

# Hospital Mass Casualty Response Plan Considerations

The term “mass casualty incident” (MCI) refers to the combination of patients and care requirements that require mobilization of additional resources to meet the demand. MCIs generally occur without warning and a concise plan is needed to ensure rapid and efficient response. The considerations in this document can assist hospitals in developing a new—or vetting an existing— MCI plan.

Historically, hospitals have referred to the MCI plan as the “disaster plan.” However, many types of disasters, both internal (e.g., fire, armed assailant), and external (e.g., extreme weather, mass violence) can affect the hospital. While the MCI plan may be the most often activated, it is important that the terms used and resources mobilized are specific to a **mass trauma incident**. The MCI response plan can be part of (or a separate annex to) the hospital’s [Emergency Operations Plan \(EOP\)](#). The EOP should, at a minimum, specify incident command system and organization, location of the hospital command center, roles and responsibilities, staffing and resource needs, and strategies for managing internal communications and public relations.

The hospital should anticipate that in a no-notice disaster, a large number of casualties may arrive at the facility prior to the plan’s formal activation. The MCI plan development process should be multi-disciplinary within the facility and include local and regional partners. The resulting plan will serve as the foundation for development of quick reference tools (e.g., job aids, job action sheets) and other resources, training, and exercises. Though the plan is the foundation, successful execution of the plan depends on adequate training, exercising, and resources. A successful plan activation can keep an MCI from becoming a true disaster.

This document provides considerations/questions that hospital staff can address in the MCI plan and descriptions/examples of specific activities that can help answer the questions under a set of general functional domains. Note that the scope of this document is primarily focused on the **first hour of a response**, though in some cases, considerations are longer-term. The strategies and tactics included are those that should be “automatic” and not depend on the activation of the hospital command center. This document does *not* include services provided during the recovery period such as hotwashes/after-action reviews, mental health support and monitoring for staff, and other crucial services that should be part of the general incident management process.

For additional information please access the following ASPR TRACIE resources:

- Mass Casualty Hospital Capacity Expansion Toolkit ([Word](#), [PDF](#))
- ASPR TRACIE [Topic Collections](#)
  - [Active Shooter and Explosives](#)
  - [Crisis Standards of Care](#)
  - [Emergency Operations Plans/ Emergency Management Program](#)
  - [Hospital Surge Capacity and Immediate Bed Availability](#)
    - [Incident Management](#)
- [Hospital Operations Toolkit for COVID-19](#)
- [Emergency Preparedness Information Modules for Nurses in Acute Care Settings](#)
  - [Module 1 Mass Casualty Incident Response](#)
- [Mass Violence/Active Shooter Incident Templates](#)
  - [Hospital Triage, Intake, and Throughput](#)

**Contributors and reviewers of this document are listed alphabetically and include:**

**Eric Alberts, CEM, CHEP, CHPP**, Corporate Director, Emergency Preparedness, Orlando Health Inc.; **Craig DeAtley, PA-C**, Director, Institute for Public Health Readiness, MedStar Washington Hospital Center; **Jeffrey Dichter, MD**, Associate Professor of Medicine, University of Minnesota; **Melissa Harvey, RN, BSN, MSPH**, Assistant Vice President, Enterprise Emergency Operations & Medical Transport, HCA Healthcare; **John Hick, MD**, HHS ASPR and Hennepin Healthcare; **Richard Hunt, MD**, Senior Medical Advisor, Office of Health Care Readiness, ASPR; **Mark Jarrett, MD, MBA, MS**, Senior Health Advisor, Northwell Health; **Steven Mitchell, MD, FACEP**, Medical Director, Washington Medical Coordination Center; Associate Professor of Emergency Medicine, University of Washington School of Medicine; **James Phillips, MD, FACEP**, Associate Professor of Emergency Medicine, Chief and Fellowship Director, Disaster and Operational Medicine, Department of Emergency Medicine, George Washington University School of Medicine and Health Services and Chair, Disaster Medicine Section, American College of Emergency Physicians; **Willie Suggs**, Coordinator, Emergency Management, TriStar Centennial Medical Center, HCA Healthcare; **Bryan Wexler, MD, MPH, CHPCP, CHEC-III, FAAEM, FACEP**, Medical Director, Disaster Preparedness and Response, WellSpan Health; Director, Division of Emergency Medicine, WellSpan, York Hospital; and Associate Professor, Department of Emergency Medicine, Drexel University College of Medicine; representatives from **Yale New Haven Health System Center for Emergency Preparedness and Disaster Response (YNHHS-CEPDR)**.

## 1. Authorities and Declaration

Considerations/ Questions	Description/ Examples
1.1. Who has the authority to activate the hospital mass casualty incident (MCI) plan?	Select positions that are in-house and functional 24/7 (e.g., nursing supervisor, emergency department [ED] lead physician, administrator on call) should have the authority to activate the mass casualty response plan leading to alerting and mobilization of resources. These individuals should be trained on their roles and responsibilities.
1.2. What are some sources of information that may be helpful to include in an MCI plan?	Emergency medical services (EMS) staff may have good information about the situation, anticipated number of victims, and severity of injuries. Include relevant phone/contact information for EMS dispatch or other key contacts for situational awareness.
1.3. What are suggested thresholds for number of victims/ED strain, that should trigger an MCI declaration?	These metrics should serve as a guideline and outlines when the facility is likely to be overwhelmed. Should include, for example, the status of the ED/surgical services at the time of the incident (e.g., current staff availability, volume and acuity of existing patient populations), the size of the facility, the time of day, and associated special response circumstances (e.g., need for decontamination).
1.4. What is the process for initiating the response?	Can include calling the hospital operator or security operations center to initiate paging/messaging. Ensure the facility has a back-up model should the primary notification process fail or be compromised.
1.5. What is the process for concluding or cancelling the response?	Similar authorities and processes should be used to notify staff about the conclusion of incident command operations or if an activation needs to be cancelled (e.g., the initial information over-estimated the number of victims). Note that ED operations may return to normal early in the event, but that continued activation may be needed for other reasons (e.g., in-patient, public relations, patient transfer).

## 2. Alerting and Mobilization

Considerations/ Questions	Description/ Examples
2.1. How are on-campus personnel alerted to the incident?	Utilize multiple modalities in the event the primary notification system fails (e.g., a combination of overhead paging, electronic health record banners, message boards, mass notification systems, and other means). Note that staff in operating rooms may not hear or see messages, thus alternative means of notification may need to be put into place.
2.2. What off-campus personnel are notified and how?	Key initial off-campus groups often include nurses, physicians, and support staff from emergency medicine, surgery, anesthesia, inpatient/critical care, blood bank, lab, radiology, security, emergency management, administration, supply chain, and sterile processing. They can be notified via text, telephone tree, page, or other traditional mass communication strategies used by the facility. Note that at night, staff may require audible alarms/phone calls to waken them.
2.3. How will personnel be kept up-to-date about the incident?	The incident commander or other designee should be responsible for regularly updating staff via text, paging, hotline, and/or other means during the incident. Information can include traffic status/closures and notifying personnel that sufficient staff have reported, or what is needed to coordinate assignment of staff to shifts to support the response. Information about the event and support resources (e.g., situation updates, psychological support resources, hotwash/debrief locations and times) should be communicated via a variety of mechanisms. <a href="#">Section 10</a> provides considerations for managing public and media information.
2.4. What are some examples of supplies that should be automatically mobilized to support an MCI? How are additional supplies obtained?	<ul style="list-style-type: none"> <li>• ED supplies (e.g., command vests, radios, pre-made bedside kits of airway/wound care materials)</li> <li>• Disaster carts from sterile supply (e.g., a cart of chest tube trays, dressings/bandages, tourniquets, and suture trays for the ED).</li> <li>• Carts designed to augment temporary care areas.</li> <li>• Major procedure/trauma trays and accompanying disposables (“trauma packs”) from the operating room, which should have increased par levels of these supplies.</li> <li>• Pediatric supplies.</li> <li>• Blood products.</li> </ul>

- Pharmacy supplies such as initial immediate “push” of critical meds to the ED (e.g., analgesia and sedation/paralytics). Describe process for unlocking medication dispensing machines during response.
- Incident-related supplies (e.g., infectious disease, chemical exposure, radiation exposure, or burn-specific supplies).
- Transport carts and wheelchairs. Determine the location of and access instructions for each.

Care areas should have access to key phone numbers (e.g. pharmacy, central supply, sterile supply, hospital command center) to request additional supplies as needed.

ASPR TRACIE’s [Disaster Available Supplies in Hospitals \(DASH\) Tool](#) can help hospital emergency planners and supply chain staff estimate supplies that may need to be immediately available during various MCIs and infectious disease emergencies based on hospital characteristics.

### 3. Security and Traffic Control

Considerations/ Questions	Description/ Examples
3.1. How is access to the facility controlled during an MCI?	Many facilities restrict ingress and may control egress for staff, patients, and visitors to one or two designated entrances during an MCI. Electronic systems or security personnel may be used to accomplish this. EMS and ambulatory entrances to the Emergency Department should be monitored by security personnel.
3.2. What changes to traffic flow onto the campus are required?	Traffic control/diversion may be needed to ensure EMS units are able to access the hospital and that abandoned vehicles do not block high-traffic areas (security personnel may be specifically trained in or have experience with traffic control).
3.3. How will changes to traffic flow be made? Where are these supplies stored?	Personnel may need to be rapidly deployed and cones, barriers, vehicles, and tape used to adjust traffic flow. Community resources (e.g., crossing guards, volunteer first responders) may also be needed.
3.4. What assistance from community law enforcement may be needed?	Local law enforcement may be needed for a variety of roles from traffic control to campus protection.
3.5. How are safety and security staff augmented and deployed for an MCI?	Whoever manages the campus security team typically holds over or calls back staff during an MCI and may seek assistance from environmental services, facilities, and others with door control and other tasks. If additional security is needed, local law enforcement, or community volunteer responders (e.g., firefighters, Community Emergency Response Teams) can monitor doors and direct persons. Note where personnel will be stationed, if screening is usually performed how is this adapted to an MCI, how are staff verified (badged), and how are staff called back / augmented during an incident.

## 4. Registration and Documentation

Considerations/ Questions	Description/ Examples
4.1. What is the process for rapid registration of patients, including unidentified patients? Where will this occur?	Typical registration processes will not work during MCI. Some hospitals have specific processes to register patients and generate a wristband in seconds. If that is not an option, there should be a process to designate the patient as “registration incomplete,” allowing them to move through the process. Hospitals can use a process for rapidly registering patients by assigning disaster names with the ability to reconcile patients’ charts once their normal registration can be resumed. Once the incident has stabilized efforts should be made to enter patients into <a href="#">electronic health records</a> (EHR) systems.
4.2. What registration tags/bands are used and where are they kept?	Wristbands may be used if they can be generated fast enough. Slap bands may be used to designate patients as “registration incomplete.” ( <a href="#">Section 6</a> includes information on triage materials.) Include these supplies where disaster registration kits or triage kits are kept.
4.3. What paper/backup processes are used for large numbers of ambulatory patients or when providers cannot keep up with EHR orders/documentation?	In addition to triage tags that may have space for some initial documentation, easily completed one-page paper charts for ambulatory minor injuries and critical patients should be available for downtime and disaster use.
4.4. How are MCI patient lists generated for family reunification and other purposes?	Intake providers (e.g., registration staff, medical personnel) should follow patient tracking protocols and indicate association of the patient with the incident on the form during registration. Additionally, an individual should be designated to compile and keep updated a list of patients associated with the incident. A regional patient tracking system is optimal to facilitate <a href="#">family reunification</a> when multiple facilities may receive patients.

## 5. Emergency Department Command and Control

Considerations/ Questions	Description/ Examples
5.1. Who serves as the ED Supervisor/Casualty Care Supervisor?	This is likely to be the ED attending physician and/or ED Charge Nurse depending on the facility's size and staffing. A vest can make for easy identification. This should be an automatic assignment rather than assigned by the hospital incident commander.
5.2. How are other leaders deployed in the ED?	Often, there is a "pod" or team center nursing or physician leader who oversees the patients in a given care area of the ED and reports to the ED/Casualty Care Supervisor. Key patient care areas in the ED can be led by a unit lead.
5.3. How are current and arriving staff assigned to areas/patients?	Arriving ED staff should locate the ED/Casualty Care Supervisor or a "pod" leader who will assign them to a patient/several patients. As staffing allows, a nurse or physician should ideally be assigned to and stay with a patient as they move through the ED, radiology/computed tomography (CT), and the rest of the process to maintain patient care and monitoring and information flow.

## 6. Initial Triage

Considerations/ Questions	Description/ Examples
6.1. Who should serve as the triage officer(s) and where is initial triage located?	Experienced providers such as nurses, emergency physicians, and surgeons should perform triage whenever possible to minimize over- and under-triage that can risk lives and scarce resources. Anticipate that many patients may have no triage prior to arrival and all patients require re-triage. There may be one triage officer for ambulance arrivals and one for ambulatory arrivals. Include process for who and how they are appointed and stationed. Ensure the triage officer is aware of any known contamination, security, or other threats.
6.2. Where are the triage tags/bands located?	Slap bands and/or tags may be used. Tags should ideally include space for initial documentation of medications, results, and findings in addition to primary and secondary destinations. These materials should be immediately available (along with other supplies such as triage vests, tourniquets, and radios) near the ambulatory and EMS entrances to the ED.
6.3. How might triage and registration interface?	Some hospitals plan for concurrent rapid registration and triage; others separate these processes. Common drivers may include the size of the hospital, staffing availability, and the process for rapid registration. Some large hospitals enter the patient into their EHR system and assign a destination in the department at the triage point; others send patients to a care area where they are subsequently entered into the system. Attempting to register during triage may lead to delays in the triage flow as registration may not keep up with incoming patients.



## 7. Space and Care Adaptations

Considerations/ Questions	Description/ Examples
7.1. How are beds cleared in the ED anticipating incoming victims?	Strategies include consolidating patients in lower acuity areas, moving pending admits up to inpatient hallways or other locations, moving stable ambulatory patients back to internal triage or observation areas, and discharging patients. Include a plan for rapid patient hand off to non-ED medical personnel staffing these areas.
7.2. Where is the overflow area for critically injured patients?	Assuming that demand exceeds available resuscitation beds, staff must determine whether to add patients to those rooms to maximize staff ability to monitor, place patients into other areas of the department suitable for critical care, or both/other strategies.
7.3. What area(s) may be used for care of patients with minor injuries?	Designated areas must accommodate large numbers of ambulatory patients with minor injuries but are close enough to the ED in case a patient deteriorates. Note the importance of careful triage (e.g., to avoid unrecognized penetrating truncal injury in ambulatory patient) and designating staff and supplies (e.g., designated MCI bins) for these areas.
7.4. What areas may be used for overflow of non-ambulatory patients?	Areas such as internal hallways in the ED, adjacent or nearby observation and procedure areas, conference rooms, and surgical services areas such as post-anesthesia care may be used to manage overflow. An established and practiced tiered approach is key to a smooth response.
7.5. Does the hospital have a “surge discharge” process/holding area? How is this activated?	The Hospital Command Center should determine the need for, and scope of, accelerated discharges based on the size of the incident. There should be a process on each unit (including ICU – which will not actually discharge but will “bump” patients to intermediate care) and holding area identified. Ensure there is a process for incident patient discharges that is different from normal/typical patient discharges.
7.6. How is inpatient care expansion achieved?	<p>Early discharge of patients who can safely be sent home. Each monitored/floor unit should be prepared to receive a certain initial number of patients from the ED. Designated spaces for critical patient care expansion should be activated. Doubling rooms may be instituted depending on the hospital plan. Procedure areas and large meeting areas may be designated as “holding areas.”</p> <ul style="list-style-type: none"> <li>• The ASPR TRACIE Mass Casualty Hospital Capacity Expansion Toolkit (<a href="#">Word</a>, <a href="#">PDF</a>) provides assistance on mapping inpatient care expansion.</li> </ul>
7.7. What are some sources of additional staff for the ED and Operating Rooms (ORs)?	Rapid response teams, in-house teams, and others may be designated to support the OR and ED. Include protocols for requesting additional assistance from the labor pool/Hospital Command Center. OR and ED staff responding from home should always go first to their work areas and then to the labor pool/staging area if they are not needed. Consider using EMS personnel to assist in the ED if they are able to remain.

<p>7.8. How is “one way” patient flow maintained?</p>	<p>For example, if a patient needs CT a decision should be made whenever possible on disposition from the scanner straight to the OR, Post Anesthesia Care Unit (PACU), pre-induction, observation areas, or inpatient units to keep patients from returning to a bed in the ED that is already occupied by a new patient.</p> <ul style="list-style-type: none"> <li>• The ASPR TRACIE <a href="#">Mass Violence/Active Shooter Incident Template</a> provides additional information on <a href="#">Hospital Triage, Intake, and Throughput</a>.</li> </ul>
<p>7.9. How are radiology services adjusted during an MCI?</p>	<p>Standard orders for whole body or “pan scans” may be needed. Ensure that scan interpretations are matched to the correct patient. Ultrasound can be another helpful triage tool. Radiology/CT techs should be on the MCI call-back list to ensure expansion of services to the degree possible. Ideally, a radiologist should be present in the CT control area to provide “wet read” interpretation to the providers. A “downtime” paper interpretation left with each patient may be helpful in an MCI.</p>
<p>7.10. How will morgue capacity be expanded if needed?</p>	<p>Decedents should be moved as quickly as possible to the hospital morgue or a temporary holding area so that they are not taking up patient care space. This area must be secure and should be close to areas where family members may come for viewing (<a href="#">Section 9</a> provides additional information for family support). A unit leader should be assigned to this operation.</p>

## 8. Secondary/Tertiary Triage

Considerations/ Questions	Description/ Examples
8.1. Who is responsible for decisions on prioritization for OR (or transfers, if the hospital does not provide definitive care or is overwhelmed and needs to transfer patients)?	A prioritization/triage framework should exist to ensure cases are prioritized when OR resources (or transport resources in the case of smaller hospitals) are overwhelmed. Prioritization decisions should include consideration of acuity, resources, and outcome (e.g., prioritizing unstable patients with isolated abdominal injury ahead of more complex neuro or vascular trauma).
8.2. How is this secondary triage indicated?	Triage tags and/or bedside documentation may include secondary triage considerations/priority for OR.
8.3. What is the preferred destination for first, second, and third priority OR cases?	A hospital might send first priority cases to pre-induction, second priority to PACU, and third/fourth priority to ICU. If there is a question about capacity check with the Surgical Services Supervisor or similar leader.
8.4. How is re-triage managed in the ED and inpatient units, particularly as priorities, resources, and/or patient conditions change?	Patient re-assessment is key to avoiding deterioration. A provider may need to be assigned to re-assess patients particularly in waiting areas. Patients can deteriorate or improve and should be re-prioritized and additional interventions performed as needed or as resources allow.
8.5. If a decision is made to downgrade or de-prioritize based on the patient's condition, what are the expectations for obtaining support for that decision?	If a patient is to be categorized as "expectant" based on their injuries, a second opinion from a clinical colleague may be needed. These patients should be re-assessed over time in case resources allow more aggressive care or they defy expectations. Palliative care should be provided to all patients (e.g., pain and symptom control).
8.6. If the hospital is not a specialty center, how will input be obtained (particularly for burn trauma, and pediatric patients) about priority for transfer/interventions?	The hospital should have an understanding with specialty receiving facilities that they may need guidance on prioritization of care and interventions for their patients. This consultation with a specialty provider should be rapidly available in-person or virtually.

## 9. Family Support

Considerations/ Questions	Description/ Examples
9.1. What are the procedures for unaccompanied minors and for reunification with parents?	<p>MCI plans should include a component for designating unaccompanied minors and creating a “safe area” for them to await reunification with loved ones once their care is complete. Plans should indicate the threshold to confirm that the loved one is legally permitted to receive a discharged child. Family photos, documents, and other methods may be described in the policy. Nurses and other clinical staff, behavioral health staff, social workers, victim services advocates, and others may play a critical role in this process.</p> <ul style="list-style-type: none"> <li>ASPR TRACIE’s <a href="#">Tips for Health Care Facilities: Assisting Families and Loved Ones after a Mass Casualty Incident</a> and <a href="#">Family Reunification and Support Topic Collection</a> highlights considerations for planning for, activating, and operating hospital or health care facility family information center, support center, and/or assistance center.</li> </ul>
9.2. Where will the Family Support Center (FSC) be located?	<p>The FSC process may be documented in the EOP. The FSC location should be large in size and physically separate from, but in proximity to, the ED and away from media location(s). It should have good cellular and Wi-Fi connectivity, refreshments, outlets to allow loved ones to charge devices, and other attributes. Consider having access to another separate room connected to or near the FSC where private discussions can take place or where grieving loved ones can go.</p>
9.3. Who is responsible for the FSC, and what is their role?	<p>Designated individuals at the hospital have a primary role in rapidly setting up the FSC. This can vary depending on the size of the facility. Behavioral health staff, chaplains, social workers/case managers, administration, and clinic/outpatient support staff (e.g., physical therapy) may be used to staff the FSC.</p>
9.4. Who will provide family updates and briefings?	<p>A senior leader or other designated family support leader from the hospital administration optimally should give individual updates and large group briefings at scheduled intervals.</p>
9.5. Is there a specific phone number/extension for family inquiries?	<p>If there is not a direct number for reunification inquiries, there should be a designated person with a current list of disaster patients that the call can be forwarded to by the operator. This individual should be able to note caller and patient information in case an immediate match is not identified. Hospital personnel should not provide personal cell phone numbers. Planning should address that there will be a large demand for this assistance in-person and virtually (phone, text, and online).</p>

<p>9.6. What is the process for taking information on patients that may be unidentified?</p>	<p>A standard information form that captures physical characteristics, clothing, jewelry, and other attributes should be used for both family seeking patients and for the health care staff caring for unidentified patients. Pictures of the patient and/or special markings may be used. The FSC should be able to cross-reference the form to quickly match patients with their loved ones. Ideally, multiple hospitals in the area should use the same form and process to avoid duplication of effort.</p>
<p>9.7. What is the visitor policy during an MCI?</p>	<p>Many hospitals enact visitor restrictions during an MCI. At the same time, parents/caregivers can be particularly helpful at the bedside (e.g., serving as medical surrogates or proxies). Specific security concerns may also influence these policies. In general, congestion is high during these events and restricting visitors to one per patient is a reasonable starting point.</p>
<p>9.8. How and where will initial viewing of the deceased by the family be managed?</p>	<p>Outlining this process is particularly important if there are multiple decedents. A nearby procedural or other area that allows privacy may be used for this purpose. Chaplaincy, nursing, and/or behavioral health staff may need to facilitate viewing/death notifications. Clinical staff should be available in case family members have medical emergencies. Personal effects should not be released to families prior to clearance by the medical examiner/law enforcement.</p> <ul style="list-style-type: none"> <li>• ASPR TRACIE's <a href="#">Exchange Issue 16</a> and <a href="#">Fatality Management Topic Collection</a> provide resources on decedent management during disasters.</li> </ul>

## 10. Information Management

Considerations/ Questions	Description/ Examples
<p>10.1. What is the process for managing public information?</p>	<p>This function is managed through the Hospital Command Center. However, rapid communication about the location and timing of press conferences, communication to the public about what to do and what not do (e.g., do not send food or donations to the hospital), and communication about the FAC and resources will be needed rapidly. ASPR TRACIE's <a href="#">Risk Communications/Emergency Public Information and Warning</a> Topic Collection provides resources for communicating to the public.</p>
<p>10.2. What is the process for monitoring social and traditional media?</p>	<p>Both social and traditional media must be monitored for misinformation and rapid correction messages communicated. This function must be initiated rapidly after an MCI occurs. ASPR TRACIE's <a href="#">Social Media in Emergency Response</a> Topic Collection provides resources for managing media.</p>

## 11. Integration with Other Hospitals/ Health Care Coalition/ Emergency Management

Considerations/ Questions	Description/ Examples
11.1. What is the process for coordinating with other hospitals?	A regional MCI plan should include a process for balancing EMS destinations to avoid overwhelming a single hospital when several options exist. Patient load-balancing may be needed when a facility close to the event is overwhelmed or when a specialty center needs to make room. Transfers for upgrade in care should also be addressed. These operations should be coordinated by a <a href="#">Medical Operations Coordination Center</a> or similar construct.
11.2. How is coordination initiated and who can make the request for support?	Document how to initiate requests for regional support and who can request that support (in some cases the hospital incident commander is designated in regional plans). Regional support may include information sharing, patient transfer/load-balancing, and/or sending additional resources to the affected hospital. This may be requested via phone call, radio, or other process that may be coordinated by different entities (e.g., health care coalition, emergency management, parent health care system) depending on the jurisdiction.
11.3. What is the process for requesting additional transportation support (e.g., EMS ground or rotor-wing)?	Determine how to initiate requests (coordinated with the Hospital Command Center) for emergency EMS support for transfers, particularly if critically injured patients cannot be cared for at the hospital where they present. Ensure phone numbers and other request mechanisms (e.g., radio) are documented and readily available to ED command staff. EMS should have processes to request mutual aid, strike teams, and other resources as required to support hospital and 911 needs.
11.4. Are there other transportation options?	Some jurisdictions may have mass casualty buses and other specialized transport or routine basic life support providers that can assist with patient transport. MCI plans should include the options and document current contact/mobilization information.

<p>11.5. If the facility is rural, is there a plan for managing multiple arriving helicopters?</p>	<p>Facility parking lot(s) may be occupied during an MCI. Patients may need to be moved by EMS to another nearby location where multiple helicopters can safely land and take off. Confirm that the rotor-wing services understand the alternate location and that EMS has plans and procedures/designated individuals for maintaining flight line safety. This is generally the responsibility of the EMS Air Operations Officer but includes approach/departure, lighting, and site management (e.g., debris control, loading/unloading monitoring, radio communications). Consider fire suppression at off-site landing zones, how to request fire department support, and where to station apparatus so they are out of the immediate landing zone yet available for quick response.</p>
<p>11.6. How does the hospital interface with jurisdictional agencies (emergency management, possibly public health) during an MCI?</p>	<p>The MCI plan should list steps for when, whom, and how to contact the jurisdictional EOC for support (particularly for issues with traffic control, security needs, and public information). Jurisdictional agencies should be prepared for these requests and understand the regional hospitals plans.</p>