

Regional MCI plan Meeting Notes

Stakeholders in attendance:

Billy Ferguson, FCDPS Bobby Baker, LGMC Charles Coffelt, CCPT Chris Garrett, VDH Dale Wagoner, HCDPS David Linkous, VDH Jason Campbell, LFD Jason Ferguson, BCES Joey Stump, RCFRD Joey Trigg, REMSI	Keith Dowler, VDH Lee Simpkins, Radford Fire Marci Stone, Bedford Co Mike Guzo, Roanoke City Neal Turner, Montgomery Co Roger Glick, Carilion Clinic Stan Crigger, VDEM Steve Allen, Patrick Co Steve Davis, VDH Tammy Turpin, Carilion Clinic	Etthan Miller, LGH-P Joe Coyle, Chairperson Rob Logan, WVEMS Connie Purvis, BREMS Krista Henderson, CCPT Mike Garnett, WVEMS Jeff Echternach, NSPA Winnie Pennington, VDH-OEMS
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Meeting Called at 09:30 by Chairperson Joe Coyle

Project Presentation and around the room introductions.

Capture of feedback to the question *“What need(s) would a regional MCI plan fulfill for your agency / organization?”*

- What we need to do, is what we are doing right now, Regular Meetings among responders. Hospitals are doing this now, and have been for some time
- Provide a Resource in the ‘toolbox’ that could add to the current resources that EMS Responders call upon
- A plan that offers preparedness to fill the gaps that were identified from the VT Shooting. Looking to identify gaps as a region and address them
- Look at resources, Assemble a tool that can be used throughout the region
- Standardization from one locality to another, Regional plan that allows everyone to be on the same page, and prevents everyone from doing a five minute plan training when a large scale event kicks off. Eg “This is how WE do it”
- Development and maturity of the Alternate Care Site, to alleviate surge of emergency rooms
- A plan that everyone can work off of, understanding that plans can be the same, function without x
- Multi-casualty incident response document that can draw together resources and provide a common framework for response
- A document that can help responders who may not ‘own’ a initial response or have jurisdictional authority: How their resources can be plugged into the event and address the various needs therein
- Standardization of practices, coordination among all agencies and in one, functional document
- A good plan, one that goes beyond “Take all the patients to the closest hospital”

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- A regional plan that can serve as a model for southwest Virginia
- Communications procedures that go from scene to receiving points, and address gaps at each point therein
- Collaboration, resources and sharing, and what happens when patients arrive at the hospital
- Ability to address unique situations, counties who are in two ems councils, a plan that offers standards, and does not forget about the needs of the end user
- A field resource guide for front line users, in addition to previous comments.
- A plan that is a grass roots effort, and is not necessarily, created from a template someone else handed us, one that is not confined to the 'definition' of any one form, such as resource document, field guide, or plan. A plan that addresses the regional needs and is accessible (in it's use, and implementation)
- Address patient movement outside of the region, differences in protocols and standards of management of an MCI, Develop something were "I" don't have to think about where "I'm" going to drop my patient off at (with respect to how I'll treat my patient, or manage my incident).
- A plan that addresses how we are going to move patients. Every local plan speaks to patient movement, but to tackle how and with what resources.

Discussion of Definitions, and 'Resource Document' vs. 'Comprehensive Plan'

The basic differences between a Resource Document and a comprehensive plan were discussed. These differences are highlighted below:

Resource Document	Comprehensive Plan
<ul style="list-style-type: none"> • Identifies Resources <ul style="list-style-type: none"> – Methods to activate – Stipulations – Contact Information • Capabilities • Common Triggers <ul style="list-style-type: none"> – For activation and use • Does not address Liability • Education Component 	<ul style="list-style-type: none"> • Prescriptive • Identifies methods of command and control • Demonstrates Ownership • Guides response • <i>Has a liability component</i> • Framework for Response • Education Component

Points of discussion / Comment:

- What may be an MCI to a small rescue squad would not be the same to a large EMS agency. This group may be able to assemble a plan that addresses the needs from a small locality to a larger agency
- Would like to see a smaller field guide (component) within a larger, parent document

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- Resource Documents often mature out of a well developed plan. Many agencies have a plan, with a resource guide
 - Definitions are going to be important. There is a difference between an MCI and a Surge event. What can be an MCI event in a small community differs in the capacity of a large hospital
 - Address communication to hospitals, The Earlier... the better
 - EMS sometimes feels a struggle to assemble a clear communication quickly, Feels like htat, on occasion, there is a rush to produce information, when information is not verified or confirmed
 - This plan could clarify what the hospital will accept as a statement of information. The field guide may be a good starting point. There may not be a perfect solution, but we can get pretty close.
 - A point of caution on resources: How do we know that those resources are available each, and every time.
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Discussion of the RHCC as a singular call to disperse information

The RHCC has the capability to receive a notification from EMS and distribute that message to affected hospitals.

- There needs to be clarity on the use of a “one call” solution. The RHCC may be able to be notified for the initial incident, but when the time comes to make transports to facilities, such as “red-yellow-and green tag” patients, the Hospital needs to receive that phone call.
 - The RHCC has a lot of capabilities, but needs the input of the EMS Community to help model what it needs to do as a standard, to support EMS and its communication with Hospitals.
 - There needs to be a benchmark or measure to clarify what the RHCC is able to do
 - What it can do Now,
 - What it can do after some training and process mapping,
 - What it is unable to fulfill
 - This discussion would benefit in a workgroup for this committee, a group that could better define the role the RHCC needs to play in assisting in managing communication for large-scale events
 - RHCC offers a lot of technology resources, such as Web EOC Connectivity, Integration with the FAC and Patient Identification model
 - Suggestion that the MCI Committee address some operational expectations and desires in a workgroup
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Follow Up: RHCC POC requested to review capabilities, and address the feedback above

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Discussion of the plans Scope

- A Well defined scope is essential. Will this be a plan that addresses up to one operational period, or more?
 - Watch for 'Scope Creep'
 - A Plan, that is a cohesive document, with annex that accounts for / functions as a field guide as well as a resource document sounds like the general direction to follow
 - EMS Surge and Hospital Surge are two different things, Definitions will be important
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Discussion of Training

- This needs to be exercised and trained on. Exercising does not necessarily mean full scale events that consume time and resources. Drills may be small and more attainable
 - Given financial times, budgets do not allow for off duty staff drilling and our on-duty resources are taxed as it is
 - Funding streams exist to support backfilling stations for drills. This is something we can explore later as the plan matures
 - Training may be imbedded in a workgroup or may be decided after the plan is created. This group should identify the education plan
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Discussion of State Guidance for planning

- Some of the guidance is already addressed in local plans, It's more of a federal and state requirement than an actionable item. It's been addressed already
 - The remaining guidance seems to be where we need to focus
 - This plan should look at the difference between choosing to send patients to neighboring hospitals vs. being forced to
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Workgroups

A concept of workgroups and task breakdown was presented to the group. Workgroups were proposed as EMS, Hospital, Communications, RHCC, other. For persons not currently at the table, the group was asked who else needs to be involved. Involvement may be active committee participation and development, or it could be a 'reach back'.

To start discussion, workgroups arranged by Discipline were proposed. Workgroups by discipline with subgroups were discussed. An alternative to organize groups by task to avoid silos and bring cohesive discussion together. A discussion of the workgroups and their structure is contained below.

- Need to include in discussion / deliberation 911 Dispatchers, Involvement
- Fire should be included, Involvement
- Law Enforcement, Reach back

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- MRC, Reach back
 - Address the workgroups by assigned tasks, maybe we look at the state guidance to form the components of the plan.
 - Coordination will be important here.
 - In order to start the workgroup discussion, we need to establish what the scope will be.
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Closing comments and future meetings

Next steps for group will include confirmation of the scope. A Scope will be drafted based on comments captured thru meeting. From there, the next meeting will affirm the scope, and establish workgroups. Coordinators for the group will distribute meeting notes, collect any additional feedback from stakeholders or any reach back feedback from their municipal contacts, and coordinate the next meeting.