Med-Care Ambulance Service

Mass Casualty Plan

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Med-Care Ambulance MCI Plan
Record of Updates/Revisions

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PREFACE

This plan is intended to be utilized in emergency mass casualty situations involving multiple casualties within Med-Care Ambulance Services response area and the operational boundaries of the participating EMS systems.

This plan should be implemented whenever a mass casualty incident develops which requires resources beyond the normal day-to-day operations, mutual aid or which may overwhelm an individual department, service, hospital or community.

This plan provides for a uniform operational guideline for handling mass casualty incidents within the structure of the National Incident Management System (NIMS).

PURPOSE

This plan defines and coordinates the medical and ancillary resources within Med-Care Ambulance Service to achieve the following:

1. Establish an EMS and Unified Command System Management Structure
2. Effective utilization of services in the area.
3. To define common terms and language.
4. To provide an organized and effective response plan and on scene operations while operating at the scene of a mass casualty incident, to save lives and limit the casualties.

OVERVIEW OF THE PLAN

The Incident Command/Management System is established according to Med-Care Ambulance Policy and will follow NIMS guidelines, with higher ranking officers assuming Incident and EMS Command upon their arrival. Appropriate mutual aid is requested through Oxford Regional Communication Center (ORCC). Any special equipment such as the Mass Casualty Incident (MCI) Trailer or the IMAT vehicle should be requested as early as its need is identified. See Appendix C for list of important resource numbers.

EMS Command will be immediately assign an EMS Branch Director to oversee all EMS operations within the immediate scene and will coordinate patient and resource management including triage, on scene treatment, and on scene patient loading and transportation determinations.

If necessitated by the magnitude of the incident where more than one entity assigns an operations officer it will be determined by Incident Command as to who will be the
overall Operations Section Chief Officer and who will be reassigned as Branch Directors within their particular designation.

The EMS Branch Director will notify EMS Command of the nature of the incident, the approximate number of patients involved, and will advise command if “this is a mass casualty incident”. The EMS Branch Director may also request assignment to an alternate channel/frequency for further communications.

Triage is initiated as soon as possible, utilizing the Step-Up-To Mass Casualty Incidents Horizontal Triage system. The START (Start Triage and Rapid Transport) method shall be the triage method of choice, however, other methods may be employed so long as primary triage does not place tags. METTAG’s will be applied to each victim by the Secondary Triage Officer.

EMS Command will immediately notify ORCC what level of response they will need to handle the event and then he/she will notify the Rumford Hospital that a Mass Casualty Incident has been declared and advice them of an approximate patient count. EMS Command will secure the Rumford Hospital Frequency as a communications link for the Rumford Hospital Command and the EMS Command to communicate throughout the event.

Rumford Hospital will contact all potential receiving facilities requesting their bed and patient capability. Rumford Hospital will notify these facilities of the nature of the incident and the approximate numbers of casualties. Rumford Hospital will then communicate with the EMS Commander the transport plan and hospital capabilities. Rumford Hospital will continue to update this information to avoid overloading any individual receiving facility. Determination of patient destination must be a collaborative decision between field and hospital personnel to account for uncontrollable variables in hospital capability such as an influx of patients arriving by private transportation.

The EMS Branch Director will obtain an updated count of victims and METTAG categories, from the Secondary Triage Officer, and report this information to EMS Command.

A hospital medical team may be requested for specific patient needs such as prolonged entrapment or special procedures and transport.

A staging area will be established by EMS Command. Arriving vehicles and personnel will report to the staging area and remain in their ambulances at all times, awaiting assignment. The EMS Branch Director should consider delegating direct communication between the Treatment and Loading Officers with the Staging Officer for assignment of personnel and transporting ambulances.

Any additional branches needed such as fire suppression, rescue, hazard control will be under the jurisdiction of the Incident Commander and appointed as needed. As the event
expands the Incident Commander may reassign a new operations section chief depending upon which agency has a lead role in the event.

Patients are triaged and then moved to the patient treatment area for initial treatment and assignment to a transporting ambulance. The safe and efficient packaging of patients is a critical role that can not be hastily performed and will require EMS supervision for every patient. If the environment is not unsafe then the appropriate time will be taken to properly package every patient prior to evacuation to the patient treatment area. The treatment area officer will have direct communications with the Loading Officer to coordinate removal from the treatment area and transport to the appropriate facility. Each ambulance will be notified by the Loading Officer of their destination and instructions for hospital communication. Under most circumstances, transporting ambulances will not contact the hospital unless medical advice is required.

The receiving hospital will be notified by the Loading Officer of the number of patients in the ambulance, their METTAG Identification number, and their triage category.

Transporting ambulances should return to the staging area after delivering their patients unless otherwise instructed by ORCC at the direction of EMS Command.

When all patients have been transported, the EMS Branch Director will notify EMS Command.

INCIDENT MANAGEMENT

The National Incident Management System (NIMS) incorporating ICS shall be used as the basis for the command structure used at any Mass Casualty Incident. This is in keeping with local and national trends. The NIMS system can be adapted and expanded to meet the demands of the crisis involved. On a countywide scale the incident may expand to a large geographic area involving several jurisdictions. A sample NIMS system in larger incidents would include a Unified Command Staff and 4 recognized General Staff accepted sections. These sections would include Operations, Planning, Logistics, and Administration (finance). The Incident Commander directly supervises each Section Chief. The various groups and divisions that would be involved in a Mass Casualty Incident would fit under the supervision of one of these Section Chiefs.

UNIFIED COMMAND

When a Mass Casualty Incident extends to multiple geographic jurisdictions or involves shared management responsibilities with more than one agency in a single jurisdiction, a Unified Command is the most effective emergency management structure.

The Unified Command group would include individuals designated by their jurisdictions or by various key departments within a jurisdiction. This group is responsible for developing overall objectives, strategy and priorities for the incident. In order for effective implementation and communication in achieving these objectives, an Incident Commander is selected from this group to be in charge of incident operations.
Criteria for the selection of an Incident Commander are based on factors such as;

1. Greatest jurisdictional involvement.
2. Greatest number of resources involved.
3. Statutory Authority.
4. Individual qualifications i.e., knowledge of IMS (Incident Management System).

The Unified Command staff assembles at a central location in order to develop their objectives and monitor the incident. This location is usually at or near the incident until such time an EOC (Emergency Operations Center) is established and then it may be moved. In some instances it could be at the Mobile Command Post (IMAT-1). The designated area should afford some privacy from distractions yet it must have communications availability.

NIMS, continues to be the basic framework for the emergency management structure whatever the size of the incident. In larger incidents sections, branches, divisions and other work units are expanded to meet the needs. The establishment of command and command posts remain the same with the exception that direction of the incident becomes a shared responsibility if Unified Command is established.

**SAFETY OFFICER**

The Safety Officer is part of the Command Staff and is appointed by and reports directly to the Incident Commander. This officer is responsible for ensuring the safety of rescuers and victims, and must enforce all safety rules on the scene. This includes wearing of appropriate protective clothing, proper protection of patients, as well as being vigilant of unsafe acts or conditions, either due to the incident itself or secondary hazards as a result of the incident.

The safety officer has the authority to order any safety hazard corrected immediately, and must report any such hazards to the Incident Commander. If the incident scene is too large for the Safety Officer to personally monitor, aides should be requested through Incident Command.

**PUBLIC INFORMATION OFFICER**

Media presence at the site of the incident requires Incident Command to establish an effective link through a Public Information Officer (PIO). The Public Information Officer is appointed by the Incident Commander and is a part of the Command Staff. This officer provides a regular place for the media to assemble away from the command post and a single individual to provide the information required for complete and accurate reporting, with timely updates on the progress of the incident. In large events it may be appropriate to establish a Joint Information Center (JIC) where representatives from the various agencies will report to the media on behalf of their particular operations.
All information provided to the media will be issued through the PIO, and these press releases must be approved by Incident Command prior to their release. Remember that the best relationship is an honest one. Tell what happened, what action was taken and the outcome, always doing this in a good taste and with compassion toward the victims and their families. The PIO is also responsible for the safety of the media personnel, and must ensure that they are not allowed to be placed in any potentially hazardous positions or situations.

**ESTABLISHING COMMAND**

**First Unit on Scene**

Regardless of the location, nature or extent of the disaster, the first police officer, fire officer, or EMS unit to arrive on the scene shall verbalize and assume initial command and control authority, and shall:

1. Assess the scene and check for unusual hazards
2. Advise ORCC of the situation, including patient count, if any
3. First arriving Med-Care Unit/Officer will assume EMS Command responsibilities, establish a preliminary command post and advise ORCC of such action, including initial size-up of event, locations of command post, and location of the staging area for incoming ambulances and personnel. This person will remain in command until such time he/she is relieved of these responsibilities by a senior officer
4. Use vehicles and personnel present for EMS Command, EMS Branch Director, Primary and Secondary Triage Officers, Treatment Officer, and Transport Officer.
5. EMS Command shall determine if the situation is an MCI and request the appropriate level response of mutual aid through ORCC.
6. The EMS Command shall as soon as possible notify the Rumford Hospital that a Mass Casualty Incident has been declared and give them any and all information known as to the total amount of patients and the type and extent of injuries.
7. If not already on scene or responding to the scene, make sure that the On-duty Shift Officer, Chief, and Assistant Chief have been notified of the incident.
8. If not already on scene or responding to the scene, request the IMAT vehicle and Team to respond to the incident.
9. If needed, request the MCI trailer be brought to the scene
10. Med-Care Ambulance has outlined in Appendix D the MCI Plan Response Levels that mutual aid ambulance services are to be called. These sheets are organized in levels and are designed while considering geographical relationships within the communities.

In most incidents the senior officer of the Fire Department with jurisdiction on scene will be designated as the overall Incident Commander and a Med-Care Ambulance officer will assume EMS Command and assign an EMS Branch Director. All parties will work collaboratively in efforts to maximize scene activities effectively.

**COMMUNICATIONS**

Effective operations require a combination of communications forms.

Communication provides the connection between management (EMS Command and EMS Branch Director) and personnel (the working units), as well as the link between Command and the outside world.

Effective communications in a Mass Casualty Incident are absolutely critical and require discipline among all units to assure consistent, error free orders and directions.

Several Channels will be required to coordinate on scene operations and should be established as soon as possible to get the various agencies operating on their own individual channels.

**Forms of Communication**

1. **Face-to-Face:** This is the best communications form because the participants can combine a variety of interpersonal methods as they speak.

2. **Radio:** Radio communications provide a remote capability when face-to-face communications are not possible. This form of communication, however, can also lead to messages being misunderstood or not heard at all. It is critical that radio communication be short, concise and made only when necessary as not to tie up the radio frequency and block emergency traffic. When orders are delivered via radio the receiving party should always repeat back the orders to ensure that the message was received appropriately.

3. **Mobile Telephones (cellular):** Provide for a direct link with fixed facilities or other mobile telephones. In times of a disaster, cellular telephone systems become overloaded and hard to utilize. For this reason, cellular telephones should not be considered a primary communications source. When utilizing IMAT 1 there is also the availability of a Satellite Telephone for the usage by the Command Staff.

4. **Standard Operating Procedures:** Effective SOP’s can eliminate the need for verbal communications during critical moments of the operation. Med-Care has both
Standard Operating Procedures as well as Field Operations Guides to assist all personnel with performing their individual responsibilities in an efficient and pre-determined manner.

Communication Procedures

As part of the process of establishing a Command Post, the Incident Commander is also responsible for establishing, maintaining and enforcing effective uncluttered communications.

Paramount in achieving this objective is a thorough understanding of who is responsible for what communications and to whom.

Command therefore, must assign frequencies to operating units, keeping in mind, which sections need to communicate with each other. In the event of a large incident, a Communications Officer or an aide to the EMS Commander for communications may be appointed to control communications. Since a representative of each group (Police, Fire etc.) responding will be at the Command Post, any interagency communications (in the absence of a common frequency) will have to be relayed through the Command Post or the Communications Officer.

Communications

Incident Command shall identify and assign radio frequencies to be used during the incident. Communications shall be established, and a Communications Officer appointed as needed. Command shall utilize only communications equipment that provides adequate communications capabilities with ORCC, Police, Fire and area hospitals. The following frequencies are the most common frequencies available for use at a MCI incident:

- **State EMS:** 155.385
- **State Fire:** 154.310 (Fire Departments)
- **Med-Care Prime (not ORCC):** 155.295
- **Tac 1:** 154.265
- **Tac 2:** 154.280
- **Tac 3:** 154.295
- **Medical Mutual Aid:** 155.280
- **State Wide Car to Car (Law Enforcement)**
CONOPS

The Incident Commander, in conjunction with the Oxford County EMA Director, if needed, shall request through the MEMA Director authorization for CONOPS (Communications Operation Plan). The following are the steps for requesting CONOP:

- The Incident Commander calls MEMA at 1-800-452-8735 to make request to the MEMA Director, or their designee (the 1-800 line is available 24/7).
- Be prepared to identify yourself, your situation, your specific request, and contact information.
- The MEMA Director will consider the request and approve or disapprove in accordance with the criteria listed in the CONOPS Document.
- When the MEMA Director authorizes a CONOPS level, MEMA will request that State of Maine Public Safety Dispatch immediately issue a teletype requesting a general broadcast alert for the region where the incident is occurring. Additionally it shall be included in the information to be broadcast, which channel has been designated as the in-bound frequency for all units responding to the incident. Once on scene, in-bound units will be redirected to the appropriate frequency by the Incident Commander, or their designee. MEMA will also notify the Incident Commander when this occurred.
- All the communication centers with the incident region shall immediately broadcast that a CONOPS incident is in effect, and shall indicate at what level (1-6) so that responders know what channels are now dedicated to the Incident Commander in charge of that incident.
- As the incident escalates, or deescalates the Incident Commander may again call MEMA to adjust the request. If the CONOPS authorization is no longer required, the Incident Commander will contact MEMA to request stand-down of the CONOPS, which in turn will be broadcast by MEMA to all pertinent stations.
- Upon completion of and authorized CONOPS event, the MEMA Director will ensure that an after-action review (AAR) is conducted within a reasonable time.

Guidance Criteria for MEMA Director to Authorizing use of CONOPS Freq.

Should and event occur that meets or exceeds the following criteria;

- An event/incident involving response from 4 or more agencies
- An event/incident involving a duration of at least 6 or more hours
- An event/incident involving response from at least 3 levels of government
- An event/incident where normal use of common simplex (local talk-a-round) channels will not support the incident commanders needs

If any three (3) of the previous criteria are met, the incident commander may request a “CONOPS” level 1 thru 6 be activated to support their operations.
**CONOPS Levels 1 through 6**

There will be six levels of CONOPS to be known as CONOPS 1 through CONOPS 6. These levels correspond to the number of CONOPS frequencies authorized for temporary use to an Incident Commander by the MEMA Director, depending upon the needs of the situation. For example, a CONOPS 3 request would result in the authorization of the first three frequencies for the event: SWSP, NWCC, and EMS/LASAR being dedicated to that particular event for its duration.

**CONOPS Frequencies**

The following are the 6 frequencies associated with CONOPS 1 through 6:

1. SWSP 154.710 State Wide State Police
2. NWCC 155.475 Nation Wide Car to Car
3. EMS/LASAR 155.160 EMS/Land/Air/Search and Rescue
4. SPCC 154.935 State Police Car to Car
5. SWF 154.310 State Wide Fire
6. SWCC 154.695 State Wide Car to Car

**IMPLEMENTATION**

The initial arriving unit of Med-Care Ambulance must determine if the incident is a Multiple Casualty Incident or a Mass Casualty Incident. *Multiple Casualty Incidents* are defined as an incident with more than 2 patients that may require on duty personnel to bring more ambulances to the scene and/or splitting of crews with fire and/or police personnel driving units to the hospital. These incidents can be handled by Med-Care Ambulance personnel on duty at that time. Any incident requiring more resources than mentioned above will be declared a Mass Casualty Incident and the Med-Care Ambulance Mass Casualty Plan will be implemented.

The implementation of the Mass Casualty Plan should be strongly considered when:

1. An incident of such magnitude occurs that requires the marshaling of resources over and above the normal day-to-day pre-hospital care.

2. The nature of illness or mechanism of injury includes adults and/or pediatric populations, totals of:
   a. Four (4) or more critical patients
   b. Two (2) critical with a total of six (6) or more patients, or
   c. One (1) critical with ten (10) or more total patients, or
   d. Fifteen (15) or more non-critical patients
Activation could be withheld under circumstances of very minor complaints/symptoms/injuries when strictly BLS and not requiring oxygen.

**EMS BRANCH DIRECTOR**

The EMS Branch Director, if necessary, will designate Primary Triage, Secondary Triage, Treatment, and Loading Officers to coordinate each of these functions.

EMS Branch Director must first determine the number and extent of injuries and communicate this information and the nature of the incident to EMS Command. EMS Command will then notify Rumford Hospital that a Mass Casualty Incident has occurred. EMS Command must also advise Rumford Hospital which hospitals are closest to the incident site. An alternate channel may be requested for communications, or a cellular phone link may be established and maintained.

EMS Command, after receiving information from the EMS Branch Director, will reassess the **Level of Response** for mutual aid services and upgrade or downgrade as appropriate. See appendix D. It has been determined that 2 levels above what is required to handle the event shall be requested by the EMS Incident Commander. One Level will respond to the Med-Care Station and the Second level above the incident requirements will be sent to the Rumford Hospital to transport out critical patients funneled through the system.

The EMS Branch Director must continually assess the need for additional ambulances, personnel and equipment. This Officer must also, in consultation with EMS Command, assess the need for medical teams. If Lifeflight transportation is requested then the Incident Commander must be notified and a landing zone established.

The EMS Branch Director will be responsible for determining the extent of documentation that is required per incident and will relay that decision to the Loading Officer.

**TRIAGE**

Triage is the process of sorting two or more patients and is accomplished by evaluating the severity of each injury or medical problem. This process is used to determine who will receive care first, using available resources.

Patients are treated after being sorted. At an MCI sorting involves four levels of triage:

1. **First Level:** The first level of triage is *Primary Triage*. Here patients are rapidly assessed, and then immediate life-threatening conditions are corrected. METTLAGS are not placed on patients during this level
2. **Second Level:** The second level of triage at an MCI is known as *Secondary Triage*. In this step, patients are sorted by priority for evacuation to a treatment area, with color coded triage tags (METTAGS) used to identify patient priority before immobilization takes place.

3. **Third Level:** During third level triage, patients in the red category are sorted further by priority of needs for the limited resources in the treatment area. This is done by the Treatment Officer as patients are brought into the Treatment Area. Red tagged patients are categorized into either Group A or Group B, depending on their need for immediate care when they arrive at the treatment area. Those who need immediate care are categorized in Group A. In this way, should the number of red-tagged patients exceed the amount of resources available, when they arrive, all of the most severely injured patients –those in Group A- will receive these resources first. Care for those in Group B will be delayed until additional ambulances arrive. Patients in the Yellow Group will receive care after all red tagged patients have been seen. (A/B sorting is done only when there is not enough providers to treat all the red-tagged patients when they arrive)

4. **Fourth Level:** Fourth level of triage is the joint responsibility between the Treatment and Loading Officer. Here the red and yellow tagged patients are sorted again to determine their priority for loading into ambulances, the level of care required during ambulance transport, and the hospital to which each patient will be taken. The order of priority for loading: Red A, Red B, then Yellow tagged patients.

**PRIMARY TRIAGE OFFICER**

The Primary Triage Officer (PTO) is appointed by and reports to the EMS Branch Director. After receiving this appointment the PTO will don the “Primary Triage” vest then locate the Job Action Sheet and supplies from the MCI Kit.

The Primary Triage Officer (PTO) will rapidly assess and correct any life threatening conditions. The three critical conditions to be managed at the scene of an MCI are A,B,S, which stands for *airway, bleeding,* and *shock*. There is always concern that someone who has not yet been seen may have severe injuries. To avoid delay in reaching these patients, the PTO should assign and direct available people on the scene, including uninjured patients and EMS personnel, to care for patients with life-threatening conditions. The PTO should continue to circulate among patients remaining at the scene to monitor changes in their conditions until all patients have been moved to the treatment area.

Upon completion of duties the Primary Triage Officer will report to the EMS Branch Director for reassignment. In most circumstances this will be reassignment to the treatment area.

The Primary Triage Officer (PTO) identifies life-threatening conditions that need immediate care at an MCI by asking three questions:
• To what degree is the condition life threatening?
• What is the probability that intervention will save a life?
• To what extent will available resources be tied up caring for the person with the condition?

Managing Critical Conditions:

• **Airway**: patient is not breathing or is having difficulty breathing  
  o Open airway  
  o If child is not breathing give up to 5 breaths before moving to next patient
• **Bleeding**: blood flowing from wound  
  o If a wound is actively bleeding i.e., blood is flowing from the wound – apply direct pressure
• **Shock**: Patient progressing into shock  
  o Cover the patient to keep warm

**SECONDARY TRIAGE OFFICER**

The second level of triage at an MCI is known as Secondary Triage. In this step, patients are sorted by priority for evacuation to a treatment area, with color coded triage tags used to identify patient priority before immobilization takes place.

The Secondary Triage Officer (STO) is appointed by and reports to the EMS Branch Director. Upon receiving appointment the STO will locate the MCI Kit and gather all supplies needed, review the Job Action Sheet, and don the appropriate “Secondary Triage” vest.

The Secondary Triage Officer (STO) will view all patients and correct any remaining life-threatening problems (bleeding, airway, and shock)

The Secondary Triage Officer (STO) will classify each patient according to their need for treatment, and tag each patient according to the color scheme of the METTAG system. Red and Yellow tags will be placed on the patient’s foot, Green tags will be placed loosely around the patients neck. (See Triage/METTAG system further on in this plan)

Upon completion of secondary triage, the STO will give the EMS Branch Director a total number of all patients tagged. This total will consist of total red tags, yellow tags green tags and black tags. The total number of used tags should be checked against tags remaining to the total number of tags started with to verify that all patients have been accounted for and triaged. Supplied along with the Job Action Sheet is a page that will assist in counting the total number of patients tagged along with each classification that the Secondary Triage Officer will fill out prior to reassignment.
Upon completion of duties the Secondary Triage Officer will report to the EMS Branch Director for reassignment.

METTAG SYSTEM

METTAG “Medical Emergency Triage Tag”

The METTAG is a triage tag provided by the American Journal of Civil Defense.

The tag provides perforated sections to simplify categorization of victims. The codes include color, number and symbol classifications for priority of treatment and transportation. (See appendix A)

Once the appropriate category is determined, the tag is affixed to the patient in a safe manner. The perforated sections of the tag are removed to leave the selected category as the last color.

The time, date, name and address of the victim can be entered and an area is provided for medical notes.

The reverse side of the tag includes body diagrams to document sites of injury and a chart to log the time, BP, pulse and respiratory rate of the victim. Any IV’s or medications given should be documented in the space provided.

Diagonal tear offs on upper corners may be used to indicate casualty positions at the accident site where this is important; to attach to a severed limb; placed with personal effects; or any other use which is deemed advisable by local authorities.

Receiving facilities should be retaining the METTAG as part of the permanent medical record.

See Appendix A for sample of the METTAG and Appendix B for instructions on the use of the METTAG.

TREATMENT OFFICER

The Treatment Officer is appointed by and reports to the EMS Branch Director. Upon receiving appointment the Treatment Officer will locate the MCI Kit, gather all supplies needed to perform assigned duties, review the Job Action Sheet, and don the appropriate “Treatment Officer” vest. The Treatment Officer will utilize the first three ambulances that arrived on the scene to strip them of equipment and bring it to the treatment area for utilization of patient care. If needed the Treatment Officer will
request through the EMS Branch Director that the MCI trailer be brought to the incident and as close to the Treatment Area as possible.

The Treatment Officer will immediately set up a “Treatment Area”. This area should be clearly marked and have a single check-in point and an exit point that is fluent to the transportation loading area.

When patients are brought into the treatment area the Treatment Officer will verify the tag color and direct patients in the treatment area. If A/B sorting is used, the Treatment Officer will assure that all red tagged patients will be marked A or B as they enter the treatment area. The Treatment Officer will supervise all patient care by assigning medical personnel to appropriate areas. The treatment officer will coordinate the zoning of patients so that the Red A’s are closet to the exit point to be loaded for transport more rapidly.

The Treatment Officer prioritizes patients for transportation and communicates with the Transport / Loading Officer about the prioritization decisions. Coordination and communication between the Treatment Officer and the Transport / Loading Officer are essential.

Periodically, the Treatment Officer updates the EMS Branch Director on the number and color categories of patients. The Treatment Officer is authorized to delegate any of these tasks to subordinates.

**PATIENT TREATMENT AREA**

It is the Treatment Officers responsibility to set up the Treatment Area.

There should be only one check-in point, which opens toward the MCI scene and is clearly marked. Also there should be only one exit from the Treatment Area, which opens toward the loading area.

**In the event of an MCI, Maine EMS Protocols are to be considered Standing Orders for the duration of the event**

The Treatment Area is divided into two areas: Red and Yellow.

- If A/B sorting is done, the Red area is further divided into the Red A and Red B areas, with the Red A area placed closest to the loading area because Red A patients have the highest priority for loading and transportation to hospitals. The Red B area and the Yellow area follow in order.

- The Treatment Area should be large enough to permit space between patients for giving care. Six feet between each patient is enough space.
The Treatment Area can be marked in a variety of ways using available materials

- Color tape and anchors to mark the boundaries of the treatment area
- Traffic cones to create the entrance
- Colored flags on poles, colored cloth to lay on the ground, or tarpaulins to identify interior sections
- A green treatment area should be set up a short distance away from the yellow and red areas

Med-Care Ambulance should be the first arriving units. These units, along with the MCI Trailer, should be deployed as supply vehicles rather than transport vehicles. While treatment is being performed, equipment and supplies should be obtained from these vehicles and brought to the Treatment Area. When the need arises for additional equipment, the Treatment Officer should relay what is needed to the EMS Branch Director who in turn shall secure desired requests through EMS Command.

**TRANSPORT / LOADING OFFICER**

The Transport / Loading Officer is appointed by and reports to the EMS Branch Director. Upon being appointed the Transport / Loading Officer will locate the MCI Kit, gather all needed supplies, review the Job Action Sheet, and don the appropriate “Loading Officer” vest.

The Transport / Loading Officer must also establish a patient loading area accessible to the Treatment Area that allows for safe and coordinated access and egress of ambulances. This area should be chosen to avoid hazards such as exhaust fumes blowing toward the Treatment Area.

The Transport / Loading Officer must also establish communication with the Staging Officer and request the number and capabilities (ALS, BLS) of available ambulances, buses, or alternate transporting vehicles. These vehicles should be requested as needed and sent to the loading area, where patients will be assigned to ambulances based on triage categories.

The Transport / Loading Officer must maintain a written log of the patients who have been loaded and advise the EMS Branch Director of ambulance availability. The written log should contain the following information:

- Tag color
- Tag number
- Hospital to which the patient was taken
- Name of the ambulance company
- Time of departure
The Transport / Loading Officer will also be responsible for providing the receiving hospital with information about each patient when the ambulance leaves the loading area. The following information shall be relayed to the receiving hospital:

- Tag color
- The last four digits of the tag number
- Sex and approximate age of the patient
- Major injury of other problems
- Estimated time of arrival

In the event that patients are scattered over a wide area or multiple treatment areas have been established, transportation may set up a checkpoint to which all ambulances report for destination orders before going enroute to hospitals. In any case, only one Transport / Loading Officer should communicate with the hospital to avoid confusion. At a multiple site incident, an aide may be located at each site to fulfill transportation functions, but a single Transport / Loading Officer must coordinate all patient movement. When all patients have been transported, the EMS Branch Director, EMS Command, and the receiving hospitals must be advised.

**TRANSPORTING AMBULANCES**

Upon arrival at the scene, ambulances must report to the staging area and turn off vehicle’s warning lights. At this point, the paramedic/EMT in charge should report to the Staging Officer. The rest of the crew must remain with the vehicle until otherwise ordered. From staging, the crew may be ordered to perform any number of tasks. The crew must remain together as a team and have appropriate protective gear as required by the task. If assigned to a non-transporting role (such as triage, treatment or an aide to a sector) the vehicle must be parked in a position that will not cause scene congestion. Supplies should be taken only as ordered.

If assigned to transport patients, the ambulance should report to the patient loading area. Here the Transport / Loading Officer will assign the units patients and a destination. In a situation with a relatively small number of patients, the crew may be directed to give an abbreviated report to the hospital. Otherwise, no report should be given unless a change in patient’s condition necessitates direct medical control. Patient treatment enroute should be administered according to MEMS Protocols. Likewise, ORCC should not be notified of the units leaving the scene or arrival at the hospital.

A list of supplies used or patient charge sheet should be made out and correlated with the patient’s METTAG number. The ambulance crew should also retain one corner (if available) of the METTAG as a record of whom they transported. The crew of each ambulance should minimize turnaround time at the hospital and, unless directed otherwise, return to the incident staging area for further utilization.
STAGING

The staging of all incoming ambulances, fire apparatus and other resources is the responsibility of the Staging Officer, who will be appointed by the Incident Commander.

The first unit at the staging location will assume the role of Staging Officer until such time as he/she is released by command.

The Staging Officer must maintain communications with the EMS Branch Director or the Transport / Loading Officer to supply necessary ambulances, as well as to advise on available resources, and send requested resources to the scene.

The Staging Officer is also in charge of actually managing the staging area, assuring orderly parking, maintaining clear access to the incident site and maintaining an accurate log of currently available equipment, apparatus and manpower. In a large-scale incident, the Staging Officer may need to request one or more aides through EMS or Incident Command to assist in these functions.

SUPPORT SERVICES

Purpose

In any large-scale incident, consideration should be given with regards to the long term needs and services to the community. Some of these considerations may include finance, external resources coordination, etc. These services will be coordinated through the Logistics and Finance Sections within the Incident Management System.

The function of the Logistic and Finance Sections should be directed more towards mitigating the “after effects” following an emergency such as requesting State or Federal Disaster Assistance or stress debriefings for the emergency responders.

Government Officials

Government Officials that respond to the scene can be incorporated into the Support Services Section. They may be valuable in the role of advisor or aide to command. Their services also may be a valuable liaison to State Government.

If the incident is of sufficient magnitude to require this level of organization, it would be appropriate to activate a local or County Emergency Operations Center (EOC). At this point Government Officials should report to the EOC and begin coordination of long-term plans, including recovery, shelter and restoration plans.
Unsolicited Resources

It is common that members of the general public will offer their professional or business services during the aftermath of an emergency. Examples would include medical assistance or heavy equipment and operators. This type of assistance can be very helpful, but only if it is closely coordinated through the Unified Commanders. Coordination of these services can be accomplished through the Support Services Section and the formation of a remote “Resource Marshaling Area”.

FIRST AID STATION

Emergency Personnel

Provisions should be made for on scene first aid for the providers and workers at the disaster site. The first aid station could be in the patient treatment areas or it could be a separate entity. Any worker who has sustained a serious injury should be triaged and treated the same as the other on scene disaster victims.

General Public

It shall be the responsibility of the Logistics Officer to establish an aid station accessible to members of the general public and community for any injuries that they may have sustained. Such aid stations should not require the primary resources from the actual scene operations. Supplies and personnel could possibly be provided by volunteers from the American Red Cross or other private resources such as medical clinics, hospitals or other non-involved EMS agencies.

The location of the aid stations should be remote from the disaster site but readily available to the public. Example sites could include fire stations, city or village halls, schools, etc.

Communications equipment capable of summoning additional equipment such as an ambulance should be available at the aid station in the event of a more seriously injured patient.

REHABILITATION

The Incident Commander in conjunction with the Logistics Section Chief will be responsible for establishing a rehabilitation area for responders at lengthy incidents. In adverse weather conditions, an ambulance or an indoor facility should be made available to shelter personnel.

At the rehab area, fluids for re-hydration, an area to remove protective gear and rest should be available. Food should be considered if the incident is of a long duration. All responders reporting to rehab must also be medically monitored (vital signs,
temperature if appropriate, treatment and documentation of minor injuries) at this area. If the incident is of an extremely long duration and abnormally high-stress, a Critical Incident Stress Debriefing Team (CISD) may be requested to respond to the scene, and should be assigned to the rehab area as well.

**MEDICAL TEAMS**

A Medical Team, from an appropriate medical facility, may be requested from the EMS Operations Officer through the Incident Commander to respond to the scene for specific patient needs. This may include prolonged incidents, entrapment or need for special procedures such as surgical amputation or major crush injuries. This need should be identified so that any special equipment required can be brought to the scene with the Medical Team.

The Medical Team will be transported to the incident scene by an emergency vehicle, to be arranged by the hospital. The Medical Team will report to the Staging Officer (unless otherwise directed through Incident Command), and await assignment by the EMS Branch Director. (Staging should notify Command immediately upon their arrival).

**LAW ENFORCEMENT FUNCTIONS**

Law Enforcement Officers shall operate under the Law Enforcement Branch and report to the Law Enforcement Branch Director as instructed.

The police responsibilities at a medical emergency can be divided into two stages. The initial stage begins with the notification of the event to police communicators and provides for an orderly conversion of the scene to fire and rescue control upon their arrival.

During the first stage, police duties include determination of scope and severity of the incident, securing the emergency scene, first aid, search and rescue of injured, and initiation of plans through their supervisor.

The second stage includes other emergency operations, maintaining security of the emergency scene, establishing traffic perimeters and evacuation routes, providing crowd control, body identification, prevention of looting, and appropriate investigation of the incident.

The Law Enforcement Branch Director assigned shall be determined by the responding Police Agencies procedures for such an event. Specific police responsibilities should be implemented in accordance with local disaster plans.
As a reminder for EMS Providers, if the scene involves Weapons of Mass Destruction, (WMD) consider the need for evidence preservation.

**AMERICAN RED CROSS**

In the case of any mass casualty incident there are those that could be displaced from their homes and require temporary placement. One of the functions of the American Red Cross is to provide temporary shelter either in a mass shelter or by individual placements.

In the event that a mass casualty incident is of such magnitude that sheltering is required, the American Red Cross will be requested.

The Red Cross Chapter covering this area of Oxford County is the United Valley Chapter, located in Lewiston Maine. The contact number is (207) 795-4004. This agency can assist those persons that become affected by a mass casualty incident but do not require medical aid.

**RECEIVING HOSPITALS**

EMS Command, in communications with Rumford Hospital, will identify potential receiving hospitals and request an estimate of the number and severity of patients each facility can accept. In most circumstances all patients will be delivered to the Rumford Hospital as a funneling point and then directed out to definitive care facilities.

The Transport / Loading Officer should be in communications with receiving hospitals of changes in numbers and severity of patients each receiving hospital can accept.

Under most circumstances, ambulances will not be communicating with the receiving facilities unless medical advice is necessary.

In large or prolonged incidents, area hospitals may be asked to provide medical teams to respond to the incident site.

After patients arrive at the hospital, the METTAG number should be recorded and correlated with assigned hospital numbers for continuity of patient identification. METTAGS must be retained as part of the permanent medical record.
RADIOLOGICAL/HAZARDOUS MATERIALS INCIDENTS

In the event that radioactive materials are involved in incidents causing their spillage or release, EMS Command will immediately notify the ORCC to dispatch all applicable State Response Teams, including specifically the local fire department, the Regional Response Team, and the Decon Strike Team.

No EMS personnel will be allowed into the Warm or Hot zone unless trained to do so as part of the Fire/Haz-Mat Team. All personnel entering the Warm/Hot zones must wear appropriate protective equipment and self contained breathing apparatus as determined necessary.

The Fire Department/Haz-Mat Unit will establish a decontamination area and ensure that any person who entered the contaminated area is properly decontaminated prior to leaving the warm zone into the treatment area or from leaving scene. Ensure that all contaminated equipment and clothing is marked and isolated within the decontamination area for proper disposal or cleaning. It is vital that contaminated and uncontaminated materials not be intermixed.

Request Medical Strike Teams as needed. Institute BLS and ALS procedures, and advise Rumford Hospital to lock-down and set up the De-Con Tent.

The Transport / Loading Officer will notify the receiving hospital of the patient’s condition, type and duration of exposure, treatment at the scene, decontamination status, and ETA to hospital. Obtain from the receiving hospital the actual receiving area at the hospital.

If there is a need to evacuate a large geographical area surrounding the incident, the Incident Commander will obtain from the Staging Officer any extra resources available in staging, to assist the Fire/Police Departments with evacuation.

Do Not eat, drink, or smoke anywhere on the scene. Do Not use food or water that may have been in contact with material from the incident.

CRITICAL INCIDENT STRESS DEBRIEFING

Early consideration should be given towards providing those emergency workers at the scene with early defusing and debriefings. These services can be coordinated under the Support Services Sector.

The locations, times, and format for the defusing can be coordinated at the EOC or Command Post between CISD team and Incident Command.
Upon Command determination of the need for CISD team involvement at the scene of the disaster, notification of the Tri-County EMS CISD team will occur through established protocols.

Upon arrival of the CISD team, a designated intake/discharge area is developed. All responders to the disaster will go through the intake and discharge areas for each shift worked.

To access the CISD team call United Ambulance Service (207) 777-6000. This is a 24 hour number, and their dispatch will notify the CISD team. Make sure that a return number to Incident Command is left with dispatch so that a representative from the CISD team can make contact and get details of the incident.

**RESOURCE MARSHALING AREA**

**Purpose**

During the aftermath of any large-scale incident, it is common for members of the general public to offer the use of their professional or business services. These unsolicited resources may not be immediately needed but as the recovery phase of the incident unfolds may prove to be extremely helpful as long as they are closely coordinated with official operations.

Since past incidents have proven that the amount of unsolicited resources could be great it is important to develop a “Resource Marshaling Area”, away from the incident scene, to itemize these available resources and track their use and control their access to the scene.

**Procedure**

In the event Incident Command deems it necessary, the Support Service Section will establish a Resource Marshaling Area away from the incident scene in an area large enough to hold large amounts of heavy equipment. They will inventory the unsolicited resources and make a list of these resources available to the Incident Commander.

In the event any of these resources are requested, the Support Services Section will maintain a log of who provided the service, the type of service, the duration the service was rendered, and contact information on the company providing the service. The resource will then be assigned to the area needed.

When the assignment is completed the resource will be instructed to return to the Resource Marshaling Area for possible reassignment or release.
**DEFINITIONS**

ALS: Advanced Life Support: Advanced pre-hospital services utilizing Basic Life Support plus definitive therapy, including the use of invasive procedures, drugs, and defibrillation.

BLS: Basic Life Support: Pre-hospital emergency service utilizing basic, non-invasive emergency care, treatment and transport.

CONOPS: The State of Maine Communications Operations Plan

COMMAND: The radio designation for the Incident Commander. Refers to the person, functions and the location of the Incident Commander.

COMMAND AIDES: The person(s) appointed by the Incident Commander to assist with the functions at the command post, as assigned by the Incident Commander.

COMMAND POST: The standard position for the Incident Commander, usually stationary, inside a command vehicle or in a specified area as designated by the Incident Commander. It is identified by a green flashing light or an orange flag.

COMMAND VEHICLE: Vehicle used for the transportation of Command Officers, storage of pre-incident plans and other significant incident data. Generally used as the Command Post.

COMMUNICATIONS OFFICER: Responsible for handling the communications between the Incident Commander and ORCC and all other incident radio sectors.

EMA: Emergency Management Agency.

EMS BRANCH DIRECTOR: Appointed by the Incident Commander, coordinates and controls the EMS operations, and works within the Operations Section under the direction of the Operations Section Chief.

OPERATIONS OFFICER: Appointed by the Incident Commander, coordinates all Operations within the Operations Section.

FORWARD CONTROL POINT: An identifiable location established for a hazardous materials or radiological incident beyond which is the “point of no return” without decontamination procedures being established for those exiting the area.

INCIDENT COMMANDER: The individual in charge of the overall incident.

LEPC: Local Emergency Planning Committee, mandated by the federal Superfund Act to coordinate information pertaining to hazardous materials incidents.
LOADING OFFICER: That person appointed by EMS Command to establish the loading of ambulances and recording patient destinations. Responsible for the direction of ambulances to the appropriate medical facilities, and for relaying pertinent patient data to the receiving hospital.

MASS CASUALTY: An incident of such magnitude that requires marshaling of resources over and above the normal day to day pre-hospital care and may involve:
1. Three or more critical, or
2. Two critical when dealing with five or more total patients, or
3. One critical when dealing with ten or more total patients, or
4. Fifteen or more non critical patients

MEDICAL TEAM: A team of medical personnel (i.e. doctors and RN’s) from Rumford Hospital who respond to the scene when requested by the EMS Commander. They are to report to Staging for assignment.

METTAG SYSTEM: Medial Emergency Triage Tag: A system of categorizing patients utilizing uniform, multicolored patient tags to identify the patients’ condition.

ORCC: Oxford Radio Communications Center.

PATIENT TREATMENT AREA: The area designated for treatment that is used to treat and load patients into transporting ambulances. This area should be located in such a position that it allows for coordinated accesses and egresses or ambulances.

PUBLIC INFORMATION OFFICER: The ONLY person designated by the Incident Commander to provide ALL information to the media.

PRIMARY TRIAGE OFFICER: Is responsible for rapidly and continuously assessing all patients and providing life saving care.

RECEIVING FACILITY: A hospital facility that is approved to receive patients from a, mass casualty incident.

REHABILITATION AREA: An area outside the fire ground perimeter where crews are assigned for rest, nourishment, comfort and medical evaluation.

RESOURCE HOSPITAL: Refers to a hospital with the authority and responsibility for the EMS System as approved by the Maine Department of Public Health.

SAFETY OFFICER: Responsible for assessing and correcting unsafe conditions and/or actions at the incident. Reports directly to the Incident Commander and should be a Chief Officer if possible.
SEARCH AND RESCUE: The function of searching an area or building for victims in an organized way.

SECONDARY TRIAGE OFFICER: Is responsible for viewing all patients after the Primary Triage Officer and classifying each patient with a color coded METTAG according to their need for evacuation and treatment.

SECTION CHIEF A person assigned to the responsibility of supervision and operations within one of the 4 General Staff Sections.

STAGING AREA: That location where incoming personnel and equipment are held for orderly deployment. A Staging Officer manages this area.
  • LEVEL ONE STAGING: An undesignated location approximately one block from the scene where additional incoming equipment will hold, pending assignment.
  • LEVEL TWO STAGING: Used for large, complex, or lengthy operations. Additional units are staged together in specific locations.

TRANSPORTATION AIDE: That person appointed by the Transportation Officer to assist them with any task(s) needed to complete the transportation function.

TREATMENT OFFICER: That person appointed by EMS Command who is responsible to establish and manage the Patient Treatment Area. This individual determines transportation priorities.

TRIAGE: Sorting of multiple casualties into priorities for emergency care or transportation to definitive care depending on the extent of injuries or medical problems.

TRANSPORTATION OFFICER: See Loading Officer Above.
Appendix A
INSTRUCTIONS FOR METTAG (MT-137)

DISPENSE controlled number of tags to triage personnel.

STABILIZE most seriously injured patients first, if possible.
   a. Enter time of triage (plus date, if advisable) on tag.
   b. * Enter name if patient is conscious and coherent, or give brief description.
   c. * Enter home street address, if practical.
   d. * Enter home city and state, if practical.
   e. Enter other pertinent information on blank lines.
   f. Enter name of person doing triage on bottom line.
   g. On reverse side, indicate injuries on body diagrams.
   h. Enter as appropriate: Time, blood pressure, pulse and respirations (breaths per minutes) in vital signs chart. Indicate if pulse is (1) full or weak, (2) regular or irregular. Recording of vital signs is ongoing.
   i. Enter intravenous (IV), intramuscular (IM) and time.
   j. Determine severity of patient’s injuries and prioritize appropriate action based on the priority levels indicated below. Tear off all colored tabs BELOW that priority level. The bottom color remaining on the tag will guide the follow-up actions required. Any removed colored tags should be retained (these bar-coded tabs may be used for additional identification purposes, if needed).
   k. Attach tag securely to clothing or body (arm, leg, around neck, etc.) so that it is clearly visible.
   l. Use Code 128 bar code system, a standard bar code system used throughout the medical industry.

DIAGONAL TEAR OFFS on upper corners may be used to indicate casualty positions at the accident site where this is important; to attach to a severed limb; placed with personal effects; or any other use which is deemed advisable by local authorities.

TRANSPORT victims to best available hospitals STRICTLY BY PRIORITY.

Priority Levels:

I Red (critical, in need of immediate care)
II Yellow (serious, but transport can be delayed until after Priority I)
III Green (emergency transportation not considered necessary)
0 Black (dead, move to morgue)

COLLECT unused tags and estimate total casualty count.
PATIENT'S METTAG serial number should be used to link tag information to hospital admission and medical records.

* These steps may be delayed or accomplished by others while awaiting transport or during transport.
### Appendix C (Hospital/Ambulance Phone List)

#### Mass Casualty Response Plan

<table>
<thead>
<tr>
<th>Agency/Organization</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals</strong></td>
<td></td>
</tr>
<tr>
<td>Rumford Hospital</td>
<td>369-1051</td>
</tr>
<tr>
<td>Central Maine Medical Center</td>
<td>782-1110</td>
</tr>
<tr>
<td>St. Mary's Regional Medical Center</td>
<td>777-8136</td>
</tr>
<tr>
<td>Stevens Memorial Hospital</td>
<td>743-5933</td>
</tr>
<tr>
<td>Franklin Memorial Hospital</td>
<td>779-2580</td>
</tr>
<tr>
<td>Androscoggin Valley Hospital (Berlin NH)</td>
<td>603-752-2200</td>
</tr>
<tr>
<td>Bridgton Hospital</td>
<td>647-6000</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Ambulance Services</strong></th>
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<tbody>
<tr>
<td>Andover Rescue</td>
</tr>
<tr>
<td>Bethel Rescue</td>
</tr>
<tr>
<td>Tri-Town Rescue</td>
</tr>
<tr>
<td>Northstar (Farmington, Livermore, Rangeley, etc.)</td>
</tr>
<tr>
<td>Buckfield Rescue</td>
</tr>
<tr>
<td>United Ambulance</td>
</tr>
<tr>
<td>Pace Ambulance</td>
</tr>
<tr>
<td>Turner Rescue</td>
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<tr>
<td>Oxford Rescue</td>
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<table>
<thead>
<tr>
<th><strong>Air Ambulance Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifeflight of Maine (Lewiston and Bangor)</td>
</tr>
<tr>
<td><em>For additional Transport Helicopters call Med-Com and ask for NEAR ASSN.</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Police</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rumford</td>
</tr>
<tr>
<td>Mexico</td>
</tr>
<tr>
<td>Dixfield</td>
</tr>
<tr>
<td>Oxford SO</td>
</tr>
<tr>
<td>Androscoggin SO</td>
</tr>
<tr>
<td>Franklin SO</td>
</tr>
<tr>
<td>State Police</td>
</tr>
<tr>
<td>Bethel</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Other Resources</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>New Page Haz-Mat Team</td>
</tr>
<tr>
<td>Maine Department of Environmental Protection</td>
</tr>
<tr>
<td>Department of Environmental Protection</td>
</tr>
<tr>
<td>Maine Dept. Health and Human Services Radiation Control Program</td>
</tr>
<tr>
<td>Maine Emergency Management Agency</td>
</tr>
<tr>
<td>Oxford County EMA</td>
</tr>
<tr>
<td>Maine EMS</td>
</tr>
<tr>
<td>Tri-County EMS</td>
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Regional IMAT Teams:

<table>
<thead>
<tr>
<th>Region</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northern Maine</td>
<td>493-4328</td>
</tr>
<tr>
<td>Penquis/Downeast</td>
<td>942-6335</td>
</tr>
<tr>
<td>Central Maine</td>
<td>580-0997</td>
</tr>
<tr>
<td>Mid Coast</td>
<td>471-0663</td>
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<tr>
<td>Western Maine</td>
<td>784-3622</td>
</tr>
<tr>
<td>York/Cumberland</td>
<td>324-1111</td>
</tr>
<tr>
<td>11th Civil Support Team</td>
<td>877-9623/441-4109</td>
</tr>
<tr>
<td>Androscoggin County Cobra Team</td>
<td>784-6421</td>
</tr>
<tr>
<td>Augusta Fire Department</td>
<td>626-2420</td>
</tr>
<tr>
<td>Bridgton Fire Department</td>
<td>647-8814</td>
</tr>
<tr>
<td>Brunswick Fire Department</td>
<td>725-6572</td>
</tr>
<tr>
<td>Central Maine Emergency Response Team</td>
<td>872-5551</td>
</tr>
<tr>
<td>Franklin County Haz-Mat Team</td>
<td>778-2680</td>
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<tr>
<td>International Paper</td>
<td>897-6766</td>
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<tr>
<td>Madison/Anson Fire Department</td>
<td>696-3307</td>
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<tr>
<td>NAS Brunswick Fire Department</td>
<td>921-3333</td>
</tr>
<tr>
<td>Ogunquit Fire Department</td>
<td>646-4947</td>
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<tr>
<td>Paris/Norway/Oxford Fire Department</td>
<td>800-733-1421</td>
</tr>
<tr>
<td>Skowhegan Fire Department</td>
<td>474-3400</td>
</tr>
<tr>
<td>York County ERT</td>
<td>985-6123</td>
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## Appendix D MCI Plan Response Levels

<table>
<thead>
<tr>
<th>Service:</th>
<th>Phone Number:</th>
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<tbody>
<tr>
<td><strong>Level 1</strong></td>
<td></td>
</tr>
<tr>
<td>Med-Care Recall Tones ORCC/911</td>
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</tr>
<tr>
<td>Med-Care Back-Up Units ORCC/911</td>
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</tr>
<tr>
<td>Andover Rescue ORCC/911</td>
<td></td>
</tr>
<tr>
<td>Bethel Rescue ORCC/911</td>
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<tr>
<td>Rumford Fire EMS ORCC/911</td>
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<tr>
<td>Tri-Town Rescue ORCC/911</td>
<td></td>
</tr>
<tr>
<td>Northstar Ambulance 800-492-0120</td>
<td></td>
</tr>
<tr>
<td>Lifeflight of Maine; Lewiston 1-888-421-4228</td>
<td></td>
</tr>
<tr>
<td><strong>Level 2</strong></td>
<td></td>
</tr>
<tr>
<td>All of Level 1</td>
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<tr>
<td>Northstar Ambulance 800-492-0120</td>
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</tr>
<tr>
<td>Turner Rescue 225-3129</td>
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<tr>
<td>Buckfield Rescue ORCC/911</td>
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<td>Oxford Rescue ORCC/911</td>
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<tr>
<td>Pace Ambulance ORCC/911</td>
<td></td>
</tr>
<tr>
<td>United Ambulance 1st Unit 777-6000</td>
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</tr>
<tr>
<td>Lifeflight of Maine; Bangor 1-888-421-4228</td>
<td></td>
</tr>
<tr>
<td>Mexico Fire (manpower) ORCC/911</td>
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</tr>
<tr>
<td>Dixfield Fire (manpower) ORCC/911</td>
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<tr>
<td>Peru Fire (manpower) ORCC/911</td>
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<td><strong>Level 3</strong></td>
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<td>All of Level 1 and 2</td>
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<td>United Ambulance-Lewiston 2nd Unit 777-6000</td>
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<tr>
<td>Monmouth Rescue 933-4446</td>
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<td>Winthrop Rescue 377-7226</td>
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<td>Augusta Fire 626-2375</td>
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<td>DHART Air Ambulance 1-800-650-3222</td>
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<td><strong>Level 4</strong></td>
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<td>All of Level 1,2, and 3</td>
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<td>Lisbon Rescue 353-2500</td>
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<tr>
<td>United Ambulance-Bridgton 647-5222</td>
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<tr>
<td>Delta Ambulance - Augusta 623-4900</td>
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<tr>
<td>Gorham NH EMS 603-466-3336</td>
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<tr>
<td>Berlin NH EMS 603-752-1020</td>
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<tr>
<td>Stoneham Rescue ORCC/911</td>
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<tr>
<td>Fryeburg Rescue ORCC/911</td>
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<tr>
<td><strong>Level 5</strong></td>
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<tr>
<td>All of Level 1,2,3, and 4</td>
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<tr>
<td>AMR 800-899-3434</td>
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<tr>
<td>Northeast 800-215-2000</td>
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</tr>
<tr>
<td>Delta Waterville 872-4000</td>
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<tr>
<td>Freeport EMS 865-4800</td>
<td></td>
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If additional air ambulances are required (Helicopters) notify Med-Com(same as Lifeflight of Maine number) for activation of New England Air Association. This will pull helicopters from other states around New England.