WESTERN REGION BURN DISASTER CONSORTIUM

BURN MASS CASUALTY OPERATIONS PLAN

UPDATED JUNE 2024

PRODUCED IN COOPERATION WITH:

WESTERN REGION BURN DISASTER CONSORTIUM

HEALTH UNIVERSITY OF UTAH

UHA | 100 YEARS UTAH HOSPITAL ASSOCIATION

UTAH DEPARTMENT OF HEALTH

WRAP-EM Western Region Alliance for Pediatric Emergency Management AZ CA NV OR WA UT

WRBDC Resources:

All Western Region Burn Disaster Consortium plans, training modules and guidelines, including Initial Management Guidelines for the Pediatric Burn Patient, Prolonged Care of the Burn Patient in a Non-Burn Facility Following a Mass Casualty Incident (96 Hour Plan), Burn Crisis Standards of Care Guidelines, Crisis Triage Officer and Triage Officer Team Training, and more can be found online and on smart phones and other devices.

http://crisisstandardsofcare.utah.edu
Search for the "Burn CSC App" on smart devices

WRBDC Coordinator:

24/7 Disaster Line: 866.364.8824

Annette Newman (Matherly), MS, RN CCRN
Disaster Consultant, Utah Hospital Association
Western Region Burn Disaster Coordinator, American Burn Association
State Coordinator, Western Regional Alliance for Pediatric Emergency Management
Network Operations and Hub site Support, Pediatric Pandemic Network
Cell: 435.901.1425
Email: annettenewman2020@gmail.com

Acknowledgments & Disclaimer:
Planning efforts expressed in this document were supported by the National Bioterrorism Hospital Preparedness Program, the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response under award number U3REP19056. The content is solely the responsibility of the authors and does not necessarily represent the views of the Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response.

Photo Credit: *Photograph on cover page taken by Keith Bedonie of the San Juan Interagency Hotshot Crew, used with permission.*

TABLE OF CONTENTS

INTRODUCTION **3**
Overview 3
Purpose 3
Scope 3
Legal Authorities 3
Background 4
Western Burn Region 4
Plan Activation Levels 4
Burn Mass Casualty Incident 5
Medical Operations Coordination 5
Planning Assumptions 7

CONCEPT OF OPERATIONS **8**
The First 24 Hours 8
Notifications 8
Plan & Coordination Center Activations 8
Western Region Burn Bed Census 8
Initial Patient Coordination 9
Burn Incident Notification Flowchart 10
The Ongoing Response 11
Partner Roles & Responsibilities 11
WRBDC Coordination Center 13
Organizational Structure 13
Response Actions by Activation Level 14
Operational Overview 15
Clinical Support to Non-Burn Facilities 16
Patient Transfer Coordination 17
Resource Request Coordination 19
Support of Medical Care Operations 20
Anti-Discriminatory Policies 20
Patient Care Resources 21
Burn Injury Guidelines for Care 21
Burn Equipment & Supplies 21
Triage Flowcharts & Burn Management Algorithm 21
EMS Burn Triage Flowchart 22

Hospital Burn Triage Flowchart....23

Acute Burn Management Algorithm....24
Burn Center Consult Criteria....26
Patient Documentation & Privacy....26
Pediatric Considerations....27
Pediatric Burn Patient Care....27
Pediatric Planning Recommendations & Supply Checklist....27
Behavioral Health....28
Family Reunification....28
Contingency & Crisis Care....29
Burn Crisis Standards of Care....29
Burn Crisis Standards of Care Activation Algorithm....30
The 96-Hour Plan....31
Burn Disaster Smartphone App....31
Fatality Management....33
Transportation....33
All Patient Transfers....33
Air Transports....34
Deactivation & Recovery....34

APPENDIX....**36**

INTRODUCTION

OVERVIEW

PURPOSE

This document provides guidance for healthcare coalitions, burn centers, state public health preparedness professionals, healthcare entities, and other stakeholders planning for a burn mass casualty incident (BMCI). A BMCI is defined as any burn incident where capacity and capability significantly compromises patient care. This plan identifies the experts and specialized resources that must be engaged in a burn mass response, and the mechanisms and processes that will be used to ensure best possible patient care for burn patients.

SCOPE

This plan is intended for use by the Western Regional Burn Disaster Consortium (WRBDC) and its partners in managing a burn mass casualty incident within the region. Regional coordination and healthcare facility support are the primary focuses. The plan may also be used in response to a BMCI outside of the region, or by a healthcare coalition providing coordination during a more localized burn event. This document is intended to support, not replace, existing policies or plans by providing uniform response considerations in the case of a BMCI. It is a resource document and does not constitute policy or impose any obligations. Each jurisdiction and entity will require internal documents and policy that addresses specifics of their organizational response.

LEGAL AUTHORITIES

The response strategies and processes described herein are not legally binding, and there is no legal obligation to participate. However, participation by hospitals, healthcare systems and their partners is encouraged to ensure the best possible patient outcomes for all those treated in the Western Region. Where possible, the plan leaves the majority of the decisions and processes up to the healthcare systems and transfer centers. The use of a coordination body is outlined in order to assist healthcare systems when overwhelmed, by leveraging resources and supplies to assist in caring for patients, or transferring patients to other systems with specialty services.

BACKGROUND

WESTERN BURN REGION

The Western Region Burn Disaster Consortium consists of 28 burn centers and burn capable facilities who have joined together to support response efforts for one another throughout the Western United States. The American Burn Association (ABA) has designated the following member states:

- Alaska
- Arizona
- California
- Colorado
- Hawaii
- Idaho
- Montana
- Nevada
- New Mexico
- Oregon
- Utah
- Washington
- Wyoming

The Western Region Burn Disaster Consortium has been actively engaged in preparing and responding to burn events for almost a decade, and has produced many useful resources and educational materials for burn and non-burn facilities. Notable among these are the 24 Hour Plan (initial steps, including notifications and activations), Prolonged Care of the Burn in a Non-Burn Facility Following a Mass Casualty Incident (or 96 Hour Plan, best practices for caring for a burn patient), and others. These plans were utilized in developing this comprehensive operations plan, ensuring consistency and unification of efforts. All WRBDC plans and related resources can be found online (https://crisisstandardsofcare.utah.edu), and most can be accessed through an app on smart phones and other devices (search for the "Burn CSC App").

PLAN ACTIVATION LEVELS

Although the focus of this plan is to respond to a burn mass casualty incident (BMCI), it should be noted that the plan may be activated to various levels, each with different actions depending on the severity of the potential or actual burn incident. The following table outlines activation levels of the Western Region Burn Disaster Coordination Center, and this Concept of Operations Plan. WRBDC Coordination Center activation is meant to be flexible and scalable, depending on the nature and details of an incident. Activation during a slower-moving incident

may go through each level in order, but in a fast-moving incident, the WRBDC may skip directly to full activation.

WRBDC PLAN ACTIVATION LEVELS	
Activation Level	**Activation Trigger**
Stand-By / Ready State	• Fire Season • Mass gatherings • Civil unrest
Partial Activation	• Notification of an incident within the region with the potential to cause burn injuries
Full Activation	• Notification of an incident within the region, with a surge of burn patients expected or arriving
Recovery	• Surge levels begin to plateau or recede • Staffing and resource impacts begin to subside • Threat no longer exists (i.e., fire is suppressed)
Demobilization	• Facilities are able to handle any remaining patients on their own • Recovery activities are completed

BURN MASS CASUALTY INCIDENT

A BMCI is defined as any incident where capacity and capability significantly compromises patient care, in accordance with individual Burn Center, state, regional or federal disaster response plans. Additionally, several smaller incidents within a locality or region may also amount to a burn mass casualty incident, if taxing on burn staff, facilities or resources. This type of event will exceed the resources of a single jurisdiction, and therefore will require the use of a tiered approach beginning with the local community hospital and engaging a broad array of state, regional and national stakeholders, depending on the scope of the incident.

MEDICAL OPERATIONS COORDINATION

Federal guidance advocates the use of one or more Medical Operations Coordination Cells (MOCC) to assist in an incident that overwhelms the capacity of hospitals in a given area. The following description of how a MOCC may provide needed coordination during an incident is from the Establishing Medical Operations Coordination Cells webinar, provided by the Assistant Secretary of Preparedness and Response's Technical Resources, Assistance Center, and Information Exchange (https://files.asprtracie.hhs.gov/documents/fema-mocc-toolkit.pdf):

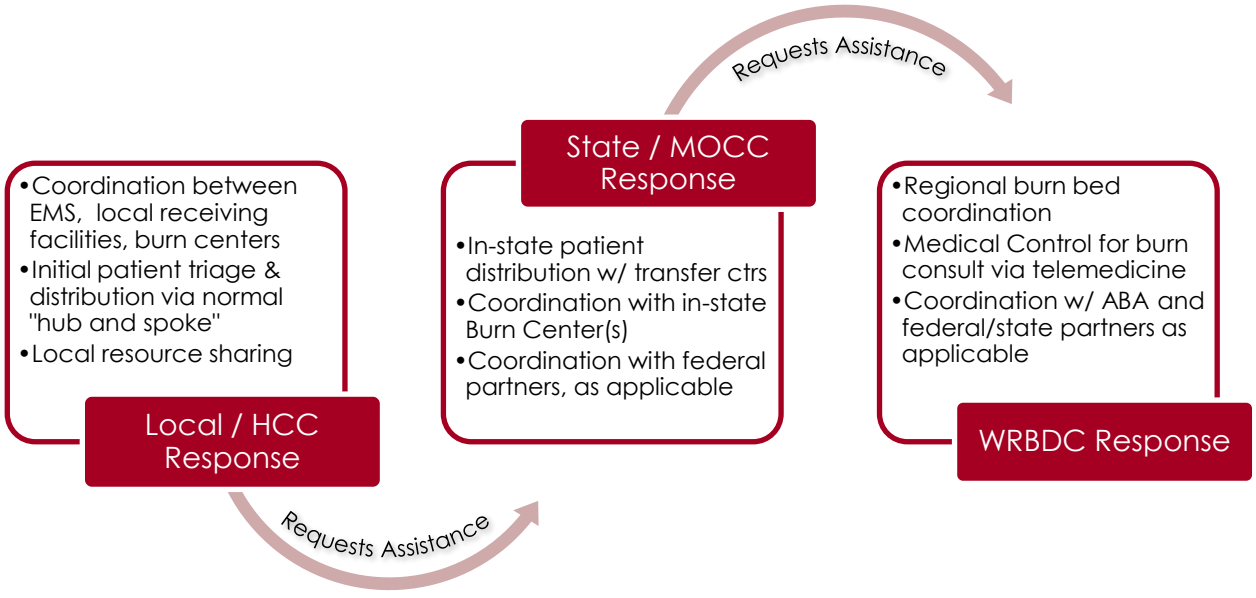
- Some hospitals are overwhelmed with {burn} patients, while successful mitigation has created excess capacity in nearby hospitals, creating an opportunity to transfer patients.
- MOCCs are a strategy to optimize patient distribution by augmenting EOCs with clinical experts that synthesize and coordinate healthcare capacity.

- The MOCC strategy can be implemented nationwide (at sub-state, state-, and regional levels), permitting flexibility for states while optimizing patient distribution.

If burn bed coordination and assistance is required beyond the local and state levels, the Western Region Burn Disaster Consortium Coordination Center will be activated to provide regional-level response assistance. The following steps outline the potential flow of activations and response for a large burn mass casualty incident, in accordance with state laws governing response:

1. Mass casualty incident involving burns occurs, local 911 notified
2. Local EMS begins notifications, patient triage and distribution from incident scene per existing protocols and typical "hub and spoke" procedures. Local receiving facilities notify local healthcare coalition (HCC) to assist with coordination and resource sharing as needed.
3. If local response agencies and the HCC is overwhelmed, state assistance is requested and activated to work with Transfer Centers to help inform in-state patient distribution and resource coordination. Use of in-state Burn Center(s) may be coordinated through this level of response, if not already involved.
4. If out of state assistance for patient care, burn bed availability, and/or resources is required, the Western Region Burn Disaster Consortium Coordination Center may be activated. The WRBDC will work with the state for situational awareness, existing burn center telemedicine programs and appropriate patient transfer agencies in order to help facilitate appropriate transfer to regional burn beds for definitive care.

Local-State-Regional Response Flow



PLANNING ASSUMPTIONS

The following assumptions provide the basis for the emergency response procedures outlined within this plan. It is expected that all participating facilities and supporting agencies are aware of and agree to the following:

- All hospitals providing emergency care may receive burn patients and should be able to provide initial assessment and stabilization.
- Partnering agencies within the jurisdiction, including emergency medical services (EMS), Healthcare Coalitions (HCCs), public health, and emergency management will have primary responsibility for response including initial casualty distribution and subsequent triage of patients for forward movement.
- Agencies with primary response coordination responsibilities, including state and local public health and emergency management, will coordinate transfers with the closest burn center and the Western Region Burn Disaster Consortium Coordination Center in accordance with established regional protocols.
- Burn Centers and Level 1 and Level 2 trauma centers should plan for a major role in the receipt and care of burn patients and understand their role in a BMCI in their community or state.
- Care of critical burns is extremely resource intensive and requires specialized staff, expert advice, and critical care transportation assets.
- Severe burn patients often become clinically unstable within 24 hours of injury, complicating transfer plans after this time frame.
- Federal resources (e.g. ambulance contracts, National Disaster Medical Systems teams), though potentially available to assist, cannot be relied upon to mobilize and deploy for the first 72 hours.
- In a Burn Mass Casualty Incident (BMCI) it may be necessary to implement a Centralized Unified Command in order to ensure contingency care strategies are utilized evenly by all healthcare facilities. This will ensure the highest level of surge capacity possible, prior to entering crisis care.
- The American College of Surgeons Committee on Trauma (ACS-COT) Guidelines for the transfer of patients to a burn center may need to be modified in order to do the greatest good for the greatest number of patients.

CONCEPT OF OPERATIONS

THE FIRST 24 HOURS

The initial response to a burn mass casualty incident will be the responsibility of the local public health and emergency management agencies, partnered with local healthcare organizations, utilizing all available local resources. Existing protocols for incident command, burn center notification, coordination of resources, and distribution of patients will be adhered to. However, local efforts will likely be exhausted and require external resource, care and coordination assistance. Although adjacent localities or states may provide assistance per existing memorandums of understanding (MOUs), formal assistance through the established process outlined below will ensure efforts are timely, efficient and well-coordinated.

1. NOTIFICATIONS

The Burn Center (BC) impacted by the incident will notify local, state, regional and federal partners according to emergency operations plans and procedures. In addition, **the impacted Burn Center or its partners should immediately call the Western Region Burn Disaster 24/7 Disaster Hotline at 866-364-8824** and ask to speak to a Western Region Burn Disaster Coordinator. Agencies who may request assistance from the Burn Disaster Hotline include the impacted Burn Center, the American Burn Association (ABA), ABA Regional Coordinators, Department of Health and Human Services (HHS), non-burn facilities impacted by the event, and state agencies such as health, emergency management and public safety. See the Activation Algorithm and Notification Flowchart at the end of this section.

2. PLAN & COORDINATION CENTER ACTIVATIONS

Upon notification from the affected burn center or local, state or federal partners, the Western Region Burn Disaster Consortium (WRBDC) will activate its Coordination Center, this Operational Plan, and any other related emergency plans or protocols. The WRBDC will be activated to a level appropriate for the response, and may include simply one Coordinator or multiple staff fulfilling a variety of roles. More details on the personnel and activities of the Coordination Center can be found in the "Western Region Burn Coordination Center" section of the plan.

3. WESTERN REGION BURN BED CENSUS

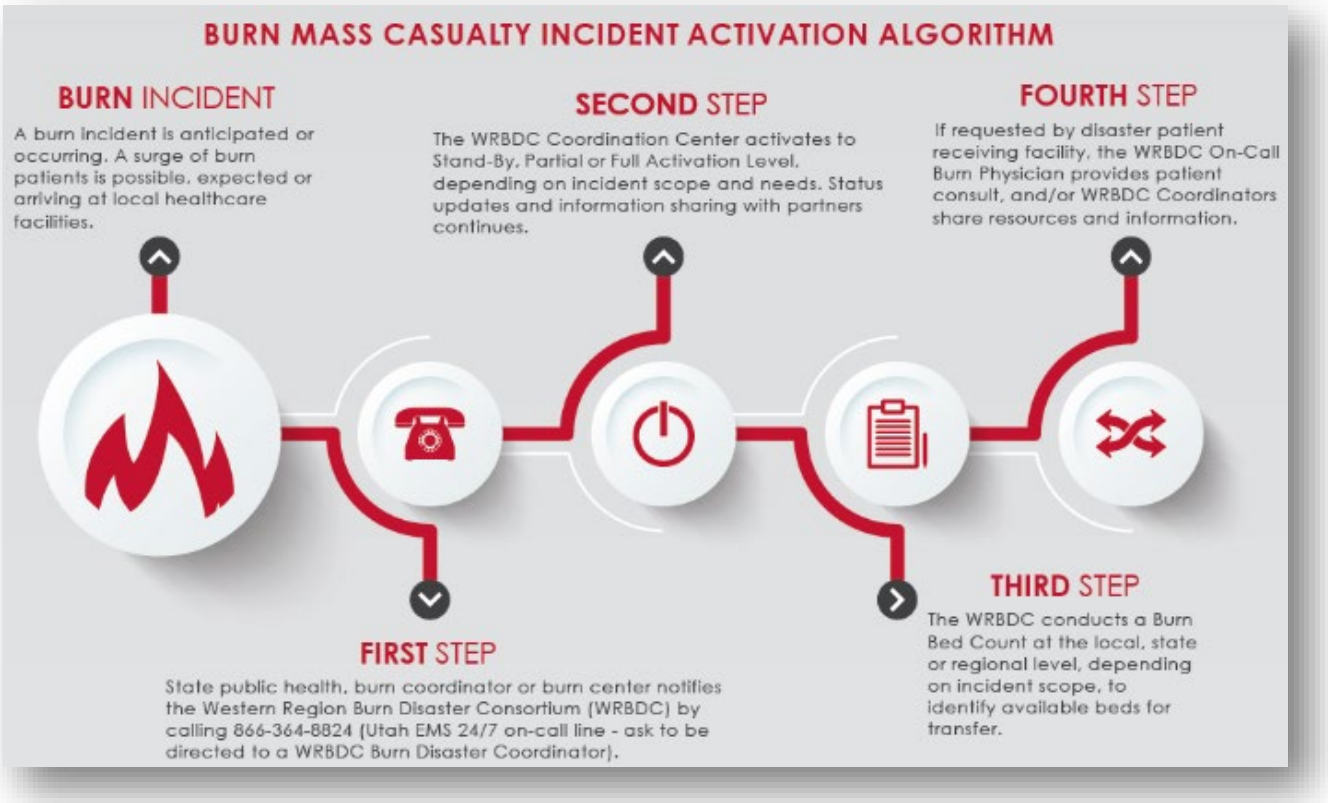
The Coordination Center will conduct Western Region burn bed census counts using the Utah Notification and Information System (UNIS) Burn Provider Group, text groups, or email that will be sent to all applicable regional providers. (**NOTE:* if the disaster is located in Utah and infrastructure damage occurs rendering communication technologies unusable, disaster efforts will be initiated by the **Nevada Hospital Association** Mass Notification System). Bed census

counts will be conducted immediately, and again at 24 hours post-incident **or as needed**. Bed census counts are inclusive of surge capacity, and consider individual burn center capability. The WRBDC will use the Nevada Hospital Association Burn Center Status Board (*Appendix B*) to record and share bed counts. The watchboard data can be downloaded and shared for optimal situational awareness.

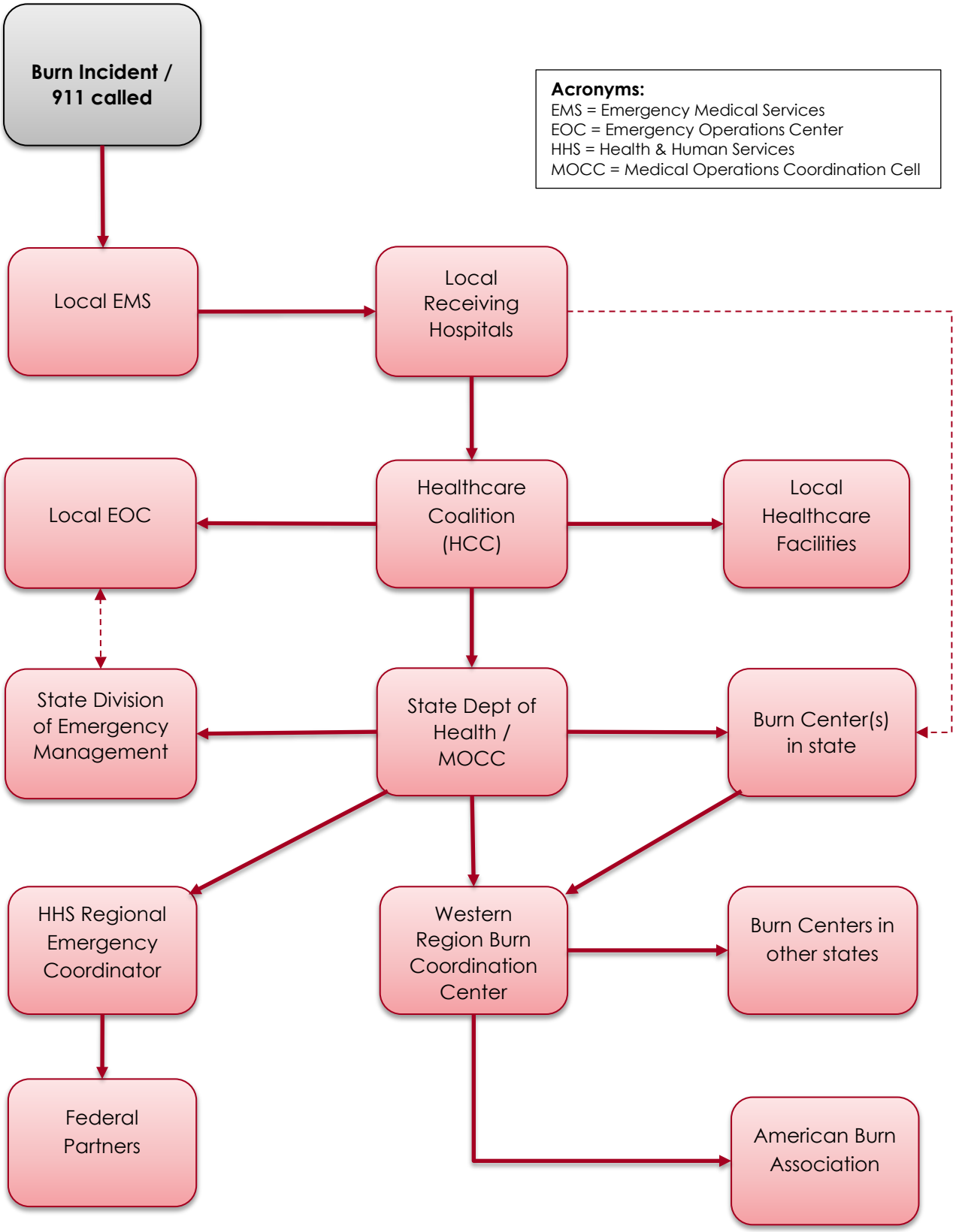
Regional Burn Surge Availability. There are approximately 469 total burn beds in the region, with approximately **160-180** available on an average day. Including surge estimates, this would leave 200-260 surge beds potentially available for a BMCI. There are two facilities within the WRBDC that take only pediatrics, Shriners Hospital for Children in Northern California and Children's Hospital Colorado. Kapi'olani Medical Center in Hawaii does not have designated burn beds; however, it can accept burn patients as physicians also work at Straub Hospital Burn Center. Alaska Native Medical Center and New Mexico Regional are located within a trauma center and have burn capabilities. Most burn centers care for both adult and pediatric patients, so the majority of the 469 beds could be used for either adult or pediatric patients.

4. INITIAL PATIENT COORDINATION

The impacted healthcare organizations will immediately begin triage and treatment. If a Burn Center or non-burn facility requires patient transfer to a Burn Center with available burn beds, the WRBDC will assist with determining appropriate patient destinations, transportations and patient documentation and tracking, and coordinate these needs between the referring and receiving facilities, as requested.



BURN INCIDENT NOTIFICATION FLOWCHART



THE ONGOING RESPONSE

PARTNER ROLES & RESPONSIBILITIES

Local organizations and agencies within the impacted jurisdiction will have primary responsibility for response, including initial triage and casualty distribution. Suggested response roles for local, state and national stakeholders and partner agencies are summarized in the table below. These roles were adapted from the ASPR TRACIE Mass Burn Event Overview.

PARTNER	RESPONSE ROLES
EMS Local Healthcare Coalition Public Health (PH) Emergency Management (EM)	• Rescue, transport, and distribute casualties to appropriate local facilities in accordance with established • Request/mobilize any coalition/regional caches of burn supplies. • Activate coalition coordination mechanisms and any burn-specific plans. • Coordinate local lists of casualties and clinical information. • Triage/prioritize patients for forward movement to specialty centers in accordance with established BMCI protocols and /or expert input. • Coordinate with burn experts to determine appropriate destinations for patients that cannot be accommodated in the local healthcare system with assistance from state and ABA. • Assure that appropriate clinical information is relayed between the referring and receiving facilities during the transfer process. *Secondary Roles:* • Coordinate information with state/federal ABA partners.
Closest Burn Center	• Provide patient care. • Activate facility and regional surge capacity plans to accommodate multiple patients. • Liaison between local response and regional ABA coordinating center. *Secondary Roles:* • Assist with patient triage for forward movement. • Support facilities providing care for burn patients in the area via telephone or telemedicine and/or request support from WRBDC coordination center. • Ensure burn surge facilities use existing resources (such as the acute care poster, buddy badge and Burn Guidelines for Care).
State PH/EM	• Support local jurisdiction with state-level coordination and requests for assistance (e.g., state and federal declarations). • Assure that patient triage, tracking, and transport needs are addressed. • Make requests for burn care assets, including dressings and other materials from the Strategic National Stockpile (SNS). • Engage Emergency Management Assistance Compact (EMAC) assets to provide inter-state support for transportation, staff, or other logistics.

	Secondary Roles: ● Liaison between local, state and federal resources. ● Support bed polling and matching functions as required in coordination with ABA regional center.
Sub-state/State MOCC or equivalent	● Optimize burn patient distribution and healthcare capacity by augmenting EOCs with clinical experts that assist with coordination ● Coordinate burn resource and supply needs between healthcare systems
Western Region Burn Coordination Center	As warranted and requested by the local response: ● Serve as the point of contact (POC) for the regional ABA system. ● Conduct bed polling initially and as needed within ABA region (and request assistance from adjacent regions as required). ● Assist the affected local burn center and state PH in determining appropriate patient destinations and transportations. ● Assist with the tracking of patient movement including arrival to destination centers. Provide updates as requested. ● Facilitate requests for tissue bank products, as well as graft equipment and other specialized supplies, if requested. ● In collaboration with state and regional partners, including the ABA, establish when the BMCI has concluded. ● Establish any post-incident system needs and initiate the AAR process. *Secondary Roles:* ● Assist with bed matching (right patient to right bed/facility, while being mindful of family units). ● Facilitate exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations. ● Assist the affected local burn center and/or burn surge facility by providing expert advice or telemedicine as requested. Engagement of other WRBDC facilities will be imperative. ● Circulate / facilitate additional staff and supply needs as possible (e.g., notify regional facilities of specialized resource / staff requests that they may be able to assist with) in conjunction with affected communities and ASPR Regional Emergency Coordinator (REC). ● Provide situational awareness to all appropriate agencies.
ABA National Headquarters	● Provide expertise and advice on request from a member center. *Secondary Roles:* ● Provide expertise and advice to inform the federal response.
Health & Human Services / Assistant Secretary for Preparedness & Response	● Provide federal support to local and state activities as requested/ authorized under the National Response Framework including supplies, staff, and transportation assistance through the Federal Coordinating Officer (FCO) appointed to the State for the incident. ● Coordinate approved use of National Disaster Medical System (NDMS) personnel or transportation assets. *Secondary Roles:* ● Coordinate information and access to burn expertise during BMCI. ● Support/assist states and ABA information and system needs (e.g., bed polling/data management).

WRBDC COORDINATION CENTER

In order to meet the goal of best possible patient outcomes after a burn mass casualty incident (BMCI), the establishment of a Western Region Burn Disaster Consortium Coordination Center that offers real-time consultation for hospital staff to assist with the management or stabilization of patients while awaiting transfer is invaluable. The WRBDC Coordination Center will be staffed by a task force of physicians and/or advanced practice clinicians, nurses, and Department of Health and other assistive personnel. Coordination will occur virtually using a video calling system, such as Zoom, or other appropriate platforms for visual communication. Additional communications may occur via email, text, and telephone.

ORGANIZATIONAL STRUCTURE

The central function of the WRBDC is to facilitate timely communication between the various stakeholders to ensure equitable patient transfers and resource sharing. It aims to do this by ensuring the use of a workable platform for all, engaging relevant health systems and supporting agencies, and utilizing existing protocols and procedures where possible. The following organizational principles apply:

- **Virtual Coordination Cell** - The WRBDC will operate through virtual conference calls, emails, or texts. A virtual platform will reduce overhead expenses and leverage existing equipment, worksites, and systems.
- **Engaging Stakeholders** - All WRBDC hospital systems, EMS, Hospital Associations, Department of Health, Emergency Management and Federal partners may have digital representation. The number and type of stakeholders engaged will depend on the level of WRBDC activation.
- **Continued Use of Existing Hospital System Transfer Centers** – Involving and coordinating with existing hospital system transfer centers prevents a disruption of existing workflow.
- **Patient Transport Support** - Transport of patients will be fielded by EMS and supporting agencies. The transferring facility can also use internal transportation procedures if available.
- **WRBDC Coordinator** – All Center activities will be managed by a **Coordinator or coordinators,** responsible for working between facilities, states, and with federal partners. Coordinators are on call 24/7 for response. Duties can be found on the Job Action Sheet (*Appendix C*). In a small-scale event, it may be only the coordinator who is activated.
- **WRBDC Medical Control** - The coordination center will consult with a Burn Physician to address region-wide bed control. Additionally the physician will provide clinical guidance as needed to non-burn facility providers and in collaboration with the coordinator to ensure patients are transferred to a hospital with the appropriate level of care. The on-call rotating schedule for burn physicians (*Appendix P*) and the Job Action Sheet *(Appendix C*) are attached to this plan.

RESPONSE ACTIONS BY ACTIVATION LEVEL

The following table outlines activation levels of the WRBDC Coordination Center and this Operational Plan.

WRBDC PLAN ACTIVATION LEVELS		
Level	**Partners to Notify**	**Actions to Take**
Stand-By / Ready State	• Status updates with WRBDC members via email notification and meetings	• Regular/quarterly Burn Bed Counts • Maintain WRBDC Burn Physician On-Call schedule • Establish text chain with on-call team for Information sharing and updates • Plan updates and exercises • Telemedicine improvements / connections tested
Partial Activation	• Burn Centers in the affected State or catchment area • State or local burn coordination center(s) • Federal, regional, and state health, public health, and emergency management partners	• Activate WRBDC CONOPS Plan • Activate WRBDC Coordinators and On-Call Physicians • Establish text chain with partners for Information sharing and updates • Conduct Burn Bed Count of Burn Centers in affected state / catchment area • Connect local healthcare facilities near the impacted area with closest Burn Centers to test any existing telemedicine connection and review response plan steps as requested • Disseminate burn disaster app resources and guidance to local healthcare facilities, burn centers near the impacted area and on call Burn Physicians if local burn centers and on call Physicians do not have telemedicine resources. • Disseminate plans, resources, and guidance to local receiving facilities
Full Activation	• Burn Centers in the affected State or catchment area • State or local burn coordination center(s) • Federal, regional, and state health, public health and emergency management partners	• Activate WRBDC CONOPS Plan • Activate WRBDC Coordination Center & On-Call team • Notify American Burn Association contacts • Conduct Burn Bed Count for all Burn Centers in Western Region • Integrate into state or federal response, including EOC, as requested • Establish / continue text chain with partners for information sharing and situational awareness • Disseminate plans, resources, and guidance to local receiving facilities • Support triage and coordination of patient care via On-Call Physician and/or connecting local receiving facilities with local Burn Centers • Support appropriate transfer of patients by determining Burn Centers with available beds and assessing other factors including family members, wrap-around services, and additional needs.

		• Support coordination of ongoing patient care at local receiving facilities through resources, guidance, and telemedicine

OPERATIONAL OVERVIEW

The Western Region Burn Coordination Center fulfills several vital roles following a burn mass casualty incident. Upon activation, Coordination Center personnel will utilize the WRBDC Job Action Sheets (*Appendix C*) and perform the activities listed below, as needed:

Immediate / First 24 Hours:

- **Partner Notification** – notify ABA leadership and WRBDC members of the BMCI, and enlist help as necessary.
- **Burn Bed Census** – conduct bed census counts immediately to identify available burn beds for patient transfer.
- **Assistance Requests** – request assistance (including resources, transferring and/or care of patients) from region member facilities, EMS, and/or adjacent regions.
- **Situational Awareness** – provide updates to WRBDC members, partners and all other appropriate agencies, including bed census reports and incident action plans (IAPs) or situation reports as necessary.
- **Technical Assistance** – assist the affected local burn center and/or non-burn facility by providing expert advice, telemedicine and just in time training resources as requested.
- **Bed Matching** – assist with bed matching, i.e. finding the right bed and facility for each patient requiring transfer coordination.

Ongoing Response

- **Patient Information** - facilitate the exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations.
- **Patient Tracking** - assist with the tracking of patient movement including arrival at destination centers.
- **Resource Requests** - facilitate requests for tissue bank products, graft equipment or other specialized supplies; this may be in collaboration with the ABA.
- **Federal Partner Coordination** - facilitate staff and supply needs with ASPR Regional Emergency Coordinator (REC).

Demobilization

- **Incident Conclusion** - establish when the BMCI has concluded, in collaboration with state and regional partners.
- **Outpatient Follow-up** - assist in disseminating outpatient follow-up guidance for burn patients in the affected area as requested, and in collaboration with the local burn center.
- **Behavioral Health Follow-up** - assist with psychosocial follow-up and after care programming in the affected area as requested, in collaboration with the local burn center.
- **After Action** - identify any post-incident system needs and initiate the After Action Report process.

CLINICAL SUPPORT TO NON-BURN FACILITIES

A key role of the Western Burn Coordination Center is providing clinical support and expert advice to non-burn providers who are compelled to board and treat burn patients prior to transfer to another facility, or when specialized care elsewhere is unavailable or unattainable.

The Western Burn Region Disaster Consortium has done considerable work over the last decade to ensure that burn educational resources and materials are available to all non-burn facilities to prepare for a burn disaster. Many non-burn facilities in the region are well-prepared to receive and care for patients for a short amount of time; however, clinical guidance and expertise may still be desired in the event of a burn patient or BMCI. When a request for help is given to the WRBDC Coordination Center from a non-burn facility, the WRBDC task force will meet to discuss available options and provide support as necessary and possible, which may include one or more of the following:

- Maximizing **Real-time telehealth provider support** for critical care, utilizing burn providers who are credentialed in multiple states. Telemedicine capabilities are currently available in multiple hospitals in the region, as listed on the WRBDC Burn Center Telemedicine Capabilities Sheet (*Appendix N*).
- Where telemedicine is not available, the **BMCI Burn MedPic App** may be used to securely share patient images and make them available to WRBDC on call burn physicians. Image forwarding either via the app or secure email, accompanied by provider- to- provider discussions, may be utilized to effectively determine extent of patient's burns and provide assistance for triage and treatment courses. Details on downloading and using the app are found in the "Contingency and Crisis Care" section of this document.
    - *Note: Providers who wish to practice in multiple states, including via telemedicine or the Burn MedPic App, can visit the Interstate Medical Licensure Compact website for licensure requirements (www.imlcc.org)*.
- **Mobile Task Force deployment**, in collaboration with local and state partners, is a final potential option. The Task Force would likely include a Burn Physician or Advanced Practice Clinician, a registered nurse, and assistive personnel, all trained in burn treatment and response. Upon arrival at an impacted non-burn facility, these individuals would deliver just-in-time training to facility staff to enable them to provide specialized burn care. Most equipment and supplies would be provided by the impacted facility, but some basic personal and medical supplies force members may want to take with them are listed in the Mobile Task Force Go-Bag (*Appendix G*).

Additional resources and support for medical care operations provided by the WRBDC are outlined in the "Support of Medical Care Operations" section.

PATIENT TRANSFER COORDINATION

If secondary distribution of patients to burn specialty centers is requested, **WRBDC Coordinator/s,** utilizing existing hospital system transfer systems, can assist with facilitation of transfers between hospital systems, based on clinical acuity and hospital capacity, to enable a more equitable distribution of burn patients when systems are in contingency care. The primary purpose of patient transfers facilitated by the WRBDC in collaboration with local authorities is to decompress overwhelmed healthcare facilities by enabling an equitable distribution of patients. The Hospital Transfer Decision Flowchart (*Appendix E*) can be used to determine the best patient candidates for transfer. Assistance will be provided to affected non-burn facilities, local burn center and state public health in determining appropriate patient destinations (right patient to right bed and facility), while being mindful of family units. The following steps outline the process for patient transfers coordinated through the Western Region Burn Coordination Center (see Patient Transfer Coordination diagram on the next page).

1. Requesting Facility Communicates Patient Transfer Request to the WRBDC

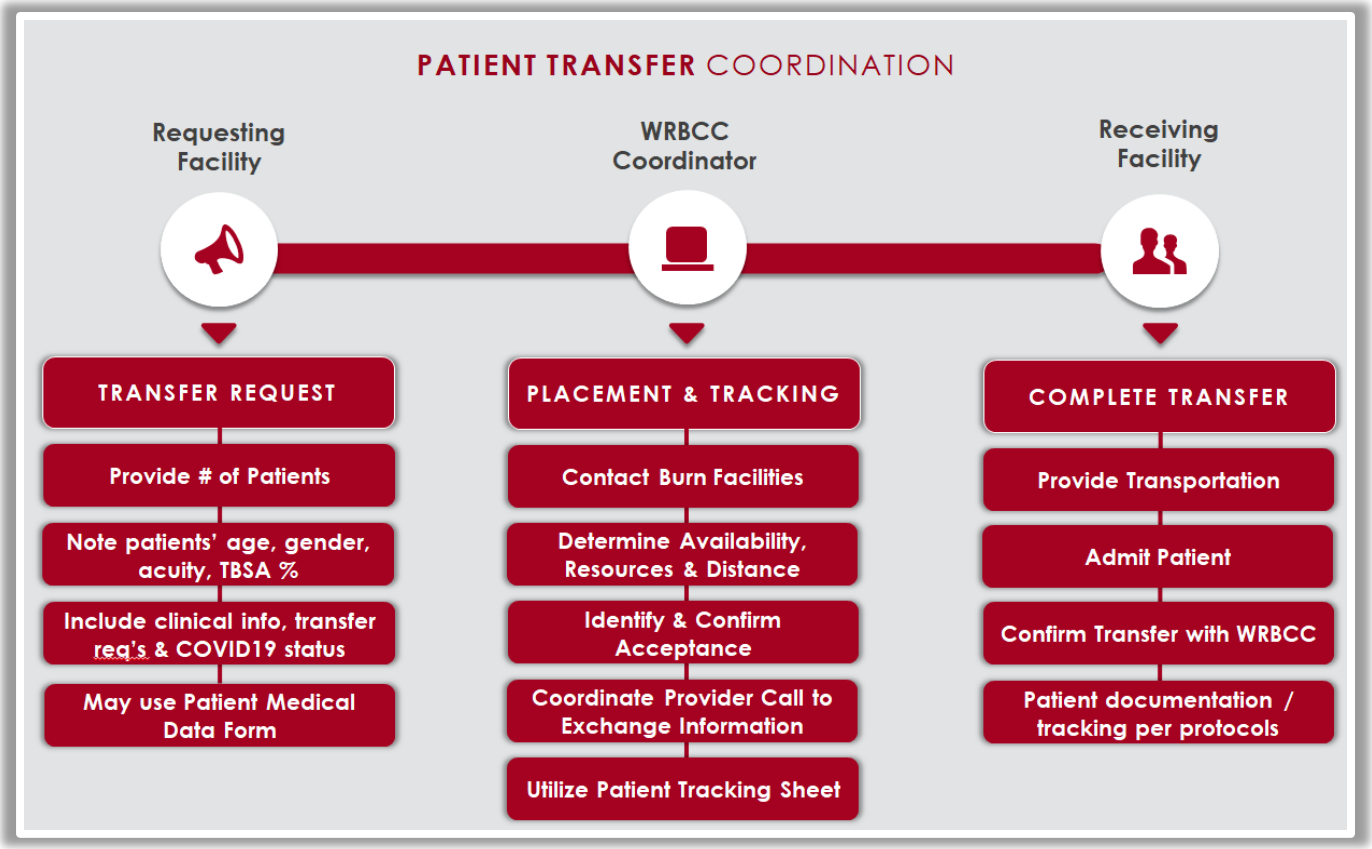
The request for burn patient transfer can be made by the requesting facility calling the WRBDC Coordinator, or through communications with the requesting facility and the WRBDC On Call Burn Physician. Patient review by the WRBDC On Call Burn Physician via telemedicine or the Burn Disaster MedPic App will ensure appropriate patients are transferred. The requesting facility will provide the following information to the WRBDC:

- The number of patients requiring transfer;
- Each patient's infectious disease status, **if applicable** (positive, negative, unknown);
- Each patient's age, gender, acuity and estimated total body surface area (TBSA) of injury, language and/or effective communication needs and level of care needed.
- Whether the patient has a family member who is also hospitalized, in order to keep family units together;
- And additional pertinent clinical information, including requirements for transfer (e.g., oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information).

The WRBDC BMCI Patient Medical Data Form (*Appendix D*) outlines a comprehensive report of the patient, including the data noted above, and may be used to provide this information.

2. WRBDC Facilitates Patient Placement & Tracking

After receiving pertinent patient information, the WRBDC Coordinator will reference the most recent Burn Bed Census and contact burn receiving facilities to determine the most appropriate placement of patients. Patient placement decisions will be based on bed availability information and facility levels of care, as well as considerations for keeping family units together, and will be determined in consultation with the WRBDC On Call Burn Physician. Additional decision-making information is found on the WRBDC Regional Bed Census (*Appendix B*) and the Western Region Burn Center Telemedicine Capabilities *(Appendix N)*. These documents detail all burn facilities in the Western Region Burn Disaster



Consortium including adult and pediatric bed availability, level of care, location, and additional features including surge capabilities. The Western Region Burn and Trauma Centers Spreadsheet will also be utilized, as it outlines all healthcare facilities and their associated trauma level, as well as burn centers.

If Crisis Standards of Care are implemented, by governor declaration or other state protocol, the patient CSC Burn Triage Tables (*Appendix F*) may be utilized by a physician at the point of care in collaboration with a burn provider to assist in decision making The American Burn Association (ABA) guidelines for care in austere or crisis conditions can be found online, as listed below:

- ABA Disaster Response Plan
- ABA Disaster Response webpage
- ABA Guidelines for Care in Austere Conditions:
    - Introduction to Burn Disaster, Airway and Ventilator Management, and Fluid Resuscitation, Article or Slides
    - Special Care Topics, Article or Slides
    - Special Etiologies: Blast, Radiation, and Chemical Injuries, Article or Slides
    - Surgical and Nonsurgical Wound Management, Article or Slides
    - Patient Care Priorities for the First 24 Hours, Just-in-Time Training Document
- Most recent Burn Triage Tables

Once a burn receiving facility has been identified and confirms acceptance of the patient(s), the WRBDC will coordinate a clinical provider call between the requesting facility and receiving facility to exchange patient information and determine transportation requirements. The WRBDC BMCI Patient Medical Data Form (*Appendix D*) can be used to assist with information exchange. Telemedicine and digital images of the patient's burns will be utilized, if existing infrastructure allows, ensuring an accurate total body surface area (TBSA) is calculated and placement is appropriate. WRBDC personnel will utilize the WRBDC BMCI Patient Tracking Sheet (*Appendix Q*) to document and track all patient transfers. This sheet records important patient data needed for transfer, as well as receiving facility information.

3. Receiving Facility Completes and Confirms Successful Patient Transfer

The Transportation Guidelines found in this document will be followed to ensure the safety of both transporter and patient. Transport of patients will be handled by the EMS and supporting agencies, according to existing plans and protocols. If the transferring facility has transportation procedures within the healthcare system, these may also be utilized. Once the patient has been transferred and admitted, the receiving facility will contact the WRBDC to confirm the completion of the process. The WRBDC will document the transfer and its completion on the WRBDC BMCI Patient Tracking Sheet (*Appendix O*).

RESOURCE REQUEST COORDINATION

Hospitals encountering a need for burn care resources will first attempt to acquire the needed item(s) using their normal or emergency procurement methods. This can be done in collaboration with state, regional, and federal partners and in accordance with existing MOUs. The WRBDC may assist in acquiring scarce or specialized resources when necessary, possibly in collaboration with the ABA. The following process will be followed to ensure a locally-driven response, with support as needed in a tiered approach.

Tiered Resource Request Process:

1. *Healthcare Facility / System* – when an unmet resource need exists, the facility will first utilize existing channels within its hospital system to acquire the needed item(s). If the system cannot meet the request, the local jurisdiction ESF 8 desk and/or regional healthcare coalition coordinator (HCC) should be notified.

2. *Local ESF 8 / State ESF 8* – Local ESF 8/HCC will initiate efforts to obtain the needed item(s) by contacting facilities in their jurisdiction. If unmet, the request is then sent to the State ESF 8. ESF 8 and/or healthcare coalition coordinators will make arrangements for any available resources to be sent to the requesting facility. Note that scarcity of resources may prompt prioritization recommendations to be established by local and state health officials, shared with hospitals through disaster communication channels.

3. *Regional WRBDC* – if the resource need is unable to be met from the healthcare system or from healthcare coalitions or local and state emergency support, the facility may request resource assistance from the WRBDC. The WRBDC will assist in identifying another facility that is able to provide the resource, in collaboration with the ABA where necessary. The requesting facility is responsible for completing any necessary paperwork and will work with the WRBDC to coordinate transportation of the resource.

In the event that region-wide resources are scarce or unavailable, including tissue bank products and specialized supplies, the WRBDC task force will convene to discuss available options and recommendations, in conjunction with ABA personnel.

SUPPORT OF MEDICAL CARE OPERATIONS

Healthcare facilities are responsible for all patient triage and treatment, tracking, care documentation, family reunification, rehabilitation, and management of deceased patients at their facility, but may request assistance as needed from the WRBDC (as outlined in the previous section). Facilities will first and foremost follow internal policies and procedures for patient care and emergency response. This plan is meant only as supplemental support and direction in instances where this may be helpful.

ANTI-DISCRIMINATORY TREATMENT POLICIES

Factors that have no bearing on the likelihood or magnitude of benefit, including race, disability, gender, sexual orientation, gender identity, ethnicity, ability to pay, socioeconomic status, perceived social worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources, are not to be considered by providers making allocation decisions. For more information on laws governing these practices, please refer to the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act.

PATIENT CARE RESOURCES

The WRBDC has put together an extensive collection of burn resources for non-burn and burn facilities. Training resources and planning documents aid in preparing facilities for a burn mass casualty incident, and guidelines to be followed during a response. In addition to being available online at https://crisisstandardsofcare.utah.edu, nearly all of these resources are also

available as an app on smartphones and other devices (search for the "Burn CSC" app). This allows instantaneous in-field access to evidence based information on burn and soft tissue injury to assist in delivery of care. The following sections describe some of these resources in more detail, many of which are included in full or in part in the Appendix, and the *Resources* section of this plan provides information on accessing them.

BURN INJURY GUIDELINES FOR CARE

The WRBDC has put together an extensive collection of burn resources for non-burn and burn facilities to ensure staff are trained in clinical procedures for burn injuries. The "Burn Injury Guidelines for Care" document was first produced in 2022 as a collection of best practices, clinical guidance, algorithms, fluid rates, wound dressings, radiation injury care, and a burn resource table that includes extensive additional resources such as clinical training videos and websites with up-to-date care information. It has been revised to align with updated Advanced Burn Life Support (ABLS) recommendations and additional best practice. This document can be accessed at this link: Burn Injury Guidelines for Care, or on the WRBDC website at https://crisisstandardsofcare.utah.edu. The website also provides access to the WRBDC acute burn poster and buddy badge.

BURN EQUIPMENT & SUPPLIES

To aid non-burn facilities in understanding what supplies and equipment to have on hand for the treatment of a burn patient, the Wound Care Supply Guideline for Burns and the Pediatric Equipment and Supplies List are included in Appendices I and J. Please note that these lists are not exhaustive and are meant to be a supplement to standard supply cart items and personal protective equipment a facility would typically provide.

TRIAGE FLOWCHARTS & BURN MANAGEMENT ALGORITHM

The impacted healthcare organizations will immediately begin triage and treatment according to local protocols. The WRBDC EMS and Hospital Triage Flowcharts on the following pages were created to show the flow of response from initial on-scene triage to hospital re-triage, including burn-specific considerations. The WRBDC has also developed an algorithm with burn care instructions for non-burn hospitals to follow in the absence of facility or regional burn protocols. The Hospital Acute Burn Management Algorithm provides best practices in conducting primary and secondary surveys, and is found after the Triage Flowcharts. Please note that algorithms and flowcharts do not supersede local or state protocols.

EMS Burn Triage Flowchart

Note: Flowchart does not supersede local/state protocols.

Mass Casualty Incident Involving Burns Occurs

On-scene **EMS triage** established. Patients are triaged according to local protocols such as START, JumpSTART, or SALT.

DO NOT DELAY transport at scene waiting for the helicopter to arrive. Begin transport to closest hospital or establish rendezvous point.

Notify local medical control of the number and severity of patients.

On-scene **treatment** established – Medical Control will always be the final word on treatment in the field.

Transport critical patients directly to **Burn Center** if possible but without causing delay in transport. Follow normal hub and spoke protocols for patient transport and care. Transport remaining patients according to closest, most appropriate facility, taking care not to overload any one facility, using the colored triage guidelines below:

Immediate	Delayed	Minor	Expectant
If Burn Center/s can take all RED patients, transfer there via air ambulance if possible. Otherwise, divide patients between Burn Center and Level 1 or 2 Trauma Centers.	Consider transferring patients via air or ground ambulance to closest Level 2 or 3 Trauma Center.	Consider transferring patients via ground ambulance or other available transport to Level 3,4 or 5 Trauma Center or closest available hospital.	Provide comfort care, preferably in designated area separate from other patients. Provide psychological support to patient and family.

****Burn Patients** do not always fit standard triage protocols. Consider the following:

>20% TBSA 2nd/3rd degree burn. Burns with multiple trauma, burns with **definitive** airway compromise.	10-20% TBSA 2nd/ 3rd degree burn. Suspected inhalation injury or **potentially** requiring intubation, normotensive GCS>14	<10% TBSA 2nd/3rd degree burn. No inhalation injury, not intubated, normotensive GCS>14

Additional burn notes: Standard ATLS principles of care should be followed. Airway swelling is progressive. All burn patients should be kept warm and dry unless decontamination is required.

Hospital Burn Patient Triage Flowchart

Note: Flowchart does not supersede local/state protocols

Mass Casualty Incident Involving Burns Occurs

On-scene **EMS** triage and treatment, notifications, and patient transport to nearby hospitals according to established protocols.

Receiving **hospital notifies** Burn Center, healthcare coalition, public health, Western Region Burn Coordination Center per existing protocols.

Western Region Burn Coordination Center (WRBCC) activated

Consult with a **Burn Care physician** via the nearest Burn Center or the Western Region Burn Coordination Center (WRBCC) by calling the 24/7 Disaster Line: **866.364.8824.**

Receiving **hospitals stabilize, resuscitate and treat** in consultation with a Burn Care Physician. Utilize the 96 Hour Plan for treatment guidelines.

Use the BMCI Hospital Acute Burn Management Algorithm to aid in patient evaluation and care. **Triage burn patients** using the Definition of Patient Condition colored boxes below.

Receiving hospitals determine **patient care plans** in consult with Burn Center, Substate/State Medical Coordination Cell or equivalent, and/or WRBCC.

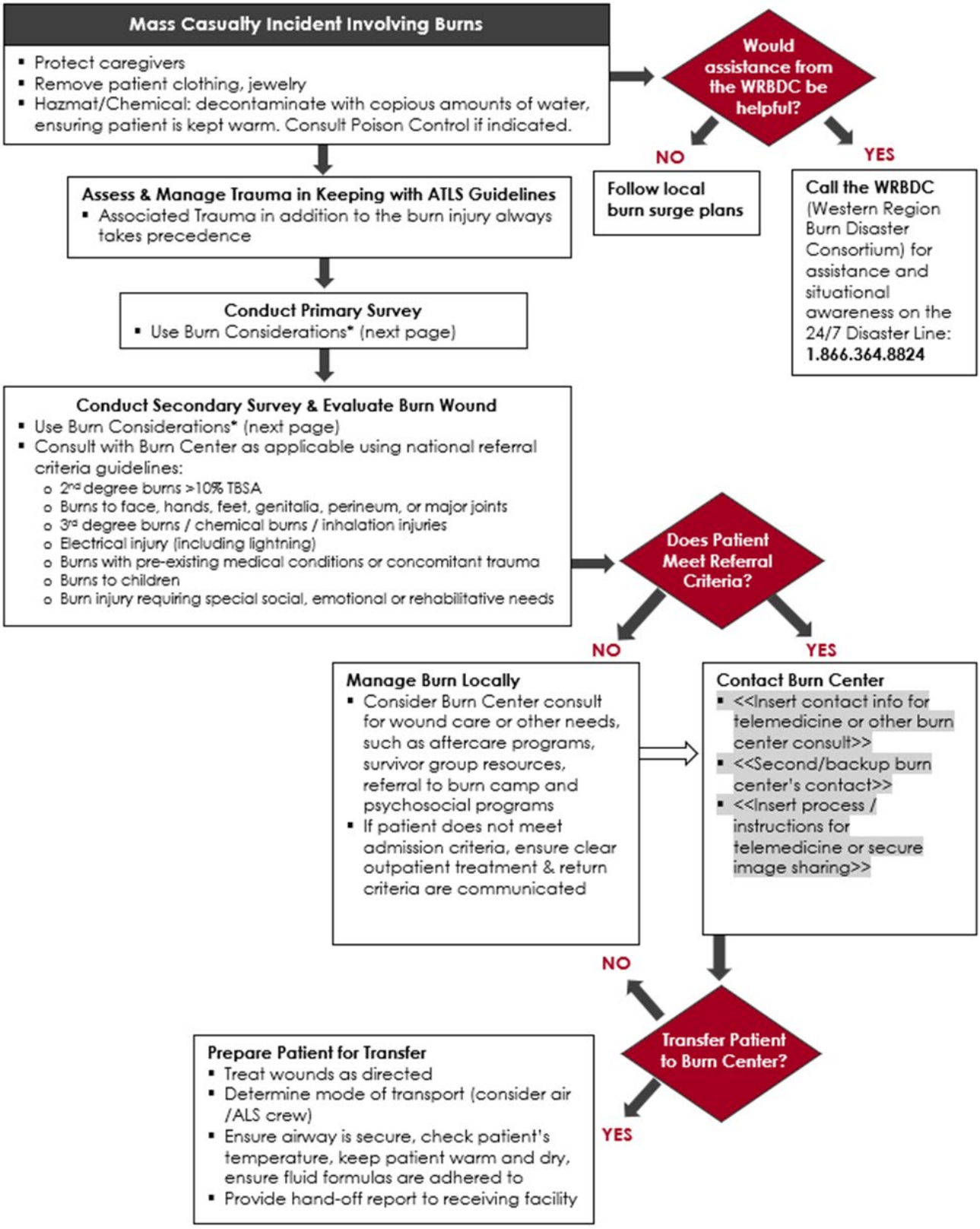
Receiving hospitals determine **transfer priorities and destinations** in consult with a Burn Care physician

Patient Triage Definition:

Immediate/Critical	Delayed/Serious	Minor	Pediatric
>20% TBSA 2nd/3rd degree burn. Burns with multiple trauma, burns with **definitive** airway compromise.	10-20% TBSA 2nd/ 3rd degree burn. Suspected inhalation injury or **potentially** requiring intubation, normotensive GCS>14	<10% TBSA 2nd/3rd degree burn. No inhalation injury, not intubated, normotensive GCS>14	Pediatrics are defined as anyone under the age of 15 years

****Priority Patients:** Immediate/critical patients with a head injury should be transferred to a level 1 or level 2 trauma facility as soon as possible.

Hospital Acute Burn Management Algorithm



BMCI Hospital Acute Burn Management Algorithm: Evaluation Considerations & Ongoing Management

PRIMARY SURVEY

Airway
- 100% O2 via NRB
- Pulse oximeter and consider ABG
- Consider airway involvement:
  - Early intubation typically with burns >20% TBSA
  - Upper airway edema may make intubation impossible as symptoms progress
  - Secure ETT with ties passed around head; no tape (it does not stick to burned tissue)
  - NG/OG should be inserted on all intubated patients
  - Swelling is progressive; consider early intubation in patients with larger burns, burns to the head, those receiving large volumes of fluid resuscitation and in younger children
  - Consider monitoring patients with a possible inhalation injury for 24 hours

Breathing
- Monitor chest expansion in circumferential torso burns

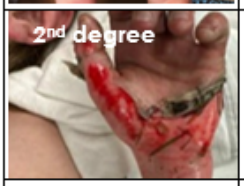
Circulation
- Large bore IV or I/O (priority >20% TBSA)
- Do not bolus unless associated trauma
- Elevate burned extremities and ensure adequate pulses
- **If burn >20% TBSA**, administer IV fluid at initial fluid rate (LR is fluid of choice, but NS can be used if LR is not available):
  - ≤5 years: 125 mL/hr
  - 6-12 years: 250 mL/hr
  - ≥13 years: 500 mL/hr

Disability
- Monitor GCS – typically A&O (awake, alert & oriented)

Environment
- Remove all clothing and jewelry
- Expose / keep warm and dry
- Do not use wet dressings / blankets

BURN WOUND EVALUATION

It is not always possible to know burn depth for days, as appearance may be deceiving, and injury may deepen.

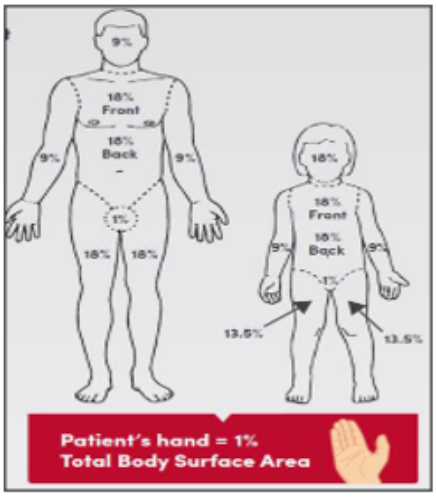
Type of Wound	Depth of Injury	Wound Properties
	Superficial Minor damage to epidermis Skin intact *Do not include in % TBSA	▪ Painful ▪ Red ▪ No blister formation immediately ▪ Mild swelling
	Partial thickness Epidermis destroyed, some damage to dermis	▪ Pink, red ▪ Swelling ▪ Weepy ▪ Blanching ▪ Blisters ▪ Painful
	Ful thickness All epidermis and dermis destroyed	▪ White, red, brown, black ▪ Hard and leathery ▪ Insensitive to pin prick

SECONDARY SURVEY

- Evaluate wound & calculate TBSA (use burn diagram and burn wound evaluation)
- Consider Burn Center consult via telemedicine
- Check tetanus status
- Pain management – small, frequent doses with reassessment
- Calculate **Burn Fluid Resuscitation Rate** for a 24-hour period, adjusting for urine output (U/O) (LR is fluid of choice, but NS can be used if LR is not available)-

Scald/Flame:
- Adults & Children (≥13 yrs):
  2 mL x kg x TBSA% divided by 16
  (U/O 0.5 mL/kg/hr or 30-50 mL/hr)
- Infants/Children (≤12 yrs):
  3 mL x kg x TBSA% divided by 16 plus D5LR at maintenance rate using 4/2/1 rule
  (U/O 0.5-1 mL/kg/hr or 30 mL if over 30 kg)

Electrical/Deep Tissue:
- 4 mL x kg x TBSA% divided by 16
- Adults with pigment in urine: U/O 75-100 mL/hr
- Pediatrics: U/O 2 mL/hr



ONGOING BURN MANAGEMENT

- Continue trauma resuscitation and burn care in collaboration with Burn Center as needed.
- Prophylactic antibiotics are not indicated for burns.
- 12 lead EKG for electrical injury
- Circumferential burns/electrical contact sites: hourly pulse checks to affected extremity.
- Continue with fluid resuscitation – associated trauma or inhalation injuries may require additional fluid.
- Monitor urine output – slowly adjust fluid based on target goals (below) & clinical response:
  - **Scald/Flame:**
  - Adults = 0.5 mL/kg/hr (30-50 mL/hr) of urine
  - Pediatrics = 1 mL/kg/hr of urine
  - **Electrical injury/red pigment** (myoglobinuria)
  - Adults = 75-100 mL/hr of urine
  - Pediatrics = 2 mL/kg/hr of urine

BURN CENTER CONSULT CRITERIA

Some burn injuries are best managed by consulting a Burn Center physician. The American Burn Association's criteria for consult with a burn center includes the following burn injuries:

1. Partial thickness burns greater than 10% TBSA
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
3. Full thickness (third degree) burns in any age group.
4. Electrical burns, including lightning injury.
5. Chemical burns.
6. Inhalation injury.
7. Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
8. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses greatest risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgement will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
9. Burned children in hospital without qualified personnel or equipment for the care workers.
10. Burn injury in patient who will require special social, emotional, or rehabilitative intervention.

The WRBDC will work to ensure non-burn facilities are aware of these criteria, and assist in linking facilities with Burn Centers when criteria have been met.

PATIENT DOCUMENTATION & PRIVACY

Patient Tracking. Healthcare facilities will follow routine and/or disaster protocols for tracking patient movement within their hospital system. More uncommon patient movement, including transfers from a facility to a destination facility outside of the hospital system or state, may be facilitated by the WRBDC, in collaboration with state and regional partners. The WRBDC BMCI Patient Tracking Sheet (*Appendix O*) will be utilized by the WRBDC coordination center to ensure consistency across the region in patient tracking efforts. Facilities may utilize their own patient tracking forms, or those provided by the Hospital Incident Command System (HICS) which can be found online at https://emsa.ca.gov/hospital-incident-command-system-forms-2014/.

Patient Care Documentation. Hospitals will utilize their existing or normal medical records to document patient assessment and medical care given to burn victims. The WRBDC BMCI Patient Medical Data Form (*Appendix D*) may be used to record details of the extent and depth of the burn. This form may be utilized for patient transfers, and to accompany the patient to the recipient facility. The WRBDC will support Burn Center efforts to collect comprehensive burn patient data from all treating healthcare facilities. This data may be submitted to the ABA burn database according to established protocol by burn centers who receive burn patients, to be used for educational and research purposes.

Patient Privacy. While privacy is important, patient protected health information (PHI) can be disclosed without authorization when needed during a disaster and under certain circumstances. This includes when the information is needed for:

- Patient treatment
- For or on behalf of a public health authority
- To persons at risk of contracting or spreading a disease (if authorized by law)
- When there is an imminent threat to public health or safety

The Appendix conditions a valuable resource put together by ASPR TRACIE that describes what information can be released, to whom, and under what conditions, entitled HIPPA and Disasters: What Emergency Professionals Need to Know (*Appendix H*).

PEDIATRIC CONSIDERATIONS

A good planning figure is to assume that a minimum of 25% of victims from any mass casualty incident will be children. It is critical that healthcare facilities, including burn and non-burn centers, have the education and resources necessary to assess and treat pediatric patients. The WRBDC will be available to assist in coordinating real-time telemedicine support from pediatric and burn specialty physicians. Where telemedicine is not available, image sharing and provider-to-provider discussions can be used to assist in caring for a pediatric burn patient.

PEDIATRIC BURN PATIENT CARE

Burn-specific pediatric care resources can be found in the Burn Injury Guidelines for Care, and include primary assessment, intervention and care, fluid infusion rates, pain medication management, and even comfort holds for a burn injured child.

PEDIATRIC PLANNING RECOMMENDATIONS & SUPPLY CHECKLIST

General readiness to handle any pediatric patient is also helpful in planning for pediatric burn patients. In order to plan for the possibilities of caring for critically ill and injured pediatric patients, Pediatric Planning Recommendations (*Appendix K*) for policy and protocol implementation as well as a Pediatric Equipment and Supplies Checklist (*Appendix J*) are attached to this plan. Another helpful resource is the 2020 Emergency Department Checklist compiled by the Pediatric Readiness Project. This document lists the most critical components for emergency departments, including guidelines for providers, patient safety, policies, medications, equipment and supplies. This resource can be found online at www.pedsready.org.

Additionally, the Western Regional Alliance for Pediatric Emergency Management (WRAP-EM) was founded with the goal of developing a "coordinated, collaborative and sustainable regional pediatric disaster planning and response capability." This group has put together an

extensive collection of pediatric preparedness and response resources which support the significant pediatric-specific needs encountered by both initial care in place and the subsequent movement of children following a burn event: https://wrap-em.org/index.php.

BEHAVIORAL HEALTH

Given the nature and scope of a burn mass casualty incident, it can be expected that a number of those who witnessed, were injured by, or responded to the event will experience some mental trauma in relation to the incident. Healthcare facilities should be prepared to identify and respond to these issues in their patients, patients' families, and their staff to the best of their ability.

In a large-scale disaster scenario, psychological first aid is an evidence informed approach, whose purpose (according to The American Psychological Association) is to "assess the immediate concerns and needs of an individual in the aftermath of a disaster". Psychological First Aid advocates that mental health clinicians and emergency response workers work to understand the victim's world view, project a sense of calm, normalize feelings and reactions, provide information needed to de-escalate acute distress and provide education to the individual or family regarding "next steps" to take. The Burn Injury Guidelines for Care includes several mental health resources, including "Behavioral Health Tips & Resources," which includes brief tips as well as several resources for Psychological First Aid and Aftercare Support, along with Pediatric Psychological First Aid guidelines. There are also comprehensive mental health resources provided by ASPR TRACIE Disaster Behavioral Health Resources Page.

The WRBDC will work to ensure non-burn facilities are aware of mental and behavioral health considerations and have incorporated these things into their Burn Surge Annexes.

FAMILY REUNIFICATION

The process of reuniting family members with those who went missing during a BMCI, including burn victims, is the responsibility of local emergency management and first responders. Healthcare facilities may be asked to provide special assistance to law enforcement, mass care authorities, the Red Cross or others to facilitate reunification. Hospitals can serve as a natural reunification site, since family members and friends are likely to check facilities for individuals who have gone missing. Setting up a reception site within or nearby the facility can be helpful in connecting patients with loved ones. A great planning resource for this purpose is the "Hospital Reception Site Planning Guide," developed in the western region by the Coyote Crisis Collaborative of Arizona. The plan and several additional resource documents are available online at https://coyotecampaign.org/documents/. Some helpful documents from this guide have been adapted and shared in the Appendix, with the intent to assist healthcare facilities with their own planning. Family Reunification Resources (*Appendix L*) include:

- Hospital Incident Command System (HICS) Chart, including a Family Reunification Unit
- Definitions
- Family and Friends Intake Form
- Child Identification Form
- Hospital Reception Site Recommended Equipment & Supply Checklist

CONTINGENCY & CRISIS CARE

The WRBDC aims to support healthcare facilities in staying in contingency standards of care rather than crisis care. Resources are available to support a healthcare facility experiencing surge at any level, however.

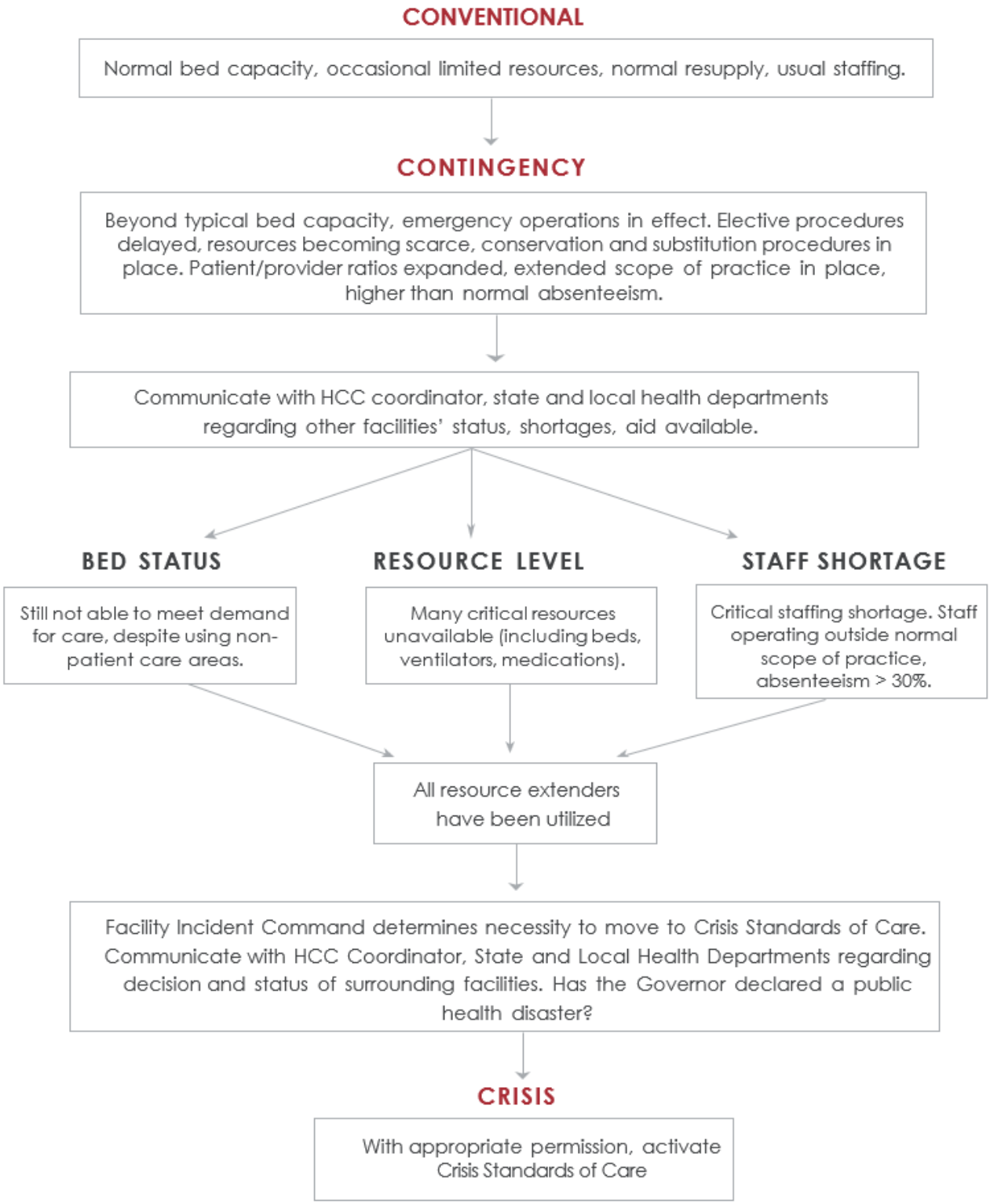
BURN INJURY GUIDELINES FOR CARE

An overwhelming public health emergency, such as a burn mass casualty incident, may greatly impact the availability of appropriate hospital beds, staff and resources. Providers may not be able to provide the same level of care that they otherwise would like to, given shortages or other difficulties resulting from the disaster. Burn Crisis guidelines were originally developed by the Utah Hospital Association (UHA) Crisis Standards of Care Workgroup to aid in scarce resource allocation and crisis decision making. These guidelines were revised in 2022 with the Western Region Burn Disaster Consortium and partners with the goal of assisting in contingency and deep contingency care to hopefully avoid crisis care. The new document, Burn Injury Guidelines for Care, covers the following clinical topics:

- Adult primary and secondary assessments
- Pediatric primary and secondary assessments
- Fluid resuscitation
- Wound management
- Pain medication
- Physical therapy
- Radiation injury
- Triage and transfer decisions

The Burn Crisis Standards of Care Algorithm on the following page depicts the flow from conventional to contingency standards of care, and how activation of crisis standards of care may occur.

BURN CRISIS STANDARDS OF CARE ACTIVATION ALGORITHM



THE 96 HOUR PLAN

A mass casualty incident with a significant number of burn-injured patients creates unique challenges due to the scarcity of burn centers and the complexity of the initial care required. Medical management poses unique challenges to healthcare professionals, many of whom will have limited amounts of knowledge and expertise in burn care. In acknowledgement of this, the Western Region Burn Disaster Consortium has developed multiple resources to assist non-burn centers to care for those with burn injuries and ensure best practices will still be implemented, despite the constraints of a large-scale incident.

The Prolonged Care of the Burn Patient in a Non-Burn Facility Following a Mass Casualty Incident (found in the *Burn Injury Guidelines for Care*) is a collection of training modules and quick-reference response guides created to ensure all facilities are able to provide care to a burn patient for up to 96 hours (these documents are also referred to as the 96 Hour Plan). The essential, better and best care recommendations build on each other so that movement from one to the other is outlined as additional resources become available. These guidelines were developed by a multidisciplinary team of 41 pertinent local, state, tribal, regional, national, federal and international experts from 13 States and 3 countries. The team contained both burn and non-burn providers and military personnel.

The four e-learning modules and all supplemental material of the 96 Hour Plan can be found online (*Resources)*, or can be requested from the app store on both android and apple devices under University of Utah Burn CSC. Available E-Learning Modules & Quick Reference Guides from the 96 Hour Plan are found in the Burn Injury Guidelines for Care, and include:

- Module 1 - Initial assessment and Management
- Module 2 - 0-48 hours of care
- Module 3 - 48-96 hours of care
- Module 4 - Transfer and Transport

BURN DISASTER SMARTPHONE APP

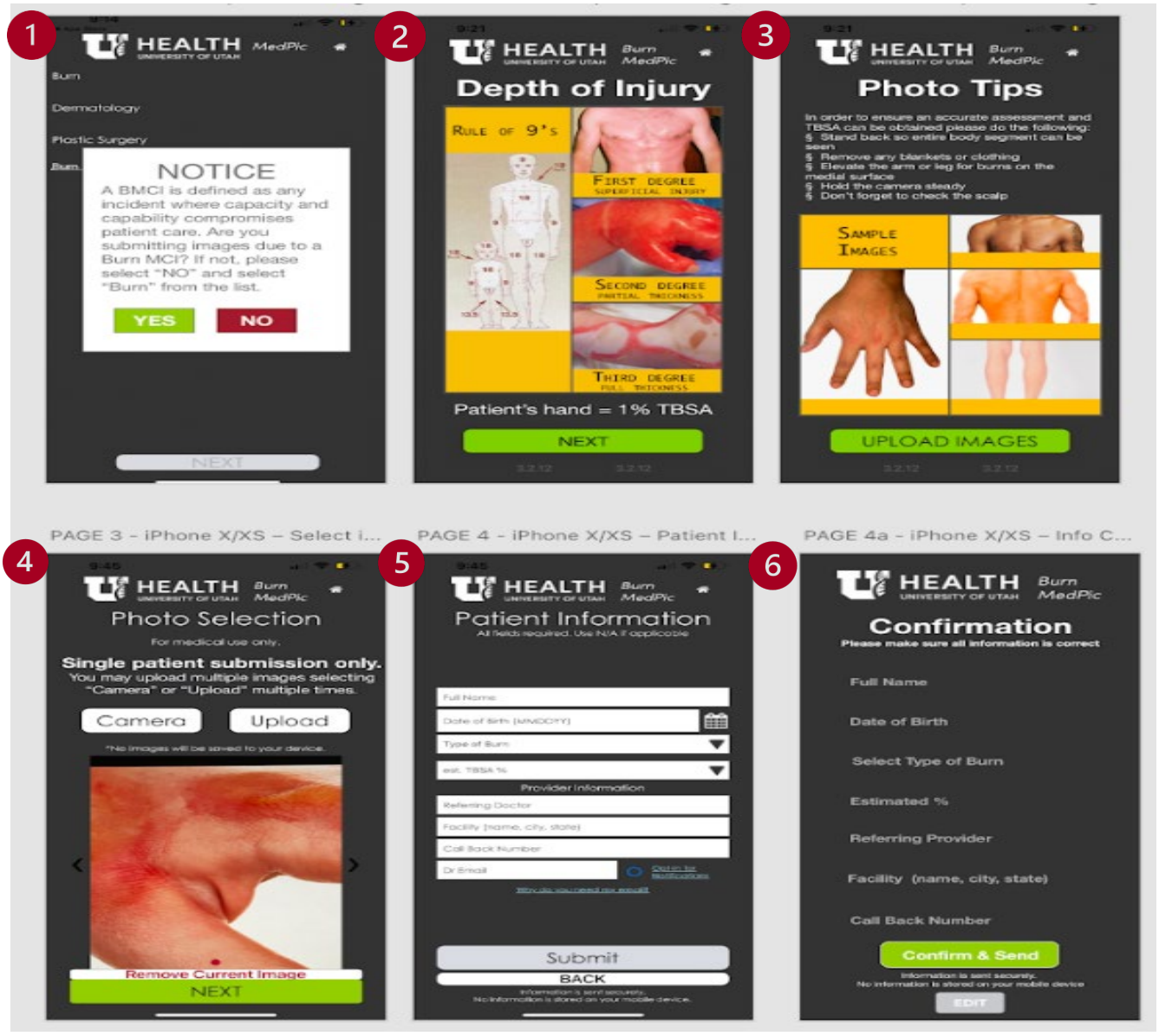
The Burn Mass Casualty Incident MedPic App is designed for disaster patient receiving providers to use during a burn surge incident which overwhelms local resources. The app would be utilized secondarily to any existing telemedicine platform. It allows non-burn providers to securely share patient photos and information with a burn physician for consultation on patient triage, transfer and referral decisions. Download the app by scanning the QR code at right, or search UofUHealth MedPic App in the App Store or on Google Play.

If you have an IPHONE

If you have an ANDROID

Instructions for App Use:

1. Click "Yes" that you are experiencing a burn mass casualty incident.
2. Using the Rule of 9s diagrams and burn depth images provided, determine a rough estimate for the % TBSA and degree of burn. Remember first degree burns are not counted in the % TBSA.
3. Follow the photo tips provided to ensure the burn physician can make an accurate assessment of the injury.
4. Multiple photos of one patient may be submitted together, but only submit photos for one patient at a time.
5. Provide all known patient information to help the burn consulting physician gain awareness. Obtain patient consent for image sending if the patient is able to communicate.
6. Confirm the information is correct and click to submit. You will receive a call back within 30 minutes or less. Keep patients dry and warm, but do not dress any burn wounds until you have been contacted.



FATALITY MANAGEMENT

The deceased from a BMCI will be handled per local and/or state practice, and in collaboration with the Medical Examiner's Office if applicable. The Medical Examiner's Office may provide certain criteria for determining whether a death requires further investigation. For example, state code may require Medical Examiner involvement if the mass burn incident was caused by intentional behavior meant to cause injury or death. Additionally, if there is any question as to the exact cause and manner of death for any victim, the Medical Examiner may need to be engaged.

Depending on the cause of the BMCI, law enforcement may ask EMS and /or the hospitals for the personal effects and other materials associated with a burn related death.

TRANSPORTATION

It should be noted that the WRBDC is not a transportation entity. Guidance and information on transportation may be provided to non-burn facilities, however.

A significant limiting factor in a regional response may be the availability of emergency medical services transport (ambulances). EMS support and coordination is essential to the logistical goals of this effort. Note that patient transfer coordination will include step-down transfers and assistance to local authorities as needed for family reunification efforts. EMS regulations differ widely by jurisdiction; therefore, patient movement will occur in accordance with local protocols and in collaboration with appropriate state, national, and federal agencies. To expedite safe, efficient and appropriate transfer of burn patients, the following guidelines should be adhered to. Note that supplementary Transportation Guidelines to Reduce the Spread of Highly Infectious Disease (*Appendix M)* is attached to this plan.

ALL PATIENT TRANSFERS

- Whenever possible an Advanced Life Support (ALS) /critical care capable vehicle shall be used to transport a critical burn patient.
- Hospitals needing to transfer patients to a local Burn or Trauma Center should employ their normal private sector EMS transport contracts.
- An individual facility may make arrangements directly or request assistance from local ESF 8, regional Healthcare Coalition (HCC), according to local emergency management plans and protocols.
- Local ESF 8 desks, regional HCCs, and Emergency Medical Resource Centers (EMRC) will utilize internal policies and procedures to solicit assistance from private sector EMS, and public safety Fire and EMS for immediate help.
- If local transport resources have been exhausted, and/or if patient(s) need to be transported to another state within or outside of the region, transport request can be made directly to the WRBDC.

- Prior to transporting any patients, facility acceptance for the patient(s) should be confirmed by the WRBDC.
- The requesting facility should notify the WRBDC of what transportation arrangements have been made.
- The facility or agency arranging air or ground transportation should coordinate with the NOAA National Weather Service for current or future weather conditions. Information can be provided for local and on-route forecast conditions, including wind speed, temperature, pressure and inclement weather.
    - Western Region Operations Center Duty Officer (Salt Lake City, Utah), 801-524-7907, wr.roc@noaa.gov
        - If communications are down in Salt Lake and/or the NWS Western Region Duty Officer is unreachable, call the Central Region Operations Center at 816-200-1140.
- Additional transportation guidelines have been developed for handling patients during an infectious disease outbreak (*Appendix M*).

AIR TRANSPORTS

- Aeromedical transports should be used when available, applicable and as weather permits.
- The facility or agency arranging air transportation should coordinate with aeromedical transports to determine whether medical rotor aircraft can land and take off due to complex conditions, including extreme high temperatures and elevation (i.e., launching or landing in summer months in St. George, Utah, and Las Vegas, NV may be impossible).

DEACTIVATION AND RECOVERY

The Western Region Burn Coordination Center will assist in establishing the point when a Burn Mass Casualty Incident has concluded, in collaboration with state, regional and federal partners. Triggers for incident conclusion include decreasing patient volumes and hospital staffing and supplies are at or near normal levels. The WRBDC will demobilize when these triggers occur, and when there is no longer a need for coordinated burn-specific activities.

The WRBDC will initiate the After Action process, soliciting and compiling analysis feedback from all responding agencies. Identified gaps and areas of strengths will be noted in an After Action Report, distributed to all pertinent agencies and partners. Changes to plans and procedures, including this document, will be based off of identified gaps.

The Appendix includes a template for an Improvement Plan Matrix Template (*Appendix Q*) to quickly capture areas needing improvement and the corrective actions that can be taken to close gaps.

The following table lists the partners the WRBDC will notify as an event de-escalates, and what actions to take to recover and demobilize our response efforts.

WRBDC De Activation Levels		
Level	**Partners to Notify**	**Actions to Take**
Recovery	• Notify federal, regional, and state health, public health, and emergency management partners of recovery phase initiation	• Support coordination of after-care programming • Continue to disseminate information and guidance as needed • Continue text chain with partners for situational awareness and information sharing
Demobilization	• Notify federal, regional, and state health, public health, and emergency management partners of demobilization phase	• Disengage from state/federal integration, if applicable • Conduct incident Hot Wash with partners activated during the response • Complete other incident documentation as needed • Complete After Action Report and/or Improvement Plan Matrix to capture corrective actions needed for any identified gaps in planning efforts

APPENDIX

A. Acronyms 37

B. WRBDC Regional Bed Census 38

C. WRBDC Job Action Sheets 40

- WRBDC Coordinator 40
- WRBDC Medical Control 41

D. WRBDC BMCI Patient Medical Data Form 42

E. Hospital Transfer Decision Flowchart 44

F. Crisis Standards of Care Burn Triage Tables 45

G. WRBDC Mobile Task Force Go-Bags 47

H. HIPAA and Disasters: What Emergency Professionals Need to Know 49

I. Wound Care Supply Guideline for Burns 55

J. Pediatric Equipment & Supplies 56

K. Pediatric Planning Recommendations 58

L. Family Reunification Resources 59

- Hospital Incident Command System (HICS) Chart 59
- Definitions 60
- Hospital Reception Site Equipment & Supply List 62
- Family & Friends Intake Form 64
- Child Identification Form 65

M. Transportation Guidelines to Reduce the Spread of Highly Infectious Disease 66

N. WRBDC Burn Center Telemedicine Capabilities 68

O. BMCI Patient Tracking Sheet 70

P. WRBDC Physician On-Call Schedule 71

Q. Improvement Plan Matrix Template 72

R. Burn Surge Planning Resource Table 73

S. WRBDC Contacts and Training & Exercise Documents 75

A. ACRONYMS

ACRONYM	MEANING
AAR	After Action Report
ABA	American Burn Association
ABLS	Advanced Burn Life Support
ALS	Advanced Life Support
ACS-COT	American College of Surgeons Committee on Trauma
ASPR	Assistant Secretary for Preparedness Response
BMCI	Burn Mass Casualty Incident
CONOPS	Concept of Operations (Plan)
CSC	Crisis Standards of Care
DHHS/HHS	Department of Health and Human Services
DOH	Department of Health
EM	Emergency Management
EMAC	Emergency Management Assistance Compact
EMRC	Emergency Medical Resource Center
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Active Labor Act
ESF#8	Emergency Support Function – Health & Medical
FEMA	Federal Emergency Management Agency
HCC	Healthcare Coalition Coordinator
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
ICS	Incident Command System
ICU	Intensive Care Unit
MCI	Mass Casualty Incident
MOU	Memorandums of Understanding
NBF	Non-Burn Facility
NDMS	National Disaster Medical System
NOAA	National Oceanic and Atmospheric Administration
PAPR	Powered Air Purifying Respirator
PH	Public Health
PHI	Protected Health Information
POC	Point of contact
PPE	Personal Protective Equipment
REC	Regional Emergency Coordinator
TBSA	Total Body Surface Area
TRACIE	Technical Resources, Assistance Center, & Information Exchange
UNIS	Utah Notification and Information System
WRBDC	Western Region Burn Disaster Consortium

B. WRBDC REGIONAL BED CENSUS

The WRBDC partnerships with the Nevada Hospital Association (NHA) to determine region-wide burn bed availability, including surge availability, for drills and during a real incident through the Burn Watchboard. Surge numbers include available beds and any extra patients the facility may be able to take. Surge numbers should take into consideration unit capability, including staffing and equipment.

Definition of Patient Condition for Burn Bed Census:

Green (minor): <10% TBSA 2nd/3rd Degree Burn. No Inhalation Injury, not intubated, normotensive GCS >14.

Yellow (serious): 10-20% TBSA 2nd/3rd Degree Burn. Suspected Inhalation Injury or requiring intubation, normotensive GCS >14.

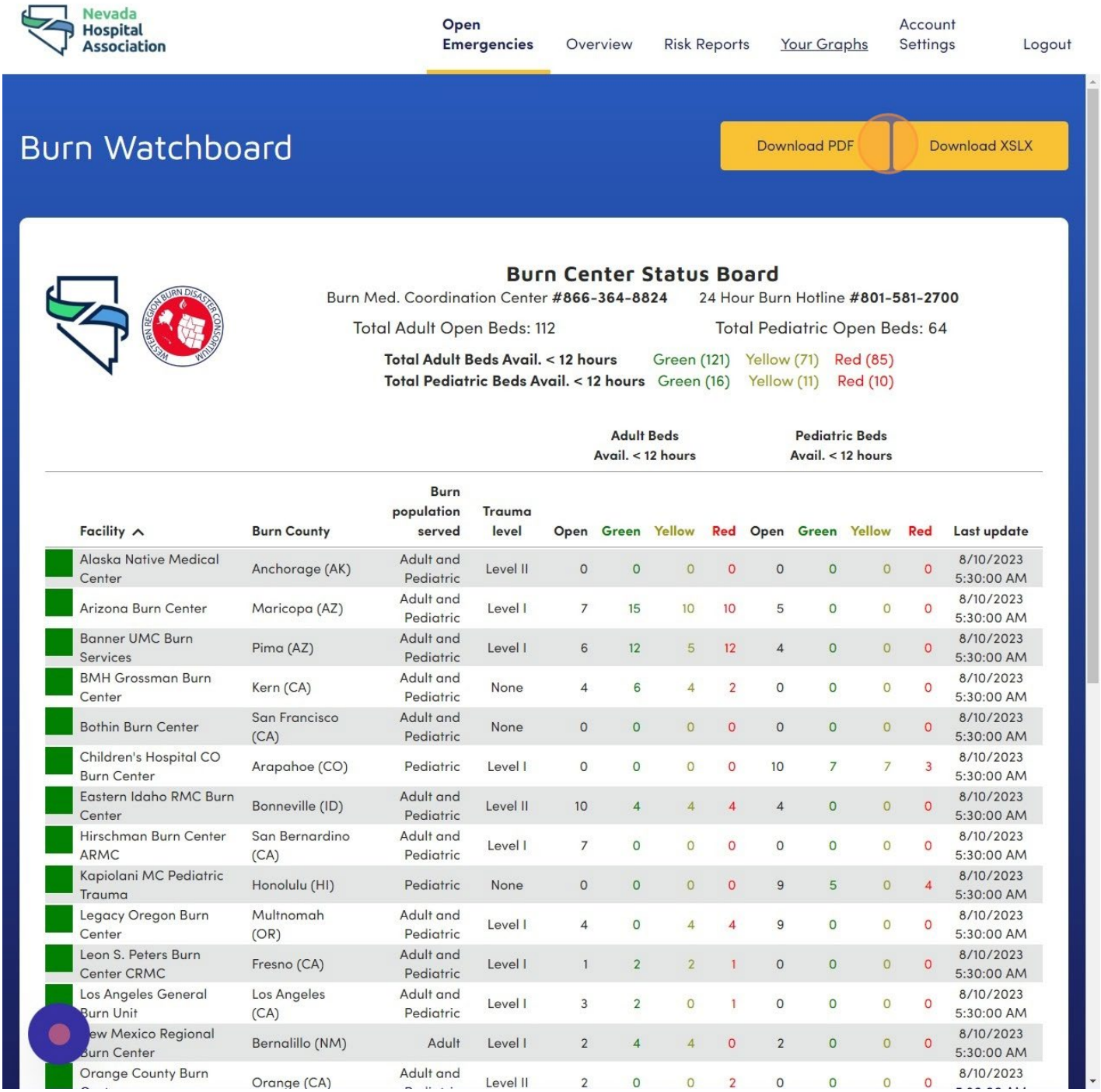
Red (critical): >20% TBSA 2nd/3rd Degree Burn. Burns with multiple traumas, burns with definitive airway compromise. Red patients will most likely need ventilators, your facility must have the proper amount of equipment!

Pediatrics are defined as anyone under the age of 14 years old.

Burn Bed Count Process:
When requested by the WRBDC Coordinator, all burn centers enter their burn bed availability into the system via the status update tab. Contact the WRBDC Coordinator or chris@nvha.net with any system issues.

Instructions for using the Burn Watchboard:

1. Navigate to proseko.prosekoconsulting.com/login.
2. Enter email address and password, and click to agree to terms of use.
3. Click "Login".
4. From the home or overview screen, click "Open Emergencies" near the top. From the dropdown menu, click "Burn Watchboard". (See picture on next page).
5. The Burn Watchboard will appear, showing all burn centers in the region and total available beds. This Burn Watchboard can be sorted by any column headers by clicking on the title you wish to sort. A pdf file or Excel document can also be downloaded by clicking the applicable button at the top right of your screen.
6. To see historical bed census data, go back to the home screen and click on the "Burn Counties" section on the left-hand side. Graphs will appear, showing adult and pediatric surge capacity. Hover your cursor over a date for specific data. Click or unclick the check marks in the graph legends to display those data elements.
7. If you select a county from the menu, you will see the aggregate data for that county.
8. If you are associated with a burn center, you can select your county, and your burn center's name will appear. Click on your burn center's name to see the data entered specifically for your center. You cannot see data for other burn centers.



Burn Center Status Board

Burn Med. Coordination Center **#866-364-8824** 24 Hour Burn Hotline **#801-581-2700**

Total Adult Open Beds: 112 Total Pediatric Open Beds: 64

Total Adult Beds Avail. < 12 hours Green (121) Yellow (71) Red (85)
Total Pediatric Beds Avail. < 12 hours Green (16) Yellow (11) Red (10)

					Adult Beds Avail. < 12 hours				Pediatric Beds Avail. < 12 hours				
Facility	Burn County	Burn population served	Trauma level	Open	Green	Yellow	Red	Open	Green	Yellow	Red	Last update
Alaska Native Medical Center	Anchorage (AK)	Adult and Pediatric	Level II	0	0	0	0	0	0	0	0	8/10/2023 5:30:00 AM
Arizona Burn Center	Maricopa (AZ)	Adult and Pediatric	Level I	7	15	10	10	5	0	0	0	8/10/2023 5:30:00 AM
Banner UMC Burn Services	Pima (AZ)	Adult and Pediatric	Level I	6	12	5	12	4	0	0	0	8/10/2023 5:30:00 AM
BMH Grossman Burn Center	Kern (CA)	Adult and Pediatric	None	4	6	4	2	0	0	0	0	8/10/2023 5:30:00 AM
Bothin Burn Center	San Francisco (CA)	Adult and Pediatric	None	0	0	0	0	0	0	0	0	8/10/2023 5:30:00 AM
Children's Hospital CO Burn Center	Arapahoe (CO)	Pediatric	Level I	0	0	0	0	10	7	7	3	8/10/2023 5:30:00 AM
Eastern Idaho RMC Burn Center	Bonneville (ID)	Adult and Pediatric	Level II	10	4	4	4	4	0	0	0	8/10/2023 5:30:00 AM
Hirschman Burn Center ARMC	San Bernardino (CA)	Adult and Pediatric	Level I	7	0	0	0	0	0	0	0	8/10/2023 5:30:00 AM
Kapiolani MC Pediatric Trauma	Honolulu (HI)	Pediatric	None	0	0	0	0	9	5	0	4	8/10/2023 5:30:00 AM
Legacy Oregon Burn Center	Multnomah (OR)	Adult and Pediatric	Level I	4	0	4	4	9	0	0	0	8/10/2023 5:30:00 AM
Leon S. Peters Burn Center CRMC	Fresno (CA)	Adult and Pediatric	Level I	1	2	2	1	0	0	0	0	8/10/2023 5:30:00 AM
Los Angeles General Burn Unit	Los Angeles (CA)	Adult and Pediatric	Level I	3	2	0	1	0	0	0	0	8/10/2023 5:30:00 AM
ew Mexico Regional Burn Center	Bernalillo (NM)	Adult	Level I	2	4	4	0	2	0	0	0	8/10/2023 5:30:00 AM
Orange County Burn	Orange (CA)	Adult and	Level II	2	0	0	2	0	0	0	0	8/10/2023

C. WRBDC JOB ACTION SHEETS

WRBDC COORDINATOR

COORDINATION CENTER – JOB ACTION SHEET

Immediate/First 24 Hours Activities	Done	Date	Time
Partner Notification – notify ABA leadership and WRBDC members of the BMCI, and enlist help as necessary.	❑		
Burn Bed Census – conduct bed census counts immediately to identify available burn beds for patient transfer.	❑		
Assistance Requests – request assistance (including resources, transferring and/or care of patients) from region member facilities, EMS, and/or adjacent regions.	❑		
Situational Awareness – provide updates to WRBDC members, partners and all other appropriate agencies, including bed census reports and incident action plans (IAPs) or situation reports.	❑		
Burn Physician Patient Reviews – notify on call Burn MDs and assign patients for review of images, utilizing telemedicine or burn app	❑		
Initial Patient Coordination – assist the affected local burn center and state public health in determining appropriate patient destinations and transportations.	❑		
Technical Resource Sharing – push out just in time burn injury training resources to affected facilities/ coalitions.	❑		
Ongoing Response Activities	**Done**	**Date**	**Time**
Bed Matching – assist with bed matching, ie finding the right bed and facility for each patient requiring transfer coordination, being mindful of family units staying together.	❑		
Patient Information - facilitate the exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations.	❑		
Patient Tracking - assist with the tracking of patient movement including arrival at destination centers.	❑		
Situational Awareness – continue to provide updates to all partners, including bed census reports and incident action plans (IAPs) or situation reports as necessary.	❑		
Resource Requests – assist with requests for tissue bank products, graft equipment or other specialized supplies, in collaboration with the ABA as necessary.	❑		
Federal Partner Coordination – assist with staff and supply needs in collaboration with ASPR Regional Emergency Coordinator (REC) and the ABA.	❑		
Demobilization	**Done**	**Date**	**Time**
Outpatient Follow-up – assist in disseminating outpatient follow-up guidance for burn patients in the affected area as requested.	❑		
Incident Conclusion - establish when the BMCI has concluded, in collaboration with state and regional partners.	❑		
After Action - identify any post-incident system needs and initiate the After Action Report process.	❑		

WRBDC MEDICAL CONTROL
COORDINATION CENTER – JOB ACTION SHEET

Immediate & Ongoing Activities	Done	Date	Time
Technical Assistance – assist the affected local burn center and/or non-burn facility by providing expert advice or telemedicine as requested.	❑		
Patient Destinations – assist the affected local burn center and state public health in determining appropriate patient destinations and transportations.	❑		
Bed Matching – assist with bed matching, ie finding the right bed and facility for each patient requiring transfer coordination, being mindful of family units.	❑		
Patient Information – facilitate the exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations, in collaboration with the coordinators.	❑		
Resource Requests – facilitate requests for tissue bank products, graft equipment or other specialized supplies in collaboration with local and state partners and the American Burn Association (ABA).	❑		
Demobilization	Done	Date	Time
Outpatient Follow-up – assist in disseminating outpatient follow-up guidance for burn patients in the affected area as requested, in collaboration with coordinators.	❑		
After Action - identify any post-incident system needs and participate in the After Action Report process.	❑		

D. WRBDC BMCI PATIENT MEDICAL DATA FORM

MRN: _____
Date & Time:_____ **Mode of Transport & ETA:**_____

Name: _____ **DOB:** _____ **Age:**_____ **Sex**: M/F **Weight:**_____ kg/lb
Burn Date: _____ **Burn Type:** _____ **TBSA:**_____
Mechanism of Injury:_____ **Inhalation injury:** Y/N **Intubated:** Y/N
Fluid Resuscitated: Y/N **Peripheral IV:** ☐Central Line ☐A-Line **Escharotomy:** ☐ **Fasciotomy**: ☐

Referring Hospital: _____
Referring Physician:_____ Contact Number:_____
Accepting Hospital: _____
Accepting Physician: _____ Contact Number : _____
Telemedicine Completed: Y/N
Notification: ☐Spouse/S.O. ☐Parent ☐Other: _____
Name: _____ Contact Number: _____

Code Status: Full code/No code: ☐DNR ☐DNI ☐Advanced directives: Is Document Present: Y/N
Traumatic Injuries: Y/N Type:_____
Last Vital Signs: HR:_____ RR:_____ B/P:_____ Temp:_____ O2 sat:_____
Diabetic: Y/N last meal:_____ **Insulin Drip:** Y/N **Last Blood Sugar** *(date, time & value)*: _____
Tetanus Booster: Y/N (Last Date of Tetanus): _____
Critical Meds- MAR Attached: Y/N *(if not attached: include medication, dose, route &time given)*:_____
_____
Critical Labs:_____
Pertinent DX Exams: _____
_____

Neuro: Dx:_____ GCS:_____ PERRLA:_____
Pulmonary: Dx:_____ ETT Size:_____ Depth:_____ FiO2:_____
Vent Settings:_____ Chest tube: _____ ABG: _____
COVID19 Status: ☐Positive + ☐Negative - ☐Person Under Investigation (PUI)
Cardiovascular: Dx:_____ Rhythm/ Ectopy: _____
Vasoactive Drips:_____
Renal: Dx:_____ Foley: Y/N Volume last hour_____ml
Dialysis: Y/N Last Dialysis*(Date/Time)*: _____
GI: Dx:_____ NPO: Y/N Reason:_____ Feeding Tube: Y/N

Sending Facility

Time & Date Departed: _____
Equipment Sent with Patient: ☐ IV Pumps:_____ ☐ Monitor:_____
☐ Pulse Oximeter:_____ Ventilator/CPAP/BIPAP:_____
Other:_____
Items Sent with the Patient:_____

Receiving Facility

Time & Date Arrived:_____ Received by:_____
Receiving Facility MR#:_____
Equipment Received with Patient:_____
Items Received with patient: _____
_____

WRBDC BMCI PATIENT MEDICAL DATA FORM

MRN:_____

Interpreter: Y / N Language: Sign Language: Y /

COVID19 Status:
Positive + / Negative - / PUI

Past Medical History:

Allergies:

Medications: *(include dose, route & time given)*

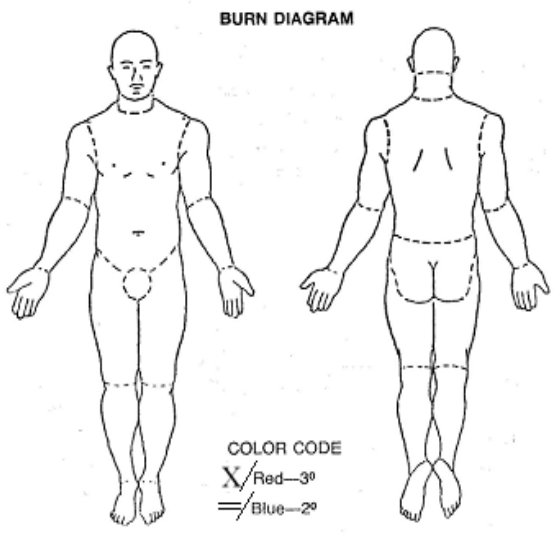
All Continuous IV infusions: *(include rate & dose)*

Feeding Tube: *(include formula type & rate)*

Labs:

Na	Cl	BUN	Gluc	WBC	Hg	Plt	Mag_____
K	CO2	Creat			Hct		Phos_____

Narrative Summary of Care:



E. HOSPITAL TRANSFER DECISION FLOWCHART

Hospital Burn Patient Transfer Decision Flowchart

Note: Flowchart does not supersede local/state protocols

Burn Patients in Non-Burn Facility Requiring Transport

Consult with a **Burn Care physician** via the nearest Burn Center or the Western Region Burn Coordination Center (WRBCC), **866.364.8824**

Obtain/estimate each **patient's age**

Verify total body surface area (TBSA %) using the Rule of Nines and/or the Lund and Browder Burn Estimate Chart with a second practitioner. This should be done after wounds are cleaned and preferably utilizing telemedicine in consultation with a burn center provider.

In collaboration with a Burn Center provider, use the Baux Score and/or Burn Triage Tables to determine the **triage category** (or likelihood of survival) of all patients. Consider transfer of patients in the following priority order (see patient categories and Tables below):

1. Medium, High, and Very High Survival are most likely to benefit from specialized care
2. Low Survival category patients have a mortality rate of 50-90% even with prolonged, intensive resources
3. Very Low Survival category patients have >90% mortality

Determinations regarding which specific patients should be transported and in which order, will ultimately rest with the practitioner's judgement. The following variables, in addition to the Baux Score and/or Burn Triage Table category, should be considered:

- Degree of injury, depth/size of burn, if inhalation injury
- Comorbid factors: renal disease, obesity, liver disease, HIV/AIDS, pulmonary disorders, alcohol abuse, CHF, metastic cancer, peripheral vascular disorders
- Facility capabilities
- Time, distance, transport method(s)

Arrange transport based on patient priority ordering and variables, according to local policies and processes, and complete the **Transfer Checklist.**

Burn Triage Table Patient Categories *Very high, high, and medium survival patients are more likely to benefit from specialized burn care.	
Outpatient	Survival and good outcome expected without requiring initial admission
Very High Survival	Mortality ≤10%, anticipated stay ≤14-21 days, 1-2 surgical procedures
High Survival	Mortality ≤10%, anticipated stay ≥14-21 days, multiple surgical procedures
Medium Survival	Mortality 10-50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures
Low Survival	Mortality 50-90%, even with provision of prolonged, intensive resources
Very Low Survival	Mortality ≥90%, even with prolonged aggressive care

F. CRISIS STANDARDS OF CARE BURN TRIAGE DECISION TABLE

Burn Crisis Standards of Care planning efforts have provided guidelines to follow when numbers of seriously ill patients greatly surpasses the capability of available care and normal standards of care can no longer be maintained. Among the planning documents created for this purpose are burn triage decision tables, as seen on the following page. The tables included here illustrate the anticipated ratio of resources to benefit from the treatment of burns of various sizes in various aged patients. Each category reflects both the volume of resources necessary to care for the patients in each group, and the expected outcome based on data extracted from the American Burn Association National Burn Repository. The 2014 ABA chart has been modified for Utah's Crisis Standards of Care Plan, with permission, and is shown on the next page. The references for this table and the most current one are as follows:

- Original reference: Taylor S et al, Redefining the outcomes to resources ratio for burn patient triage in a mass casualty. *J Burn Care Res 2014;35:41-5*.
- Most recent reference: Kearns RD. et al, Actionable, Revised (v.3) and Amplified American Burn Association Triage Tables for Mass Casualties: A Civilian Defense Guideline. *J Burn Care Res 2020; 41:4*.

Please note that application of these guidelines will require physician judgement at point of care, and their use may require governor approval, depending on state protocols. These tables do not account for other coexisting conditions or concomitant trauma, which should be considered when making transfer or triage decisions.

Use the following color definitions for the Burn Triage Tables found on the following page:

COLORED CATEGORY	DEFINITION
Outpatient	Survival and good outcome expected without requiring initial admission.
Very High	Mortality ≤10%, anticipated length of stay ≤ 14-21 days, 1-2 surgical procedures.
High	Mortality ≤10%, anticipated length of stay ≥14-21 days, multiple surgical procedures.
Medium	Mortality 10-50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures.
Low	Mortality 50-90%, even with provision of prolonged, intensive resources.
Very Low Survival / Expectant	Mortality ≥90%, even with prolonged aggressive care.

CSC BURN TRIAGE DECISION TABLE, CONT.

***Please refer to the explanation, reference & colored categories on the previous page.**

	Burn Size Group, %TBSA All									
Age	0–9.9	10–19.9	20–29.9	30–39.9	40–49.9	50–59.9	60–69.9	70–79.9	80–89.9	≥ 90
0–1.99	Very High	Very High	High	High	High	Medium	Medium	Medium	Low	Low
2–4.99	Outpatient	Very High	High	High	High	Medium	Medium	Medium	Low	Low
5–19.99	Outpatient	Very High	High	High	High	High	Medium	Medium	Low	Low
20–29.99	Outpatient	Very High	High	High	High	Medium	Medium	Medium	Low	Low
30–39.99	Outpatient	Very High	High	High	Medium	Medium	Medium	Low	Low	Expectant
40–49.99	Outpatient	Very High	High	Medium	Medium	Medium	Medium	Low	Low	Expectant
50–59.99	Outpatient	Very High	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant
60–69.99	Outpatient	High	Medium	Medium	Low	Low	Low	Expectant	Expectant	Expectant
≥ 70	Very High	Medium	Low	Low	Low	Expectant	Expectant	Expectant	Expectant	Expectant

	Burn Size Group, %TBSA NO Inhalation Injury									
Age	0–9.9	10–19.9	20–29.9	30–39.9	40–49.9	50–59.9	60–69.9	70–79.9	80–89.9	≥ 90
0–1.99	Very High	Very High	High	High	High	High	Medium	Medium	Medium	Medium
2–4.99	Outpatient	Very High	High	High	High	High	High	Medium	Medium	Medium
5–19.99	Outpatient	Very High	High	High	High	High	High	Medium	Medium	Low
20–29.99	Outpatient	Very High	High	High	High	Medium	Medium	Medium	Medium	Low
30–39.99	Outpatient	Very High	High	High	Medium	Medium	Medium	Low	Low	Expectant
40–49.99	Outpatient	Very High	High	High	Medium	Medium	Medium	Low	Low	Expectant
50–59.99	Outpatient	Very High	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant
60–69.99	Very High	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant	Expectant
≥ 70	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant	Expectant	Expectant

	Burn Size Group, %TBSA WITH Inhalation Injury									
Age	0–9.9	10–19.9	20–29.9	30–39.9	40–49.9	50–59.9	60–69.9	70–79.9	80–89.9	≥ 90
0–1.99	High	Medium	Medium	Medium	Medium	Medium	Low	Low	Medium	Medium
2–4.99	High	High	High	High	High	Medium	Medium	Medium	Low	Low
5–19.99	High	High	High	High	Medium	Medium	Medium	Medium	Low	Low
20–29.99	Very High	High	High	Medium	Medium	Medium	Medium	Low	Low	Expectant
30–39.99	Very High	High	High	Medium	Medium	Medium	Medium	Low	Low	Expectant
40–49.99	Very High	High	Medium	Medium	Medium	Low	Low	Low	Low	Expectant
50–59.99	High	Medium	Medium	Medium	Medium	Low	Low	Expectant	Expectant	Expectant
60–69.99	Medium	Medium	Medium	Low	Low	Low	Expectant	Expectant	Expectant	Expectant
≥ 70	Medium	Medium	Low	Low	Expectant	Expectant	Expectant	Expectant	Expectant	Expectant

G. WRBDC MOBILE TASK FORCE GO-BAGS

BURN COORDINATION CENTER - BURN MASS CASUALTY INCIDENT

PHYSICIAN

Front Pocket - Resources

- ❑ Notebook
- ❑ MD edition resource clip board
- ❑ 1– Sharpie / 4 – Pens / 2-Red/blue pencil / Pencil sharpener
- ❑ Calculator

Second pocket - Personal Supplies

- ❑ Shampoo / Conditioner / toothpaste/toothbrush/bar soap
- ❑ 1 pack wipes / 1 Hand sanitizer
- ❑ 2 pouches-Tylenol /4 tablets- Advil
- ❑ Snack pack – crackers, gum, and granola bars
- ❑ Charging plug

Main Pocket

- ❑ Water bottle
- ❑ Safety glasses
- ❑ 1 – Arrowgard MAC two- lumen Central venous access kit
- ❑ IV start kits (Adult and pediatric)
- ❑ 1-Lac Kit
- ❑ Stethoscope
- ❑ Trauma shears
- ❑ Tourniquet
- ❑ Head lamp
- ❑ Carabiner

REGISTERED NURSE (R.N.)

Front Pocket - Resources

- ❑ Notebook
- ❑ Lippincott drug book for nurses
- ❑ Broselow tape
- ❑ Nursing edition resource clip board
- ❑ 2 – Sharpies / 4 – Pens / Red/blue pencil / Pencil sharpener

Second pocket - Personal Supplies

- ❑ Shampoo / Conditioner / toothpaste/toothbrush/bar soap
- ❑ 1 pack wipes /2 bottles Hand sanitizer
- ❑ 2 pouches-Tylenol /4 tablets- Advil
- ❑ Snack pack – crackers, gum, and granola bars
- ❑ Charging plug

Main Pocket

- ❑ Water bottle
- ❑ Small /medium/large gloves
- ❑ Safety glasses
- ❑ Hats / Gowns
- ❑ Masks / Ear loop masks / N95 regular & small
- ❑ 1 - Full shower table plastic
- ❑ Head lamp
- ❑ Carabiner

Patient Assessment

- ❑ B/P
- ❑ Stethoscope
- ❑ Finger sat monitor
- ❑ Trauma shears
- ❑ Tourniquet

ASSISTANT

Front Pocket - Resources

- ❑ Notebook
- ❑ Nursing edition resource clip board
- ❑ 1 – Sharpie / 4 – Pens / Red/blue pencil

Second pocket - Personal Supplies

- ❑ Shampoo / Conditioner / toothpaste/toothbrush/bar soap
- ❑ 1 pack wipes /bottle Hand sanitizer
- ❑ 2 pouches-Tylenol /4 tablets- Advil
- ❑ Snack pack – crackers, gum, and granola bars

Main Pocket

- ❑ Water bottle
- ❑ Power strip
- ❑ 6-large wound veil packs
- ❑ 13-stat wrap
- ❑ Safety glasses
- ❑ Head lamp
- ❑ Carabineer
- ❑ Stethoscope
- ❑ Trauma shears
- ❑ Tourniquet
- ❑ Burn paperwork
- ❑ Burn CSC Guidelines

H. HIPAA and Disasters: What Emergency Professionals Need to Know

Updated September 11, 2017

Disasters and emergencies can strike at any time with little or no warning and the local healthcare system in the midst of an emergency response can be rapidly inundated with patients, worried family and friends looking for their loved ones, and media organizations requesting patient information. Knowing what information can be released, to whom, and under what circumstances, is critical for healthcare facilities in disaster response. This guide is designed to answer frequently asked questions regarding the release of information about patients following an incident.

NOTE: This guide does NOT replace the advice of your facility Privacy Officer and/or legal counsel who should be involved in planning for information release prior to an event, developing policy before a disaster that guides staff actions during a disaster, and during an emergency when contemplating disclosures.

This guide does address what information can be disclosed and under what circumstances. Covered entities can disclose needed patients' protected health information (PHI) without individual authorization:

- If necessary to treat the patient or a different patient or if the information would help treat a different patient
- To a public health authority, as outlined below
- At the direction of a public health authority, to a foreign agency acting in collaboration with the public health authority
- To persons at risk of contracting or spreading a disease or condition (if authorized by other law)
- With certain people involved with patient's care/ responsible for the patient
- When there is imminent threat to public health/ safety

Covered entities:

- Health plans
- Healthcare clearinghouses
- Healthcare providers (e.g. hospitals, clinics, pharmacies, nursing homes) who conduct one or more covered healthcare transactions electronically.

Business associates:

- Persons or entities that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI.
- Subcontractors that create, receive, maintain, or transmit PHI on behalf of another business associate.

What is HIPAA and the Privacy Rule?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, the HIPAA Privacy, Security, and Breach Notification Rules, protect the privacy and security of patients' PHI, but is balanced to ensure that

appropriate uses and disclosures of the information may still be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes.

Does HIPAA Apply to Me or My Organization?

The HIPAA Privacy Rule applies to disclosures made by employees, volunteers, and other members of a covered entity's or business associate's workforce. Covered entities are health plans, healthcare clearinghouses, and those healthcare providers that conduct one or more covered healthcare transactions electronically, such as transmitting healthcare claims to a health plan.

Business associates generally include persons or entities (other than members of the workforce of a covered entity) that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI. Business associates also include subcontractors that create, receive, maintain, or transmit PHI on behalf of another business associate.

HIPAA does not apply to disclosures made by those who are not covered entities or business associates (although such persons or entities are free to follow the standards on a voluntary basis if desired).

When Can PHI Be Shared?

Patient health information, or PHI, can be shared under the following circumstances:

Treatment. Under the HIPAA Privacy Rule, covered entities may disclose, without a patient's authorization, PHI about the individual as necessary to treat the patient or to treat a different patient. Treatment includes the coordination or management of healthcare and related services by one or more healthcare providers and others, consultation between providers, providing follow-up information to an initial provider, and the referral of patients for treatment.

Public Health Activities. The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to PHI that is necessary to carry out their public health mission. Therefore, the HIPAA Privacy Rule permits covered entities to disclose needed PHI without individual authorization:

- **To a public health authority** that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability, or to a person or entity acting under a grant of authority from or under contract with such public health agency,. This could include, for example: the reporting of disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions.
- **At the direction of a public health authority**, to a foreign government agency that is acting in collaboration with the public health authority.

- **To persons at risk** of contracting or spreading a disease or condition if other law, such as state law, authorizes the covered entity to notify such persons as necessary to prevent or control the spread of the disease or otherwise to carry out public health interventions or investigations.

Covered entities can disclose needed PHI without individual authorization:

- If necessary to treat the patient or a different patient
- To a public health authority authorized by law to collect or receive such information
- At the direction of a public health authority, to a foreign agency acting in collaboration with the public health authority
- To persons at risk of contracting or spreading a disease or condition (if authorized by other law)
- With certain people involved with patient's care/ responsible for the patient for reunification or when in the patient's best interest
- When there is imminent threat to public health/ safety

Disclosures to Family, Friends, and Others Involved in an Individual's Care and for Notification. A covered entity may share PHI with a patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care. A covered entity may also share information about a patient as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care, of the patient's location, general condition, or death. This may include—if necessary to notify family members and others—the police, the press, or the public at large.

- The covered entity should get verbal permission from individuals or otherwise be able to reasonably infer that the patient does not object, when possible; if the individual is incapacitated or not available, covered entities may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
- In addition, a covered entity may share PHI with disaster relief organizations such as the American Red Cross, which are authorized by law or by their charters to assist in disaster relief efforts, for the purpose of coordinating the notification of family members or other persons involved in the patient's care, of the patient's location, general condition, or death. It is unnecessary to obtain a patient's permission to share the information in this situation if doing so would interfere with the organization's ability to respond to the emergency.

Imminent Danger. Healthcare providers may share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public – consistent with applicable law (such as state statutes, regulations, or case law) and the provider's standards of ethical conduct.

Disclosures to the Media or Others Not Involved in the Care of the Patient/Notification. Upon request for information about a particular patient by name, a hospital or other healthcare

facility may release limited facility directory information to acknowledge an individual is a patient at the facility and provide basic information about the patient's condition in general terms (e.g., critical or stable, deceased, or treated and released) if the patient has not objected to or restricted the release of such information or, if the patient is incapacitated, if the disclosure is believed to be in the best interest of the patient and is consistent with any prior expressed preferences of the patient. Reference 45 CFR 164.510(a). In general, except in the limited circumstances described elsewhere, affirmative reporting to the public or media of specific information about treatment of an identifiable patient, such as specific tests, test results or details of a patient's illness, may not be done without the patient's written authorization (or the written authorization of a personal representative who is legally authorized to make healthcare decisions for the patient).

General or aggregate information in mass casualty events that does not identify an individual or meets the requirements of the HIPAA Privacy Rule's de-identification provisions is *not* considered PHI (e.g., X number of casualties were received by the hospital with the following types of injuries).

Minimum Necessary. For most disclosures, a covered entity must make reasonable efforts to limit the information disclosed to that which is the "minimum necessary" to accomplish the purpose. (Minimum necessary requirements do not apply to disclosures to health care providers for treatment purposes.) Covered entities may rely on representations from a public health authority or other public official that the requested information is the minimum necessary for the purpose.

Note: The disclosures listed above are at the discretion of the covered entity and are not required disclosures under the Rule. Some of these disclosures may be required by other federal, state or local laws (for example, mandatory reporting of positive infectious disease test results).

Does the HIPAA Privacy Rule Permit Disclosure to Public Officials Responding to a Bioterrorism Threat or other Public Health Emergency?

Yes. The HIPAA Privacy Rule recognizes that various agencies and public officials will need PHI to deal effectively with a bioterrorism threat or emergency. The public health threat does not have to reach a declared emergency status. If information is needed by a government agency to protect the health of the public (e.g., a food-borne outbreak), the agency may request and receive appropriate clinical and other information about the patient's disease, care, and response to treatment. To facilitate the communications that are essential to a quick and effective response to such events, the HIPAA Privacy Rule permits covered entities to disclose needed information to public officials in a variety of ways. Further, if the covered entity has obligations to report test results and other information to public health agencies by statute, rule, or ordinance, the HIPAA Privacy Rule generally permits these disclosures.

Covered entities may disclose PHI, without the individual's authorization, to a public health authority acting as authorized by law in response to a bioterrorism threat or public health emergency (reference 45 CFR 164.512(b)), public health activities). The HIPAA Privacy Rule also permits a covered entity to disclose PHI to public officials who are reasonably able to prevent or lessen a serious and imminent threat to public health or safety related to bioterrorism (reference 45 CFR 164.512(j)), to avert a serious threat to health or safety). In addition, disclosure of PHI, without the individual's authorization, is permitted where the circumstances of the emergency implicates law enforcement activities (reference 45 CFR 164.512(f)); national security and intelligence activities (reference 45 CFR 164.512(k)(2)); or judicial and administrative proceedings (reference 45 CFR 164.512(e)).

Is the HIPAA Privacy Rule "Waived" or "Suspended" During an Emergency?

The HIPAA Privacy Rule is not suspended during a public health or other emergency; however, under certain conditions the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the HIPAA Privacy Rule section 1135(b)(7) of the Social Security Act, if such a waiver is deemed necessary for the particular incident when the Secretary declares a public health emergency and the President declares an emergency or disaster under the Stafford Act or National Emergencies Act. For more information, access "Is the HIPAA Privacy Rule suspended during a national or public health emergency?" Access Hurricane Irma and HIPPA Bulletin: Limited Waiver of HIPAA Sanctions and Penalties During a Declared Emergency for an example of how sanctions and penalties could be waived in a declared emergency.

Does the HIPAA Privacy Rule Permit Disclosure to Law Enforcement?

A HIPAA-covered entity may disclose PHI to law enforcement with the individual's signed HIPAA authorization. A covered entity may disclose directory information as mentioned above to law enforcement upon request. Further disclosures to law enforcement for purposes of re- unification and family notification are permitted as discussed above.

A HIPAA-covered entity also may disclose PHI to law enforcement without the individual's signed HIPAA authorization in certain incidents, including:

- To report to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.
- To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the premises of the covered entity.
- To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct.
- When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity.
- To report PHI to law enforcement when required by law to do so (such as reporting gunshots or stab wounds).
- To comply with a court order or court-ordered warrant, a subpoena or summons issued

- by a judicial officer, or an administrative request from a law enforcement official (the administrative request must include a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used).
- To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person, but the information disclosed must be limited to certain basic demographic and health information about the person.
- To respond to a request for PHI about an adult victim of a crime when the victim agrees (or in limited circumstances if the individual is unable to agree). Child abuse or neglect may be reported, without a parent's agreement, to any law enforcement official authorized by law to receive such reports.

How Does the HIPAA Privacy Rule Apply to Disclosures Involving Foreign Nationals?

Covered entities may disclose PHI for all persons, regardless of nationality, according to the disclosures listed in the Privacy Rule and discussed above. Disclosure of PHI to embassies, consulates or other third parties, such as the American or International Red Cross acting in a capacity to facilitate notifications or repatriation following an emergency, is permitted under the existing disclosures of the HIPAA Privacy Rule, as referenced above.

For More Information

- Bulletin: HIPAA Privacy in Emergency Situations
- Can healthcare information be shared in a severe disaster?
- Health Information Privacy – Is HIPAA Privacy Rule Suspended during a National or Public Health Emergency?
- Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement
- HIPAA Privacy Rule: Disclosures for Emergency Preparedness – A Decision Tool
- Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations
- Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans. Appendix A: Information Sharing. (Page 29 of 33)
- When does the Privacy Rule allow covered entities to disclose PHI to law enforcement officials?
- HIPAA Policy Brief

For more information on HIPAA and Public Health:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html
For more information on HIPAA and Emergency Preparedness and Response:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/index.html
General information on understanding the HIPAA Privacy Rule may be found at:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

I. WOUND CARE SUPPLY GUIDELINE FOR BURNS

Taken from the Utah Crisis Standards of Care Guidelines, Appendix B: Burn Crisis Standards of Care. Suggested wound care supplies for the treatment of ten patients with 50% TBSA burns for three dressing changes.

Description	Quantity	Notes
Wound Veil (24in x 36 in)	30 packets *Recommend adding an additional 5 packets when possible*	Two sheets per pack. If Wound Veil is unavailable, Adaptic can be substituted. There are approximately six 9x16 Adaptics to one package of veil, equaling 180 packages.
Mesh Gauze (18in x 18in)	30 boxes *Recommend adding an additional 5 packets when possible*	6 gauze per pack
Fluff roll or Kerlix (4.5 x 4.1 yd)	150 rolls *Recommend adding an additional 5 rolls when possible*	Estimated at 5 rolls per dressing
Kerlix sponges (4in x 4in)	30 boxes *Recommend adding an additional 5 boxes if possible*	10 sponges per box
Tubular elastic dressing retainer #1 (otherwise known as netting)	2 boxes	50 yds per box
Netting # 3	2 boxes	50 yds per box
Netting # 5	2 boxes	50 yds per box
Netting # 8	2 boxes	50 yds per box
Netting # 11	2 boxes	50 yds per box
Beta sept 4% (960 ml) or a mild, non-perfumed soap or baby shampoo.	15 bottles of Beta sept 30 bars of soap, 1 per patient per day 30 1 fluid oz bottles of baby shampoo, 1 per dressing change	Can use 5 bottles of Beta sept per day for the 10 patients and pout at a central location; NOT in the patients room due to cross contamination risk.
Basin (large)	15	This number includes 5 extra in case additional are needed.
Scissors sharp/blunt	30 pairs	Could decrease this number to 20
Tape (1 in x 10 yds)	30 rolls	
Elastic bandage (4in x 4.5yd) (Ace wrap)	4 bundles (total of 40 Aces)	10 bandages per bundle

This is a simplified list containing only burn-specific supplies. Other items that could be required would include personal protective equipment, IV tubing, LR (suggest 100 liter bags), topical ointments or silver-impregnated products, warming blankets, heater unit (3 units with 10 blankets), IV/blood warmers with tubing (3 units and 30 sets of tubing). Optimally, supply carts are locked and burn wound care fast reference cards are laminated and tied to the cart. In the event that dressing supplies are exhausted, burn wounds can be placed in a topical ointment/wound product and dressed with clean cotton t-shirts, socks, gloves, biker shorts, onesies, maxi pads or diapers.

J. PEDIATRIC EQUIPMENT & SUPPLIES

Taken from Utah Crisis Standards of Care Guidelines, Appendix A: Pediatric Disaster Surge Planning.

General pediatric equipment, supplies and medications will assist in facility in being prepared to handle any pediatric patient, including a pediatric burn patient. Items should be easily accessible, clearly labeled and logically organized. Staff should be educated on the location and use of all items. The following are suggestions and not intended to be all-inclusive.

General Equipment	
Patient warming device	Length based weight estimator
Intravenous blood/fluid warmer	Age appropriate pain scale assessment tool(s)
Restraint device(s)	Diapers (all sizes), wipes and wee bags for urine collection
Weight scale in kilograms	A minimum of 5 cribs, port-a-cribs or playpens (in storage). If Adult beds are your only option, use beds with side rails, set at lowest possible height and electric controls unplugged

Monitoring Equipment	
Blood pressure cuffs- Neonatal, Infant, Child, Adult-arm	Pulse oximeter with Pediatric and Adult probes
Electrocardiography monitor/defibrillator with Pediatric and Adult capabilities, including pads/paddles	Continuous, end-tidal CO2 monitoring device
Hypothermia thermometer	

Vascular Access Supplies	
Arm boards – Infant, Child, Adult	Umbilical vein catheters - 3.5 F, 5.0 F
Catheter over the needle device - 18, 22, 24 gauge	Central venous catheters - 4.0 F, 5.0 F, 6.0 F, 7.0 F
Intraosseous needles or device - Pediatric and Adult	Intravenous Solutions - Normal Saline; Ringers Lactate; Dextrose 5% in normal saline (+/- 20 KCL)
IV administration sets with calibrated chambers, extension tubing and/or infusion devices with ability to regulate rate and volume.	

Fracture Management Devices	
Extremity splints	Spine stabilization devices appropriate for children of all ages
Femur splints, Pediatric and Adult sizes	

Respiratory Equipment	
Endotracheal Tubes - Uncuffed 2.5mm, 3.0 Cuffed or uncuffed 3.5mm, 4.0, 4.5, 5.0, 5.5 Cuffed- 6.0mm, 6.5, 7.0, 7.5	Laryngoscope handle
Feeding Tubes - 5F, 8F	Magill Forceps

Laryngoscope blades - Straight (size 1, 2, 3) Curved (2, 3)	Nasopharyngeal airways - Infant, Child and Adult
Oropharyngeal airways - Size 0, 1, 2, 3, 4, 5	Stylets for endotracheal tubes - Pediatric and Adult
Suction Catheters - Infant, Child and Adult	Tracheostomy tubes-2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5mm
Yankauer suction tip	Bag-mask device, self-inflating - Infant 450 ml, Adult 1000 ml
Masks to fit bag-mask device adaptor – Neonatal, Infant, Child, Adult	Clear Oxygen masks – Standard Infant, Child, Adult
Partial non-rebreather Infant	Non-rebreather Child and Adult
Nasal Cannulas - Infant, Child, Adult	Nasogastric Tubes - Child 10F, Adult 14-18F
Laryngeal mask airway - Sizes 1, 1.5, 2, 2.5, 3, 4,5	

Specialized Pediatric Trays or Kits	
Lumbar puncture tray (including Infant 22 gauge, Pediatric 22 gauge, and Adult 18-21 gauge), lumbar puncture needles.	Chest tubes, to include Infant, 10-12F, Child 16-24F, Adult 28-40F
Supplies/kit for patients with difficult airway (supraglottic airways of all sizes, laryngeal mask airway, needle cricothyrotomy supplies, surgical cricothyrotomy kit)	Newborn delivery kit, including equipment for resuscitation of an infant (umbilical clamp, scissors, bulb syringe, and towel.)
Tube thoracostomy tray	Urinary catheterization kits and urinary (indwelling) catheters (6F-22F).

Pediatric Medications	
Atropine	Adenosine
Amiodarone	Antiemetic agents (Zofran)
Calcium Chloride or Gluconate	Dextrose (D10W, D50W)
Epinephrine -1:1,000, 1:10,000 solutions	Lidocaine
Magnesium sulfate	Naloxone hydrochloride
Sodium bicarbonate (4.2%, 8.4%)	Activated charcoal
Analgesics – Oral and Parenteral (ibuprofen, Tylenol, fentanyl, morphine, versed, ketamine)	Anti-microbial agents (parenteral and oral) (a minimum of amoxicillin, ceftriaxone, Keflex, clindamycin, flagyl, cefepime or ceftazidime)
Anticonvulsant medications (Ativan or versed)	Antidotes (common antidotes should be accessible to the ED)
Antipyretic drugs (Ibuprofen, Tylenol)	Bronchodilators (albuterol, racemic epinephrine)
Vasopressor agents	Neuromuscular blockers (Rocuronium)
Sedatives (see Analgesics – Oral and Parenteral)	Tetanus vaccine
Inotropic agents (epinephrine and norepinephrine)	3% NS – Hypertonic Saline

K. PEDIATRIC PLANNING RECOMMENDATIONS

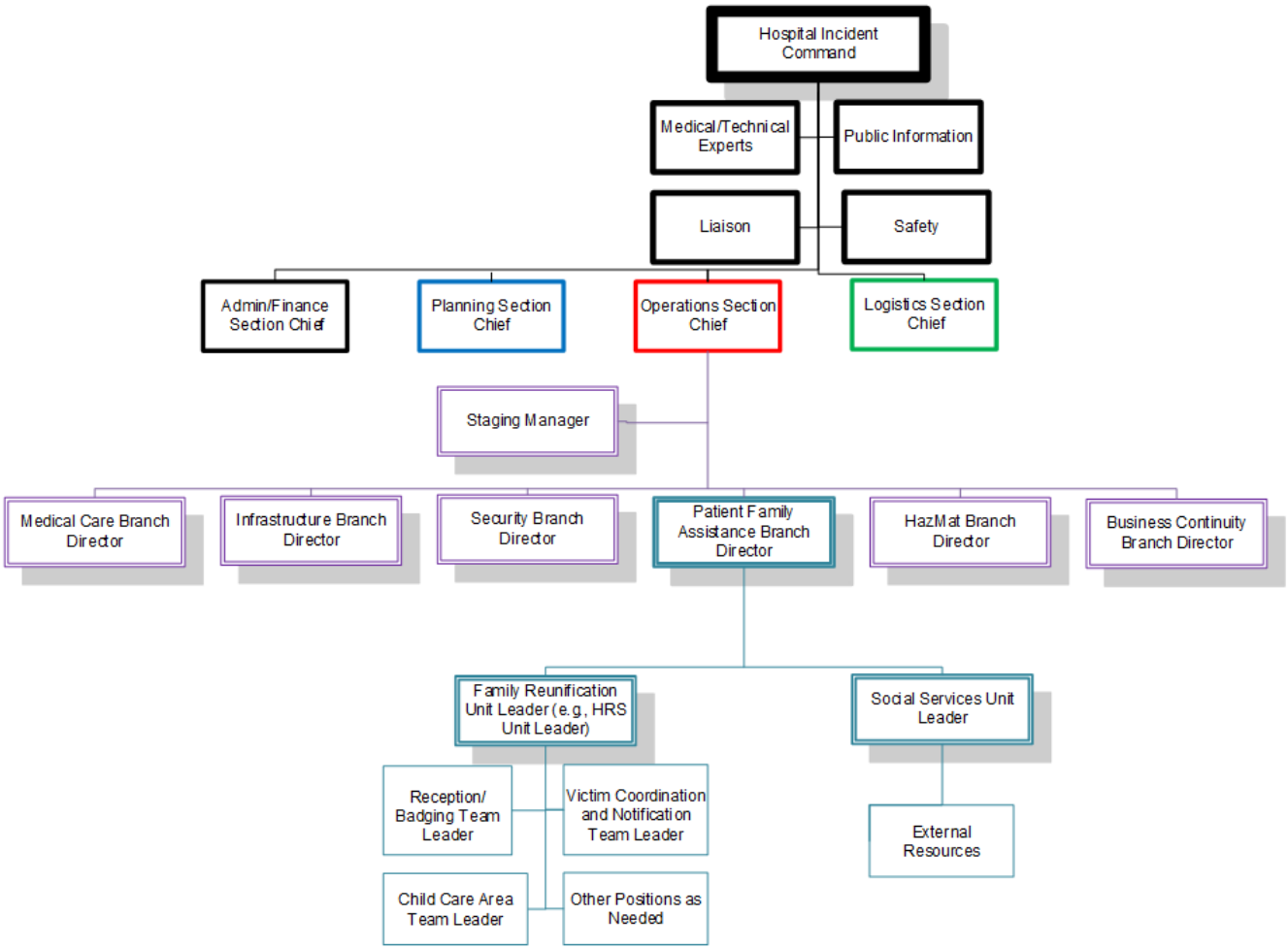
Taken from Utah Crisis Standards of Care Guidelines, Appendix A: Pediatric Disaster Surge Planning.

- A staff pediatric champion should be identified to oversee pediatric planning and policies and serve as a regular member of the Hospital Disaster Committee.
- Identify hospital staff with pediatric experience.
- Pediatric specific training should be conducted for facility staff on a regular basis. This should include Pediatric Advanced Life Support (PALS), and special considerations for dealing with the unique vulnerabilities of children in a disaster situation (dealing with unaccompanied minors, preverbal children, greater body surface area to weight ratio, increased skin permeability, different requirements for decontamination, less intravascular volume reserve). Several courses will help the clinician best care for the pediatric victim of disaster. Recommended courses include PALS and/or Pediatric Education for Prehospital Professionals (PEPP).
- Ensure appropriate pediatric equipment is available.
- Create and stock pediatric carts in designated areas.
- Plan for pediatric pharmaceuticals.
- Provide a length-based standard method for estimating weight in **kilograms** (eg, Broselow Tape). This should be kept in a clearly identified place.
- Plan for providing appropriate pediatric nutrition.
- Plan for the special security needs of children.
- Consider establishing telemedicine capability.
- Add special considerations for children to your hospital decontamination plan.
- Develop and exercise a hospital-based pediatric disaster triage system.
- Provide a well-accepted pediatric reference book. *The Harriet Lane Handbook* is considered an accurate source of information on pediatric diagnosis and treatment. This should be kept in a readily accessible place.
- The following policies for the emergency care of children should be developed:
    - Documentation of pediatric vital signs and actions to be taken for abnormal vital signs
    - Consent including when parent or legal guardian is not immediately available
    - Death of a child in the Emergency Department
- All-hazards disaster preparedness plans / policies that address the following pediatric issues:
    - Patient identification policies must be determined.
    - Decontamination, isolation and quarantine of families and children.
    - Minimization of parent-child separation (includes pediatric patient tracking, and timely reunification to family of separated children).
    - Policies should detail Family Centered Care, including:
        - Involving families in patient care decision making
        - Family presence during all aspects of emergency care, including resuscitation
        - Education of the patient, family and regular caregivers
        - Discharge planning and instruction
        - Bereavement counseling
    - Utilize medical imaging policies that address age or weight-appropriate ionizing radiation dosing for children.
- Maintain policies for sedation and analgesia for pediatric medical procedures.
- Care of children with special healthcare needs.
- Evacuation of pediatric patients.

L. FAMILY REUNIFICATION RESOURCES

The following resources were adapted from the Hospital Reception Site Planning Guide, developed by the Coyote Crisis Collaborative from Arizona and accessible online at _____.

HOSPITAL INCIDENT COMMAND SYSTEM (HICS) CHART



Functions of the Family Reunification Unit:

1. Provide a private and secure place for families to gather, receive and provide information regarding loved ones involved in the incident.
2. Provide a secure area away from the media and curiosity seekers.
3. Provide a pediatric safe zone for uninjured, unaccompanied minors.
4. Facilitate information sharing with hospitals and other partners to support family reunification.
5. Address psycho/social, spiritual, informational, functional, medical and logistical needs to the best of the hospital's ability.
6. Coordinate death notifications when patients die at the hospital and the identity is known.
7. Make appropriate referrals to the Family Reunification Center (FRC).
8. Communicate with the FRC and Emergency Call Center (ECC) regarding victim and family locations, as appropriate. Notify the FRC and ECC about demobilization.

FAMILY REUNIFICATION RESOURCES

DEFINITIONS

Family	Any individuals that consider themselves to be a part of the victim's family, even if there is not a legal familial relationship. This could include friends, partners, legal guardians, caretakers, and loved ones that have defined themselves or are indicated by other family members to be "family".
Immediate Family	A defined group of relations, used in rules or laws to determine which members of a **person's** family are affected by those rules. It normally includes a person's parents, spouses, siblings and children.
Custodial Parent	The parent, also considered the primary care parent, with which a child resides full or part time, depending on court-ordered custody agreements. Most custodial parents have been awarded physical custody of a child by a court of law.
Legal Guardian	A person or entity who has been granted the legal authority (and the corresponding duty) to care for the personal and property interests of another person, called a ward.
Legal Next of Kin	The nearest blood relatives of a person who has died, including the surviving spouse.
Separated Children	Children who have been separated from both parents or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.
Uninjured, Unaccompanied Minors	Children who have been separated from both parents, legal guardians, and other relatives and are not being cared for by an adult who, by law or custom, is responsible for doing so.
Reunification	The process of reuniting family members with their missing or deceased loved one.
Emergency Call Center (The ECC)	Following a mass casualty or mass fatality incident, this designated space is activated as a communications hub to collect information from families and friends of possible victims (integrates Medical Examiner/Coroner interviews); to direct families and friends to appropriate Hospital Reception Sites, Family Reunification Centers, or Family
Emergency Call Center (The ECC) continued	Assistance Centers for reunification and assistance; and to direct other callers to appropriate recipients, such as Public Information Officers.

County Family Assistance Center (Long-term, with activation occurring up to 72 hours after the event)	Following a large mass casualty or mass fatality incident, this designated county or state space is established as a centralized location for families (and friends) to gather, receive information about the victims and grieve, protect families from the media and curiosity seekers, facilitate information sharing to support family reunification (e.g., direct families to Hospital Reception Sites if victims are known to have been transported to the location), and provide death notifications when identity is known. This Center is long-term and may target delivery of a range of services and/or may focus on families and friends of missing or deceased victims.
Family Reunification Center (The FRC is short-term, occurring from the time of the incident up to 12+ hours)	In the immediate hours after a mass casualty or mass fatality incident, this designated community space is established as a centralized location for families (and friends) to gather, receive information about the victims and grieve, protect families from the media and curiosity seekers, facilitate information sharing to support family reunification (e.g., direct families to Hospital Reception Sites if victims are known to have been transported to the location), and provide death notification when patients die and identity is known. This Center is short-term and may be replaced by a Family Assistance Center or shelter in the event the County or State or other jurisdiction deems this to be necessary.
Hospital Reception Site (The HRS remains open from time of incident to 72 hours thereafter or until the Hospital Incident Commander declares "all clear," and the Site demobilizes)	A hospital space designated to provide a private and secure place for families to gather, receive information about the patients and grieve, protect families from the media and curiosity seekers, facilitate information sharing with other hospitals and partners to support family reunification (e.g., direct families to Family Reunification Center if victims are missing), and provide death notification when identity is known per hospital polices and reunite family with known victim at location.
Access and Functional Needs and Support	For purposes of this document, access and functional needs (AFN) are those with physical and cognitive disabilities (blind, hard of hearing, autistic, and so forth), limited or non-English speakers, homeless, and frail and/or elderly. Examples of support services include durable medical equipment (DME), consumable medical supplies (CMS), and personal assistance services (PAS). Individuals requiring functional needs assistance may have physical, sensory, mental health, and cognitive and/or intellectual disabilities affecting their ability to function independently without assistance. Others who may benefit from functional needs assistance include women in the late stages of pregnancy, seniors, and people whose body mass requires special equipment.

FAMILY REUNIFICATION RESOURCES

HOSPITAL RECEPTION SITE EQUIPMENT & SUPPLY LIST

Resource	*Scaling Guide*
Reception/Check-In	
Administrative supplies	As needed
Badging equipment	1 badging machine per 50 clients
Chairs	Number of Tables x 2
Clipboards	1 per staff at registration
HRS forms	Multiple copies for staff
Signage	As needed
Tables	1 per 2 filled positions
Telephones	1 per 2 filled positions
Telephone lists	1 per phone
Assembly Area	
Chairs	Enough for all clients
Communications boards	1 or more as needed
Audio/visual equipment	2 microphones, 4 speakers, 1 projector, 2 screens, 1 remote
Podium	1
Signage	See below
Tables	As needed
Charging station	
Trash cans	
Family Interview/Notification/Counseling Rooms	
Administrative supplies	As needed
Chairs	6 for family, 1-2 for staff
Internet Access	
Signage	As needed
Tables	1
Telephones	1
Telephone lists	1 per phone
Tissues	As needed
Trash cans	
Child Care Area	
Age-appropriate toys	As appropriate
Cribs/cots	
Diaper changing tables	
Diapers	
Formula	
Digital camera	1
First aid kit	1
Folding partitions	As needed
Linens, blankets, pillows	

Rest mats	
Small refrigerator	1
Trash cans	
Meal Area (As Appropriate)	
Food	3 meals a day throughout duration of operations
Signage	
Tables and chairs	1 table per 2 clients (rectangular) or 1 per 8 clients (round) and 8 chairs per table
Trash cans	
Victim Coordination Area	
Administrative supplies	As needed
Chairs	
Internet Access	
Tables	1 per counseling room
Telephones	
Tissue	
Command Meeting Area	
Chairs	1 per staff member
Tables	2 staff per table
Conference Call Phone	1
Staff Area	
Administrative supplies	As needed
Chairs	1 per staff
Conference call phones	1
FAX machine	1
Photocopier and supplies	1
Printer	1
Radio	1 for each member command staff, section chief, and branch directors. Others if possible.
Signage	1
Tables	Able to seat all command staff
Telephones	3
Telephone lists	1 per phone
Trash cans	
Other Supplies	
AED	As required
Fire extinguisher	As required
Wheelchairs	

FAMILY REUNIFICATION RESOURCES

FAMILY & FRIENDS INTAKE FORM

Name:
Phone Number:
Address:
Relationship to Missing Person:
Missing Person Information: Name:
Gender:
Age:
DOB:
Height/Weight:
Race:
Hair Color:
Eye Color:
Tattoos/Other Identifiers:
Occupation:
Primary Language:
Notes:

FAMILY REUNIFICATION RESOURCES

CHILD IDENTIFICATION FORM

Name of child: _____

Age:_____ DOB:_____ Male:_____Female:_____

Address, if available: _____Phone:_____

Uninjured/unaccompanied minor, circumstances (who, where, when, clothing, etc.)

Eye color: _____ _____ Hair color: _____

Distinguishing Marks_____

_____

_____

Name of accompanying adult:

Age:_____ DOB:_____ Male:_____ Female:_____

Relationship to child: _____

Accompanying adult treated for illness or injury? Yes___ No___

Admitted? Yes___ No__ If so, where? _____

Does the child or adult have an ID band? Yes___ No__

Is there a photograph of the child? Yes___ No__ If so, where is the information catalogued (such as a school)?

M. TRANSPORTATION GUIDELINES TO REDUCE THE SPREAD OF INFECTIOUS DISEASE

MAKE TRANSPORT DECISIONS QUICKLY

- It is critical that transport decisions regarding burn injured patients with a highly infectious disease are made quickly to avoid further decompensation and deterioration of patient's condition.

CONSIDER ADVANCED LIFE SUPPORT & AIR AMBULANCE

Advanced Life Support personnel may be required in case of decompensation of the patient.

- Many small rural agencies have advanced EMTs rather than paramedics. Advanced EMTs can manage the airway, however they are only approved to administer a limited number of medications. They are likely able to manage a moderately ill patient.
- Advanced EMTs may not be appropriate depending on the condition of the patient. If a higher level of care is deemed necessary, air ambulance transfer will likely be required.

LIMIT RISK OF DISEASE SPREAD

- Non-intubated patient: Risk of droplet contact with non-intubated patient.
- Patient requiring oxygen: Consider nasal cannula when possible to avoid possible aerosolization and droplet spread within an oxygen mask.
- Patient requiring bronchodilator: Nebulizer treatments will put the crew at greater risk of airborne exposure.
- Ventilator dependent: some smaller agencies may not have ventilator capability.
- Hemodynamic instability: This will present a challenge especially with longer transport. Consider stabilizing patients prior to transfer while maintaining isolation.

COORDINATE TRANSFER TIME

- Once a transport decision is made, coordinate the transport to eliminate the transporting agency having to wait for extended periods of time. Consider the time needed for the transport agency to arrive at the facility when coordinating transport.
- If transport is determined immediately to be needed, call the transporting agency and ask for an ETA and coordinate times with them to minimize time transferring crew waits for the patient to be ready.

SHORTEN TRANSPORT TIMES

- Consider the distance and time of transport when making a transport decision. For a very high-risk, potentially unstable patient, shorter transport times will lead to less exposure to the transporting crew.

- Ground transport should be limited for shorter trips if possible, otherwise air transport may be more appropriate.

NOTIFY DISPATCH OF INFECTIOUS DISEASE STATUS

- When speaking with dispatch, advise them that the patient has tested positive for a highly infectious disease, or is a person under investigation (PUI).
- Notify dispatch of all the necessary medical equipment, ventilators, medication pumps, personal protective equipment (PPE), etc.

COORDINATE AIR AMBULANCE TRANSPORTS

- All potential air ambulance transports need to be communicated to the WRBDC and other applicable agencies.
- As a highly infectious disease spreads, critically ill patients will increase, and air ambulances may be stretched thin, resulting in increased wait times for transfer by air ambulance.

SECURE THE AIRWAY PRIOR TO TRANSPORT

- If advanced airway is required, or anticipated, secure the airway prior to transferring the patient to avoid having to secure an advanced airway in the confined space of an ambulance or air ambulance.

NOTIFY DISPATCH ASAP OF PPE REQUIRED

- Advise the transporting crew dispatch of the PPE required during transport as soon as that is established. Most agencies will not readily have PAPR available and may need to gather appropriate PPE. This will prevent having to call another crew with appropriate PPE.
- Be aware rural transporting agencies will likely have much less variety and possibly availability of PPE.

MINIMIZE TRANSPORTING CREW EXPOSURE

- The goal is for EMS to be in the receiving Burn Center the shortest amount of time possible to avoid further contamination.
- When giving / receiving a patient report with the transporting agency, do so outside of the patient isolation room to minimize exposure.
- Observe, encourage, and ensure the transporting agency has proper PPE donned prior to entering the patient room or any patient contact.
- If air ambulance, we recommend the pilot remain outside the hospital to minimize exposure.

N. WESTERN REGION BURN CENTER TELEMEDICINE CAPABILITIES

The following details can help connect local healthcare facilities with nearby burn centers, to facilitate burn physician review of patient images.

Facility Name	Burn Center Number	Telemedicine Capabilties
Alaska		
Alaska Native Medical Center (Trauma Center with Burn Capabilities)	907-563-2662	Yes
Arizona		
Arizona Burn Center at Valleywise Health	Bed desk- 602 694- 4600 Main Operator 602-344-5726	Hard-wired and internet •HD Sony & Polycom telemedicine/conferencing codecs+Tandberg Video Bridge •Isolated network •Lease Vidyo licenses. Zoom, polycom and Cisco.
Banner University Medical Center, Tucson	520- 694- 0111	Yes
California		
Bakersfield Memorial Hospital Grossman Burn Center	661-323-2876 Burn Center 661-327-4647	Yes, InTouch
The Edward G. Hirschman Burn Center at Arrowhead Regional Medical Center	909-580-2100	Store and forward of digital images
Community Regional Leon S. Peters Burn Center	559-459-4220	Yes
Southern California Regional Burn Center at LAC & USC Medical Center	323-409-7991	Scanning pictures
UCI Regional Burn Center	714-456-5304	Store and forward of digital images
Firefighters Burn Institute Regional Burn Center UC Davis Medical Center	916-734-3636	No
Shriners Hospitals for Children - Northern California	916-453-2111 (ICU)	Yes
UCSD Regional Burn Center	619-543-6502	Yes - zoom platform
Bothin Burn Center at Saint Francis Memorial Hospital	415-353-6255	Designated cell phone for pictures
Santa Clara Valley Medical Center Regional Burn Center	408-885-6666	No
Orange County Global Medical Center	714-953-2377 clinic 714-953-2503	No
Torrance Memorial Medical Center	310-517-4622	No
The Grossman Burn Center-West Hills	818-676-4177	Yes
Colorado		
University of Colorado Hospital Burn Center	720-848-7583	Picture Scanning and Telemedicine
Children's Hospital Colorado	303-549-4636	Yes
Burn and Reconstructive Center at Swedish Medical Center	Transfer Access Number: 888-796-6378 BICU 303 788-7171	Yes
Western States Burn Center	970- 810-6099 Back up number 970-810-2283 (Burn and ICU CN)	Vidyo live format and image store and forward. Outpatient audiovisual telemed via Microsoft teams. Acute consultation from outlying facilities - can receive text or emailed photos to the burn physician on call, initiated by calling the transfer center: 866-806-6262. Back up number is 970-810-2283 - (burn and ICU CN) ask for burn attending.

Hawaii		
Straub Clinic and Hospital Burn Unit	808-522-3731, 808 522-4000	Yes
Kapi'olani Medical Center for Women & Children	808 983-6000	Yes
Idaho		
Eastern Idaho Regional Medical Center Burn and Reconstructive Centers of Idaho	Burn CNC 208-881.1757 Burn ICU desk 208.529.7855	Yes
Nevada		
Lions Burn Center-UMC	702-383-2268	No
Sunrise Hospital and Medical Center	Burn Center 702 961-6470 Referral center 855 863-9595 Clinic number 702 961-7552	No
New Mexico		
New Mexico Regional Burn Center	505-272-2721	No
Oregon		
Oregon Burn Center	503-413-4232	No telemed on unit, but use RITA PICS that is utilized by all hospitals in area
Utah		
University of Utah Health Burn Center	801-581-2700	Elizabeth Mark; 801.897.7620; u0522640@utah.edu•Polycom system on an isolated network to Montana, Utah and Wyoming. This system is open to incoming calls when dialing our IP address•Telemedicine bridge•Intouch laptop/robot system connecting to Idaho, Grand Junction CO and Nevada • Vidyo for some sites. Store and forward with encrypted email address. Use Medpic app and also have encrypted email link.
Washington		
University of Washington Regional Burn Center	206-744-3127	All calls go thru the UW Medicine Transfer Center 24/7 at 1-888-731.4791

Please also see the Western Region Burn and Trauma Centers spreadsheet, which outlines each Western Region state's hospitals and their associated trauma levels. Click on the link below:

Western Region Burn and Trauma Centers Spreadsheet

O. BMCI PATIENT TRACKING SHEET For Use in the WRBDC Coordination Center

STATE:

FACILITY NAME:

Patient Name (Last, First, MI)	Contin. IV Infusion	Venti-lated	% TBSA	Traumatic injuries	Tele-medicine done	Co-morbidities (include COVID status)	Green	Yellow	Red	Priority (High, Med, Low)	Ideal transport method	POC at receiving facility	POC Number	Patient transfer done
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				

FACILITY NAME:

Patient Name (Last, First, MI)	Contin. IV Infusion	Venti-lated	% TBSA	Traumatic injuries	Tele-medicine done	Co-morbidities (include COVID status)	Green	Yellow	Red	Priority (High, Med, Low)	Ideal transport method	POC at receiving facility	POC Number	Patient transfer done
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				
		Y N			Y N					H M L				

P. WRBDC BURN PHYSICIAN ON-CALL SCHEDULE

Month	Dates on Call	Burn Center	Direct #	Physician Name	Cell #	Alternate Emergency #	Email Address
January							
(Backup)							
February							
(Backup)							
March							
(Backup)							
April							
(Backup)							
May							
(Backup)							
June							
(Backup)							
July							
(Backup)							
August							
(Backup)							
September							
(Backup)							
October							
(Backup)							
November							
(Backup)							
December							
(Backup)							

Q. IMPROVEMENT PLAN MATRIX TEMPLATE

This Improvement Plan has been developed for the Western Region Burn Disaster Consortium as a result of the *insert name of incident or exercise* that occurred on *date*. *Insert gaps in planning / preparation for a burn surge that were noted during the exercise by participants and by exercise evaluators. Together with the response team, determine corrective actions needed, who is responsible for their completion, and mark start and finish dates. Use this document to track progress on gap closure. *

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element	Responsible Organization	Start Date	Finish Date
Healthcare & Emergency Medical Services	*Gap noted from exercise*	*How gap can be closed*	*Example: Planning, Training, Equipping, Exercising	*Who will see that corrective action occurs*	*Desired start date*	*Mark date when complete
Operational Coordination						

R. BURN SURGE PLANNING RESOURCE TABLE

***Please see the WRBDC's Burn Injury Guidelines for Care for clinical resources and just in time training.**

Burn Training/Resources	Source	Target Audience	Type	Weblink
Hospital Resources				
ABA Burn Center Referral Criteria	American Burn Association	Response, Clinical	Guidance	http://ameriburn.org/wp-content/uploads/2017/05/burncenterreferralcriteria.pdf
Pediatric Response Resources for Burn Surge Facilities	Minnesota Dept of Health	Clinical	Guidance	https://www.health.state.mn.us/communities/ep/surge/burn/pedsorders.pdf
The Rule of Nines and Lund-Browder Charts	State of Michigan	Clinical	Guidance	http://www.michiganburn.org/docs/Rule_9s_Lund_Browder.jpg
Topic Collection: Burns (Extensive Resources & Best Practices)	ASPR TRACIE	Clinical	Guidance	https://asprtracie.hhs.gov/MasterSearch?qt=burns&limit=20&page=1
Emergency Management & Response Resources				
Burn Mass Casualty Incident Operations Plan	Western Region Burn Disaster Consortium	Response, Clinical	Guidance	https://crisisstandardsofcare.utah.edu
Burn Surge Annex	Ann & Robert H Lurie Children's Hospital of Chicago	Response, Clinical	Guidance	https://www.luriechildrens.org/en/emergency-medical-services-for-children/disaster/state-plans/burn-surge-annex/
Extensive Pediatric Response Resources	Western Regional Alliance for Pediatric Emergency Management	Response, Public, Clinical	Guidance, videos, disaster helpline	https://wrap-em.org/
Healthcare Coalition Burn Surge Annex Template	ASPR TRACIE	Response	Guidance	https://files.asprtracie.hhs.gov/documents/aspr-tracie-hcc-burn-surge-annex-template-final.pdf
Pediatric Annex for Burn Surge	State of Michigan	Response, Clinical	Guidance	http://michiganburn.org/img/about/MiBurnVer24_peds.pdf
Extensive Clinical Care & Response Resources	Western Region Burn Disaster Consortium	Response, Clinical	Guidance/ Videos	https://crisisstandardsofcare.utah.edu

Strategies for Scarce Resource Situations	Minnesota Dept of Health	Response	Guidance	https://www.health.state.mn.us/communities/ep/surge/burn/index.html
Burn Prevention & Safety Public Resources				
It Can Happen in a Flash	National Scald Burn Campaign	Public	Guidance	http://flashsplash.org/
COVID-19 Public Resources	American Burn Association	Public	Guidance	http://ameriburn.org/public-resources/covid-19-public-resources/
Burn Prevention	CDC	Public	Guidance	https://www.cdc.gov/safechild/burns/index.html
Burns Facts & Prevention	World Health Organization	Response	Guidance	https://www.who.int/news-room/fact-sheets/detail/burns
Fire & Burn Safety	Children's Safety Network	Public	Guidance	https://www.childrenssafetynetwork.org/injury-topics/fire-burn-safety

S. WRBDC CONTACTS AND TRAINING & EXERCISE DOCUMENTS

WRBDC Burn Disaster Coordinators

Annette Newman, MS, RN CCRN
Disaster Consultant, Utah Hospital Association
ABA Western Region Burn Disaster Coordinator
Cell: 435-901-1425
Email: annettenewman2020@gmail.com

Mindy Colling, MPH, MEP
Preparedness Consultant/Burn Disaster Coordinator
Colling for Preparedness
Cell: 801-509-8362
Email: collingforpreparedness@gmail.com

Kevin M. McCulley
Chief Operations Director,
Pediatric Pandemic Network
Cell: 801-641-1295
Email: kmcculley@gmail.com

All Western Region Burn Disaster Consortium plans, the "Prolonged Care of the Burn Patient in a Non-Burn Facility Following a Burn Mass Casualty Incident E-Learning modules, and Crisis Triage Officer Training are located on the following website:

https://crisisstandardsofcare.utah.edu

WRBDC 24/7 Disaster Line:
866-364-8824

WRBDC Training & Exercise Documents

Burn Injury Guidelines for Care (Clinical Training):

Burn Surge Exercise Toolkit (For Testing a Burn Surge Plan):