

For additional information regarding this plan, please contact a member of the DMSC Committee.

DEFINITIONS OF INCIDENT TYPES

"BUSINESS AS USUAL":

- A '**business as usual' incident** can be managed with routine resources.
- The incident usually involves less than three ambulances.
- Command and General Staff positions (other than Incident Command) are usually not activated.
- No written Incident Action Plan (IAP) is required.
- The incident is usually contained within the first operational period and often terminates within an hour after initial resources arrive on the scene.

SMALL SCALE INCIDENT:

- A **Small Scale Incident** will require more than routine resources to mitigate the incident.
- The incident usually involves between three and six ambulances.
- Command and General Staff functions are activated only if required.
- The incident is generally limited to one operational period in the control phase.
- A written Incident Action Plan (IAP) is not required but other documentation methods may be employed.

MEDIUM SCALE INCIDENT:

- A **Medium Scale Incident** exists when capabilities exceed the typical initial emergency response. The appropriate ICS positions should be added to match the complexity of the incident.
- The incident usually involves between six and ten ambulances.
- Some or all of the Command and General Staff positions may be activated, as well as Division/Group Supervisors and/or Unit Leader level positions.
- The incident may extend into multiple operational periods.
- A written Incident Action Plan (IAP) may be required.

LARGE SCALE INCIDENT:

- A **Large Scale Incident** generally extends beyond the capabilities of local control and may require multiple operational periods.
- The incident involves more than ten ambulances.
- Most or all of the Command and General Staff positions are filled.
- Many of the functional units may be required and staffed.
- A written Incident Action Plan (IAP) may be required for each operational period.

REGION X MULTIPLE PATIENT MANAGEMENT PLAN

3/9/12 Update

***LESS THAN THREE AMBULANCES = *BUSINESS AS USUAL*. CONTACT RECEIVING HOSPITALS AS DESIRED**

	Small Scale Incident	Medium Scale Incident	Large Scale Incident	
Definition	3 – 6 ambulances*	7 – 10 ambulances	More than 10 ambulances	**EMERGENT EVACUATION of a HEALTHCARE FACILITY** (PATIENTS REQUIRING MEDICAL CARE)
Initial Communctn	Contact closest appropriate hospital to determine their maximum patient availability. State: "WE ARE ON THE SCENE OF A Small Scale MULTIPLE PATIENT INCIDENT	Contact Resource Hospital State: "WE ARE ON THE SCENE OF A Medium Scale MULTIPLE PATIENT INCIDENT"	Contact Resource Hospital State: "WE ARE ON THE SCENE OF A Large Scale MULTIPLE PATIENT INCIDENT"	Contact Resource Hospital State: "WE ARE ON THE SCENE OF AN **EMERGENT EVACUATION of a HEALTHCARE FACILITY"**
Initial Information	• Event description • Actual # of patients • Briefly describe patient conditions	• Event description • Estimate # of patients • Estimate patient acuities (Use RED, YELLOW, GREEN) • Closest Hospitals	• Event description • Estimate # of patients • Estimate patient acuities (Use RED, YELLOW, GREEN) • Closest Hospitals	• Event description • Estimate # pts. • Closest hospitals • Potential alternative receiving facilities
Patient Disbursement	Field Command (or designee) coordinates transportation management and destination of patients. • Patients shall be disbursed to appropriate facilities (i.e. Category I trauma patients to Level I Trauma Centers within 25 minutes)	Resource Hospital coordinates transportation management and destination of patients .	Resource Hospital coordinates transportation management and destination of patients Regional Hospital Coordinating Center (RHCC*) may be employed for assistance with communication and additional resources	Resource Hospital works in conjunction with field command and administration of affected facility to determine where patients will be transported • RHCC may be employed for assistance with communication and additional resources. • Consider activation of PPERS and/or CHUG
Triage Tags	Triage tags not used	Triage tags MUST be used	Triage tags MUST be used	Triage tags MUST be used
Triage Method	Use rapid assessment to identify correct patient Category and appropriate hospital destination.	START Triage	START Triage	• Within facility use REVERSE TRIAGE • Prior to transport use START TRIAGE
Ambulance to Hospital Communication	Every transporting ambulance contacts their receiving hospital with abbreviated report (Abbreviated radio report encouraged) State: "WE ARE TRANSPORTING FROM A Small Scale MULTIPLE PATIENT INCIDENT"	**NO** CONTACT BETWEEN TRANSPORTING AMBULANCE AND RECEIVING HOSPITAL	**NO** CONTACT BETWEEN TRANSPORTING AMBULANCE AND RECEIVING HOSPITAL	**NO** CONTACT BETWEEN TRANSPORTING AMBULANCE / PATIENT TRANSPORTATION VEHICLE AND RECEIVING FACILITIES
Pt Care Reports	Complete written patient care reports as usual	Complete written patient care reports as usual	No written patient care reports (Triage Tags serve as written report)	No written patient care reports (Triage Tags serve as written report)

*RHCC Region X = NorthShore Highland Park Hospital

REGION X: Small Scale Incident ACTIVATION

	Small Scale Incident
Definition	3 – 6 ambulances
Initial Communication	Contact closest appropriate hospital to determine their maximum patient availability.
Initial Information	• Event description • *Specific* # patients • Briefly describe patient conditions
Patient Disbursement	Field Command (or designee) coordinates transportation management and destination of patients. Patients shall be disbursed to appropriate facilities (i.e. Category 1 trauma pts to Level 1 Trauma Centers within 25 minutes)
Ambulance to Hospital Communication	Transporting ambulance quickly contacts receiving hospital with an abbreviated report State: "WE ARE TRANSPORTING FROM A **Small Scale** MULTIPLE PATIENT INCIDENT"
OTHER	• Triage Tags not utilized • Use rapid assessment to identify patient category and proper destination • Complete patient care reports

TRAUMA

- Traumatic Arrest, Isolated Burns >20%: Transport to closest Trauma Center
- NO AIRWAY: Transport to CLOSEST comprehensive Emergency Department

MEDICAL

CATEGORY I	TYPE OF HOSPITAL		CATEGORY I
Unstable Vital Signs: • Systolic BP ≤ 90 x 2 (Peds ≤ 80 x 2) • Glasgow Coma Scale ≤ 13 or with blunt head injury • Respiratory Rate ‹ 10 or › 29 Anatomy of Injury: • Penetrating injuries to head, neck, torso or groin • Combination trauma with burns ≥ 20% • Two or more proximal long bone fractures • Two or more body regions with potential life/limb threat • Unstable pelvis • Flail chest • Limb paralysis and /or sensory deficits above the wrist or ankle • Open and depressed skull fractures • Amputation proximal to wrist or ankle	Transport to **highest** level Trauma Center(s) within 25 minutes	Transport to **closest** Emergency Department(s)	UNSTABLE • Altered mental status • Systolic BP ≤ 90 mmHg

CATEGORY II	TYPE OF HOSPITAL		CATEGORY II
Mechanism of Injury: • Ejection from automobile • Death in the same passenger compartment • Motorcycle crash › 20 mph or with separation of rider from bike • Rollover (unrestrained) • Falls ≥ 20 feet (Peds falls ≥ 3X body length) • Pedestrian thrown or run over • Auto vs. pedestrian / bicyclist with › 5 mph impact • Extrication › 20 minutes • High speed MVC: Speed › 40 mph, intrusion ≥ 12", major deformity ≥ 20" Co-Morbid Factors: • Age ≤ 5 without car / booster seat • Bleeding disorders or on anticoagulants • Pregnancy ≥ 20 weeks • Renal disease requiring dialysis	Transport to **closest** Trauma Center(s)	Transport To **closest** Emergency Department(s)	STABLE • Patient alert • Skin warm and dry • Systolic BP >90 mmHg

CATEGORY III	TYPE OF HOSPITAL	CATEGORY III
Other simple trauma	Transport to closest hospital(s)	Other simple medical

FIRE DEPARTMENT RESPONSIBILITIES

SMALL SCALE INCIDENT:

- Contact the CLOSEST APPROPRIATE HOSPITAL using normal modes of communication. State, *"We are on the scene of a Small Scale multiple patient incident."* Utilize the **Field Provider Log Form** (Appendix XI) for assistance with field to hospital communication.
- Report event description, specific number of patients, general patient descriptions and the closest appropriate hospitals.
- After conferring with the closest appropriate hospital, transport the agreed upon number of patients to that hospital.
- If the closest hospital cannot take all the patients from the incident, Incident Command or their designee will assign each transporting ambulance a destination hospital. **Transport no more than two patients to each remaining hospital.**
- If EMS desires more than two patients be transported to a hospital, the ECRN at the closest hospital should contact the desired hospital to confirm prior to transport.
- Communicate remaining patients' destinations to the closest hospital.
- All transporting ambulances should contact their destination hospitals with patient care reports (abbreviated reports are acceptable). All radio reports must begin with, *"We are transporting a patient from a Small Scale multiple patient incident"*.
- When the number of ill or injured patients exceeds the routine transport of patients to the nearest hospitals, contact the Resource Hospital to coordinate remaining patient distribution.
- Complete an After-Action Report (Appendix XI) following every multiple patient incident. Fax the report to the EMS Office at the Resource Hospital within 48 hours of the event.

MEDIUM or LARGE SCALE INCIDENTS:

- Contact the Resource Hospital IMMEDIATELY using normal modes of communication. State, *"We are on the scene of a Medium/Large Scale multiple patient incident"***.** Utilize the **Field Provider Log Form** (Appendix XI) for assistance with field to hospital communication.
- Requesting transportation management, report event description, estimated numbers of patients, estimated patient acuities and closest hospitals. Provide the Resource Hospital with a call-back number.
- After the Resource Hospital reports hospital capabilities, record information and assign patients and destination hospitals to ambulances.
- Maintain communication with the Resource Hospital until the scene has been cleared of patients. For each transporting ambulance report ambulance number, acuities of patients being transported and destination hospital to the Resource Hospital.
- Complete an After-Action Report (Appendix XI) following every multiple patient incident. Fax the report to the EMS Office at the Resource Hospital within 48 hours of the event.

HOSPITALS ON BYPASS:

- Contact the closest appropriate hospital regardless of the bypass status to discuss patient disbursement during a Small Scale incident.
- After conferring with field personnel, the Emergency Department physician or their designee will determine if diversion is necessary and may either accept the patient(s) or provide direction to divert the patient(s) to the next most appropriate hospital.
- Hospitals on bypass must receive patients from a Medium or Large Scale multiple patient incident.

EARLY COMMUNICATION WITH THE HOSPITAL IS INDICATED EVEN IF PATIENT COUNTS AND CONDITIONS HAVE NOT BEEN REFINED!

RECEIVING HOSPITAL RESPONSIBILITIES

SMALL SCALE:

Each medical control hospital within Region X must be prepared to manage initial calls from local emergency responders during a Small Scale incident. The closest appropriate hospital will be contacted by a field provider representative for an initial discussion of patient disbursement. During some incidents, it may be possible for the closest hospital to accept all or most patients.

- Following the initial disbursement of patients to the closest hospital, each area-wide hospital will receive NO MORE THAN TWO patients from a multiple patient incident (according to appropriate trauma triage criteria) without giving specific approval prior to transport.
- In the event that EMS would like to transport more than two patients to a hospital (most often victims from the same family), the ECRN at the closest hospital will contact the desired hospital to confirm the receipt of additional patients prior to transport.
- Receiving hospitals will be notified of their arriving patients via normal modes of field to hospital communication. Providers will announce, "*We are transporting a patient from a Small Scale multiple patient incident"* at the beginning of their radio report. Most often, this will be the first notification for the receiving hospital that a multiple patient incident has occurred.
- **Receiving hospitals MAY NOT divert ambulances transporting patients from a multiple patient incident.**

MEDIUM or LARGE SCALE:

- If patient numbers or acuity prevents the even disbursement of patients to local hospitals, or if field providers are in need of immediate assistance for any reason, field providers will contact their Resource Hospital for assistance with transportation management.
- Upon receiving notification from the Resource Hospital, receiving hospitals should immediately report their ability to accept specific numbers of red, yellow and green patients.
- NOTE: Ambulances transporting patients from the scene will NOT contact the receiving hospital prior to their arrival.
    - Consider activation of internal hospital mass casualty/disaster plan in order to accommodate a larger number of patients.
    - Be prepared to report availability of medical personnel to send to the scene.
    - Maintain a log sheet of communication with the Resource Hospital.
    - Report increases or limitations in treatment capability to the Resource Hospital.
    - Be prepared to send pre-assembled bags of medical supplies to the scene (per state and regional guidelines).

HOSPITALS ON BYPASS:

- Pre-hospital providers will contact the closest appropriate hospital regardless of its' bypass status in order to discuss patient disbursement during a Small Scale incident.
- After conferring with field personnel, the Emergency Department physician or their designee will determine if diversion is necessary and may either accept the patient(s) or provide direction to divert the patient(s) to the next most appropriate hospital.
- Hospitals on bypass must receive patients from a Medium or Large Scale multiple patient incident.

(Continued on next page)

Receiving Hospital Responsibilities, continued

DO NOT ATTEMPT TO STOP PATIENT FLOW FROM INDIVIDUAL AMBULANCES **NOT** ASSOCIATED WITH THE DISASTER SCENE.

Once the Resource Hospital has been contacted by field personnel for assistance with transportation management
ALL COMMUNICATION MUST GO THROUGH THE RESOURCE HOSPITAL!

- Do not attempt to contact the scene.
- Do not attempt to contact dispatch.
- Do not divert individual ambulances.

*Complete an After-Action Report (Appendix XI) following every multiple patient incident. Originals of all log sheets and disaster related records should be forwarded to the hospital EMS Coordinator within 48 hours of the event.

RESOURCE HOSPITAL RESPONSIBILITIES

The Resource Hospital is contacted by scene personnel when the number of ill or injured patients exceeds the routine transport of patients to the nearest appropriate hospitals in order to coordinate the remaining patient distribution.

NOTE: ***The Resource Hospital may be contacted at any time to assist field personnel.***

Upon notification by scene personnel that a Medium or Large Scale multiple patient incident has occurred, the Resource Hospital will assume the duties of Hospital Command, providing transportation management and serving as Medical Control throughout the incident.

The Resource Hospital shall:

- Initiate a **Hospital Communications Flow Sheet (ATTACHMENT X).**
- Collaborate with scene personnel to identify receiving hospitals based upon incident location, transport routes remaining open (consider natural disaster disruptions), volume and acuity of patients, and number of patients already transported.
    - Establish inter-hospital communications with possible receiving hospitals via telemetry, radio intercom, landline phone or MERCI 155.280.
    - Inform the hospitals about the nature of the incident, including approximate number, acuity and type of patients.
    - Assess receiving hospitals' resources *(may be incident specific)*:
        - Ability to receive patients, including numbers of red, yellow and green
        - Blood inventory
        - Ability to decontaminate patients
        - Ability to send medical personnel and supplies to the scene
- Continue to monitor, log and communicate receiving hospitals' capacity throughout incident.
- Identify and alert additional receiving hospitals as casualty load exceeds the initial receiving hospitals' patient capacity.
- Maintain communication with the scene Incident Commander or their designee, relaying receiving hospital availability and providing on-going transportation management.
- Consider contacting the alternate Resource Hospital for assistance with communication.
- Consider contacting the RHCC if regional coordination or assistance with communication as required. (Highland Park Hospital: 847-432-2294/5)
- Obtain status of specialized facilities as needed (burn units, pediatrics, etc.)
- Consider notifying Life Source Blood Services (847-298-0530) if a multiple patient incident has occurred (if nature of casualties implies need for transfusions).
- Coordinate medical personnel to respond to the site as needed.
- Serve as Hospital Command liaison with disaster and public agencies.
- An After-Action Report (Appendix XI) should be completed following every multiple patient incident. Originals of all log sheets and disaster related records should be forwarded to the hospital EMS Coordinator within 48 hours of the event.

REGIONAL HOSPITAL COORDINATING CENTER (RHCC) RESPONSIBILITIES

The Regional Hospital Coordinating Center (RHCC) is contacted by Regional Resource Hospitals for assistance with communications and obtaining additional resources.

The RHCC shall:

- Initiate a Hospital Communications Flow Sheet (Attachment X).
- Collaborate with requesting hospital to determine and attempt to meet logistical needs, including;
    - On-scene medical personnel/teams
    - Medical equipment/resources
- Communicate with other regions for assistance, as needed.
- Contact the Illinois Department of Public Health for assistance and/or notification, as needed.

TACTICAL COMMUNICATIONS PLAN

Tactical interoperable communications is defined as the rapid provision of on-scene, incident based, mission-critical voice communications among all first responder/first receiver agencies, as appropriate for the incident.

For the purposes of this plan, the tactical communications being emphasized include:

- Field Command ↔ Hospital
- Ambulance ↔ Hospital
- Hospital ↔ Hospital

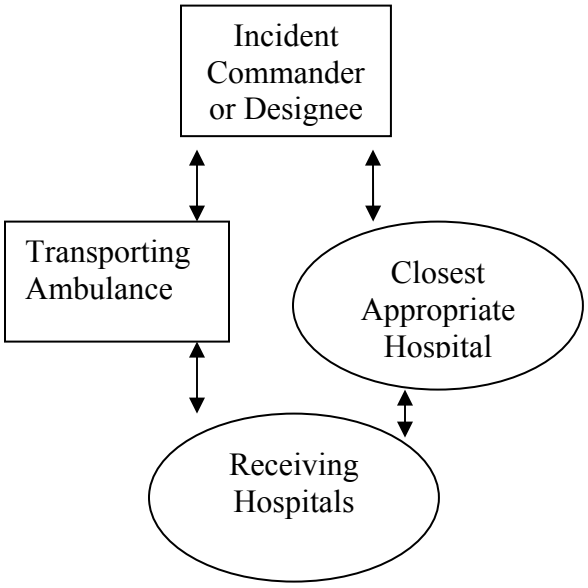
The *minimum* technological capabilities required to achieve tactical communications for this plan include:

- Telemetry radio
- Handheld portable radio or cellular phone
- Landline
- MERCI radio

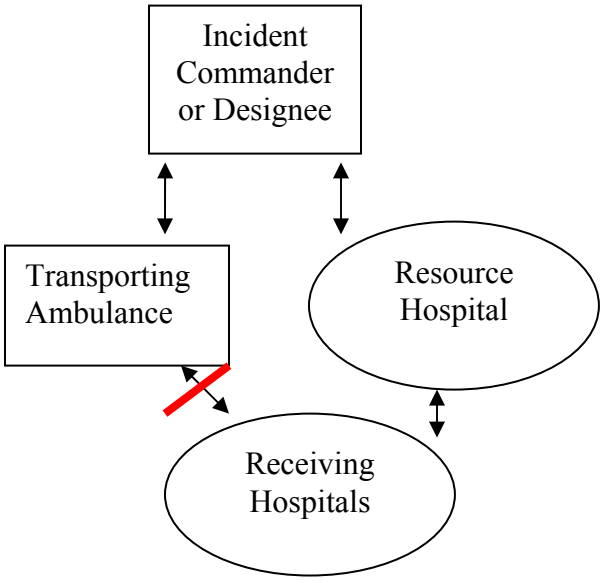
Barriers to communication include:

- Weather
- Infrastructure breakdown; phone lines
- Infrastructure breakdown; cellular service
- Magnitude of the event

Small Scale:



Medium/Large Scale:



HOSPITAL/FIELD PROVIDER AFFILIATIONS

RESOURCE HOSPITAL ALTERNATES

During a Medium Scale or Large Scale incident, *Hospital Command will be assumed by the Resource Hospital affiliated with the fire department that has jurisdiction over the incident location*. However, the Resource Hospital may be directly affected by the disaster or overwhelmed by patients and unable to function in that role. In such a case, Hospital Command will be assumed by the first or second alternate hospital, as designated below.

REGION X

Hospital Command will be assumed by **Condell Medical Center** for the following:

Countryside FPD	Libertyville	Round Lake FPD
Grayslake	Mundelein	Wauconda
Lake Forest	Lake Bluff	Knollwood

First Alternate: Vista Medical Center East Second Alternate: Highland Park Hospital

Hospital Command will be assumed by **Highland Park Hospital** for the following:

Deerfield-Bannockburn	Highwood
Glencoe Public Safety	Northbrook
Gurnee	
Highland Park	

First Alternate: Saint Francis Hospital Second Alternate: Vista Medical Center East

Hospital Command will be assumed by **Saint Francis Hospital** for the following:

Evanston	Skokie
Lincolnwood	Wilmette
Northfield	Winnetka/Kenilworth
	Wheeling

First Alternate: Highland Park Hospital Second Alternate: Condell Medical Center

Hospital Command will be assumed by **Vista Medical Center East for** the following:

Antioch	Newport Township	Waukegan
Beach Park	North Chicago	Winthrop Harbor
Great Lakes	Lake Villa	Zion

First Alternate: Condell Medical Center Second Alternate: Highland Park Hospital

PARTICIPATING MABAS DIVISIONS APPENDIX I

MABAS Division	Primary Dispatch Number	Back-up Dispatch Number
MABAS Division I Northwest Central Dispatch	847-590-3300	847-272-2121 RED Center
MABAS Division III RED Center	847-272-2121	847-590-3300 NWCD
MABAS Division IV CEN COM	847-546-2121	847-566-6131 Mundelein

MABAS DIVISION I

Department	EMS System	Primary Dispatch Number
Wheeling	Saint Francis	847-724-5700

MABAS DIVISION III

Department	EMS System	Primary Dispatch Number
Deerfield/Bannockburn	Highland Park	847-724-5700
Evanston	Saint Francis	847-866-5095
Glencoe	Highland Park	847-724-5700
Glenview	Lutheran General	847-537-2121
Highland Park	Highland Park	847-432-7730
Highwood	Highland Park	847-724-5700
Lincolnwood	Saint Francis	847-724-5700
Morton Grove	Lutheran General	847-724-5700
Niles	Lutheran General	847-724-5700
Northbrook	Highland Park	847-724-5700
Northfield	Saint Francis	847-446-2131
North Maine	Lutheran General	847-724-5700
Park Ridge	Lutheran General	847-825-2131
Skokie	Saint Francis	847-982-5300
Wilmette	Saint Francis	847-724-5700
Winnetka/Kenilworth	Saint Francis	847-724-5700

MABAS DIVISION IV

Department	EMS System	Primary Dispatch Number
Abbott Park	Condell	847-937-2200
Antioch	North Lake County	847-395-8585
Beach Park	North Lake County	847-451-8000
Countryside	Condell	847-566-4121
Deerfield*	Highland Park	847-945-4066
Grayslake	Condell	847-223-2121
Great Lakes	North Lake County	847-688-6902
Gurnee	Highland Park	847-244-8640
Knollwood	Condell	847-234-2161
Lake Bluff	Condell	847-546-2121
Lake Forest	Condell	847-546-2121
Lake Villa	North Lake County	847-395-8585
Libertyville	Condell	847-362-2121
Mundelein	Condell	847-566-6131
Newport Township	North Lake County	847-244-8640
North Chicago	North Lake County	847-596-8774
Round Lake	Condell	847-546-2121
Wauconda	Condell	847-526-2306
Waukegan	North Lake County	847-599-2608
Winthrop Harbor	North Lake County	847-872-2131
Zion	North Lake County	847-872-8000

*Also associated with Division I

AREA-WIDE HOSPITALS APPENDIX II

REGION X RHCC HOSPITAL

Highland Park Hospital 847-432-2994 / 2995

REGION X RESOURCE HOSPITALS

- Condell Medical Center 847-362-2963
- Highland Park Hospital 847-432-2994 / 2995
- North Lake County / Vista Medical Center East 847-360-4234
- Saint Francis Hospital 847-864-6564 / 8550

	Telemetry / Cell Line
Alexian Brothers Medical Center	847-437-8118
Condell Medical Center	847-362-2963
Evanston Hospital	847-492-9453
Glenbrook Hospital	847-729-9260, or 847-657-6010
Good Shepherd Hospital	847-381-9480
Highland Park Hospital	847-432-2294, or 847-432-2295
Lake Forest Hospital	847-295-1440
Lutheran General Hospital	847-696-0743
Midwestern Regional Med Center	847-244-5629
North Chicago VA Medical Center	224-610-1075 224-610-1076
Northwest Community Hospital	847-259-8720
Resurrection Medical Center	773-774-8455
Saint Alexius Medical Center	847-490-6930
Saint Francis Hospital	847-864-6564, or 847-864-8550
Skokie Hospital	847-674-2665
Vista Medical Center East	847-360-4234
Vista Medical Center West	847-360-2323
Aurora Kenosha (Wisconsin)	262-694-1968 262-694-1973
St. Catherine (Wisconsin)	262-656-1151 262-656-1153

REGION X FREESTANDING EMERGENCY CENTERS

Northwestern Grayslake Emergency Center	847-535-8736
Vista Medical Center Lindenhurst Campus	847-356-4705

Information Only:

REGION IX RHCC HOSPITAL

Sherman Hospital 847-429-2950

PARTICIPATING PRIVATE AMBULANCE PROVIDERS

APPENDIX III

Provider	Phone Number	Contact Information
Advance Ambulance	773-774-8999 (dispatch)	-Advise company of need(s) -Request that Shift Manager be paged
A-TEC Ambulance	847-362-0200 (dispatch)	-Advise dispatch of need(s) -Request that Chief Officer be paged
D.P. Murphy Ambulance	847-816-4600 (dispatch)	-Advise dispatch of need(s)
LJH Ambulance	800-261-0123 262-658-4422 (dispatch)	-Advise dispatch of need(s) -Request that 'management' be paged
Midwest Ambulance	847-745-0050	- Advise dispatch of need(s)
Paratech Ambulance	414-365-5900	- Advise dispatch of need(s)
Superior Ambulance	630-832-2000 (dispatch)	-Advise dispatch of need(s) -Request that Regional Manager be paged

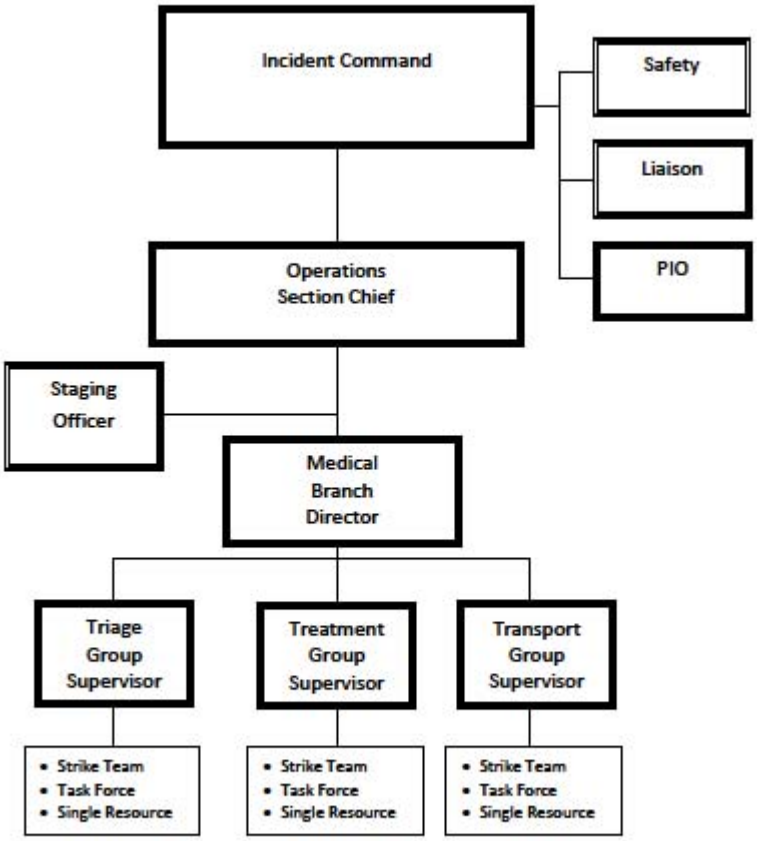
Private Providers Emergency Response System (PPERS)
Primary Dispatch Number – 800-558-6050

Collaborative Healthcare Urgency Group (CHUG)
847-803-2484

MODEL POSITION DESCRIPTIONS APPENDIX IV

The position descriptions contained herein are dictated by experience as necessary for the successful management and resolution of a multiple patient incident. The performance outlines are simply suggestions and are not intended to be viewed as a requirement for activation of the plan.

INCIDENT MANAGEMENT SYSTEM ORGANIZATION



MEDICAL BRANCH

The Medical Branch may be organized as either a separate group or section under the Incident Management System, depending on the scope of the incident. Functions of the medical branch include triage, patient treatment and transportation. A single Medical Group Supervisor at a multiple patient incident may coordinate all these functions. However, such duties may be delegated as appropriate to a separate Triage Unit Leader, Treatment Unit Leader and/or Transportation Unit Leader in a multiple patient incident, overseen by a single Medical Group Supervisor who reports directly to Incident Command.

MEDICAL GROUP SUPERVISOR

Appointed By	Incident Command
General Description	Oversees the medical section of a multiple patient incident. May appoint and supervise triage, treatment and transportation units.

Responsibilities may include:

- Determining the approximate number of patients and extent/type of injuries
- Immediately advising either the closest hospital or the Resource Hospital (depending on the size/scale of the incident) that an incident has occurred, utilizing normal modes of communication.
- Communicating patient numbers and acuity to the hospital.
- Advising the hospital of those hospitals closest to the incident scene.
- Determining the patient destination hospitals for each patient not transported to the closest hospital (during a Small Scale incident) and assigning such patients to a transporting ambulance crew.
- Advising transporting ambulances of their assigned destination hospitals according to communication received from the Resource Hospital in a Medium Scale or Large Scale incident.
- Maintaining communication with the hospital throughout the incident, OR appointing a group or branch supervisor to assume communication with the hospital.
- Continually assessing the need for additional ambulances, personnel and equipment, making such requests through Incident Command.
- Assessing the need for medical teams and aero-medical transportation (according to local system policy) in consultation with the Resource Hospital and Incident Command. (If aero-medical transportation is required, staging must be notified by the Medical Group Supervisor to set up an appropriate landing zone.)
- Determining the extent of documentation (in the form of a patient care report) required per incident, relaying information to the Transportation Unit Leader who will pass the information to transporting ambulance crews.
- Ensuring that an After-Action Report (Appendix XI) is generated following each incident and that a copy of the report has been faxed to the EMS Office at the Resource Hospital of the host department.

MEDICAL SUPPLY UNIT LEADER

Appointed By	Medical Group Supervisor
General Description	Secures and organizes medical supplies and equipment

- Supplies and equipment include, but are not limited to, backboards, oxygen supplies, dressings and bandages, medications, volumes of sterile water, IV fluids and equipment.

This logistical function may be necessitated in Medium Scale or Large Scale incidents or when specialized equipment and/or supplies are required.

Additional supplies and equipment may be obtained via mass casualty bags located on each ambulance or by requesting the mass casualty trailer be brought to the scene.

TRIAGE UNIT LEADER

Appointed By	Medical Group Supervisor
General Description	Provides coordination necessary for effective categorization and transportation of patients from the incident to the treatment area.

Responsibilities include:

- Supervision of triage personnel during the initial phase of a multiple patient incident.
- Determining and relaying number of patients and general acuity to the Medical Group Supervisor, updating information as necessary.
- Reporting any needs regarding equipment and manpower to the Medical Group Supervisor.
- Confirming that ALL patients have a triage tag present and that the appropriate area of the tag has been retained by triage personnel.
- Reporting to the Medical Group Supervisor for reassignment upon completion of triage and transfer of patients to the Treatment Unit Leader.

TREATMENT UNIT LEADER

Designated By	Medical Group Supervisor
General Description	Establishes and manages the patient treatment area.

Responsibilities include:

- Overseeing EMS personnel in the treatment and frequent reassessment of patients in the treatment area.
- Prioritization of patients for transport to hospitals.

The designation of the Treatment Unit Leader is intended for use in larger incidents where the Medical Group Supervisor would be unable to coordinate activities in the patient treatment area.

TRANSPORTATION UNIT LEADER

Designated By	Medical Group Supervisor
General Description	Establishes loading of ambulances and records patient destination.

Responsibilities include:

- Communication with the Resource Hospital (initial communication may have been established by Medical Group Supervisor or their designee).
    - The Transportation Unit Leader will:
        - give patient numbers and triage categories to the Resource Hospital.
        - receive and record hospital capabilities as reported by the Resource Hospital.
        - give specific hospital destination for each ambulance to the Resource Hospital, including number of patients and triage categories.

- Establishment of patient loading area allowing for safe and coordinated access and egress of ambulances.
- Communication with Staging Area Unit Leader, requesting specific number and capabilities (ALS, BLS) of available ambulances.
- Notation of each patient's triage tag number on a log sheet.
- Assignment of a destination hospital to each transporting ambulance.

STAGING AREA UNIT LEADER

Designated By	Operations Chief or Incident Command
General Description	Management of all incoming fire/rescue apparatus, ambulances and other resources.

Note: -The staging area is designated by Incident Command.
-The first unit at the staging location will assume the role of Staging Unit Leader until such time as they are relieved by an officer designated by the Medical Group Supervisor.

Responsibilities include:

- Maintaining communication with (either Transportation or Treatment Unit Leader) to supply required vehicles.
- Maintaining communication with Incident Command to advise on available resources.
- Sending requested resources to the scene.
- Management of the staging area, assuring orderly parking, maintaining clear access to the incident site.
- Maintaining an accurate log of currently available equipment, apparatus and manpower.
- Collection of mass casualty bags located on each ambulance in staging upon request from the Medical Group Supervisor.
- Ensuring all incoming units are equipped with a Passport. A Passport make-up kit must be available at staging to supply proper accountability materials to any units that may be operating at the incident that do not have a Passport, such as private ambulances or hospital teams.

In a large-scale incident, the Staging Unit Leader may need to request additional personnel from Incident Command to assist in these functions.

DISASTER PLAN LEVELS APPENDIX V

FEDERAL PLAN

The National Disaster Medical System (NDMS) is a cooperative effort between the Department of Homeland Security (DHS), Department of Health and Human Services (HHS), Department of Defense (DOD), Department of Justice (DOJ), Department of Veterans Affairs (VA), Federal Emergency Management Agency (FEMA), state and local governments and the private sector. NDMS includes Disaster Medical Assistance Teams (DMATs) and Clearing-Staging Units (CSUs) at the disaster site or receiving location, a medical evacuation system and more than 100,000 pre-committed non-federal acute care hospital beds in more than 1,500 hospitals throughout the United States. NDMS does not replace, but rather supplements, state, regional and local disaster planning efforts. The program provides for "mutual aid" among all parts of the nation and is able to handle large numbers of patients that might result from a domestic disaster situation or an overseas conflict.

In the event of a major disaster, the Governor of an affected state may request federal assistance and the President may make a declaration of a major disaster or an emergency either before or after the incident occurs. The presidential declaration triggers a series of federal responses coordinated by FEMA. These operations may include activation of NDMS when appropriate. Upon system activation, the NDMS operations support center is activated to coordinate federal health and medical responses to the disaster.

NDMS Plan Activation Sequence

1. A mass casualty incident has occurred requiring NDMS activation.
2. After initial stabilization, patients are transported to a hospital in the area of the mass casualty.
3. Once stabilized, patients are prepared to be transported via the best available means.
4. The Federal Coordinating Center for the areas covered by this plan (Great Lakes Naval Hospital) will contact the Governor of Illinois and the Illinois Department of Public Health (IDPH) to notify them that a national disaster has occurred and that the NDMS plan has been activated.
5. Illinois Masonic Medical Center (IMMC) is notified by the IDPH that the NDMS has been activated.
6. IMMC notifies the area-wide RHCC hospitals (Highland Park Hospital (HPH) and Sherman Hospital) of the disaster and activation.
7. IMMC, HPH and Sherman Hospital will contact the Chicago and suburban hospitals within their regions to obtain status reports.
8. Once NDMS has been activated, bed status reports will be generated at least every 12 hours until directed to discontinue.
9. IMMC is responsible for assigning receiving hospitals for all patients who arrive via O'Hare International Airport or another designated receiving facility/area.
10. Prior to landing at O'Hare or another designated receiving facility/area, IMMC and the RHCC hospitals will receive manifests giving details of all patients.
11. If medical assistance is required for arriving patients, once hospital assignments have been made, IMMC and HPH will make arrangements for transportation to medical facilities via Chicago Fire Department and other EMS providers for those patients arriving in the area.

STATE PLAN

The State of Illinois Emergency Medical Disaster Plan is not meant to take the place of the NDMS plan, but exists to address the preparedness, response and recovery to an emergency medical situation within the State of Illinois. The goal of the plan is to provide assistance to allow emergency medical services personnel and health care facilities to work together in a collaborative manner in situations where local resources are overwhelmed.

State Disaster Plan Activation Sequence

1. The Governor of Illinois is notified by a local government official (mayor, county commissioner, etc) that a disaster has occurred. The Governor makes the determination to 'declare' a disaster thereby initiating the state disaster response plan.
2. The Deputy Director of the Office of Preparedness and Response is notified by the Governor's office and activates the appropriate phase of the Disaster Plan (Phase I or Phase II), determines required resources and requests assistance from the appropriate RHCC Hospitals.
    - The RHCC Hospitals covered by this plan include;
        Region X – Highland Park Hospital
        Region IX – Sherman Hospital
3. Each RHCC directs the Resource Hospitals within their region to immediately contact each of their Associate and Participating Hospitals. All hospitals in each region will provide accurate information on the Hospital Health Alert Network (HHAN).
4. The RHCC hospital shall consider the activation of the Regional Medical Emergency Response Team (REMERT).
5. Every hospital will report on some or all of the following information, based on the level of activation (Phase I or Phase II) via the HHAN:
    - ED availability
    - Adult monitored beds
    - Pediatric monitored beds
    - Total other beds
    - Total units blood
    - # ventilators – adult, peds, both
    - # Field bags
    - # Walking decontamination patients per hour
    - # Littered decontamination patients per hour
    - Special needs

All hospitals must continually update required information on the HHAN until notified by their Resource Hospitals that the disaster has officially ended.

O'HARE INCIDENT/DISASTER PLAN
Region XI / City of Chicago EMS System

Implementation:

- This plan is to be implemented if any incident/disaster occurs within the confines of O'Hare Airport/field.
- Advocate Illinois Masonic Medical Center (AIMMC) will be contacted by the Chicago Office of Emergency Communications (911 Center) or Chicago Fire Department (CFD) Officer in Charge (4-4-11).
- Utilize the "O'Hare Disaster Log Sheet" for record keeping.

Upon notification, AIMMC will:

1. Page EMS System Coordinator ID# 9694 (or call cell phone).

2. Notify the following facilities (see phone # sheet):

    - Highland Park Hospital (who will activate their notification list)
    - Resurrection Medical Center
    - Our Lady of Resurrection
    - Swedish Covenant Hospital
    - Additional hospitals may be needed; CFD will advise AIMMC if this need occurs.

    - Highland Park Hospital will call the following facilities:

        - Lutheran General
        - Northwest Community
        - Alexian Brothers (Elk Grove Village)
        - Gottlieb Memorial
        - Westlake Hospital
        - Elmhurst Hospital
        - St Alexius Medical Center (Hoffman Estates)
        - Loyola Medical Center
        - Good Samaritan

3. AIMMC most likely will *not* receive patients –although this depends on the incident.

4. Regional Medical Emergency Response Teams (RMERT) may be requested by CFD to be dispatched to the scene-contact the EMS System Coordinator to arrange teams.

5. Maintain communications with the field and hospitals until "scene cleared" by CFD Incident Command at the scene.

6. **NOTIFY ALL HOSPITALS** *once scene is cleared*.

7. Submit paperwork to EMS Coordinator or EMS Office.

Updated: April 2012 Advocate Illinois Masonic Medical Center

O'HARE INCIDENT PARTICIPATING CALLS

Region XI / Chicago EMS System

The following is a list of hospitals that have agreed to support O'Hare Airport in the event of an incident/disaster:

		ED Direct Lines:
ADVOCATE ILLINOIS MASONIC MEDICAL CENTER notifies:		
Highland Park Hospital	777 Park Avenue West Highland Park	847-480-3751
Resurrection Medical Center	7435 West Talcott Avenue Chicago	773-774-8455 (tele)
Our Lady Of Resurrection	5645 West Addison Street Chicago	773-794-7601
Swedish Covenant	5145 North California Avenue Chicago	773-989-3800
HIGHLAND PARK HOSPITAL notifies:		
Lutheran General	1775 Dempster Street Park Ridge	847-696-0743 (tele)
Northwest Community	800 West Central Avenue Arlington Heights	847-618-3920
Alexian Brothers	800 Biesterfield Road Elk Grove Village	847-981-3599
Gottlieb Memorial	8700 West North Avenue Melrose Park	708-450-4975
Westlake Hospital	1225 Lake Street Melrose Park	708-343-8375
Elmhurst Hospital	155 E Brushhill Road Elmhurst (new address)	331-221-0202 (new # confirmed)
St Alexius Medical Center	1555 Barrington Road Hoffman Estates	847-490-6930
Loyola Medical Center	2160 South First Avenue Maywood	708-216-9080
Good Samaritan	3815 Highland Avenue Downers Grove	630-275-1160

Updated: April 2012 Advocate Illinois Masonic Medical Center

DATE: _____ **TELE LOG # _____**
TIME: _____ **Page _____ of _____**

O'HARE VICTIM INCIDENT LOG

CFD EMS Chief/OFFICER:_____ PHONE #: _____
INCIDENT TYPE: _____
APPROXIMATE # of VICTIMS: _____
SPECIAL CIRCUMSTANCES:
_____

Hospital	Person Notif & Time	# Pts CAN Accept	# Pts SENT	Ambulance Transporting	Comments
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		
		R _____ Y _____ G _____	R _____ Y _____ G _____		

All Clear At:_____
ECRN/ECP Signature:_____

Updated: April 2012 Advocate Illinois Masonic Medical Center

TRAINING GUIDELINES APPENDIX VI

In an effort to improve the effectiveness of this multiple patient management plan, all participating hospitals and pre-hospital providers have agreed to adhere to the following guidelines when planning training activities:

FIRE DEPARTMENTS

1. Field training exercises may include the transportation of patients to receiving hospitals via ambulances upon mutual agreement prior to the exercise.
2. Training for all personnel shall be carried out at the local and division level. Special emphasis should be given to the job functions associated with the incident management system of organization.
3. A variety of training options may be utilized to facilitate this purpose, including lecture/discussion, tabletop exercises and small-scale field exercises.
4. Local fire departments are encouraged to continue working with hospitals in their own community that participate in this plan for the purpose of assisting one another in meeting training and hospital accreditation requirements.
5. In an effort to maintain proficiency, fire departments may choose to utilize SMART tags with START triage principles during small scale incidents. This is a voluntary endeavor that does not require communication to the receiving hospital.
6. Training exercises within the geographic boundaries of this plan shall be communicated to the Resource Hospital for communication back to the Regional DMSC Committee. Knowledge of impending exercises and critiques of said exercises following these drills are essential to a continual assessment of this plan.

HOSPITALS

1. EMS continuing education training with respect to multiple patient incidents will focus on the areas of plan implementation, communication, field triage and treatment.
2. Hospitals are encouraged to partner with their local fire department in this in-house training to enhance local preparedness.

PRIVATE AMBULANCE PROVIDERS

Private ambulance companies will work with their Resource Hospital to assure appropriate participation and compliance with the plan.

NOTE: An After-Action Report (Appendix XI) should be completed following all training activities involving the regional Multiple Patient Management Plan within 48 hours of the event.

MEDICAL PERSONNEL REQUESTED TO THE SCENE

APPENDIX VII

Incident Command may request hospital-based medical personnel to respond to the scene of an incident for specific needs. This request shall be communicated through the Resource Hospital. Personnel shall be assembled based on the specific need (e.g., surgical, toxicological, psychiatric, etc.).

The medical personnel shall:

- Respond with supplies to meet the needs of the specific incident.
- Respond with a police escort or via other official means of transportation. The escort will provide security, ensure a rapid response, and assist with access into restricted areas.
- Report directly to the Command Post.
- Be identified by a green helmet and/or reflective vest indicating "Medical Team", or other official uniform.

Additional medical personnel may be asked to respond to the scene based upon regional and state protocols, including the Regional Emergency Medical Response Team (REMERT) and the Illinois Medical Emergency Response Team (IMERT). A request for such teams must be made by the Resource Hospital to the RHCC Hospital.

Self-dispatching of personnel to a disaster scene is STRICTLY PROHIBITED!

TRIAGE TAG INSTRUCTIONS APPENDIX VIII

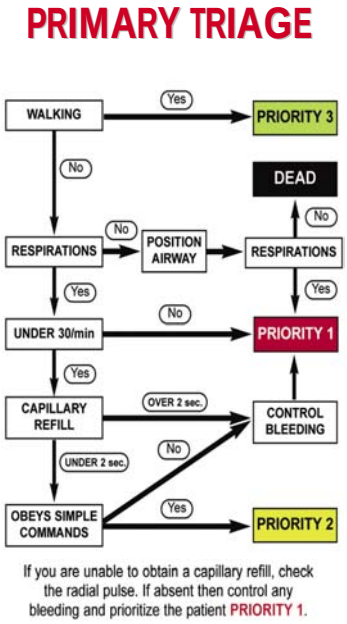
Region X has adopted the SMART Incident Command System® as a standard for the process of START triage which includes the use of specific triage tags. The SMART® tag is designed to show just one color at a time but can be refolded to reflect any change in status. The triage process should be repeated at each link of the incident management chain. The primary (first) triage method will be used to sort victims into groups and is based upon vital signs and level of consciousness. The secondary triage method is utilized to prioritize treatment and transport goals and is based upon anatomic and physiologic criteria. The information included herein applies only to the SMART® System.

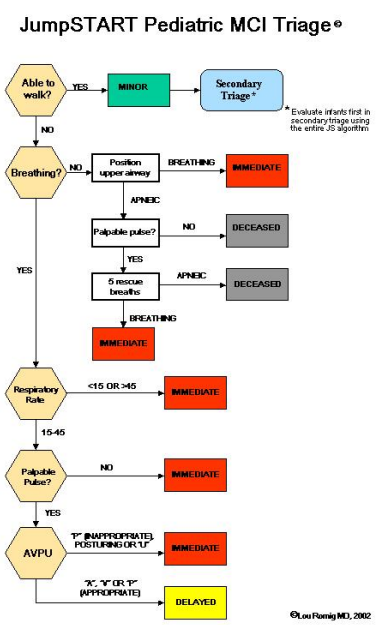
Components of the Triage Pack:

- Folding SMART® triage tags
- Mini-light sticks to identify RED patients at night
- Dead tags
- START Triage prompt cards
- Jump START Triage prompt cards
- Dynamic record of casualties already triaged
- Pencil

Primary Triage Procedure:

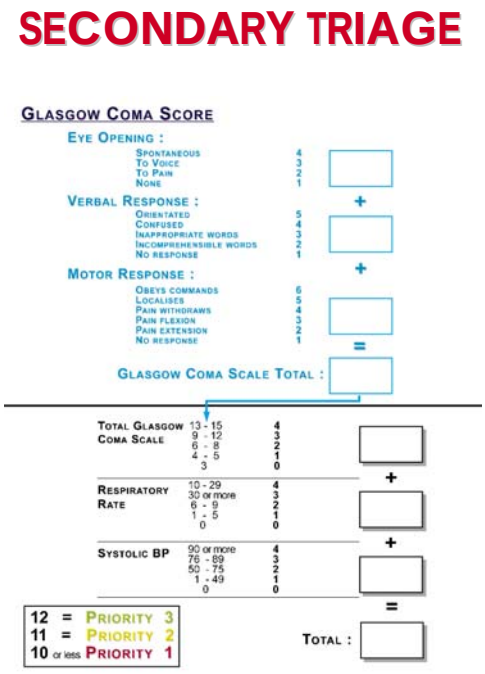
1. Triage personnel shall obtain a Triage Pack (designed to be carried on a belt to leave the hands free).
2. Ensure appropriate PPE.
3. The START triage process generally begins with a request for all ambulatory victims to move to an area of refuge (generally tagged Green or Priority 3).
4. Approach each remaining victim and assess triage priority by using the START Triage Prompt Card for adult victims and the Jump START Prompt Card for child victims.
5. Assign triage priority by removing the SMART® Tag from the plastic sleeve and folding the tag so the appropriate color priority is visible.
6. Attach the elastic band to the victim's upper extremity.
7. If light is inadequate at the triage site, use a mini-light stick in addition to Red triage tag to designate most serious victims.
8. Life support interventions should be limited to opening the airway and hemorrhage control. This step may depend upon readily available resources.
9. Upon completion of the primary triage process, victims may be moved to a designated (color-coded) collection area.





Secondary Triage Procedure:

1. Upon arrival in a collection area, each victim should be (re)assessed by using the Glasgow Coma Scale, respiratory rate and systolic blood pressure.
2. The results of the secondary triage will determine treatment and transport priorities.
3. Secondary triage may also result in a change of original assigned priority code. This may be accomplished by refolding, but not removing or replacing, the original tag. Movement of the victim to another collection site is not necessary pending #2, above.
4. Prior to transport from the scene, the tag transport strip will be removed and retained by the transportation officer.



POST-INCIDENT RECOVERY SERVICES APPENDIX IX

Multiple agencies provide critical incident stress management. Local emergency services providers are encouraged to have a plan in place for the implementation of post-incident recovery services, including critical incident stress management. Listed below is a selection of groups able to provide such services to emergency personnel.

AGENCY	TELEPHONE NUMBER
Northern Illinois Critical Incident Stress Management Team	800-225-2473
DuPage County Crisis Intervention Unit	630-627-1700 (24 hours)

APPENDIX X

FORMS AND LOGS

- Field Provider Log Form
- Emergency Department Log Form
- After-Action Report
- ICS 214 Activity Log (Communications Flow Sheet)
- Abbreviations/Acronyms

03/12

REGION X
MULTIPLE PATIENT MANAGEMENT PLAN

Your Name:

Contact Phone #:

FIELD PROVIDER LOG FORM

Date: _____ Time: _____ Fire Department: _____

Hospital you are contacting: _____ ED Phone #:_____

SMALL SCALE: "Business as usual"

Field personnel call the closest appropriate hospital

"Hello. This is the _____

Fire Department. We are on the scene of a Small Scale multiple patient incident. The incident is a

_____(describe the event to the ECRN).

Our total number of patients is _____.

We have: (fill in the specific numbers of patients)

_____ Category I Trauma _____ Category I Medical

_____ Category II Trauma _____ Category II Medical

_____ Category III Trauma _____ Category III Medical

How many patients can you take?" _____

If patients will be transported to other hospitals report those destinations to the ECRN and record below. **NO MORE THAN TWO PATIENTS MAY BE SENT TO HOSPITALS WITHOUT PRIOR APPROVAL FROM THE RECEIVING HOSPITAL.**

Complete table with specific hospital name(s), #'s and patient acuities.	Hospital:	Hospital:	Hospital:	Hospital:
Cat I Trauma				
Cat II Trauma				
Cat III Trauma				
Cat I Medical				
Cat II Medical				
Cat III Medical				
TOTALS				

NOTE:
1) Complete an After-Action Report (critique form)
2) Fax both this form and the After-Action Report to the EMS Office of the Resource Hospital IMMEDIATELY following the incident.

MEDIUM or LARGE SCALE

Field personnel call their Resource Hospital for Transportation Management

"Hello. This is the _____

Fire Department. We are on the scene of a _____ (Medium or Large) Scale multiple patient incident. The incident is a _____ (describe the event to the ECRN).

Our estimated number of patients is _____.

We estimate that we have the following types of patients:

RED: _____ YELLOW: _____ GREEN: _____ DECEASED: _____

Our closest hospitals are:"
(IMPORTANT: List in order of proximity to the incident)

1. _____
2. _____
3. _____
4. _____
5. _____

"MY CALL BACK TELEPHONE NUMBER IS": _____

*Use SMART® Command Board to record hospital availability and patient destinations.

NOTE:
1) Complete an After-Action Report (critique form)
2) Fax both this form and the After-Action Report to the EMS Office of the Resource Hospital IMMEDIATELY following the incident.

ECRN:

ATTENDING MD:

REGION X
MULTIPLE PATIENT MANAGEMENT PLAN

EMERGENCY DEPARTMENT LOG FORM

Date: _____ Time: _____Fire Dept: _____

Type of Incident: _____**CALL BACK PHONE NUMBER**: _____
(DO NOT forget to request call back number for field personnel!)

Check One: SMALL SCALE ☐ MEDIUM SCALE ☐ LARGE SCALE ☐

* Refer to Region X Multiple Patient Management Plan for more specific information including contact telephone numbers for Region X hospitals.

SMALL SCALE (*only*): "Business as usual"

Field personnel will call the closest appropriate hospital.

Total # Patients: _____

_____ Category I Trauma ____ Category I Medical

_____ Category II Trauma ____ Category II Medical

_____ Category III Trauma ____Category III Medical

During a Small Scale Multiple Patient Incident the caller will ask you 'how many patients can your hospital receive?'

How many patients can your hospital receive? _____

The FD caller will tell you which hospitals will receive the rest of the patients. Please record below, including those transported to your hospital.

*Transporting ambulances **will** contact receiving hospitals with radio reports.

Complete table with specific hospital name(s), #'s and patient acuities.	Hospital:	Hospital:	Hospital:	Hospital:
Cat I Trauma				
Cat II Trauma				
Cat III Trauma				
Cat I Medical				
Cat II Medical				
Cat III Medical				
TOTALS				

NOTE:
1) Complete an After-Action Report (critique form)
2) Submit both this form and the After-Action Report to your EMS Coordinator.

MEDIUM or LARGE *(RESOURCE HOSPITALS (RH) ONLY)*

Field personnel will request Transportation Management from the RH.

Estimated total # of patients: _____

RED: _____ YELLOW: _____ GREEN: _____ DECEASED: _____

- During a Medium or Large Scale Patient Incident the caller will give you the names of the closest hospitals. **CALL THOSE HOSPITALS FIRST**.
- Ask for their ability to receive specific types and numbers of patients.
- *Remind receiving hospitals they will NOT receive a radio report from transporting ambulances.*
- Relay the information back to the FD caller.

	RED	YELLOW	GREEN	**TOTAL**
Hospital: Phone #:				
Hospital: Phone #:				
Hospital: Phone #:				
Hospital: Phone #:				
Hospital: Phone #:				

**Use additional forms if contacting more than five hospitals.*

Time patient disbursement information was relayed to field personnel: _____

*CONTACT THE RHCC IF ASSISTANCE IS REQUIRED: Highland Park Hospital: 847-432-2294 / 2295

NOTE:
1) Complete an After-Action Report (critique form)
2) Submit both this form and the After-Action Report to your EMS Coordinator.

REGION X
MULTIPLE PATIENT MANAGEMENT PLAN

Name:

FD or Hosp:

AFTER-ACTION REPORT

Date of Incident: _____ Time of Incident: _____ Primary Fire/Rescue Agency: _____

Description of Incident: _____

Check One:

SMALL ☐: Total # patients: ____ (Specific # Trauma: Cat I___ Cat II___ Cat III___ Medical: Cat I___ Cat II ___ Cat III ___)

MEDIUM ☐ / **LARGE** ☐: Total # patients: _____ (Specific #: Red _____ Yellow _____ Green _____ Deceased _____)

Please answer the following questions. Use the reverse side for additional comments (take note when faxing form).

Which hospital was first contacted by field personnel?_____

Mode of communication between field and hospital: Cell phone ☐ Telemetry ☐ MERCI ☐ Other:_____

Any difficulties with initial communication? No ☐ Yes:_____

Was it difficult to determine the Scale of the incident? No ☐ Yes:_____

Any difficulties with triage? No ☐ Yes:_____

Receiving Hospitals / # pts to each hospital: _____

Any difficulties with patient disbursement? No ☐ Yes:_____

Any difficulties with ambulance to hospital communication (Small Scale only): No ☐ Yes:_____

Was the two-sided Multiple Patient Management Plan **REFERENCE CARD** used? Yes ☐ No ☐

If yes, was it helpful? Yes ☐ No ☐ Comments: _____

Was a Region X Multiple Patient Management Plan **LOG FORM** used? Yes ☐ No ☐

If yes, was it helpful? Yes ☐ No ☐ Comments: _____

Overall, how effective was Region X Multiple Patient Management Plan in successfully disbursing patients from the scene to area-wide hospitals?

Very Effective ☐ Effective ☐ Ineffective ☐ Very Ineffective ☐

The success of the plan depends on your detailed comments. Please provide us with any additional information that may be helpful:

_____

_____

Hospital Personnel – Submit this form and Emergency Department Log form to your hospital EMS Coordinator.
Field Personnel – Fax this form and Field Provider Log Form to the Resource Hospital EMS Office.

03/12

Communications Flow Sheet

ACTIVITY LOG (ICS 214)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:	
3. Name:	4. ICS Position:	5. Home Agency (and Unit):
6. Resources Assigned:		
Name	ICS Position	Home Agency (and Unit)
7. Activity Log:		
Date/Time	Notable Activities	
8. Prepared by: Name:	Position/Title:	Signature:
ICS 214, Page 1	Date/Time	

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:
7. Activity Log:	
Date/Time	Notable Activities
8. Prepared by: Name:	Position/Title: Signature:
ICS 214, Page 2	Date/Time

ABBREVIATIONS / ACRONYMS

Altered Standards of Care - When victims' needs outweigh immediately available resources, the usual standard of care may be altered to provide for allocation of scarce resources in order to save as many lives as possible.

CHUG - Collaborative Healthcare Urgency Group, website: http://www.chughurt.com/

DMSC – Disaster Management Services Committee

ECRN – Emergency Communications Registered Nurse

EMS - Emergency Medical Services

HAN – Hospital Alert Network

Healthcare Facility – A hospital, nursing home or other fixed location at which medical and health care services are performed.

IAP - Incident Action Plan

IMERT – Illinois Medical Emergency Response Team, website: http://www.imert.org/

MABAS - Mutual Aid box Alarm System

Multiple Patient Incident – An incident in which there is more than one patient and healthcare needs exceed immediately available resources.

Post-Action Review – Evaluation of actions taken during an incident in order to improve future performance through education or process/policy change.

PPERS - Private Provider Emergency Response System

Region X – EMS/Trauma Region as defined in the IDPH EMS Act: northern boundary of Illinois/Wisconsin state line to Route 83, southern boundary of Chicago/Evanston border to Park Ridge city limits, eastern boundary of Lake Michigan and western boundary of Route 83 to Route 173 west to Route 59 south to Route 60, east to Route 83 to the Lake/Cook county line, east to Milwaukee Avenue then south to Des Plaines River Road, south to Central Road, east to I294, south to Dempster Street, east to the Niles city limits south to the Chicago city limits.

RHCC – Regional Hospital Coordinating Center

RMERT – Regional Medical Emergency Response Team