Region II EMS
MCI Plan

Central MA EMS Corporation

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(Awaiting MDPH approval)

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PREAMBLE

The Central Massachusetts Emergency Medical Systems Corporation (Region II EMS Council)/ Worcester Metropolitan Medical Response System (WMMRS) Mass Casualty Incident (MCI) Plan (hereinafter "Region II MCI Plan") is a planning document to help mitigate the effects of an MCI or emergency evacuation within the Massachusetts Department of Public Health's (MDPH) EMS Region II.

The plan was developed with input from EMS services and agencies expected to be involved in MCI operations. It was written to be consistent with all other Region II plans as applicable. Ongoing planning, training and revisions are expected in an effort to continually improve MCI management.

EMTs, ambulance services, allied health professionals, state and local government representatives, and disaster-related support organizations share a responsibility in the success of this plan. Assimilation of the plan's contents, implementation of its guidelines, and recommendations for improvements will contribute to its purpose. CMEMSC will make available on its website the most current approved Region II MCI Plan.

AUTHORITY

The Central Massachusetts Regional EMS council is established within Massachusetts General Law Chapter 11C: Section 4. Central MA Emergency Medical Systems Corporation (CMEMSC), serving as the Regional EMS council, is charged with assisting and supporting MDPH's Office of Emergency Medical Services (OEMS) in carrying out the provisions of this law and in developing and implementing the state and regional EMS plans. 105 CMR 170.050(B) (10) requires the development of a statewide MCI plan and 105 CMR 170.104(L) stipulates that the Regional EMS Councils must develop regional EMS plans that incorporate all components of the state plan.

Fatality management during MCIs within Region II will be coordinated in cooperation with, and under the direction of, the Massachusetts Office of the Chief Medical Examiner, Massachusetts Emergency Management Agency (MEMA), local law enforcement officials and/or the Massachusetts State Police.

SCOPE

The scope of the Central Massachusetts EMS Council MCI Plan covers Region II's 76 communities, 11 hospitals, all ambulance services operating in the Region, and other stakeholders in the system.

PURPOSE

The purpose of the Region II MCI plan is to provide the necessary information the EMS provider needs to facilitate successful operations during a large-scale incident. The plan will cover step-by-step procedures including response, communications, patient tracking, resource requests, and facility evacuations. Additional information, including response guidelines, specific resources, and hospital evacuation plans are included in the appendices. Providers are expected to have completed National Incident Management System (NIMS) Incident Command System (ICS) training.

I. MCI (Mass Casualty Incident) OPERATIONS

MCI Operations will follow the National Incident Management System (NIMS) Incident Command System (ICS).

A. EMS Actions at an MCI (or potential MCI)

1. Declaration of an MCI: The following individuals or organizations have authority to declare an MCI:
    - First EMT on site with a CMED radio
    - Ambulance service supervisor
    - The public safety agency responsible for overall incident management
    - Worcester Central Medical Emergency Direction (CMED)

2. The first unit on scene will conduct a scene size-up using the mnemonic METHANE:
    M = Major incident declaration through CMED
    E = Exact location; staging area
    T = Type of incident
    H = Hazards; present and potential
    A = Access; best route for responders; landing area
    N = Number of casualties, type, and severity (see Level)*
    E = Emergency services; present and required

    *The number of potential patients will determine the level of the incident for mutual aid purposes:
    Level 1: 1-10
    Level 2: 11-30
    Level 3: 31-50
    Level 4: 51-200
    Level 5: Greater than 200
    Level 6: Long Term Operation (more than two operational periods)

3. The responder contacting Worcester CMED will be assigned a dedicated medical communications channel for the duration of the incident.

4. Worcester CMED will notify area hospitals.

5. The local EMS agency or Worcester CMED will request/or assign ambulances within that area to be dispatched to the scene on initial assignment, for triage and other purposes as needed according to the designated EMS Branch Director.

6. The designated EMS Branch Director will work with the Operations Section Chief/Incident Commander to establish triage, treatment, transport, communications, and EMS staging areas.

7. The EMS Branch Director will assign an individual (e.g., Transportation Supervisor) to communicate with Worcester CMED. This individual will coordinate the transport, assignment of destination, and tracking of patients from the scene of the MCI.

8. The EMS Branch Director may request, in coordination with the Operations Section Chief/Incident Commander, additional EMS resources through Worcester CMED, including but not limited to, Regional Strike Teams, Ambulance Task Forces (ATF), Regional Mass Casualty Support Units (RMCSU), regional communications trailer, Mass Decontamination Units (MDU), regional staff, and patient tracking equipment.

9. The EMS Branch Director, in coordination with the Operations Section/Incident Commander, may begin the demobilization process after the Transportation Supervisor has confirmed that all patients have been transported.

See ***Appendix A: Pre-Hospital Provider Responsibilities/Goals/Guidelines***
See ***Appendix B: CMEMSC Resources***

B. Patient Tracking

Patient tracking is the responsibility of all members of the EMS community and Region II hospital emergency departments. See ***Appendix B: CMEMSC Resources***

Procedure for Injured and Treated Patients:

1. EMS providers will follow the same process as outlined under *MCI Operations Section A: EMS Actions at an MCI (or potential MCI).*

2. All patients will receive SMART Tag™ triage tags

3. The patient tracking equipment will be requested through Worcester CMED by the EMS Branch Director. CMED will automatically deploy the EMTrack™ Scanners and patient tracking shall take place for any Level II or higher MCI. Patient tracking equipment may be requested for incidents with fewer than eleven (11) patients.

4. An incident shall be created by the Worcester CMED Operator or the Regional Administrator in EMTrack™ ASP prior to tracking patients.

5. The EMTrack™ Host Service will report to the EMS Branch Director.

6. The EMTrack™ Host Service will assume the role of Tracking Supervisor, unless otherwise directed by the EMS Branch Director, and shall:
    - Set up the Mobile Command Unit
    - Set up the EMTrack™ Handheld Scanner Units
    - Ensure Scanners are logged in to proper incident and location
    - Assign Scanners to personnel operating in Triage, Treatment and Transport sections as needed
    - Supervise use of Scanners to ensure patients are scanned properly

7. All patients on scene will be scanned into the incident in the Transportation section prior to leaving the scene.

8. Patients that are treated and released will be documented in EMTrack™ Scanners.

9. Receiving hospitals shall be notified of incoming patients by Worcester CMED and via EMTrack™ ASP.

10. Receiving hospitals view EMTrack™ ASP to review patient data entered.

11. Upon arrival at the hospital, the patient is marked as received in EMTrack. ™

Procedure for Non-injured Evacuees:

1. The patient tracking equipment will be requested through Worcester CMED by the EMS Branch Director.

2. Tracking shall take place for any Level III or higher incident that includes thirty-one (31) or more evacuees that need to be sheltered.

3. The EMTrack™ Host Service will report to the EMS Branch Director and will assume the role of Tracking Supervisor, unless otherwise directed by the EMS Branch Director, and shall:
    - Set up the Mobile Command Unit
    - Set up the EMTrack™ Handheld Scanner Units
    - Ensure Scanners are logged in to proper incident and location
    - Assign Scanners to personnel operating in Triage, Treatment and Transport sections as needed.
    - Supervise use of Scanners ensuring evacuees are scanned properly and ensure that patients, who are received by facilities that are unable to scan patients electronically, are entered into EMTrack™ ASP manually

4. Receiving shelters may view EMTrack™ ASP to review data entered.

5. Scanners will be assigned to the receiving shelters, if available.

6. Upon arrival at the shelter, the evacuee will be marked as received in EMTrack™

7. Patient data will be manually entered in EMTrack™ when hardware is not available on-scene.

C. Emergency Medical Response

The MCI plan assumes that agencies will respond to mutual aid requests at all emergency scenes under local dispatch protocols. Units and crews will continue to operate under local protocols until such time as it has been determined that a regional MCI has been declared and the Region II MCI plan has been activated by the Incident Commander.

In the interest of safety, efficiency and accountability, response to the MCI scene by individual providers in their privately owned vehicles (POVs) is prohibited. Providers who respond will be directed to their respective agencies or, at the discretion of the Incident Commander and if they have appropriate EMS identification, may be directed to the incident Staging Area. They will not be allowed direct access to the MCI site

EMS providers will utilize the SMART patient triage method when evaluating patients and will tag patients utilizing the SMART triage tags as designated by MDPH/OEMS for identifying MCI patients.

D. Medical Direction, EMS Pre-Hospital Treatment Protocols/Triage

In the absence of on-line medical direction, patient care will be rendered in accordance with the most current version of the MDPH/OEMS EMS Pre-Hospital Treatment Protocols. EMS personnel will follow the SMART triage method and will use the MDPH/OEMS designated SMART Tag™ for tagging and medical documentation.

E. Psychological Assistance and Support

Regional and local teams of mental health and peer de-briefers have been trained and are available throughout the Commonwealth. Regional Critical Incident Stress Management (CISM) teams can be activated through Worcester CMED.

F. Resource Management

Regional Mass Casualty Support Unit (RMCSU) Deployment

1. The EMS Branch Director may request additional EMS resources through Worcester CMED.
2. Worcester CMED will deploy the two RMCSUs (trailers) closest to the incident.
3. Worcester CMED will advise the EMS Branch Director on scene when units are in route.

EMTrack™ Scanners

1. Worcester CMED will deploy the EMTrack™ patient scanners.
2. Worcester CMED will create EMTrack™ incident on EMTrack™ ASP website
3. Worcester CMED will advise the EMS Branch Director when the EMTrack™ scanners are in route and the incident has name has been created on the EMTrack™ ASP website.
4. Worcester CMED will inform hospitals and Tracking Officer that the website is operational once the providers arrive on scene.
5. Upon conclusion of the incident the Worcester CMED Supervisor will archive the incident on the EMTrack™ ASP website.

AmbuBus

1. The EMS Branch Director may request the Region II AmbuBus for patient transport.
2. Worcester CMED will contact WRTA to deploy the AmbuBus to scene.
3. AmbuBus will be assigned a MED channel and be in contact with Worcester CMED while in route to the scene.

Disaster Communications Trailer

1. Upon activation of a Level 4 MCI, or by request, CMED will deploy the Disaster Communications Trailer to the scene.
2. Whenever possible, the trailer will be deployed by vehicle equipped with warning lights, siren and CMED radio.
3. The towing vehicle will be assigned a MED channel and be in contact with Worcester CMED while in route to the scene. The trailer will be managed on scene by CMEMSC staff.

G. Mass Decontamination

Large numbers of patients may need to be decontaminated during an MCI. MDPH and the Department of Fire Services (DFS) have established a Community Response Plan for the use of Mass Decontamination Units (MDU) within the Commonwealth. These units are strategically located statewide and can be accessed in the event of a large scale incident through the local fire department or Worcester CMED.

See ***Appendix B: CMEMSC Resources***

H. Responder Rehabilitation

The need for deployment of a rehabilitation sector or group to an MCI for medical responders should be based upon duration of operations, physical demands, tactical requirements and environmental conditions.

Rehabilitation staff will follow the most current version of the MDPH/OEMS EMS Pre-Hospital Treatment Protocols, including Appendix U: Fire Rehab.

1. The EMS Branch Director may request, in coordination with the Operations Section Chief/Incident Commander, additional EMS resources through Worcester CMED.
2. Worcester CMED will contact the closest Fire District Control Point for the deployment of the Fire Service Rehabilitation Units, if requested.

See ***Appendix M***: Rehabilitation Resources

I. Radiological Incidents

1. The EMS Branch Director should immediately notify the Operations Section Chief if radiation is suspected or evident. Appropriate resources should be requested through the Incident Command Structure.
2. The EMS Branch Director should notify CMED who will contact the MDPH's duty officer.

J. Ambulance Task Forces/Regional Strike Teams

Ambulance Task Forces

Ambulance Task Forces may be requested by District Fire control points using the "closest forces" concept. Pre-established running cards shall list the designated Task Forces. Each Fire District establishes incoming response cards by closest forces for the district. Different listings may apply to various sections of the District based on closest Task Force and what individual resources may already have been used. Ambulance Task Forces shall be made up of five (5) ambulances and a Task Force Leader. Task Force type may be ALS or BLS with preferred staffing of three (3) qualified people. Task Forces may be all ALS or BLS or mixed ALS and BLS.

See ***Appendix B: CMEMSC Resources***

Regional Strike Teams

Intentionally left blank until completion of formalized plan.

K. Fatality Management

The Mass Fatality Plan for the Commonwealth of Massachusetts will be implemented when an incident results in fatalities that exceed the normal operating capacity of the responding agencies.

The plan establishes roles and responsibilities of the responsible agency and describes the necessary collaboration with partner agencies and organizations involved in a mass fatality response. This plan is meant to be used in conjunction with established standard operating procedures and protocols.

A mass fatality can occur anywhere in Massachusetts and may be the result of a natural, accidental or intentional event. A mass fatality is not defined solely by the number of fatalities. Other factors include the condition of the remains, the accessibility of the scene, the complexity of the recovery and resources and capabilities of responding agencies.

Plan Activation

The Mass Fatality Management Plan shall be activated by the Chief Medical Examiner or his/her designee in circumstances that fall under the jurisdiction of the Office of the Chief Medical Examiner (OCME). The Commissioner of the MDPH shall activate the plan when managing a mass fatality that does not fall under the jurisdiction of the OCME. OCME reporting guidelines are found in MGL Chapter 38.

Multiagency Coordination

Responding to a mass fatality will involve multiple agencies and organizations. Upon activation of this plan a Unified Command will be established that will include a representative from the responsible agency and the lead law enforcement agency having jurisdiction, as well as the Massachusetts Emergency Management Agency (MEMA). Agency representatives from local jurisdictions involved in the incident should be included in the Unified Command, depending on the nature of the incident. No single agency can manage a mass fatality without support from other agencies. All agencies involved will work together to ensure the complete recovery and processing of remains, care of the victims' families, and the maintenance of daily operations. Incidents, such as a pandemic or a widespread natural disaster, that cross jurisdictional boundaries may require agencies to manage the incident as multiple incidents or to establish an Area Command.

CMEMSC Response

The response by EMS providers will follow the same process as outlined under *MCI Operations Section A: EMS Actions at an MCI (or potential MCI)* of the MCI Plan. The EMS Branch Director, in coordination with the Operations Section Chief/Incident Commander, should request that Worcester CMED/Region II EMS contact the OCME for the declaration of a Mass Fatality Incident.

L. Demobilization

1. National Incident Management System (NIMS) demobilization procedure will be followed as required.

2. The on-scene EMS Branch Director should confer with the IC to determine any additional patient care needs for EMS prior to contacting Worcester CMED.

3. A declared MCI shall be terminated as soon as practical following the completion of transport of all the patients.

4. The Transport Group Supervisor/or EMS Branch Director will be responsible for notifying Worcester CMED that all patients have been assigned to transport units and that all on-scene patient care activities have been completed and ended at the MCI or Evacuation site or sites.

5. The EMS Branch Director contacts Worcester CMED via radio to follow up that the EMS components of the MCI are demobilized.

6. CMED will notify all hospitals that the MCI has concluded.

II. COMMUNICATIONS

A. Worcester CMED MCI Procedures

Upon receiving declaration of an MCI, Worcester CMED will:

1. Send out a Health & Homeland Alert Network (HHAN) Alert to the MCI Region II Group (which will notify the Executive Director, Assistant Director, Worcester CMED Supervisor, Regional Medical Director, and MMRS Coordinator.)

2. Assign a MED channel to the Communications or Transportation Supervisor at the scene. (All information will be relayed to Worcester CMED on this channel.)

3. Ask the IC/EMS Branch Director if deployment of the following is required:

    a. Region II personnel to respond to the scene in the communication vehicles 2C1 or 2C2 (automatically deployed for a Level 3 or higher MCI)
    b. RMCSU (MCI trailer) (see Article 5, section 8.02)
    c. EMTrack™ patient scanners sent to the scene. EMTrack™ scanners to be deployed automatically for Level 2 MCI or greater (see Article V.c., Article VIII, section 8.01).
    d. Disaster Communications Trailer with Mobile Command post (automatically deployed for declared Level 4 MCI)
    e. AmbuBus for patient transport

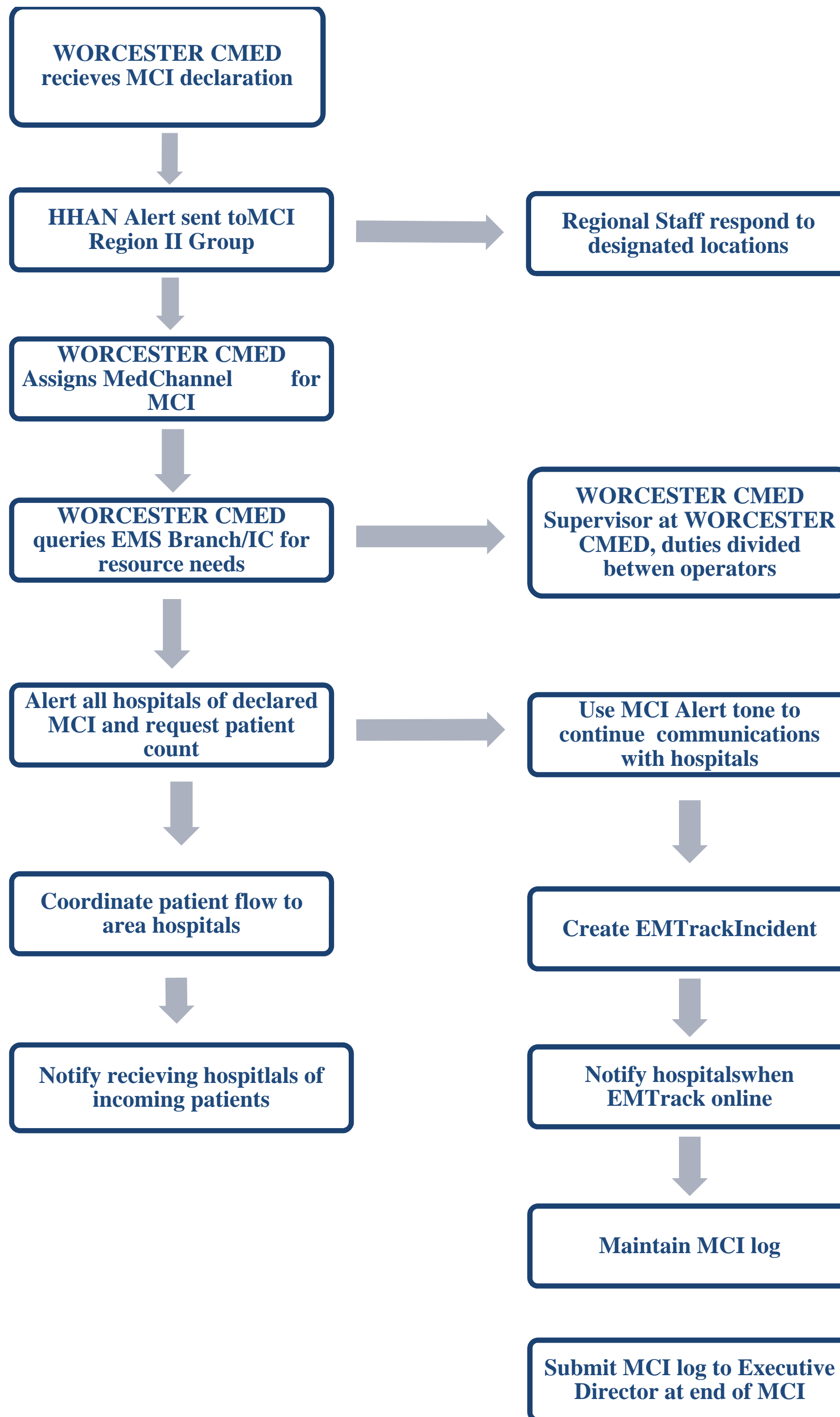
4. Deploy any requested resources.

5. Notify all hospitals in the immediate MCI area by intercom and obtain a current emergency patient count using the Emergency (MCI) Patient Count form.

6. Create incident on EMTrack™ website (if scanners are deployed).

7. Notify receiving hospitals if/when EMTrack™ equipment is put into service on scene and give hospitals/Transportation Supervisor the created name of the incident.

8. Coordinate the destination of the patients and inform the Transportation Supervisor of the destination hospital for each patient; reminding the Transportation Supervisor that individual EMS unit entry notifications are not to be made.


WORCESTER CMED
recieves MCI declaration
HHAN Alert sent toMCI
Region II Group
Regional Staff respond to
designated locations
WORCESTER CMED
Assigns MedChannel for
MCI
WORCESTER CMED
queries EMS Branch/IC for
resource needs
WORCESTER CMED
Supervisor at WORCESTER
CMED, duties divided
betwen operators
Alert all hospitals of declared
MCI and request patient
count
Use MCI Alert tone to
continue communications
with hospitals
Coordinate patient flow to
area hospitals
Create EMTrackIncident
Notify recieving hospitlals of
incoming patients
Notify hospitalswhen
EMTrack online
Maintain MCI log
Submit MCI log to Executive
Director at end of MCI

B. <u>Interoperability</u>

When services that operate on different radio frequencies need to communicate, Worcester CMED can facilitate their communication. For example, if an MCI officer operating on MED 8 required a connection with a district fire frequency, CMED would direct both units to remain on their existing channels. Next, CMED would use a "patch window" on the CMED console to connect both radios for communication to take place. Lastly, the patch is cleared when communication are complete.

CMED can patch the following frequencies:

- All Medical Channels
- Massachusetts Emergency Management Agency
- Massachusetts State Police
- City of Worcester radio system (police, fire, EMS, WDPW, WDPH)
- All District Fire Control Frequencies
- Red Cross
- UMass LifeFlight
- Local fire and police UHF and VHF frequencies

C. <u>Interagency Communications</u>

During an MCI, two services without a common frequency, but having access to MED channels, may communicate with each other through Worcester CMED as follows:

1. Units contact Worcester CMED on MED 4

2. Units are assigned a MED channel.

3. Once both units are on the assigned MED channel Worcester CMED will open a repeater and the two units will be able to communicate

4. Worcester CMED will close the channel and repeater when communications are complete

IV. HEALTH CARE FACILITY EVACUATION

The purpose of health care facility evacuation is to ensure the orderly and timely movement of patients from an affected nursing home, hospital, or other medical facility to an appropriate receiving facility. Such evacuations are classified as “emergent” or “planned.” Other situations may also be mitigated by the use of a “shelter-in-place” approach.

The evacuating facility will manage the evacuation in accordance with their Emergency Operations Plan, utilizing the Hospital Incident Command System (HICS), if appropriate. The Regional Medical Coordinating Center (RMCC) may be activated coordinate patient movement. EMS operations involving the transportation of patients will be managed using the Incident Command System (ICS). Patient distribution will be managed with direction from Worcester CMED and the RMCC.
See *Appendix B: CMEMSC Resources*

A Unified Command will be established between the hospital Incident Commander and the public safety Incident Commander.

A. Emergent Evacuation

1. The first unit on scene will conduct a scene size-up using the mnemonic METHANE:
   - M = Major incident declaration through CMED
   - E = Exact location; staging area
   - T = Type of incident
   - H = Hazards; present and potential
   - A = Access; best route for responders; landing area
   - N = Number of casualties, type, and severity (see Level)*
   - E = Emergency services; present and required

   *The number of potential evacuees will determine the level of the incident for mutual aid purposes:
   - Level 1: 1-10
   - Level 2: 11-30
   - Level 3: 31-50
   - Level 4: 51-200
   - Level 5: Greater than 200
   - Level 6: Long Term Operation (more than two operational periods)

2. The responder contacting Worcester CMED will be assigned a dedicated medical communications channel for the duration of the incident.

3. The EMS Branch Director will make contact (in person, by phone, or radio) with the evacuating facility to verify that the facility needs assistance with patient transportation and/or destinations. The EMS Branch Director or designee will contact Worcester CMED to coordinate transportation and facility needs.

4. The EMS Branch Director/Incident Commander will work to establish a Unified Command with the facility’s Incident Command Staff.

5. Worcester CMED will notify area hospitals of the planned evacuation.

6. The local EMS agency or Worcester CMED will request/or assign ambulances within that area to be dispatched to the scene on initial assignment, for triage and other purposes as needed according to the EMS Branch Director.

7. Worcester CMED will notify the Regional Director to consider RMCC activation and deployment of the EMTrack™ patient tracking system.

8. The EMS Branch Director will work with the Operations Section Chief/Incident Commander and facility staff to establish triage, treatment, transport, communications, and EMS staging areas and will assign responding personnel to those areas.

9. Personnel assigned to Transportation with facility staff will ensure that all evacuees have, at a minimum, a patient record and SMART Tag™ to accompany them to the receiving facility. The medical record, or copy, is recommended.

10. The EMS Branch Director may request, in coordination with the Operations Section Chief/Incident Commander, additional EMS resources through Worcester CMED including, but are not limited to, Regional Strike Teams, Ambulance Task Forces (ATF), Regional Mass Casualty Support Units (RMCSU), regional communications trailer, Mass Decontamination Units (MDU), regional staff, patient tracking equipment, and the AmbuBus.

11. The EMS Branch Director, in coordination with the Operations Section Chief/Incident Commander and facility staff, may begin the demobilization process after the Transportation Supervisor has confirmed that all evacuees have been transported.

See ***Appendix A: Pre-Hospital Provider Responsibilities/Goals/Guidelines***

B. <u>Planned Evacuation</u>

1. The facility representative/or on-scene responder will contact Worcester CMED as soon as possible to declare an MCI and report a planned evacuation, request activation of the RMCC, and the deployment of the EMTrack™ system.

2. Worcester CMED will assign a dedicated medical communications channel for the duration of the incident and notify area hospitals.

3. The EMS Branch Director will discuss with the evacuating facility the needs for patient transportation and/or destinations. The EMS Branch Director or designee will contact Worcester CMED to coordinate ambulance to hospital transportation and facility needs.

4. The Incident Commander will establish a Unified Command with the facility's Incident Command Staff.

5. The local EMS agency or Worcester CMED will request/or assign ambulances within the evacuation area to be dispatched to the staging area.

6. Worcester CMED will contact Fire District Control points to activate Ambulance Task Forces if requested.

7. The EMS Branch Director will work with the facility representative and the RMCC to coordinate the flow of evacuees from the affected facility to the receiving facility.

8. The EMS Branch Director will work with the Operations Section Chief and facility staff to establish triage, treatment, transport, communications, and EMS staging areas and assign responding personnel to those areas.

9. Personnel assigned to Transportation with facility staff will ensure that all evacuees have, at a minimum, a patient record (if possible) and SMART Tag™ to accompany them to the receiving facility. The medical record, or a copy, is recommended.

10. The EMS Branch Director may request additional EMS resources.

11. The EMS Branch Director may begin the demobilization process after the Transportation Supervisor has confirmed that all evacuees have been transported and approval has been granted by the Incident Commander.

See ***Appendix A: Pre-Hospital Provider Responsibilities/Goals/Guidelines***

APPENDIX A: PRE-HOSPITAL PROVIDER RESPONSIBILITIES/GOALS/GUIDELINES

EMS Goals

- *Do the greatest good for the greatest number of people.*
- Make the best possible use of resources.
- *Avoid relocating the MCI (alert CMED so patients are dispersed appropriately rather than transporting too many patients to one or two hospitals and overwhelming emergency departments).*

Provider Responsibilities/Guidelines

- Care and transportation of patients under the Region II MCI Plan during an incident or evacuation will be overseen by licensed EMS agencies that respond to the primary community's mutual aid request and under those communities' Incident Commander (IC) or the IC's designee.
- A jurisdiction(s) in which the MCI occurs will be responsible for activating mutual aid through its own Emergency Communications Center(s) or through Worcester Central Medical Emergency Direction (CMED).
- Agencies, units and personnel involved in mutual aid response to a regional MCI or evacuation will only be dispatched through the responding agency's dispatch center or CMED according to established policy. These units will be dispatched only upon IC request. Services not requested will not be allowed access to the site.
- Individual providers will report to their respective agencies and will not self-dispatch to the scene of the incident. In the interest of safety, efficiency and accountability, response to the MCI scene by individual providers in their privately owned vehicles (POVs) is prohibited. Providers who respond will be directed to their respective agencies or, at the discretion of the IC and if they have appropriate EMS identification, may be directed to the incident Staging Area. They will not be allowed direct access to the MCI site.
- All out-of-hospital providers and/or agencies responding to an MCI in Region II agree to operate under the Incident Command System, the state designated triage system and the most current version of the MDPH/OEMS Pre-hospital EMS Treatment Protocols.
- EMS agencies and/or localities agree to respond with personnel and equipment when the Region II MCI Plan is activated, subject to availability. When considering their response to requests for assistance, EMS agencies are required to maintain their emergency response capabilities to meet local needs.
- It is highly recommended that EMS personnel responding to an MCI or evacuation carry identification and proof of agency affiliation.

- EMS responders to an MCI or evacuation will be responsible for maintaining the appropriate medical documentation and appropriate ICS documentation, and for making said documentation available to ICS officials, if requested.

- EMS agencies are strongly encouraged to participate in annual MCI Plan training exercises held at various locations within the Region.

- EMS agencies are urged to require their personnel to participate in continuing education focused on MCI-related training including the Incident Command System, CMED Operations, and other training related to MCI resources and as indicated within this Plan.

APPENDIX B: CMEMSC RESOURCES

Regional Council Staff

Regional Council Staff will respond to declared MCIs or large scale incidents upon request (automatically for Level 3 or higher) to within Region II to make an assessment, assist in the overall operation of the EMS Branch as requested, and to serve as a liaison between DPH/OEMS and the EMS Branch.

Patient Tracking Equipment

CMEMSC, through Homeland Security Funding, purchased the EMTrack™ **Electronic Patient Scanning Equipment. To make this equipment available to every community in the Region, it has been distributed to three Host EMS Services and CMEMSC staff, for deployment to the scene of an MCI. Each Region hospital has also received** EMTrack™ **equipment for scanning patients on upon arrival at their facility.**

Host EMS Service Responsibilities:

1. EMTrack™ equipment shall be continually charged to ensure it is ready to be used at any time.
2. Ensure personnel are trained in the proper use of equipment
3. After the incident, equipment is returned back to its original location and fully charged.

CMED Responsibilities

1. Deploy EMTrack™ equipment from closest Host Service
2. Create Incident on EMTrack™ Website
3. Inform all users of Incident Name

Regional Administrator Duties:

1. Create new Incidents in EMTrack™ when needed.
2. Manage users of EMTrack™ in their region.
3. Ensure that users in the region understand when and how the application needs to be used.

Emergency Department Personnel Duties:

1. EMTrack™ shall be continually charged to ensure it is ready to be used at any time.
2. Ensure personnel are trained in the proper use of equipment
3. Have EMTrack™ Website open when notified of a declared MCI.
4. Confirm receipt of patients by scanning patients with EMTrack™ equipment when they arrive at the hospital.

Regional Mass Casualty Support Units (RMCSU)

All EMS services shall have authority to initiate the RMCSU, through Worcester CMED, upon making the determination that conditions warrant the dispatch. This decision shall be made in concurrence with the Incident Commander.

All trailers are stocked with MCI equipment and supplies for up to 50 adult patients, 25 pediatric patients, and 50 cadaver bags for mass fatality incidents.