Northwest Georgia - Region 1 EMS
Regional Trauma Plan

"Building Excellence in a
# Trauma System of Care through Collaboration

November 29, 2012

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Regionalization of Region 1 Trauma

EXECUTIVE SUMMARY

Traumatic injuries represent a serious health concern for Georgia. Motor vehicle crashes (MVC), which account for the majority of injuries in the state, are the leading killer of children, teens and young adults (ages 5 to 34), among the top ten causes of death for all ages. The CDC has estimated the total crash-related death cost in Georgia in one year to be $1.55 billion dollars, $17 million of that total in medical costs alone. Studies have shown that many of these deaths are preventable and that the implementation of a trauma system in other states has reduced deaths and improved outcomes from traumatic injury. While trauma patients account for a small percent of the total emergency system response, trauma accounts for a large percent of total years of potential life lost. An inclusive trauma system incorporates all emergency response resources into a system to match the needs of the trauma patient with the appropriate emergency and trauma care resources.

As a result, Georgia is working towards a state-wide trauma system. In order to meet this goal, the Georgia Trauma System will be comprised of integrated regional systems and plans. Each region will represent a trauma service area which will accommodate overlapping and traditional patient catchment areas and incorporate state-wide EMS Regional infrastructure. The Region 1 plan will organize existing resources to provide a comprehensive trauma care system to care for patients from the moment of injury through rehabilitation. This plan will address both urban and rural concerns. Rural trauma care is complicated by issues associated with geographic isolation including but not limited to, time from injury to discovery, extrication issues, distance to immediate healthcare as well as local health care resource availability. The development, implementation, and operation of a trauma system is a complex process which requires concerted efforts from all health care providers. Coordination of system activities, data-driven planning, a well defined infrastructure and stable funding are critical to the success and cost effectiveness of the system.

The pages that follow describe the essential components of the Region 1 Trauma Plan and Regional Trauma Advisory Committee (RTAC).

Mission, Vision and Goals

MISSION

The mission of the Region 1 Trauma Plan and RTAC is twofold. First, they aim to reduce the burden of trauma through injury prevention efforts focused on injury data and statistics specific to Region 1 and other regional plan participants. Second, they will strive to ensure that victims of trauma receive care
across the continuum from pre-hospital through rehabilitation that is of the highest quality to ensure the best possible outcome.

VISION

The Region 1 Trauma Plan and RTAC will provide leadership regarding the care of trauma patients within the region and across regional and state boundaries where appropriate.

GOALS

- Reduce the number of preventable deaths
- Improve outcomes from traumatic injury
- Reduce medical costs through appropriate use of resources.

OBJECTIVES

- Collaborate with participating agencies and organizations to provide oversight and guidance for system evaluation, education and training programs, and public education and prevention strategies.
- Work in conjunction with the State Office of EMS & Trauma (OEMS&T) to monitor availability of resources, assure compliance with system standards, and to develop a process for review of trauma care.
- Evaluate patient outcomes at a system level.
- Analyze the impact and results of the system and make recommendations for change as appropriate to assure quality outcomes.

REGIONAL TRAUMA ADVISORY COMMITTEE

The Region 1 RTAC is established to act as a local resource for input to and support of the Georgia State-wide Trauma Plan. It is the aim of the committee to assist in the reduction of human suffering and cost associated with preventable morbidity and mortality that result from trauma. The RTAC will be instrumental in analyzing local trauma care trends and in promoting regional injury prevention activities and quality improvement actions in an effort to reduce the incidence of trauma and when injury occurs deliver appropriate and timely trauma care across the continuum. The duties of the RTAC are as follows:

1. To promote cooperation and to support communication among trauma care providers, organizations and hospitals;
2. To provide a forum to discuss and resolve issues between trauma care providers;
3. To promote education, public awareness and prevention activities regarding regional trauma;
4. To identify and analyze trends and patient care outcomes based on trauma registry and TCC data; and,
5. To assure quality improvement activities within the system to achieve the highest level of trauma care.

AUTHORITY, STRUCTURE AND FUNDING

The RTAC is a committee of the Region 1 EMS Council who is responsible to the Office of EMS and Trauma (OEMS&T) under the Department of Public Health. There is collaboration between the RTAC, Region 1 EMS Council, OEMS & T and the Georgia Trauma Care Network Commission (GTCNC) and all stakeholders with an interest in trauma system development and improvement.

The GTCNC established the Regional Trauma Care Network Planning Framework in September of 2009. This framework is used as a guide to develop and implement regional trauma plans. The GTCNC reviews and approves regional trauma system plans in conjunction with the OEMS&T. The GTCNC also manages and distributes financial resources for the trauma system.

The Georgia OEMS&T, under the Department of Public Health will be the authoritative structure for the regional plan, with the Region 1 EMS Council as the regional authority. Figure 1 demonstrates the RTAC structure and reporting relationships.
RTAC MEMBERSHIP

RTAC members are appointed by the Region 1 EMS Council Chair. There will be a minimum of 15 and a maximum of 24 members appointed. The RTAC functions under the bylaws of the Region 1 EMS Council. The members of the RTAC will be central to the success of the regional plan and state-wide trauma system development. The membership shall be active and will require contribution and interaction of all the members.

The membership of the RTAC will be made up of stakeholders who are representative of the demographics of the region and the various components of the trauma system. The membership and makeup of the RTAC shall be approved by the Region 1 EMS Council. The RTAC Chair will preside at all RTAC meetings. The chair will set the meeting agenda and facilitate meeting discussion. The chair must be a full voting member of the Region 1 EMS Council.

The Vice-chair shall perform the duties of the chair when the chair is absent from a meeting. The Vice-chair is not required to be a member of the Region 1 EMS Council.

The Coordinator will serve as the point person and secretary. They will call the role and determine if a quorum is present. They will maintain all minutes of the meetings and distribute to the general membership. They will review and maintain copies of all organizational correspondence and assist in the dissemination of information to the general membership. They will also serve with the Chair and Vice Chair to collaborate with all stakeholders to manage and carry the plan forward.

RTAC GENERAL MEMBERSHIP

Level I and Level II Trauma Center Representative(s) – There will be at least one representative from each within the Region.

Hospital Members (minimum of 3) – members from this group should be from senior hospital management, at least one who is a direct patient care provider, at least one from a critical care access hospital, and at least one from a rural hospital who is a designated or non-designated participating hospital.

EMS Members (minimum of 3) – at least one member will be from an urban 911 EMS service area, at least one member will be from a rural 911 EMS service area and at least one member must provide direct patient care.

Physician Members (minimum of 3) – at least one should be a rural physician who is actively providing trauma care at a designated or non-designated participating hospital, one should be a trauma surgeon.
Nurse Members (minimum of 3) – nurses serving on the RTAC should have knowledge of both pre-hospital care as well as hospital care and ideally will have experience in trauma related educational activities or injury prevention activities.

EMSC Representative (1) – There will be a member of EMSC appointed to RTAC to oversee and make recommendations on pediatric trauma care.

State Representatives (3) – There will be at least one person to represent our neighboring states of Alabama, Tennessee and North Carolina to advise and bring forth the resources and expertise of their respective trauma systems and improvement.

At-Large Members – the following areas should be considered for At-Large membership, others may be included as needed; Fire Services, Law Enforcement, Emergency Management, Air Ambulance Services, Business and Industry, Public Health to include epidemiologist, Emergency Preparedness, Government Officials, Injury Prevention, previous trauma patients and/or family members.

**OPERATIONAL AND CLINICAL COMPONENTS**

**TRAUMA REGISTRY AND TCC DATA**

Rational decision-making regarding trauma care must be made based upon the understanding of the causes, treatment and outcomes of injury. Trauma registry information and TCC data includes the actual information surrounding the event as well as the hospital course and outcome. This information can be utilized by the individual hospital, as well as at the state level for epidemiology and injury control studies. The trauma registry and the TCC provide the mechanism to collect data and to evaluate trauma care systems, patient care quality improvement, resource utilization, medical research and education on the hospital, regional and state level.

**Pre-Hospital Care**

**PREHOSPITAL COMPONENT**

In 2009, following a review of Georgia’s Trauma System, the American College of Surgeon’s Trauma System Consultation Program determined that “EMS is often a critical link between the injury-producing event and definitive care at a trauma center.” This “Critical Link” was identified when it was determined that 89% of all critical trauma patients were delivered into the system by EMS. (See Figure 2 for additional details.)

However, EMS is not definitive care. Critical trauma patients require a fully functioning system that includes a well-equipped, well trained, EMS component working hand-in-hand with physicians and
nurses who are trained and dedicated to this task. To achieve the best outcome for these patients, they must be transported to the appropriate hospital in an expeditious manner.

89% of All Traumas Enter the System Via EMS.

**Figur 2**

**RESOURCES IDENTIFICATION**

Northwest Georgia's Region 1 is comprised of 16 counties and spans 5439 square miles serving a population of 1,105,044. Appendix A of this Document provides a view of Region 1 and its relationship in the State of Georgia. EMS resources in this region consist of 17 different 911 EMS agencies. Additionally, two air ambulance services provide care within the region as needed. Regional EMS resources include:

Region 1 Ground Ambulances and Air Transport Services is located in Appendix B. A map of Georgia's air ambulance base locations is available in Appendix C.

**Triage and Facility Selection**

Trauma patient triage and the selection of the most appropriate facility may be affected by resources availability, geography, and transport time. The importance of on-scene triage decisions made by EMS providers is reinforced by Center Centers for Disease Control (CDC) supported research, The National Study on the Costs and Outcomes of Trauma (NSCOT), which identified a 25% reduction in mortality for severely injured patients who received care at a Level I trauma center rather than at a non-trauma center. However, not all injured patients can or should be transported to a Level I trauma center. Patients with less severe injuries might be served better by transport to a closer facility. Transporting all injured patients to Level I trauma centers, regardless of severity, could burden those facilities unnecessarily and make
them less available for the most severely injured patients. The CDC developed the Field Triage Decision Scheme: The National Trauma Triage Protocol for use in identifying the most severely injured patients.

While the Region 1 RTAC will develop guidelines based on a regional assessment and need, the Georgia Trauma System Primary Triage Decision Scheme, adopted largely from the CDC’s National Trauma Triage Protocol, will be utilized by pre hospital personnel to determine if patients meet the Trauma System Entry Criteria (TSEC). (Appendix E)

Region 1 RTAC will also adopt an Air Medical – Helicopter EMS Triage and decision guide to assist with decision making processes for utilization of Air Medical Services by the on –scene provider.

REGIONAL AIR MEDICAL SERVICE UTILIZATION GUIDELINES

When EMS arrives, they should assess the scene. If it is later determined by the HIGHEST TRAINED EMS PROVIDER on the scene that the AMS is not needed, it should be cancelled as soon as possible. If an AMS crew is already on the scene, the ONLY agency that may cancel any additional AMS resources is the AMS agency on the scene.

AN EMS SERVICE SHOULD NOT WAIT ON THE SCENE OR DELAY TRANSPORT WAITING FOR AMS TO ARRIVE. If the patient is packaged and ready for transport, the EMS service should initiate transport to the hospital. If possible, a landing zone will be reassigned and AMS directed to intercept with an ambulance during transport at an alternative-landing site. (See Appendix D)

PEDIATRIC FIELD TRIAGE AND FACILITY SELECTION

From the pre-hospital perspective, EMS Providers, from Medical First Responders through Paramedics need to improve their Pediatric Triage and Treatment skill sets. Pre-hospital care is an important link in the chain of survival in trauma patients and medical emergencies. There are many emergency medical service (EMS) systems that established a survival benefit for patients by early interventions performed by pre-hospital providers. But almost all of the studies were performed on the adult population. There is a paucity of data about pediatric pre-hospital care outcomes. This is primarily a result of the higher percentage of adult emergencies and thus the higher number of adult patients for whom the EMS providers are involved in the early care. Another problem may lay in the fact that pediatric emergency training is only a small part of the training curriculum for pre-hospital providers. Therefore pre-hospital pediatric care may not be performed at the same high level as adult pre-hospital care. (See Appendix G for guidelines)

Trauma is the most common cause of mortality and morbidity for children in the US. Since most traumatic injuries occur at a certain distance from dedicated trauma or pediatric trauma center, most pediatric as well as adult patients immediately after their trauma rely on pre-hospital providers and regional EMS systems. These EMS systems therefore play a pre-eminent role in stabilization and transportation to centers with definitive care facility for trauma patients.

According to a study entitled "The Epidemiology of Emergency Medical Services Use by Children: An Analysis of the National Hospital Ambulatory Medical Care Survey" (2008) by Shah MN, Cushman JT, Davis CO, Bazarian JJ, Auinger P, Friedman B (Source - Department of Emergency Medicine, University
of Rochester School of Medicine and Dentistry, Rochester, New York 14642, USA), there is an absence of nationally representative data describing pediatric patients who use emergency medical services (EMS) and the factors associated with EMS use by children.

This study characterizes pediatric emergency department (ED) visits for which the patient arrived by EMS and identifies factors associated with those visits using a nationally representative database. They reviewed 110.9 million ED visits by children aged <19 years between 1997 and 2000. Pediatric patients constituted 27.3% of all ED visits during this time, and 7.9 million (7.1%) of these patients arrived via EMS. Pediatric patients represented 13% of all EMS transports. Sixteen percent of children transported by EMS were admitted to the hospital. Sixty-two percent of pediatric patients arriving at the ED by EMS were transported as a result of injury or poisoning. The researchers concluded that pediatric patients transported by EMS are more likely to have injuries and poisoning, and have higher-acuity illness than those arriving at the ED by other means. The epidemiology of pediatric EMS use may have important operational, training, and public health implications and requires further study.

Therefore, it appears that the pre-hospital providers have limited exposure to critically injured pediatric patients. It is imperative that EMS providers have more frequent pediatric training, and more frequent competency skill verifications of critical pediatric skill sets, protocol, and destination guidelines. Available courses such as EPC, PEPP, PHTLS and P-ITLS address Pediatric Traumas for the providers. These courses and others developed by the RTAC’s stakeholders will be essential in improving pediatric trauma outcomes.

### PEDIATRIC FIELD TRIAGE DECISION SCHEME

**Step 1**

**Serious airway or respiratory compromise or impending arrest**
OR
**Immediate Life Threatening condition that cannot be managed in the field**
(i.e. Need for any airway adjunct/definitive airway, Cardiac arrest or CPR performed prior to arrival)

Transport to the closest trauma center or hospital emergency department capable of managing condition

**Step 2**

Glasgow Coma Scale (modified for pre-verbal children) ..... ≤13
Systolic blood pressure ................................................... <80 + 2 x age
Respiratory rate .............................................................. <10 or in distress
Pediatric Trauma Score ..................................................... <8

All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee

*(Egleston and Erlanger are the preferred PTC’s for penetrating torso injuries; contact while on scene)*
Open/sucking chest wound
Combination trauma with burns
Two or more proximal long bone fractures
Pelvic fractures
Open and depressed skull fracture
Spinal injury with paralysis or any neurologic deficit
Amputation proximal to wrist and ankle
All burns associated with trauma, transport by trauma field triage protocol according to injury presentation*

Head injury with any loss or alteration of consciousness
Spinal injury with risk of paralysis or neurologic deficit
Blunt chest trauma with contusion or tenderness, or with potential for hemo- or pneumothorax
Blunt abdominal trauma with contusion, tenderness or distention
De-gloving injury of extremity or laceration > 7 cm
Penetrating wound involving joint and/or significant vascular injury

Ejection from automobile
Death in same passenger compartment
Falls >20 feet or 2 times standing height
High speed auto crash: Rollover
Intrusion into passenger compartment >12 inches
Intrusion > 18 inches any site in automobile
Unrestrained child > 30 mph
Seat belt sign
High risk pedestrian/auto-bicycle, motorcycle or ATV crash, Pedestrian thrown or run over > 5 mph

Child with special health care needs
Suspected Abuse
Near drowning/ near hanging
EMS provider judgment

Yes to any: take to Level 1 or Level 2 Pediatric Trauma Center. Contact the receiving PTC at the earliest possible time, preferably while on scene, and especially if the transport time is ≥30 minutes.

*Isolated burns 2nd or 3rd degree > 10 % BSA ages < 10 and/or > 20% BSA any age OR any signs of inhalation injury transport to designated Burn Center (Grady or Stills)

Step 3

No to all: re-evaluate patient with on-line medical control

Exception to air medical guideline:
Process shall take into consideration time for transport, patient condition, and treatment window with the goal to secure the appropriate treatment for the patient as expeditiously as possible via ground and/or air. It may be more beneficial for pediatric patient to wait for air transport directly to a PTC rather than delaying definitive care by transporting to the nearest adult trauma center (unless Step 1 applies)
TRAUMA COMMUNICATION CENTER

The Georgia Trauma Commission developed the Trauma Communication Center to assist the EMS provider in identifying the appropriate trauma patients for transport to a level designated one or two trauma center. This center is to be staffed with professionals who have the ability to instantaneously identify the “status” and “capability” of each participating hospital in the system. These staff members will provide guidance to the EMS professional and notification to the Trauma Center that the patient is enroute.

After the primary triage decision that the patient meets TSEC, EMS will contact the TCC at the earliest possible time in order to enter the patient into the trauma system. If the EMS provider is unable to connect directly to the TCC they may utilize their dispatch to assist in initiating contact with the TCC. The TCC operator will offer available hospitals as transport destination recommendations based on the regional destination guidelines (Appendix D) and hospital resource availability. The final patient transport and destination decision will be made by the EMS provider. When appropriate, the TCC will connect the provider with the hospital by voice communication for patient condition reporting, and will record the voice communication. Additionally, the TCC will generate a unique system I.D. number that the EMS provider will enter into the PCR for tracking. During transport, the EMS provider may notify the TCC of any changes in the patient's condition prior to arrival at the destination hospital. The TCC will provide reports to the Region 1 RTAC for analysis and system improvement.

EDUCATION AND TRAINING

Trauma care knowledge and skills need to be continuously updated, refined, and expanded through targeted trauma care training such as Pre-hospital Trauma Life Support®, International Trauma Life Support®, and age-specific courses. The Region 1 RTAC will work hand in hand with the Office of EMS and Trauma (OEMS&T), EMS service providers, and EMS educators to periodically assess the training needs of EMS providers in the region and address any identified education gaps in order to develop robust trauma training programs.

It is essential that all licensed EMS personnel have a basic knowledge and awareness of the regional plan and the trauma system function. Additionally, they must have specific knowledge of the TSEC and of the protocols that will guide the interaction with the trauma communication center (TCC). Individual EMS Service providers, service medical directors, and initial EMS education programs will continue to ensure that all of our EMS providers are competent in providing trauma care and that there is understanding and compliance with trauma triage and destination guidelines. To assist in Regional Trauma Plan implementation and standardization of training provided, the RTAC will develop and distribute training resources specific to the Trauma Regionalization Plan. Additionally, the RTAC will deliver on-site training on request.

HOSPITAL COMPONENT
There are 16 acute care hospitals which serve the 1,105,044 residents in Region 1. The Regional Trauma Plan is being developed as an inclusive system which allows all hospitals within the region and additional participating hospitals to have a role in providing trauma care. The goal is to assure that all trauma patients receive optimal care, given available resources and the needs and locations of the patient are matched with the resources of the system. Hospitals will participate in the Georgia Trauma System on a voluntary basis, either as state-designated trauma centers or as non-designated participating hospitals.

Figure 3 shows the continuum of hospital participation in the Georgia Trauma System:

Non-Participating Hospitals  Participating Hospitals  Designated Trauma Centers

RESOURCE IDENTIFICATION

**Designated Trauma Centers**
Georgia Trauma Centers are designated by the State Office of EMS and Trauma (OEMS&T) using standards based on the American College of Surgeons Trauma Center Verification Standards. (Appendix F) The OEMS&T has defined in policy the process for trauma center designation, re-designation and regulation. As a condition of designation, trauma centers will participate in regional trauma system planning and performance improvement. Therefore, trauma centers are de-facto participants in the Georgia Trauma System and thus the regional plan. There are four levels of designation set by OEMS&T with Level I being the most resource intensive and Level IV being the least resource intensive. Currently within Region 1 there is no Level I trauma center. There are two Level II trauma centers located within Region 1.

**Non-designated Participating Hospitals**
Georgia Hospitals not designated by the Office OEMS/T may participate as non-designated hospitals or may choose to seek designation. These facilities are Georgia licensed hospitals with an emergency department and varying specialty physician coverage and service line capabilities to treat, stabilize and admit low acuity trauma patients. These hospitals commit to trauma system participation and agree to provide data to the TCC for resource availability.

Region 1 Hospitals (Designated and Non-Designated): Appendix J

Need to add others from TN, AL, NC, Regions 2, 3 and 4 that wish to participate

**Pediatric and Burn Resources**

**Pediatric Resources**

Pediatric trauma patients provide unique challenges for pre-hospital and hospital providers. Their unique physiology and ability to compensate for hypoxia and hypovolemia reduce the golden hour to the golden 30 minutes.
The Georgia Trauma System addresses the adult trauma patient from time of injury until delivery to the appropriate facility. Pediatrics on the other hand is not clearly addressed as to the level of care which the patient needs to be transported to. There are no designated pediatric trauma centers in Region 1. There are designated centers in other regions that provide care for the pediatric patients in Region 1.

A goal of the Region 1 RTAC will be to evaluate and enhance pediatric capabilities within the region and surrounding areas. (See Appendix G)

Pediatric resources are listed in Appendix J

**Burn Resources**
There are no designated burn centers in Region 1. There are designated centers in other regions that provide care to patients from Region 1. Burn resources are listed in Appendix J
While Region 1 does not have a designated burn center or unit, stabilization of the burn patient rests with the Level 1 and Level 2 trauma centers in the region until placement at a burn center can be arranged. Treatment of acute blunt and penetrating trauma takes priority over burn management and should guide destination decisions.

**TRAUMA SYSTEM PARTICIPATION**

Whether designated or non-designated, each participating hospital will have a point of contact designated 24/7 who is responsible for status determinations. The RTAC will review status records of participating hospitals as a performance improvement point. Each participating hospital must actively participate in Plan development and the regional performance improvement plan.

The advantage of Trauma System participation to non-designated hospitals is access through the Resource Availability Display (RAD) to all other participating hospitals service line availability and assistance in transfer of trauma patients to the appropriate level and located trauma center. Non-designated participating hospitals will also participate in regional trauma development activities, have access to known data, and be publicly identified as a participant in the state trauma system.

**INTER-FACILITY TRANSFER**

Inter-facility Transfer Guidelines will be established and used to assist the practitioner in identifying the types of injured patients who may benefit from early transfer to a specialty care service at another hospital within the system. These are intended to be guidelines and are not hospital specific. The goal is to identify patients who require transfer early so that the necessary arrangements can be made for transfer where optimal care can be provided without unnecessary delay. The TCC will assist any non-designated participating hospital with transfer options. (See Appendix H)

The American College of Surgeons Committee on Trauma has developed criteria for consideration of transfer. Appendix H outlines the criteria for consideration of transfer. The decision to transfer will be based on capability for stabilization and treatment at the initial receiving facility. *Stabilizing treatment prior to transfer will be based on the guidance of the receiving facility.* (See figure 4)

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<td>1. Carotid or vertebral arterial injury</td>
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2. Torn thoracic aorta or great vessel
3. Cardiac rupture
4. Bilateral pulmonary contusion with PaO2 to FIO2 ratio less than 200
5. Major abdominal vascular injury
6. Grade IV or V liver injuries requiring greater than 6 Units of Red Blood Cell transfusion in 6 hours
7. Unstable pelvic fracture requiring greater than 6 Units of Red Blood Cell transfusion in 6 hours
8. Fracture or dislocation with loss of distal pulses

B. Life-threatening injuries to Level I or II trauma center

1. Penetrating injury or open fracture of the skull
2. Glasgow Coma Scale score that is less than 14 or lateralizing neurologic signs
3. Spinal fracture or spinal cord deficit
4. Unilateral rib fractures or bilateral rib fractures with pulmonary contusion
5. Open long bone fracture
6. Significant torso injury with advanced comorbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)

*Resources for Optimal Care of the Injured Patient 2006, Committee on Trauma, American College of Surgeons.

EDUCATION AND TRAINING

Trauma care knowledge and skills need to be continuously updated, refined, and expanded through targeted trauma care training such as Advanced Trauma Life Support®, International Trauma Life Support®, Trauma Nursing Core Course®, Advanced Trauma Care for Nurses®, and age-specific courses. The Region 1 RTAC will work hand in hand with the Office of EMS and Trauma (OEMS&T) and participating hospitals to periodically assess the training needs of the region and address any identified education gaps in order to develop robust trauma training programs.

All designated trauma centers must meet the professional education and training requirements specified by the American College of Surgeons Committee on Trauma. Level I and II trauma centers can enhance the competence and skill of personnel at designated and non-designated participating hospitals by providing regular multidisciplinary education and care reviews for personnel at these centers. Also, all participating facilities will work jointly to develop and participate in data driven trauma education initiatives.

It is essential that all persons involved in the treatment of Trauma System patients have a basic knowledge and awareness of the regional plan and the trauma system functions. Additionally, they must have specific knowledge of the TSEC and of the protocols that will guide the interaction with the trauma communication center (TCC). Participating hospitals will continue to ensure that caregivers are competent in providing trauma care and that there is understanding and compliance with trauma triage and transfer agreements. To assist in Regional Trauma Plan implementation and standardization of training provided, the RTAC will develop and distribute training resources specific to the Trauma Regionalization Plan. Additionally, the RTAC will deliver on-site training on request.

An education subcommittee will be formed. The subcommittee will determine what education and training is currently being offered in Region I and compile a list of instructors. An education needs assessment will be conducted at participating hospitals. Trauma registry data, along with the results of the needs assessment, will be used to target educational opportunities for trauma system participants. Trauma care training standards for nurses and physicians providing care will be developed.
Communications

COMMUNICATIONS COMPONENT

The communications component is vital to the operation of the Georgia Trauma System as the link between all components of the system. Communications must provide easily accessible:

1. Essential information regarding the status of pre-hospital capabilities and trauma center and non-designated participating hospital resource availability a constant basis;

2. Access to Trauma System information i.e., regional guidelines and trauma system entry criteria;

3. A linkage between injury scene and definitive hospital care for the rapid exchange of the injured patient care needs and the required resources; and,

4. Support for system-wide data collection to ensure system compliance for regional performance improvement activities.

Georgia Trauma Communication Center

The Trauma Communication Center (TCC) coordinates Trauma System activities by maintaining and providing information on trauma center status and, when appropriate, on pre-hospital capabilities. This information is used to ensure that patients meeting TSEC criteria have access to definitive trauma care at an appropriate level of state-designated trauma center. The TCC is continually staffed by personnel with specific and in-depth knowledge of trauma system design, function, and protocols. While use of the TCC is not mandatory, it is a resource that will provide quick access to real time resource availability.

The TCC operates through statewide and region-specific guidelines established by the RTAC, Regional EMS Council, OEMS&T and the GTCNC. The TCC ONLY provides information and recommendations about patient destination as per pre-established regional guidelines for system function. The TCC serves as an information resource for EMS providers, trauma centers and non-designated participating hospitals.

The general functions of the TCC are to:

1. Provide information on system entry criteria based on statewide guidelines as requested by system stakeholders and providers;

2. Assign a unique system I.D. number for each patient meeting TSEC;
3. Collect brief pre-hospital database information;

4. Maintain available resource information and the functional status of all system trauma centers and non-designated participating hospitals at all times and, when appropriate, knowledge of system’s pre-hospital capabilities;

5. Provide information regarding secondary triage status of the patient based on statewide and approved regional guidelines;

6. Establish dependable communication link between field EMS provider and receiving facility;

7. Record and enter pre-hospital data for the Trauma System Communication Database;

8. Facilitate inter-facility transfers of TSEC patients between trauma centers and non-designated participating hospitals; and,

9. Coordinate communication for optimal resource utilization using pre-established statewide and regional guidelines for medical surge during mass casualty incidents or public health emergencies in collaboration with the Department of Public Health Division of Preparedness and Response and the Georgia Emergency Management Agency.

The data collection capabilities attributed to the TCC in the list above and the description of the RAD below are based upon an information system currently under development. This information is subject to change based upon selection of the information system and software design.

See Appendix M for a quick reference guide for TCC utilization.

**Resource Availability Display (RAD)**

The RAD is the point of communication between hospitals and the TCC. The plan is to have a RAD terminal at each participating hospital that provides the TCC with a continuous and real-time functional status display of all participating hospital’s capabilities.

Trauma centers and non-designated participating hospitals have distinct display options for resource availability. Trauma centers will use the RAD to display overall status as either “system-open”, “system-caution”, or “system-closed”. These status labels will inform TCC destination recommendation to EMS providers based on regional guidelines and EMS provider discretions. Non-designated participating hospitals will make RAD updates based upon the availability of specific service lines at the hospital. All information should be accurate and timely. Such availability updates will enable the TCC to make informed patient transfer recommendations.

Participating hospitals are responsible for updating their respective resource displays. The TCC maintains a consolidated system-wide available resource database. All hospital status changes will be automatically communicated to the central system monitoring station at the TCC and to all other participating hospitals. All participating hospitals can view all other participating hospitals’ resources status updates through the RAD. A record of participating hospitals’ resource status over time will be available to each RTAC for regional performance improvement activities.
DATA-DRIVEN PERFORMANCE IMPROVEMENT

The data-driven performance improvement component is essential to continued and overall Trauma System compliance and to the adequacy and improvement of the regional plan. Ongoing system compliance assessment and improvement is essential to ensure an optimal standard of care.

The regional performance improvement program will utilize, at a minimum, three data sets in order to develop and implement overall System improvements. These are:

1. The standardized pre-hospital dataset (EMS run data)
2. The Trauma Registry minimum data set maintained at each trauma center
3. The data maintained and archived at the Trauma Communications Center

The RTAC will use these elements and others to develop performance improvement programs to monitor regional system compliance and performance. Regional Plans and destination guidelines are subject to change resulting from regional performance improvement review.

Each participating hospital will conduct an internal performance improvement program. Additionally, the American College of Surgeons Committee on Trauma (ACS-COT) requires a structured effort by each designated trauma center to demonstrate a continuous process for improving care for injured patients, and as is provided for in the performance improvement program specified above.

The RTAC will determine specific and regional audit filters for performance improvement. A Regional Trauma PI Review team will be established. Trends in care and outcomes must be identified and appropriate system adjustments made to improve the quality and timely availability of trauma patient care. Ongoing evaluation of the trauma care system is essential throughout the continuum of patient care.

Performance Improvement emphasizes a continuous multidisciplinary effort to measure, evaluate, and improve both the process of care and the outcomes. The performance improvement of the RTAC will establish and monitor performance improvement benchmarks and indicators based on data-driven, nationally established guidelines for regional trauma system outcomes. This oversight includes the development and evaluation of process improvement measures from all aspects of trauma system care including injury prevention, pre-hospital, acute, and rehabilitation services. This process is in its earliest phase and primary efforts are focused on:

1. Developing a matrix of indicators that will be evaluated and how outcomes will be measured.
2. Establishing how performance improvement will impact education and training
3. Incorporating data from the Trauma Registry for performance improvement
4. Incorporating data from the Trauma Communications Center for performance improvement
5. Develop a mechanism to review under and over triage.

The Region 1 RTAC Steering Committee and BIS Assessment group completed the Trauma System Self-Assessment Supplemental Tool in July of 2012. The tool is based on national benchmarks and indicators published in the Model Trauma System Planning and Evaluation document, compiled by the US Department of Health and Human Services Administration (2006). The results of this assessment will be utilized as a foundation for how success will be measured in the region, in combination with a review of trauma systems literature and published guidelines from the Resources for the Optimal Care of the Injured Patient compiled by the American College of Surgeons Committee on Trauma (2006).

**Injury Prevention and Outreach**

One of the major goals of any trauma system is the development of programs to prevent unnecessary injuries and deaths due to trauma. The goal of these programs is to reduce behavioral and environmental risks by mobilizing communities through citizen involvement and expanded partnerships. Education and awareness strategies are often employed to encourage individuals to protect themselves from harm. The RTAC along with its collaborative partners will strive to develop effective injury prevention and outreach programs by employing multifaceted approach which includes:

1. Review of research and data to accurately describe the burden of traumatic injury
2. Review injury data from multiple sources so that interventions may be target areas of highest risk
3. Development and implementation of strategies to decrease behavioral and environmental risks factors
4. Collaboration and coordination at the community level to increase local ability to address needs.

**Rehabilitation**

The rehabilitation of the trauma patient should begin on the first hospital day. Acute care should be consistent with preservation of optimal functional recovery. The ultimate goal of trauma care is to restore the patient to pre-injury status. Not only is this in the best interest of the patient but it is less costly. Rehabilitation requires input from an organized multidisciplinary team including healthcare professionals with special training in rehabilitation. Each patient should be evaluated for rehabilitation needs as early as possible in their hospitalization. The assessment should determine the needs for specific components of therapy.

The RTAC will need to determine what resources are available for the patients of Region I and how patients are referred to inpatient and outpatient care. A mechanism to collect data from inpatient and outpatient services to include final disposition and functional outcome will need to be developed. This data would then be used to determine performance improvement standards and educational needs.
Disaster Preparedness

After the 27 April 2011, 21 December 2011 and 2 March 2012 in which 11 of the 16 counties comprising Region 1, The RTAC concluded that there should be a disaster component to the RTAC plan. It is not our intention to mimic or take away from work others are doing on Alternate Standards of Care or plans involving large scale statewide or locale responses being undertaken by Public Health, GEMA and other stakeholder agencies.

Each Disaster is different and what determines a disaster is best determined by the local EMS Provider. A disaster situation usually occurs when local resources are overwhelmed. Small Rural EMS Providers may experience disaster situations more frequent than large urban and sub-urban providers.

The Office of EMS is providing contact and resource information for each provider in Region I. This information will include emergency contact information, resources available, personnel and special teams and vehicles that are available for response.

A data base of available resources will be made available to each EMS provider in Region I and our border state partners. In addition the EMS Program Director and the District Office of Emergency Preparedness will also maintain a copy of the data base and will update annually.

In the event you experience a disaster the NW GA EMS DART should be activated as soon as possible. (See appendix N) They will help you coordinate needed resources.

Your local EMA Office shall also be contacted as soon as possible, since they can also coordinate needed resources.

The Region 1 RTAC will develop a resource document similar to the one create by the Region 1 Office of EMS and Trauma after the April 2011 events. This document (Appendix L) will entail the process for initiating a Mutual Aid Request of additional EMS Units beyond the jurisdictions normal first tier as we currently have, as described above.

In addition to this process, the appendix will list contacts for all participating services, in Region 1 and surrounding regions and states. This resource document will include staffed EMS Units, Hours, Reserve Units that could be staffed up, Specialty Services like Mass Causality Buses, Mobile Command posts, Mass Casualty trailers, etc. We will also look the each participating partner hospital to identify ED beds, Staffing Surge capacity, Surgical Services, Disaster Services and contact(s) as well as any specialty service which they may offer during a disaster.
The Northwest Georgia EMS DART is a comprehensive all hazards response group designed and trained to be able to deploy from 1 hours to 96 hrs to provide specialized EMS crews capable of handling most mass casualty pre-hospital responses. (See full DART plan – Appendix N.)
GLOSSARY of Georgia Trauma System Definitions

EMS Region
One of ten established geographic programmatic regions of the State of Georgia Office of Emergency Medical Services and Trauma within Georgia Department of Public Health.

Georgia Trauma Communications Center
A dedicated facility with specific functions that is staffed 24/7 by personnel with specific and in-depth knowledge of Trauma System design, function, and protocols, established to coordinate the needs of EMS providers responding to field incidents with the resource availability and capacity of hospitals participating in the Georgia Trauma System.

(Georgia) Trauma System
The collective body of regional trauma systems in the State of Georgia, organized to ensure statewide access to the highest standard of trauma care possible and implemented in order to decrease trauma morbidity and mortality throughout the State.

Major trauma center
A Level I or Level II Trauma Center as determined by the American College of Surgeons.

Non-designated participating hospital
An acute care Georgia licensed hospital with an emergency services department and varying specialty physician coverage and service line capabilities to treat, stabilize, and admit low acuity trauma patients. These hospitals sign a letter of commitment indicating Trauma System participation.

Non-participating hospital
A Georgia licensed hospital that has not signed a letter of commitment with the Georgia Trauma Commission indicating System participation and is not a designated Trauma Center.

Participating hospital
Any Trauma Center or non-designated participating hospital in the State of Georgia.

Performance improvement
A data-driven, documented, methodical and reviewable process for identifying and achieving component-specific, regional, or state-level system improvements.

Primary triage
The decision as to whether a patient meets Georgia Trauma System Entry Criteria.

Region
Any trauma service area—for the purpose of the pilot, this is EMS Region 5.

**Regional Trauma Advisory Committee (RTAC)**
A subcommittee of the Regional EMS Council and a body endorsed by the Georgia Trauma Commission within a trauma service area to develop, implement, and oversee a Regional Trauma System Plan.

**Regional trauma system**
Assets, capabilities, stakeholders and providers of a given trauma service area, organized to improve the area’s ability to identify and then transport Trauma System patients to an appropriate hospital for definitive care within an optimal time.

**Regional Trauma System Plan (“Plan”)**
A document developed by and for a Regional Trauma Advisory Committee that specifies and formalizes the relationships between the various regional trauma system components.

**Regional Trauma System Planning Framework (“Framework”)**
A document put forth by the Georgia Trauma Commission to be used as a planning guide for regional trauma system plan development. The Framework sets forth components and functions necessary for operation of a regional trauma system.

**Resource Availability Display (RAD)**
A computer system screen, which indicates the system-open status for Trauma Centers and resource (service line) availability for each participating hospital in the Georgia Trauma System. RAD terminals are limited to participating hospitals and the Trauma Communications Center.

**Secondary triage**
A process which considers the physiologic, anatomic, mechanism of injury, EMS provider discretion, or co-morbid criteria and region-specific trauma transport protocols used to determine the transport destination recommendations made by the Trauma Communications Center for EMS.

**Transfer center**
A hospital-based location tasked to arrange patient transfer into and out of the particular hospital.

**Transport time**
Amount of time estimated between scene departure and destination hospital considering the mode of transport, weather, traffic, and other variables.

**Trauma Center**
A Georgia licensed hospital designated by the State Office of EMS & Trauma as a Level I, II, III, or IV trauma facility. State designation standards are extrapolated from the American College of Surgeons Committee on Trauma, Trauma Center Verification Standards.

**Trauma Communications Center Operations Guide**
A document containing all functional protocols for Trauma Communications Center interaction with regional system components.
**Trauma service area**
A geographic area, which accommodates overlapping and traditional hospitals’ and Trauma Centers’ patient catchment areas and incorporates statewide EMS Regional infrastructure.

**Trauma System Communications Database**
The collective data set of all information gathered by the Georgia Trauma Communications Center including the patient unique system I.D. numbers and participating hospitals’ available resource status history.

**Trauma System Entry Criteria**
Primary triage criteria: See Appendix D.

**Trauma System patient**
A trauma patient for whom the primary triage decision determined Trauma System entry and who has been assigned a unique System I.D. number by the Trauma Communications Center and is thereby entered into the Georgia Trauma System.
Appendix B

Region 1 Ground Ambulances:

Zones Providers

Bartow County  Bartow County EMS  
112 W. Cherokee Ave, Suite 300  
Cartersville, GA 30120  
(770) 387-5160

Catoosa County  Angel EMS  
PO Box 5495  
Fort Oglethorpe, GA 30742  
(706) 861-1234

Chattooga County  Redmond Regional Medical Center EMS  
PO Box 107001  
Rome, GA 30164-7001  
(706) 295-2000

Cherokee County  Cherokee Fire and Emergency Services  
150 Chattin Drive  
Canton, GA 30115  
(678) 493-4127

Dade County  Puckett EMS  
3760 Tramore Pointe Pkwy  
Austell, GA 30106  
(770) 222-5045

Fannin County  Fannin County EMS  
344 West Main St  
Blue Ridge, GA 30513  
(706) 632-4755

Floyd County  Floyd Medical Center EMS  
500 Riverside Parkway  
Rome, GA 30161  
(706) 509-3820

Redmond Regional Medical Center EMS  
PO Box 107001  
Rome, GA 30164-7001  
(706) 295-2000
Gilmer County

**Gilmer County EMA**
325 Howard Simmons Road
Ellijay, GA 30540
(706) 635-1333

Gordon County

**Gordon County Ambulance**
**Gordon Hospital/Adventist Health System**
P.O.Box 12938
Calhoun, GA 30703
(706) 602-7800 ext 2257

Haralson County

**Ambucare EMS**
PO Box 664
Bremen, GA 30110
(770) 537-9110

Murray County

**Murray County EMS**
PO Box 1406
Chatsworth, GA 30705-1406
(706) 517-2089

Paulding County

**Clark Ambulance Service**
PO Box 1789
Dallas, GA 30132
(770) 445-2151

Pickens County

**Pickens County EMS**
422 Upper Salem Church Road
Jasper, GA 30143
(706) 253-8965

Polk County

**Redmond Regional Medical Center EMS**
PO Box 107001
Rome, GA 30164-7001
(706) 295-2000

Walker County

**Walker County Fire and Emergency Services**
107 Alex Drive
P.O. Box 130
Chickamauga, GA 30707
(706) 539-1255

Whitfield County

**Hamilton EMS**
PO Box 806
Dalton, GA 30722-0806
(706) 278-9111
In addition to the zoned 911 providers operating in Region 1, the following services have a presence in the region providing transport services;

**Non-Zoned / Transport Services operating in Region 1**

1. **AMTRAN** - 5 Coosawattee Avenue, Rome, GA 30165, (678) 898-5856
2. **Central EMS** - 3406 Oakcliff Road, Suite D8 Doraville, GA 30340 (404) 851-9911
3. **Dade County EMS** - 71 Case Avenue, Trenton, GA 30752 (706) 657-4625
4. **Lifeguard Ambulance Service of Tennessee** - 604 Watts Avenue Chattanooga, TN 32504 (205) 933-1911
5. **Metro Atlanta Ambulance Service** - 595 Armstrong Street Marietta, GA 30060 (770) 693-8480
7. **United Medical Response** - 4190 JVL Industrial Park Drive, Marietta, GA 30066 (678) 494-3320

Additional Participating Ground Ambulances:

**Air Ambulances:**

1. **AirMethods dba AirLife Georgia** has base locations in Jasper (Region 1), Gainesville (Region 2) Kennesaw and Conyers (Region 3) Newnan, Griffin, Carrollton (Region 4) AirLife Georgia 70 Airport Business Court Jasper, GA 30143 (706-253-1938)

2. **Lifeforce** has bases in Calhoun, Blue Ridge (Region 1) Cookeville and Chattanooga (TN) Lifeforce 975 East Third Street Chattanooga, TN 37403 (423-778-5433)

3. **Children’s Healthcare in Atlanta** based in Atlanta (Region 3) Contact: Dewayne Joy Children’s Healthcare of Atlanta 1645 Tullie Circle Atlanta, GA 30329 (770) 634-2965 Dewayne.joy@CHOA.org

* Though all the Air Ambulance service providers listed above respond to Region 1 on a regular basis. The Calhoun, Blue Ridge and Jasper bases are the only three helicopters currently located in Region 1.
Fixed Wing Air Transport Services

1. Critical Care Med Flight (fixed-wing)
   Matt Robinson
   P.O. Box 245
   Lawrenceville, GA 30046
   (404) 545-3990
   (770) 342-8070

2. EagleMed 28 (fixed-wing)
   Greenville Airport
   7 Airport Road Extension
   Greenville, NC
   800-525-5220
   864-242-4777
Appendix D

Regional
Air Medical Service
Utilization Guidelines

For all First Responder and EMS agencies in the Northwest Georgia EMS Region 1
Air Medical Guidelines

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INTRODUCTION

This document was created by the northwest Georgia EMS Region 1 RTAC Pre-hospital Subcommittee. Its purpose is to serve as a guide for all emergency service agencies – law enforcement, fire departments and EMS in the counties included in Georgia EMS Region 1 (Dade, Walker, Catoosa, Chattooga, Whitfield, Murray, Gordon, Floyd, Bartow, Polk, Haralson, Paulding, Fannin, Gilmer, Pickens and Cherokee). In order to maintain maximum efficiency of trauma patient transport to the closest appropriate facilities using scarce resources, it is necessary to define standards of appropriate use of air medical transport services. Adherence to these recommendations will hopefully ensure that the right patient safely arrives at the right facility in the right amount of time, while ensuring availability of air medical transport for the next patient.

CRITERIA FOR EMS REQUESTING AIR MEDICAL SERVICES

Air medical transport services (AMS), like Helicopter Transport, is an air ambulance and an extension of EMS. It should be considered in situations wherein:

1. The transport of critically ill or injured patient(s) to an appropriate facility will be faster by AMS than by ground ambulance, if time is determined to be a factor in patient care.
2. If specialized services offered by the AMS would benefit the patient(s) prior to arrival at the hospital.

The following criteria should be used when considering use of AMS:

- The patient’s condition is a “life or limb” threatening situation demanding intensive, multidisciplinary treatment and care. This may include but not be limited to:
- Patients with **physical findings** defined in the CDC adult and pediatric major trauma protocols
- Critical burn patients as defined in the American Burn Association Guidelines
- Critically ill medical patients requiring care at a specialized center to include, but not be limited to: acute stroke or ST elevation MI as defined by AHA STEMI protocol.
- A patient's condition warrants transportation to a specialty care facility as indicated by specific State or Regional Protocols and the AMS can complete such transportation faster than ground transport.
- A multiple casualty incident (MCI) threatens to overload local capabilities
- Ground transportation is compromised
- Difficult access situations such as wilderness rescue, ambulance access or egress impeded at the scene by road conditions, weather or traffic, or other situations cleared by the flight team.
- Local EMS resources are overwhelmed and further use of local EMS units will leave response area inadequately covered.

**NOTE:** Patients in cardiac arrest who are not hypothermic should be excluded from these criteria. Police, Fire, or EMS will evaluate the situation or condition and if necessary request that AMS be dispatched. This is done anywhere in the region by radio with the appropriate County Emergency Communications Center (ECC). AMS can be requested to respond to the scene when:

a. Emergency Services personnel request air medical transport  
   OR
b. In the absence of an EMS provider, any emergency agency may request AMS  
   OR
c. by procedure defined by local policy

---

**Regional Air Medical Service Utilization Guidelines**

**IMPORTANT**

When EMS arrives, they should assess the scene. If it is later determined by the HIGHEST TRAINED EMS PROVIDER on the scene that the AMS is not needed, it should be cancelled as soon as possible.

If an AMS crew is already on the scene, the ONLY agency that may cancel any additional AMS resources is the AMS agency on the scene.

**AN EMS SERVICE SHOULD NOT WAIT ON THE SCENE OR DELAY TRANSPORT WAITING FOR AMS TO ARRIVE.** If the patient is packaged and ready for transport, the EMS service should initiate transport to the hospital. If possible, a landing zone will be reassigned and AMS directed to intercept with an ambulance during transport at an alternative-landing site.
ESTIMATED TIME OF ARRIVAL (ETA) VS ACTUAL TIME OF ARRIVAL (ATA)
Upon request for air medical transport, the dispatch center will issue an Estimated Time of Arrival (ETA) based upon operational startup of the aircraft, travel time from point of origin to the call scene and point of origin for the responding AMS unit. If the ETA provided by the dispatch center is greater than the time needed to secure and transport the patient to the nearest appropriate hospital by ground ambulance, TRANSPORT SHOULD BE COMPLETED BY GROUND AMBULANCE. Further decisions should be made considering ATA.

Once a helicopter is airborne, the pilot will use the aircraft’s onboard computer to calculate a more accurate ETA based upon a global positioning system (GPS) coordinates and wind conditions. The crew will attempt to communicate this updated ETA to the scene personnel. In the event that contact cannot be made, the dispatch center will be requested to regain radio communications with the ground units and provide them the updated ETA. If the updated ETA provided by the helicopter crew or dispatch center is greater than the time needed to secure and transport the patient to the nearest appropriate hospital by ground ambulance, TRANSPORT SHOULD BE COMPLETED BY GROUND AMBULANCE. Any changes in ATA should be communicated as soon as possible to the requesting agency.

The Actual Time of Arrival (ATA) is when the helicopter has reached the location of the scene (at high orbit). All communications and times should be recorded by scene personnel for their records, especially when care of the patient was transferred to the air medical personnel.

OPERATIONAL CRITERIA FOR HELICOPTER TRANSPORT
After the decision for air medical transport, the following operational criteria should be considered prior to requesting a helicopter for direct pickup of patients:

1. Ground transportation to the appropriate critical care facility will exceed thirty (30) minutes or if on-scene time has the potential of being extended i.e. lengthy extrication etc.
2. The helicopter can be airborne and return to the nearest appropriate hospital faster than an ambulance can transport the patient(s) to the nearest appropriate hospital.
3. A proper helicopter-landing site is available.

Appropriate utilization of helicopter resources at an emergency scene includes, but is not limited to:

1. A patient’s condition warrants transportation to a specialty care facility as indicated by Specific State or Regional Protocols and the helicopter can complete such transportation faster than ground transportation.
2. A Multiple Casualty incident (MCI) threatens to overload local capabilities.
3. Ground transportation is compromised.
4. Difficult access situations such as wilderness rescue, ambulance access or egress impeded at the scene by road conditions, weather or traffic, or other situations cleared by the flight team.
5. Local EMS resources are overwhelmed and further use of local EMS units will leave response area inadequately covered.

Ground providers should notify dispatch if more than one patient requires air transport. If available, one helicopter will be dispatched per critical patient requiring air transport. AMS should be notified as soon as possible. If more than one AMS is responding then all AMS services should be notified

Note: Patients in cardiac arrest WILL NOT be transported by helicopter – unless a situation exists where air transport would be faster than ground transport to the nearest appropriate hospital.
CRITERIA FOR AMS TRANSPORT

The following criteria should be considered prior to requesting AMS at a scene of patients. Provisions for EMS provider judgment shall exist in special circumstances where the below criteria may not be met:

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<tr>
<td>1. Patients meeting current CDC Field Triage Decision Scheme: The National Trauma Triage Protocol physiological and anatomic criteria</td>
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<td>2. Patients meeting current CDC Field Triage Decision Scheme: The National Trauma Triage Protocol mechanism of injury and evidence of high-energy criteria when transport time by ground or air transport may be excessive and significant injury is suspected.</td>
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<th>PEDIATRIC CRITERIA</th>
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<td>See attachment from CDC Trauma Guidelines</td>
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<th>CRITICAL BURNS</th>
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<td>See attachment from American Burn Association</td>
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*Note that for patients with burns and coexisting trauma, the traumatic injury should be considered the first priority and the patient should be triaged to the closest appropriate trauma center for initial stabilization.*

Per the Georgia BLS Protocols, if a patient does not meet the above criteria for Adult Major Trauma, but has sustained an injury and has one or more of the following criteria, they are considered a High Risk Patient:

- Prone to bleeding disorders (i.e. hemophilia, taking anticoagulants)
- History of cardiac and/or respiratory distress disease
- Insulin dependent diabetes, cirrhosis, or morbid obesity
- Immunosuppressed patients (i.e. HIV disease, history of organ transplants or taking chemotherapy treatment)
- Age > 55

In these circumstances EMS should consider transportation to an area or regional trauma center and/or contacting medical control. For additional transport directives, please see [Appropriate Facility Transport Algorithms](http://www.acep.org/uploadedFiles/ACEP/Practice_Resources/issues_by_category/Emergency_Medical_Services/GuidelinesForAirMedDisp.pdf) found in Appendix C.

**NOTE:** Traumatic cardiac arrest and patients with an unmanageable airway will be transported to the closest appropriate hospital. See ACEP/NAEMSP Helicopter Transport Guidelines at

http://www.acep.org/uploadedFiles/ACEP/Practice_Resources/issues_by_category/Emergency_Medical_Services/GuidelinesForAirMedDisp.pdf

WEATHER CONDITIONS
AMS agencies abide by strict weather minimums to ensure the safety of their flight team and the patient. However, ground emergency service personnel generally underestimate the aircraft’s flight abilities during inclement weather. Aircraft, such as helicopters, are capable of safe flight through mild to moderate rain, snow and winds.

Weather requirements are primarily based upon the following indicators:

- **CEILING**: Height of the clouds above the ground.
- **VISIBILITY**: Distance visible in front of the aircraft

Also, the “LOCAL” flying area encompasses the entire area of northwest Georgia EMS Region 1 but the aircraft may be dispatched into the area from outside the area. Atmospheric conditions on scene may be quite different than those at the dispatch point of the aircraft.

**NOTE:** For all of these reasons, emergency service personnel at the scene are encouraged **NOT** to make weather decisions on their own.

If the air transport of a patient is being considered, ground emergency services should contact the appropriate County ECC who will advise whether or not the air medical transportation service is available. **All requested AMS should be notified of any AMS declining service requests for incident because of weather conditions.**

**DISPATCH CENTER STAND-BY CRITERIA**

A “STAND-BY” procedure may be requested by **any local dispatch center** to the appropriate County ECC based upon the report of the following:

- Gas or other type explosion
- Severe burn injury
- Head-on, Rollover or “T-Bone” collision of motor vehicles
- Motor vehicle crash involving an all-terrain vehicle (ATV), motorcycle, ejection of passenger, or pedestrian struck
- Any incident with the potential of producing mass casualties or major traumatic injuries.
- Any incident which leaves the local EMS response area inadequately covered.

Under these circumstances:

1. The appropriate County ECC will contact the AIR MEDICAL dispatch center to have the air medical crew “STAND-BY”
2. Responding EMS crews will be advised that a “STAND-BY” has been requested by the ECC.
3. Once EMS have arrived and assessed the need for AMS, a determination to launch or cancel the assigned AMS agency will be made by the highest trained EMS provider on the scene.
4. As soon as it is determined from the scene that AMS are or are not needed, the requesting County ECC shall notify the AIR MEDICAL dispatch center.

**AMS (HELICOPTER) AUTO-LAUNCH PROGRAM**

Due to the size of the area covered in the northwest Georgia EMS Region 1 by AMS, and the increased flight times needed to reach locations at the farthest borders, an “Auto-Launch” procedure will be used based upon the following:
1. Upon request to place AMS on “STAND-BY”, the AIR MEDICAL dispatch center will determine the estimated distance (in miles) from the assigned AMS unit to the incident scene;

2. Air Medical Service Providers shall have the ability to perform “Air Stand-bys” or “auto-launches” regardless of distance based on dispatch information, geographical factors, hospital locations etc.

3. The AIR MEDICAL dispatch center will then notify the requesting County ECC of the Auto-Launch status.

4. As soon as it is determined from the scene that AMS are or are not needed, the requesting County ECC shall notify the AIR MEDICAL dispatch center;

5. If for any reason the AMS unit arrives prior to this decision being made by the requesting agency, the AMS unit will remain in the vicinity of the scene until the request to have the unit land is confirmed either with the AIR MEDICAL dispatch center or directly with the requesting agency, or upon notification that the unit has been cancelled.

6. As soon as it is determined from the scene that an AMS unit will be utilized, the requesting County ECC shall notify the AIR MEDICAL dispatch center of the utilization request and the unit will be advised to proceed to the landing zone under standard AMS request procedures.

**LANDING ZONES**

The landing zone (LZ) is an area intended for the purpose of landing and taking off in the most commonly used AMS aircraft, a helicopter. The preparation of an LZ is one of the primary functions of the ground personnel. Proper preparation is essential to the safe operation of an air-medical mission.

The LZ should be adjacent to the scene to avoid the need for intermediate transport that could prolong a patient’s pre-hospital time. A helicopter should be as close to the scene as possible and practical. When a hospital’s helipad is determined to be the most appropriate landing zone to effectuate field transfer of a patient from EMS to AMS, notification shall be made from the AMS dispatch center to the hospital as soon as possible.

**LZ Criteria**

The minimum area of the LZ should not change:

<table>
<thead>
<tr>
<th>Minimum Landing Zone Area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Length</strong></td>
</tr>
<tr>
<td><strong>Width</strong></td>
</tr>
</tbody>
</table>

Although past local practice has been to allow for a smaller LZ during the day, due to the possibility of requesting AMS from other neighboring area with larger airships, having one uniform size is preferable.

An LZ must also be:

- Free of overhanging obstructions
- Generally level (Slope should not be greater than 5 degrees)
- On a firm surface. (Unpaved, shrubs, brush, grass or weeds should be less than 24 inches in height.)
Marking the LZ
Mark the four corners of the LZ. The use of flares for marking the LZ is discouraged because of the inherent fire risk. The preferred means of LZ marking is by placement of orange traffic cones in each corner. For night operations, a flashlight can be placed in each cone for illumination. The cones will likely blow over as the aircraft makes its final approach into the LZ. This occurrence should not concern the ground providers, as the cones are not light enough to be blown airborne into the rotor system.

RADIO CONTACT
As the flight team approaches the LZ, they will contact you on your own frequency. When radio contact is made, it is imperative that the flight crew communicates with the Landing Zone Officer, the one person assigned to establish and secure the landing zone. The LZ Officer should describe the LZ, any hazards in the area, wind direction, condition of the touchdown surface, and security information (i.e. crowd is secured and traffic is stopped).

NOTE: Pay special attention to looking for overhead wires and reporting their location to the pilot when the helicopter arrives overhead.

POST-LANDING OPERATIONS & PATIENT LOADING
Once a helicopter has landed, the following should be observed:

- Assure that one approaches the helicopter or enters the LZ unless directed to do so by the flight team.
- Never allow a vehicle to drive up to the helicopter.
- If you are directed to approach the helicopter by the flight team, NEVER approach the rear of the helicopter, only approach from the front. The tail rotors are invisible when spinning.

(See diagrams)
Assisting in Loading the Patient

The flight team will request for a certain number of responders to assist in carrying and loading the stretcher into the aircraft after the patient has been prepared. Follow the flight team's direction when carrying the patient toward the aircraft. Please do not allow more than four (4) responders to assist in the carry unless directed to by the flight team. Once the patient has been loaded into the rear or side of the helicopter, exit the LZ as directed by the flight crew. Never attempt to operate any of the aircraft doors or the stretcher securing device.

REPORTING INCIDENTS

Note: The Georgia Department of Public Health, Office of Emergency Medical Services mandates specific incident reporting responsibilities and requirements for all EMS Services. Incidents identified must be reported as indicated in Georgia Department of Public Health Office of Emergency Medical Services and Trauma Rules and Regulations 511-9-2-.18 “Standards of Conduct for Licensees” and 511-9-2-.19 Disciplinary Action against Licensees” as well as other state and regional policies and procedures.

Regional complaints or concerns involving AMS may be made by a patient, the public, participating organizations or individual providers. All such complaints or concerns should be submitted to the Georgia EMS Region 1 Program Director in writing to the address below:

David Foster, Program Director
Georgia EMS Region 1
1309 Redmond Road
Rome, GA 30165

Appropriate grounds for Regional AMS complaints or concerns include:

1. Deviation from accepted standards. (e.g. protocols, advisories, policies, procedures, equipment and medication schedules).

   Note: (Especially those practices specifically related to air medical operations such as the provision of accurate ETA information so that appropriate patient transportation decisions may be made by ground crews.

2. Unprofessional conduct (including but not limited to: disrespect towards patients, families, fellow providers, intoxication while on duty, breaking patient confidentially, etc.)

3. Practicing without proper Georgia licensure

4. Immoral or indecent behavior

5. Fraud, falsification of records, unauthorized possession or misappropriation of property
6. Insubordination (The scope of which rose to a level that threatened patient care and/or patient or provider safety.)

In order to handle complaints or concerns regarding the delivery of emergency air-medical services, the following procedure has been established. Additionally, all deviations from or complications to effective transfer of care from ground EMS to AMS will be reported to the Georgia Office of Emergency Medical Services and Trauma EMS Region 1 Program Director in writing.

**Complaints or concerns will be handled by the following process:**

1. Complaint or concern is brought to the attention of the Georgia Office of EMS and Trauma EMS Region 1 Program Director in writing.
2. The Georgia EMS Region 1 Program Director will communicate the receipt of the complaint or concern to the Georgia Office of EMS and Trauma which will issue a complaint number.
3. The Georgia EMS Region 1 Program Director will confirm receipt of the complaint or concern in writing to the complainant. The letter will contain a complaint number issued by the Georgia Department of EMS and Trauma.
4. The Georgia EMS Region 1 Program Director may schedule an interview with the complainant. The Georgia EMS Region 1 Program Director may request additional documents as needed for the investigation from the complainant.
5. The Georgia EMS Region 1 Program Director will notify the licensed service and/or individuals of the complaint.
6. The Georgia EMS Region 1 Program Director may schedule an interview with the licensed service representatives and/or individuals involved in the complaint. In addition, the EMS Regional Program Director may request additional related documents.
7. The Georgia EMS Region 1 Program Director may schedule interviews with witnesses of the incident as needed.
8. The Georgia EMS Region 1 Program Director will report all findings and documents to the Georgia Office of EMS and Trauma with his/her recommendation.
9. The Georgia Office of EMS and Trauma will inform the Georgia EMS Region 1 Program Director the complainant, licensed service and/or individuals of the decision on the complaint or concern with the actions against license(s) if needed.
**Appendix E**

**PRIMARY TRIAGE DECISION SCHEME**

**GEORGIA TRAUMA SYSTEM**

1. **Measure vital signs and level of consciousness**
   - Glasgow Coma Scale: \( \leq 13 \) or
   - Systolic blood pressure: \( < 90 \)
   - Respiratory rate: \( < 10 \) or \( > 29 \) (<20 in infant < one year)

   **YES**
   - Assess anatomy of injury

   **NO**
   - NO

   Steps 1 and 2 attempt to identify the most seriously injured patients. These patients meet Georgia Trauma System Entry Criteria. Take to a trauma center.

2. **Assess evidence of high-energy impact**

   **YES**
   - Falls
     - Adults: \( > 20 \) ft. (one story is equal to 10 ft.)
     - Children: \( > 10 \) ft. or 2-3 times the height of the child
   - High-Risk Auto Crash
     - Intrusion: \( > 12 \) in. occupant site; \( > 18 \) in. any site
     - Ejection (partial or complete) from automobile
     - Death in same passenger compartment
     - Vehicle telemetry data consistent with high risk of injury
   - Auto vs. Pedestrian/Bicyclist Thrown, Run Over, or with Significant (>20 MPH) Impact
   - Motorcycle Crash > 20 MPH

   **NO**

   Steps 1 and 2 attempt to identify the most seriously injured patients. These patients meet Georgia Trauma System Entry Criteria. Take to a trauma center.

3. **Age**
   - Older Adults: risk of injury death increases after age 55
   - Children: Should be triaged preferentially to pediatric-capable trauma centers

   **Anticoagulation and Bleeding Disorders**

   **Burn**
   - Without other trauma mechanism: Triage to burn facility
   - In same body area, a combination of trauma and burns (partial and full thickness) of fifteen percent or greater

   **Time Sensitive Extremity Injury**

   **End-Stage Renal Disease Requiring Dialysis**

   **Pregnancy > 20 Weeks**

   **EMS Provider Judgment (to include known patient medical history)**

   **YES**

   These patients meet Georgia Trauma System Entry Criteria. Take to a trauma center or other appropriate hospital identified in protocols.

   **NO**

   Assess special patient or system considerations

   **Transport according to protocol**

When in doubt, transport to a trauma center.
Region 1 Pre-Hospital Destination Guidelines

Indications

Trauma patients who meet any of the following trauma triage criteria should be transported to the closest appropriate trauma center. If an extended ground transport time is expected, then air transport to the closest appropriate Trauma Center may be considered. If direct ground transport to the appropriate level Trauma Center cannot be performed and air medical evacuation cannot be done, the patient should be transported to the closest appropriate hospital. Transport all patients with an unmanageable airway or uncontrolled hemorrhage to the closest appropriate hospital.

Trauma Triage Criteria (Adult and Pediatrics)

Physiologic Criteria

- Glasgow Coma Scale less than or equal to 13, or
- Systolic blood pressure of less than 90mm/Hg, or
- Respiratory rate of less than 10 or greater than 29 breaths per minute (less than 20 breaths per minute in infants less than 1 years old)

These patients should preferentially be transported to the highest level of care within the trauma system. (Level I or II)

Anatomic Criteria

- All penetrating injuries to head, neck, torso, or groin associated with an energy transfer
- Flail chest
- Two or more obvious proximal long-bone fractures
- Crushed, de-gloved, or mangled extremity
- Amputation proximal to wrist and ankle
- Pelvic fractures*, as evidenced by positive “pelvic movement” exam
- Open or depressed skull fractures
- Paralysis

These patients should preferentially be transported to the highest level of care within the trauma system. (Level I or II)

*If a patient has an isolated pelvic fracture without significant Mechanism of Injury, and does not meet Physiologic criteria, agency protocols may direct the EMS provider to contact medical control or refer to agency protocols to determine hospital destination.

Significant Mechanism of Injury**

- Falls
  - Adults – greater than 20 feet (one story is equal to 10 feet)
  - Children – greater than 10 feet, or two to three times child’s height
- High-risk auto crash
  - Intrusion – more than 12 inches to occupant site or more than 18 inches to any site
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with high risk of injury
- Auto versus pedestrian/bicyclists
  - Thrown, run over, or with significant (greater than 20 mph) impact
- Motorcycle crash
  - At speed greater than 20 mph

Transport to closest appropriate facility or Trauma Center. Need not be the highest level of trauma center.

**If patients that meet Mechanism of Injury, but do not meet Physiologic and/or Anatomic criteria, the EMS provider should contact medical control or refer to agency protocols to determine hospital destination.

Special Considerations
• **Age**  -Older Adult: Risk of injury/death increases after age 55
  -Children: Should be preferentially triaged to pediatric-capable trauma centers
• **Burns**  -Without other trauma mechanism, triage to burn center
  -In same body area, a combination of trauma and burns (partial and full thickness of fifteen percent or greater.)
• **Anticoagulation and Bleeding Disorders**
• **Time-Sensitive Extremity Injury**-such as open fracture(s) or fracture(s) with neurovascular compromise
• **End-stage renal requiring dialysis**
• **Pregnancy > 20 weeks**
• **EMS Provider Judgment** (To include known medical history, MOI involving recreational vehicles, extrication time***, etc.)
  
  ***For prolonged extrication, transport patient in accordance with local medical direction and/or agency protocol

Patients who do not meet any of the above triage criteria should be transported to the most appropriate medical facility as outlined in local EMS protocols.

**Procedure**

If an extended ground transport time to a trauma center is not anticipated:
1. Provide appropriate care.
2. If a Trauma System Patient is identified, establish early communication with the Trauma Communication Center (TCC).
3. Initiate immediate transport towards (scene time less than 10 minutes) appropriate level trauma center.
4. During transport, the TCC can serve as a communications bridge to the receiving hospital to update patient status.
5. The TCC will “patch” EMS service providers through to the receiving hospital when appropriate to provide contact with medical direction or allow for patient reporting.

If an extended ground transport time to a trauma center is anticipated:
1. Provide appropriate care.
2. If a Trauma System Patient is identified, establish early communication with the Trauma Communication Center (TCC).
3. Field transports by helicopter of trauma patients should be considered:
   a. If patient meets the clinical triage criteria for transport and should be transported to the closest appropriate level Trauma Center AND can be delivered to an appropriate Trauma Center more rapidly by air ambulance than by ground transport.
   b. If ground ambulance availability is not sufficient to provide transport to the closest appropriate Trauma Center or the utilization of local ground ambulance leaves local community without ground ambulance coverage.
   c. If patient requires a level of care greater than can be expected by the local ground provider AND if the air ambulance can be on scene in a time shorter than the ground unit can initiate transport.
4. If air transport is not elected, delayed, or unavailable, initiate immediate ground transport towards (scene time less than 10 minutes) the appropriate level trauma center.
5. During transport, the TCC can serve as a communications bridge to the receiving hospital to update patient status.
6. The TCC will “patch” EMS service providers through to the receiving hospital when appropriate to provide contact with medical direction or allow for patient reporting.

If an agency cannot perform a ground transport directly to a Level I or II Trauma Center:
(The primary objective of these guidelines is to identify and then transport Trauma System patients to a Level I or II Trauma Center for definitive care within an optimal time. However, some agencies may not be able to perform direct transport to a Level I or II Trauma Center because of geography, unavailability of resources, and other factors.)
1. Provide appropriate care.
2. If a Trauma System Patient is identified, establish early communication with the Trauma Communication Center (TCC).
3. Field transports by helicopter of trauma patients should be considered:
a. If patient meets the clinical triage criteria for transport and should be transported to the closest appropriate level Trauma Center AND can be delivered to an appropriate Trauma Center more rapidly by air ambulance than by ground transport.

b. If patient requires an immediate life-saving intervention at a level of care greater than can be expected by the local ground provider AND if the air ambulance can be on scene in a time shorter than the ground unit can transport to the closest hospital.

4. If air transport is delayed or unavailable, transport patients meeting trauma center criteria to the closest appropriate hospital.

Notes:
- Transport all patients with an unmanageable airway or uncontrolled hemorrhage to the closest hospital emergency department.
- Traumatic cardiac arrest with any electrical cardiac activity – Transport to designated trauma center if transport time is less than 10 minute difference from the closest hospital. Otherwise, transport to the closest hospital emergency department.
- Obstetric (> 20 weeks) patients that do not meet trauma criteria should be transported to closest hospital with obstetrical resources.
- If patients that meet Mechanism of Injury, but do not meet Physiologic and/or Anatomic criteria, the EMS provider should contact medical control or refer to agency protocols to determine hospital destination.
- Ground ambulances should not excessively delay transport waiting for a helicopter to arrive. If the patient is ready for transport and air transport is delayed, the EMS service may consider initiating transport to the hospital or reassigning the landing zone.
- The TCC operator will offer available hospitals as transport destination recommendations based on the regional destination guidelines and hospital resource availability. The final patient transport and destination decision will be made by the EMS provider.
- Under Georgia law, the patient has the right to determine to which hospital they choose to be taken. If the patient is a minor or incompetent, the parent or legal guardian has the right to exercise that authority.
- Consider contacting medical control to address concerns about patient care, appropriate receiving facility, or air transport decisions.
Pediatric Trauma Field Triage and Transport Protocol

Step One: Assess life threatening conditions
- Serious Airway or Respiratory Compromise or Impending Arrest or immediate life threatening condition that cannot be managed in the field

Transport to the closest trauma center or hospital emergency department capable of managing condition

Step Two: Assess Level of Consciousness and Vital Signs
- GCS < 14
- Systolic Blood Pressure < 80 + 2x age or absence of peripheral pulses vs. central
- Respiratory Rate < 10 or > 29 (< 20 in infant aged < one year)
- Heart Rate > 120 AND/OR Clinical Signs of Shock

Yes →

Step Three: Assess Anatomy of Injury
- All penetrating injuries to head, neck, torso, boxers short and T-shirt coverage areas
- Airway compromise or obstruction, flail chest, hemothorax, patients intubated on scene, maxilla-facial or upper airway injury
- Two or more proximal long bone fractures, open or closed; two or more extremity fractures
- Extremity trauma with loss of distal pulses
- Amputation proximal to wrist and ankle (follow replant protocol and local and regional plan)
- Pelvic fractures
- Open or depressed skull fractures or closed head injury with AIMS
- Paralysis or signs of spinal cord or cranial nerve injury
- Active or uncontrolled hemorrhage
- ISOLATED BURNS 2nd/3rd degree > 10% BSA ages < 10 and or > 20% BSA any age or any signs of inhalation injury; follow burn protocol and local and regional plan;
- ALL BURNS WITH ASSOCIATED TRAUMA: transport by trauma field triage protocol according to injury presentation

No

Step Four: Assess Biomechanics of Injury and Evidence of High-Energy
- Falls: PEDES > 10 feet or 2x standing height
- Intrusion: > 12 in occupant site; > 19 inches any site
- Autos or rollover
- Death in same passenger compartment
- Unrestrained child 5’ 8” years of age when > 30 mph or highway speed
- Evidence of significant change in position and location within vehicle; Seat Belt Sign
- High-risk pedestrian, cycle, ATV Crash
- All open fractures
- Auto vs. pedestrian, bicycle thrown, run over, or with significant impact, > 5 mph; Femur fracture
- Motorcycle or ATV crash > 20 mph with separation of rider or rollover
- Assault with prolonged Loss of
Transport to pediatric trauma center or pediatric capable trauma center according to local and regional process. Process shall take into consideration time for transport, patient condition, and treatment window, with the goal to secure the appropriate treatment for the patient as expeditiously as possible via ground and/or air; if > 30 min transport, consider transport to level 1 if significantly closer; plan for bi-state region accounts for out-of-state transport when appropriate.

**ANY TRAUMA PATIENT WITH SPECIAL HEALTHCARE NEEDS TRANSPORT IMMEDIATELY TO LEVEL ONE TRAUMA CENTER**

**Step Five: Assess other risk factors/special patient or system considerations**

- Age—PEDs<15 years with potential for admission to pediatric capable center
- Falls-PEDs <10 Feet
- Lower risk Crash
- MVC < 40 MPH or UNIC speed
- Auto vs. Pedestrian/Bicyclist <5 mph Impact
- Motorcycle or ATV crash < 20 mph with separation of rider or rollover
- Medical Co-Morbidity
- Anticoagulation and bleeding disorder
- End stage renal disease requiring dialysis
- All pregnant patients involved in traumatic event

**Additional Considerations**

- Burns: Isolated 10-20% 2nd or 3rd degree, <10 years and isolated burns <10% in peds
- Amputation distal to wrist or ankle of two or more digits (follow replant protocol and local regional plan)
- Penetrating injury distal to wrist or ankle
- Assault without Loss of Consciousness
- Suspected child abuse
- Near drowning / near hanging
- EMS provider judgment

Transport to pediatric trauma center or pediatric capable trauma center according to local and regional process. Process shall take into consideration time for transport, patient condition, and treatment window, with the goal to secure the appropriate treatment for the patient as expeditiously as possible via ground and/or air; if > 30 min transport, consider transport to level 1 if significantly closer; plan for bi-state region accounts for out-of-state transport when appropriate.

Transport according to routine protocol.
### Pediatric Glasgow Coma Scale

<table>
<thead>
<tr>
<th>Eye opening</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous</td>
<td>4</td>
</tr>
<tr>
<td>To verbal stimuli</td>
<td>3</td>
</tr>
<tr>
<td>To pain only</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Verbal Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientated, appropriate</td>
<td>5</td>
</tr>
<tr>
<td>Confused, disoriented</td>
<td>4</td>
</tr>
<tr>
<td>Inappropriate words</td>
<td>3</td>
</tr>
<tr>
<td>Incomprehensible words</td>
<td>2</td>
</tr>
<tr>
<td>Non specific sounds</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Motor Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obey commands</td>
<td>6</td>
</tr>
<tr>
<td>Localizes painful stimulus</td>
<td>5</td>
</tr>
<tr>
<td>Withdraws in response to pain</td>
<td>4</td>
</tr>
<tr>
<td>Abnormal flexion in response to pain</td>
<td>3</td>
</tr>
<tr>
<td>Abnormal extension in response to pain</td>
<td>2</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
</tr>
</tbody>
</table>

The GCS is scored between 3 and 15, 3 being the worst, and 15 the best. It is composed of three parameters: best eye response (E), best verbal response (V), and best motor response (M). The components of the GCS are recorded individually; for example, E2V3M4 results in a GCS of 9.

#### REFERENCES


### Pediatric Trauma Score

<table>
<thead>
<tr>
<th>Airway</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Oral or nasal airway, oxygen</td>
</tr>
<tr>
<td>Intubated</td>
<td>Intubated, cricothyroidotomy, or tracheostomy</td>
</tr>
<tr>
<td>Systolic Blood Pressure</td>
<td>&gt; 90 mm Hg: good peripheral pulses and perfusion</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>Awake</td>
</tr>
<tr>
<td>Skeletal</td>
<td>None seen or suspected</td>
</tr>
<tr>
<td>Open Wound</td>
<td>None visible</td>
</tr>
</tbody>
</table>

**Totals:**
Region 1 Hospital Guidelines for the
Inter-facility Transfer of Trauma System Patients

INDICATIONS

Trauma patients who meet any of the following trauma triage criteria shall be considered Trauma System patients. The objective is to identify and then transport Trauma System patients to an appropriate hospital for definitive care within an optimal time.

TRAUMA TRIAGE CRITERIA (ADULT AND PEDIATRICS)

Physiologic Criteria
- Glasgow Coma Scale less than or equal to 13, or
- Systolic blood pressure of less than 90mm/Hg, or
- Respiratory rate of less than 10 or greater than 29 breaths per minute (less than 20 breaths per minute in infants less than 1 year old)
*These patients should preferentially be transported to the highest level of care within the trauma system. (Level I or II)

Anatomic Criteria
- All penetrating injuries to head, neck, torso, or groin associated with an energy transfer.
- Flail chest
- Two or more obvious proximal long-bone fractures
- Crushed, de-gloved, or mangled extremity
- Amputation proximal to wrist and ankle
- Pelvic fractures, as evidenced by positive “pelvic movement” exam
- Open or depressed skull fractures
- Paralysis
*These patients should preferentially be transported to the highest level of care within the trauma system. (Level I or II)

Significant Mechanism of Injury
- Falls
  - Adults – greater than 20 feet (one story is equal to 10 feet)
  - Children – greater than 10 feet, or two to three times child’s height
- High-risk auto crash
  - Intrusion – more than 12 inches to occupant site or more than 18 inches to any site
  - Ejection (partial or complete) from automobile
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with high risk of injury
- Auto versus pedestrian/ bicyclists
  - Thrown, run over, or with significant (greater than 20 mph) impact
- Motorcycle crash
  - At speed greater than 20 mph

Special Considerations
- Age
  - Older Adults —Risk of injury/death increases after age 55
  - Children – should be preferentially triaged to pediatric-capable trauma centers
• Burns  
  o Without other trauma mechanism, triage to burn center  
  o In same body area, a combination of trauma and burns (partial and full thickness of fifteen percent or greater.)

• Anticoagulation and Bleeding Disorders
• Time-Sensitive Extremity Injury – such as open fracture(s) or fracture(s) with neurovascular compromise
• End-stage renal requiring dialysis
• Pregnancy > 20 weeks
• Provider Discretion

PROCEDURE

Ideally, most critically injured patients meeting Trauma System Entry Criteria (TSEC) should be identified at the scene by EMS providers. The Trauma Communications Center (TCC) will be notified and the regional trauma plan or guidelines will be implemented. However, a small subset of critically injured patients may present to the local Emergency Room via private vehicle or by EMS. At which point, transfer to a Level I or II trauma center will need to occur without unnecessary delay. The following guidelines was addressed to meet the needs of this small subset of patients

PATIENT ARRIVES AT PARTICIPATING HOSPITAL VIA EMS OR PRIVATE VEHICLE:

• Provide appropriate care. (Initiation of these guidelines should begin while resuscitative efforts are in progress.)

• The ER physician should perform any lifesaving procedures and attempt to stabilize the patient’s condition, within the capabilities of the facility.

• If on evaluation the ER physician determines the patient meets TSEC criteria, establish early communication with the Trauma Communication Center (TCC).

• The TCC will confirm that this is a Trauma System patient and will then enter the patient into the database and assign them an identification number.

• Based on the regional guidelines, the TCC will notify the appropriate available trauma center (transfer center) that a TSEC patient has been entered into the system and will need to be transferred to the appropriate Trauma Center.

• The TCC will connect the referring facility to the receiving facility.

• The TCC will then facilitate communication between the referring and receiving facilities so appropriate exchange of information and Physician to Physician communication will take place.  
  *This exchange of information should not delay transfer to the trauma center.*

• Once the TCC confirms TSEC criteria have been met by regional protocol the transfer may be initiated.

• All documentation mandated by EMTALA and COBRA will still need to be completed. (It is acceptable to fax to the receiving facility.)
# Hospital Resources Checklist

For Trauma Center Designation, Re-designation or Upgrade

[E = essential requirements]  
[D = Desired but not essential]

<table>
<thead>
<tr>
<th>Levels</th>
<th>Hospital</th>
<th>Reviewers met?</th>
<th>Comments (for site reviewers)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td>III</td>
</tr>
</tbody>
</table>

## A. Institutional Organization

1. Trauma program
   - E
   - E
   - E
   - E

2. Trauma service
   - E
   - E

3. Trauma team
   - E
   - E
   - E

4. Trauma program medical director
   - E
   - E
   - D

5. Trauma multidisciplinary committee
   - E
   - E
   - D

6. Trauma coordinator/TPM
   - E
   - E
   - E

## B. Hospital Departments/Divisions/Sections

1. Surgery
   - E
   - E

2. Neurologic surgery
   - E

3. Orthopaedic surgery
   - E
   - E

4. Emergency medicine
   - E
   - E

5. Anesthesia
   - E
   - E

## C. Clinical capabilities

(Speciality immediately available 24 hours a day)

- Published on-call schedule
  - E
  - E
  - E
  - E

1. General surgery
   - E
   - E
   - D

- Published back-up schedule
  - E
  - E

- Dedicated to single hospital when on-call
  - E
  - D

2. Anesthesia
   - E
   - E
   - D

3. Emergency medicine
   - E
   - E

On call and promptly available 24 hours/day

1. Cardiac surgery
   - E
   - D

2. Hand surgery
   - E
   - E
   - D

3. Microvascular/replant surgery
   - E
   - D

4. Neurologic surgery
   - E
   - E

   a. Dedicated to one hospital or back-up call
      - E
      - D

5. Obstetric/Gynecologic surgery
   - E
   - D

6. Ophthalmic surgery
   - E
   - E

7. Oral/Maxillofacial surgery
   - E
   - D

8. Orthopaedic surgery
   - E
   - E
   - D

   a. Dedicated to one hospital or back-up call
      - E
      - D

9. Plastic surgery
   - E
   - E
   - D

10. Critical care medicine
    - E
    - E
    - D

11. Radiology
    - E
    - E
    - D
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<td>IV</td>
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D. Clinical qualifications

1. General/trauma surgeon
   a. Current board certification | E | E | E |
   b. 16 hours CME/year | E | E | D | D |
   c. ATLS completion | E | E | E | E |
   d. Peer review committee attendance >50% | E | E | E |
   e. Multidisciplinary committee attendance | E | E | E |

2. Emergency medicine
   a. Board certification | E | E | D |
   b. Trauma education: 16 hours CME/year | E | E | D |
   c. ATLS completion | E | E | E | E |
   d. Peer review committee attendance >50% | E | E | E |
   e. Multidisciplinary committee attendance | E | E | E |

3. Neurosurgery
   a. Board certification | E | E |
   b. 16 hours CME/year | E | E | D | D |
   c. ATLS completion | D | D | D | D |
   d. Peer review committee attendance >50% | E | E | E |
   e. Multidisciplinary committee attendance | E | E | E |

4. Orthopaedic surgery
   a. Board certification | E | E | D |
   b. 16 hours CME/year in skeletal trauma | E | E | D | D |
   c. ATLS completion | D | D | D | D |
   d. Peer review committee attendance >50% | E | E | E | D |
   e. Multidisciplinary committee attendance | E | E | E |

E. Facilities/Resources/Capabilities

1. Volume performance
   a. Trauma admissions 1,200/year | E |
   b. Patients with ISS>15 (240 total or 35 patients/surgeon) | E |
   c. Presence of surgeon at resuscitation | E | E | E | D |
   d. Presence of surgeon at operative procedures | E | E | E |

2. Emergency Department (ED)
   a. Personnel
      1). Designated physician director | E | E | E | D |
   b. Equipment for resuscitation for patients of all ages
      1). Airway control and ventilation equipment | E | E | E | E |
      2). Pulse oximetry | E | E | E | E |
      3). Suction devices | E | E | E | E |
      4). Electrocardiograph-oscilloscope-defibrillator | E | E | E |
      5). Internal paddles | E | E | E |
      6). CVP monitoring equipment | E | E | E | D |
      7). Standard IV fluids and administration sets | E | E | E |
      8). Large bore IV catheters | E | E | E |
      9). Sterile surgical sets for:
         a). Airway control/cricothyrotomy | E | E | E |
         b). Thoracostomy | E | E | E |
         c). Venous cutdown | E | E | E |
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<td>e). Thoracotomy</td>
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<td>4. Postanesthetic recovery room (SICU is acceptable)</td>
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<td>b. Equipment for monitoring and resuscitation</td>
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<td>c. Intracranial pressure monitoring equipment</td>
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<td>e. Thermal control</td>
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<td>5. Intensive or Critical Care Unit for injured patients</td>
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<td>a. Registered nurses with trauma education</td>
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<td>b. Designated surgical director or surgical co-director</td>
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<td>c. Surgical ICU service physician in house 24 hours/day</td>
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<td>d. Surgically directed and staffed ICU service</td>
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<td>e. Equipment for monitoring and resuscitation</td>
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<td>f. Intracranial monitoring equipment</td>
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<td>g. Pulmonary artery monitoring equipment</td>
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<td>a. Available in house 24 hours/day</td>
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<td>b. On call 24 hours/day</td>
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<td>a. Inhouse radiology technologist</td>
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<td>b. Angiography</td>
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<td>c. Sonography</td>
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<td>a. Standard analyses of blood, urine, and other body fluids, including microsampling when appropriate</td>
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<td>c. Occupational therapy</td>
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<td>d. Speech therapy</td>
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<td>e. Social service</td>
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<td>F. Performance Improvement</td>
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<td>1. Performance improvement programs</td>
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<td>2. Trauma registry</td>
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<td>b. Participation in state, local, or regional registry</td>
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<td>c. Orthopaedic database</td>
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<td>3. Audit of all trauma deaths</td>
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<td>4. Morbidity and mortality review</td>
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<td>5. Trauma conference, multidisciplinary</td>
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<td>6. Medical nursing audit</td>
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<td>7. Review of prehospital trauma care</td>
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<td>8. Review of times and reasons for trauma-related bypass</td>
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<td>9. Review of times and reasons for transfer of injured patients</td>
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<td><strong>G. Continuing Education/Outreach</strong></td>
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<td>2. ATLS provide/participate</td>
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<td>3. Programs provided by hospital for</td>
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<td>a. Staff/community physicians (CME)</td>
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<td>b. Nurses</td>
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<td>d. Prehospital personnel provision/participation</td>
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| **H. Prevention** |   |   |   |   |
| 1. Injury control studies | E | D |   |   |
| 2. Collaboration with other institutions | E | D | D | D |
| 3. Monitor progress/effect of prevention programs | E | D | D | D |
| 4. Designated prevention coordinator-spokesperson for injury control | E | E | D |   |
| 5. Outreach activities | E | E | D | D |
| 6. Information resources for public | E | E | E |   |
| 7. Collaboration with existing national, regional, and state programs | E | E | E |   |
| 8. Coordination and/or participation in community prevention activities | E | E | E | D |

| **I. Research** |   |   |   |   |
| 1. Trauma registry performance improvement activities | E | E | E |   |
| 2. Research committee | E | D |   |   |
| 3. Identifiable IRB process | E | D |   |   |
| 4. Extramural educational presentations | E | D | D |   |
| 5. Number of scientific publications | E | D |   |   |

from Resources for Optimal Care of the Injured Patient: 1999. Committee on Trauma, American College of Surgeons (7/05)
REGION 1 PARTICIPATING HOSPITALS BY COUNTY

BARTOW  Cartersville Medical Center, Cartersville, GA 30120 (Active 2/15/2016)
    Trauma Designation:  Non-Designated

CATOOSA/ WALKER:  Hutcheson, Ft Oglethorpe, GA (Inactive since 12/5/2015)
    Trauma Designation:  Non-Designated

CHEROKEE  Northside Cherokee Medical Center, Canton, GA 30114 (Inactive since 1/26/2015)
    Trauma Designation:  Non-Designated

FANNIN  Fannin Regional Hospital, Blue Ridge, GA 30513 (Inactive since 10/25/2014)
    Trauma Designation:  Non-Designated

FLOYD  Floyd Medical Center, Rome, GA 30162-0233 (Active 2/15/2016)
    Trauma Designation:  Level II
    Redmond Regional Medical Center, Rome, GA 30164-7001 (Active 2/15/2016)
    Trauma Designation:  Non-Designated

GILMER  North Georgia Medical Center, Ellijay, GA 30540 (Inactive since 10/22/2013)
    Trauma Designation:  Non-Designated

GORDON  Gordon Hospital, Calhoun, GA 30701 (Inactive since 10/25/2014)
    Trauma Designation:  Non-Designated

HARALSON  Higgins General Hospital, Bremen, GA 30110 (Inactive since 6/22/2013)
    Trauma Designation:  Non-Designated

MURRAY  Murray Medical Center, Chatsworth, GA 30705-1406 (Inactive since 6/22/2013)
    Trauma Designation:  Non-Designated

PAULDING  Wellstar Paulding Hospital – Dallas, GA 30132 (Active 2/15/2016)
    Trauma Designation:  Non-Designated

PICKENS  Piedmont Mountainside Hospital, Jasper, GA 30143 (Inactive since 6/22/2013)
    Trauma Designation:  Non-Designated

POLK  Polk Medical Center, Cedartown, GA 30125 (Inactive since 6/22/2013)
Trauma Designation: Non-Designated

WHITFIELD: Hamilton Medical Center, Dalton, GA 30722 (Active 2/15/2016)
Trauma Designation: Level II

Additional Participating Hospitals:

1. Erlanger – Chattanooga, TN
   Trauma Designation: Level I

2. Children’s Hospital at Erlanger – Chattanooga, TN
   Trauma Designation: Level I

3. Children’s Healthcare of Atlanta (Region 3)
   Trauma Designation: Level I

4. Kennestone - Marietta (Region 3)
   Trauma Designation: Level 2

PEDIATRIC AND BURN RESOURCES

Pediatric Resources

1. Children’s Hospital at Erlanger – Chattanooga, TN
   Trauma Designation: Level I

2. Children’s Healthcare of Atlanta – Egleston
   Trauma Designation: Level I

3. Children’s Healthcare of Atlanta – Scottish Rite
   Trauma Designation: Level I

Burn Resources

1. Joseph M. Still Burn Center – Augusta (Region 6)

2. Grady Health System Burn Center – Atlanta (Region 3)
Appendix K

Burn Center Referral Criteria

A burn center may treat adults, children, or both.

Burn injuries that should be referred to a burn center include:

1. Partial thickness burns greater than 10% total body surface area (TBSA).
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
3. 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 the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
9. Burned children in hospitals without qualified personnel or equipment for the care of children.
10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

Excerpted from Guidelines for the Operation of Burn Centers (pp. 7986), Resources for Optimal Care of the Injured Patient 2006, Committee on Trauma, American College of Surgeons

Severity Determination

**First Degree** (Partial Thickness) Superficial, red, sometimes painful.

**Second Degree** (Partial Thickness) Skin may be red, blistered, swollen. Very painful.

**Third Degree** (Full Thickness) Whitish, charred or translucent, no pin prick sensation in burned area.
Percentage Total Body Surface Area (TBSA)
Region 1 EMS & Hospital Disaster Resources and Contacts

Appendix L

Bartow County
Bartow Co. EMS

Emergency Contacts

**Bartow EMS Office:** 770-387-5160

- **Kevin Garren, Director**
  - Work: 770-607-6205
  - Cell: 404-606-5660
  - Home: 770-663-7568
  - garrenk@bartowga.org

- **Brandon Duncan, Captain**
  - Work: 770-387-5160
  - Cell: 678-758-6670
  - duncanb@bartowga.org

- **Marty Teems, Captain**
  - Work: 770-387-5160
  - Cell: 678-725-8225
  - teemsm@bartowga.org

- **Matt Moore, Captain**
  - Work: 770-387-5160
  - Cell: 770-546-8213
  - moorem@bartowga.org

**Shift Captains**

- Office: 770-387-5160
- Cell: 404-392-5137
Catoosa County
Angel EMS
337 South Cedar Lane
P.O. Box 5495
Fort Oglethorpe, Ga. 30742
Office: (706)861-1234
Fax: (706) 861-2920
Email: angelems@comcast.net

Emergency Contacts

W. DeWayne Wilson, Director/President/CEO
Office: (706)861-1234
Cell: Nextel - (423) 593-0782
Direct Connect – 148*29*27611
Cell: I-Phone (423)488-3022
Home: (706) 858-5900
Email: wccoroner@aol.com
Email: dwilson@angelems.net

Lana G. Duff - Operations Manager
Office: (706)861-1234
Cell: Nextel - (423) 593-9408
Home: (706)861-6297
Email: lduff@angelems.net
Email: lanaduff@comcast.net

On Duty Shift Supervisor
Office: (706)861-1234
Cell: Nextel – (423)421-1449
Direct Connect – 148*29*2602
Cell: I-Phone (423) 580-9594

If you have problems reaching any of the above,
Contact the Angel EMS Dispatch center anytime at (706) 861-1234 and the dispatcher will make
contact with the person you are requesting as soon as possible

Chattooga County
Redmond EMS

Emergency Contacts
Robert Early – Director
Robert.Early@HCAhealthcare.com
Home - 706-290-8590
Work Cell - 706-252-5660
Personal Cell - 706-346-3044

Sherry Peace - Floyd County DC
Sherry.Peace@hcahealthcare.com
Work - 706-252-0822
Home - 706-235-0144
Work Cell - 706-252-1584

Herbert Dodd - Chattooga County
Herbert.dodd@redmondems.org
Work Cell - 706-844-8354

Redmond Regional Dispatch 24/7 - 706-295-2000

Cherokee County
Cherokee County Fire & Emergency Services

Emergency Contacts

Danny West, Cherokee County EMS Chief
Office: 678-493-4127
Cell: 678-614-8949 (best)
Email: dwest@cherokeega.com

Tim Prather, Cherokee County Fire Chief
Office: 678-493-4000
Cell: 770-894-3020
Email: tprather@cherokeega.com
Eddie Robinson, Training Chief
Office: 678-493-4000
Cell: 678-614-1519
Email: erobinson@cherokeega.com

Cherokee County 911 Dispatch Center
678-493-4080

Dade County
Dade County Emergency Services

Emergency Contacts
Alex Case – EMA Director
706-657-4111 – Office
423-718-2111 – Mobile
706-398-2200 - home
ACase@dadecounty-ga.gov

Dade County EMS – E-911 Dispatch 706-657-4111 24/7

Puckett EMS

Shane Garrison - Vice President
C: 770-833-5974
O: 423-894-4407
F: 877-630-8668
Puckett Dispatch: 423-894-1800 or 770-222-1988
shanegarrison@puckettems.com

Chattanooga, TN
Steve Puckett, President
C: 770-833-5976
stevepuckett@puckettems.com

Shane Garrison, Vice President
C: 770-833-5974
shanegarrison@puckettems.com

Dispatch: 423-894-1800 Fax: 877-630-8668

Fannin County
Fannin County Fire/EMS

Emergency Contacts

Robert Graham, Fannin County Fire/EMS Director
Office: 706-632-1958
Cell: 706-851-4830
Home: 706-455-0463
PSAP - 706-632-6022
Email: rgraham@fannincountyga.org

Darrell Payne, Fannin County Fire/EMS, Deputy Director
Office: 706-632-4755
Cell: 706-455-0558
Home: none
Email: dpayne@fannincountyga.org
Floyd County
Floyd Emergency Medical Services
Administrative and Education Center
500 Riverside Parkway
Rome, Georgia 30161
706.509.3820   Dispatch Center/Offices
706.802.0960   Fax

Emergency Contacts

M. L. Bud Owens, Director
Cell: 706-331-4173
Email: bowens@floyd.org

Major Robbie Hill, Operation manger
Cell: 678-873-8596
Email: rhill@floyd.org

Major Randy Pierson, Education, Quality and Billing Coordinator
Cell: 706.936.6687
Email: rpierson@floyd.org

Captain William Channell Special Operations and fleet Coordinator
Cell: 770-547-8206
Email: wchannell@floyd.org

Captain Connie Chandler
706-252-0001
Schandler@floyd.org

Captain Andy Fairel
706-331-7124
afairel@floyd.org
Floyd County
Redmond EMS

Emergency Contacts

Robert Early – Director
Robert.Early@HCAhealthcare.com
Home - 706-290-8590
Work Cell - 706-252-5660
Personal Cell - 706-346-3044

Sherry Peace -Floyd County DC
Sherry.Peace@hcahealthcare.com
Work - 706-252-0822
Home - 706-235-0144
Work Cell -706-252-1584

Herbert Dodd - Chattooga County
Herbert.dodd@redmondems.org
Work Cell - 706-844-8354

Redmond Regional Dispatch 24/7 - 706-295-2000

AMTRAN

Emergency Contacts
Dispatch: (706)291-0043

Mike Bolyard , Owner
mike@amtraninc.com
Cell (678)898-5856

Matthew Joiner, Chief Operations Officer
aj@amtraninc.com
Cell (678)234-1637
Emergency Contacts

**Tony Pritchett- Director**
706-889-6896 or 706-273-8349
Email: tpritchett@gilmercounty-ga.gov

**Ben Daniel- Assistant Chief**
Cell: 706-669-1295

**Scott Stephens - EMS Operations Captain**
Cell: 770-891-4413
Email: sstephens@gilmercounty-ga.gov

Headquarters Fire/EMS-
706-635-1333

911 Center- 706-635-8911

**Hope Ambulance Service**

Jackie Ellington – C.E.O.
Cell: 706-889-8199
tricounty@ellijay.com

Pete Martin – Director
Cell: 706-889-8174
hopeambulance1@gmail.com

Day Shift Supervisors
Cell: 706-889-2326
hopeambulance2@gmail.com

Station 1
Main: 866-213-1275
Fax: 706-273-7476

Gordon County
Emergency Contacts

Courtney Taylor, Director
Office: 706-602-7800 x2387
Cell: 770-608-1993
Email: courtney.taylor@ahss.org

Donald Bowen, Deputy Director
Office: 706-602-7800 x2079
Cell: 706-483-1578
Home: 706-625-6985
Email: donald.bowen@ahss.org

Stacy Koonce, A shift Captain
Office: 706-624-5045
Cell: 706-233-3241

Marcy Fountain, A shift Lieutenant
Office: 706-624-5045
Cell: 815-718-3185

Jennifer Henderson, B shift Captain
Office: 706-624-5045
Cell: 706-271-7285

Michael Payne, B shift Lieutenant
Office: 706-624-5045
Cell: 706-979-0605

Mark Bramblett, C shift Captain
Office: 706-624-5045
Cell: 706-506-0369

Marcus Desmond, C shift Lieutenant
Office: 706-624-5045
Cell: 706-537-0377
Emergency Contacts

ON DUTY CAPTAIN: (678)215-2799

Chief Bill Hightower, Owner/CEO
Office (770)537-1946  Funeral Home: (770)537-2375
Cell: (770)537-7620
Home: (770)537-3093
E-Mail: BH1196@aol.com

Captain Carlton Firestone, B-Shift Supervisor, Training and Education Coordinator
Office (770)537-1946
Cell: (770)324-0085
E-Mail: MedicCF3@aol.com

Captain Joe Fuller, C-Shift Supervisor, Logistics and Resources Coordinator
Office (770)537-1946
Cell: (256)201-0980
E-Mail: JoeFuller05@gmail.com

Captain Ken Worsham, A-Shift Supervisor, Durable Medical Resource Coordinator
Office (770)537-1946
Cell: (770)6394974
E-Mail: WorshamKen@gmail.com

Captain Gary Blackmon, Day Truck Supervisor, Vehicle Maintenance Coordinator
Office (770)537-1946
Cell: (770)6394974
E-Mail: GBlackmon@gmail.com

Susan Hightower, Office and Human Resources Manager
Office (770)537-1946
Cell: (770)6394974
Home: (770)537-3093
E-Mail: Susan.Hightower@ambucare.com or Ambucare@aol.com

Haralson County E-911 Center (770) 646-0077

Murray County
Murray Medical EMS

Emergency Contacts

Murray 911 Center non-emergency numbers:
706-695-7938 or
706-695-6222
706-517-3718 Fax

Larry Ballew, Director
Office: 706-517-2089
Cell: 706-260-6702
Home: 706-695-3222
lballew@murraymedical.org
Kevin Ballew, Supervisor  
Office: 706-517-3723 or 706-517-2098  
Cell: 706-217-5916  
Home: 706-695-5103  
kballw@murraymedical.org

Doug Douthitt, Supervisor  
Office: 706-517-3723 or 706-517-2098  
Cell: 706-271-8410  
Home: 706-695-1374  
ddouthitt@murraymedical.org

Paulding County  
Metro Atlanta Ambulance Service

Emergency Contacts  
Metro Atlanta Ambulance Service  
Dispatch is 770-693-8480

Karen Robinson  
Operations Manager  
Cell: 404-597-5540.  
Email: Karen.Robinson@maas911.com

Shift supervisor number is  
404-664-0879

Lee Oliver as alternate contact  
Cell: 478-951-6140  
Office: 770-693-8471  
Email: Lee.Oliver@maas911.com

Dave O’Neill
Communications Manager
Cell – 404-392-9992
Office – 770-693-8478
Email – dave.oneill@maas911.com

Pete Quinones
President/CEO
Office: 770-693-8445
Cell: 770-815-7169
Fax 770-590-8617
Email: pete.quinones@maas911.com

Paulding County Fire – (No Ambulances – 1st Responder Only)
Main office address
PCFD Administration/Station 2
535 Seaboard Ave. Hiram, Ga. 30141
Office Main number 770-222-1160
Office fax number 770-222-7131

Joey Pelfrey - Fire Chief/EMA Director
Office direct number 678-383-3428
Cell number 404-867-2881
jpelfrey@paulding.gov

Greg Elsberry- Deputy Chief- Paulding County Fire
Office direct number 678-383-3437
Cell number 404-545-0134
gelsberry@pauling.gov

Kevin New – Division Chief
Office direct number 678-383-3427
Emergency Contacts

**Sloan Elrod - Director**
Office: (706)-253-8950  
Cell: (770)-894-7496  
Home: (706)-253-1111  
Email: selrod@pickenscountyga.gov

**Beth Feininger – Training Officer**
Cell# 404-693-4014  
Email jaspurrcats@yahoo.com

**Captain on Duty:**
Office: (706)-253-8965  
Cell: (770)-894-1919

**24 Hour Dispatch Center:**
Polk County
Redmond EMS

Emergency Contacts

Robert Early – Director
Robert.Early@HCAhealthcare.com
Home - 706-290-8590
Work Cell - 706-252-5660
Personal Cell - 706-346-3044

Sherry Peace - Floyd County DC
Sherry.Peace@hcahealthcare.com
Work - 706-252-0822
Home - 706-235-0144
Work Cell -706-252-1584

Herbert Dodd - Chattooga County
Herbert.dodd@redmondemms.org
Work Cell - 706-844-8354

Redmond Regional Dispatch 24/7 - 706-295-2000
Walker County
Walker Co Fire & Emergency Services

Puckett EMS

Will Pitt – North GA Operations Chief
C: 423-463-2318
O: 423-894-4407
F: 877-630-8668
Puckett Dispatch: 423-894-1800 or 770-222-1988
WilliamPitt@pucketteems.com

Shane Garrison - Vice President
C: 770-833-5974
O: 423-894-4407
F: 877-630-8668
Puckett Dispatch: 423-894-1800 or 770-222-1988
shanegarrison@pucketteems.com

Chattanooga, TN
Steve Puckett, President
C: 770-833-5976
stevepuckett@pucketteems.com

Shane Garrison, Vice President
C: 770-833-5974
shanegarrison@pucketteems.com

Dispatch: 423-894-1800 Fax: 877-630-8668
Whitfield County

Hamilton Emergency Medical Service Emergency Contact Lists (Whitfield Co)

1105 Memorial Dr, Dalton, GA  30720
Office - 706-278-9111 or 706-278-9211
Fax - 706-295-4095

Emergency Contacts

**Scott Radeker** – Director
Cell - 423-667-9865
Home- 706-375-3770
Office - (706) 278-9211
Email- sradeker@hhcs.org

**Captain Ed Cuthbert**
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**Lieutenant Zach Downs**
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**Captain Lee Duman**
Cell- 706-463-1340
Email- lduman@hhcs.org

**Lieutenant Chris Tieck**
Cell- 706-280-3533
Email- ctieck@hhcs.org
Chattanooga, TN – Georgia Licensed Services
Emergency Contacts

**Puckett EMS**
Dispatch - 423-894-1800 or 770-222-1988
Fax: 877-630-8668
Cell - 770-833-0349

Chattanooga, TN
Steve Puckett, President
Office - 678-504-1701
C: 770-833-5976
stevepuckett@pucketteems.com

Shane Garrison, Vice President
Office - 678-504-1702
C: 770-833-5974
shanegarrison@pucketteems.com

**LifeGuard Ambulance of Tennessee**
**Chattanooga Dispatch** – 423-499-9500

The dispatcher can make any initial call in sending units for mutual aid. If for any reason I am unavailable, the dispatcher @ 423-499-9500 can assist in getting the person who can approve for longer or more aid past an initial response.

Cindy Dycus
C: 423-421-1385
cindy.dycus@lifeguardambulance.com
Appendix M

Region 1 EMS Quick Reference Guide for Utilizing the TCC

The Georgia Trauma Communications Center coordinates Trauma System activities by maintaining and providing information on designated trauma center status and, when appropriate, on pre-hospital capabilities. This information is used to ensure that patients meeting Trauma System Entry Criteria (same as CDC field triage criteria) have access to definitive trauma care at an appropriate level of designated trauma center. The Georgia Trauma Communications Center is continually staffed by personnel with specific and in-depth knowledge of trauma system design, function, and protocols.

The Georgia Trauma Communications Center operates through statewide guidelines and region-specific protocols established by the Georgia Trauma Commission. The Georgia Trauma Communications Center ONLY provides information and recommendations about patient destination as per pre-established regional protocols for System function. The Georgia Trauma Communications Center serves as an information resource for EMS providers, Trauma Centers and non-designated participating hospitals. The general functions of the Georgia Trauma Communications Center are:

- Provide information on System entry criteria based on statewide guidelines as requested by System stakeholders and providers;
- Assign a unique System I.D. number for each patient meeting Trauma System Entry Criteria;
- Collect brief pre-hospital database information;
- Maintain available resource information and the functional status of all System Trauma Centers and non-designated participating hospitals at all times and, when appropriate, knowledge of System’s pre-hospital capabilities;
- Provide information regarding secondary triage status of the patient based on statewide guidelines and approved regional protocols;
- Establish dependable communication link between field EMS provider and receiving facility;
- Record and enter pre-hospital data for the Trauma System Communications Database;
- Arrange inter-facility transfers of Trauma System patients between Trauma Centers and non-designated participating hospitals; and,
- Coordinate communication for optimal resource utilization using pre-established statewide guidelines and regional protocols for medical surge during mass casualty incidents or public health emergencies.

To access the Georgia Trauma Communications Resource Center:

Toll Free: 866.996.3314

Free Mobile to Mobile: 478.993.4478
Each EMS Region 1 provider should contact the Georgia Trauma Communications Center before patient transport if patient destination is undetermined or after patient transport if patient destination was determined.

During disasters, the Georgia Trauma Communications Center may be used to request resources if the EMS Regional Program Director is not available.

**Northwest Georgia/Region 1 EMS Disaster Assistance Response Taskforce (D.A.R.T.) Project**
Northwest Georgia/Region 1 EMS Disaster Assistance Response Taskforce (D.A.R.T.) Project

This conceptual document contains components of the operational plan that will be extracted at the time when the developmental phase is completed and approved by the EMS Dart Leadership Team, Region 1
Georgia EMS D.A.R.T. Project Executive Leadership Team

David Foster, Regional EMS Director, GA OEMS&T Region 1
DeWayne Wilson, President/CEO Angel EMS
Chief Danny West, EMS Chief, Cherokee Fire and Emergency Services
Courtney Taylor, EMS Director, Gordon Co EMS
Captain Carlton Firestone, Shift Commander, Ambucare EMS/Floyd Co SO
Captain William Pitt - EMS Training Officer, Walker Co Fire and Emergency Services
Glenn Susskind - USAR/Tactical Medic Instructor, Lifeforce Air Medical
Claude Craig, EMA/911 Director/EMAG VP, Whitfield Co
Alex Case - EMA/911 Director, Dade Co
Matthew Crumpton - GA DPH/Health Protection
Peki Prince - GA DPH/Health Protection/OEMS&T
Lee Oliver - Metro Atlanta Ambulance Service/GAEMS Board of Directors
Major Randy Pierson, Floyd EMS/NWGA EMS Systems Inc Chairperson
David Loftin, Secretary/Treasurer, NWGA EMS Systems, Inc
Tony Cooper - GA DPH District 1.1 Emergency Preparedness Specialist
David Huskey, GA DPH District 1.2 Emergency Preparedness Director
Chief Lenny Nesbitt, Calhoun Fire /GSAR 6 Commander

NWGA EMS D.A.R.T. Medical Director
Jill Mabley, MD

Region 1 RTAC Leadership
Scott Radeker, VP, Hutcheson Medical Center - Chair
Major Randy Pierson, Floyd EMS, Vice Chair
Jordon Pierson and David Loftin, RTAC Co-Coordinators

Northwest Georgia Region 1 EMS Advisory Council
Lana Duff, Angel EMS, Chair
EMS Chief Danny West, Cherokee Fire and Emergency Services - Vice Chair
Mission:

*Development of four Northwest Georgia/ Region 1 EMS Rapid Response Strike Team(s) (EMS-RRST) (four units each minimum) that will make up the EMS Disaster Assistance Response Taskforce (EMS-DART) (sixteen units each minimum) to respond to disasters and mass casualty/injury responses within the sixteen county area of Region 1 EMS as well as provide mass transportation capabilities as a resource for ESF-8.*
(These teams would also provide response and support to other areas of the State, as well as our border states as requested)

**Vision:**

To take best practices from around the nation and develop the Georgia EMS Disaster Assistance Response Team (D.A.R.T.) Plan for the state of Georgia with regards to EMS responses to major medical/disaster events. This plan will address an All-Hazards approach to personnel and resource development to include licensed Ambulance Services, Medical First Responder Agencies and Air Medical resources to provide a rapid response pre-hospital medical team and pre-hospital mass transportation capabilities.

**Objectives:**

- NWGA/R1 EMS Regional EMS Director will create a NW GA/Region 1 EMS Disaster Medical Assistance Taskforce (D.A.R.T.) Development Leadership Team to develop plan and partners.

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce (D.A.R.T.) Development Leadership Team will seek funding for plan development

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Leadership Team Develop plan and present to stakeholders

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Leadership Team will identify Region 1 EMS 911 and non-911 agencies that would dedicate an Ambulance strictly for use with the strike team through a Letter of Intent (LOI).

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Development Leadership Team will request that participating services identify a minimum of 5-10 personnel who will be trained to various levels of disaster/traumatic medical care.

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Development Leadership Team will create a training plan that all personnel will be required to have to participate on a EMS-RRST, to include, but not limited to the following– IS 100.b, 200.b, 700.a, 800.b, Hazardous Materials Awareness (HMA), and Basic Disaster Life Support (BDLS)

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Development Leadership Team will create a training plan that all supervisory personnel of a EMS-RRST or EMS-DART will be required to have to participate on a EMS-RRST, to include, but not limited to the following– IS 100.b, 200.b, 700.a, 800.b, Hazardous Materials Awareness (HMA), and Basic Disaster Life Support (BDLS), ICS 300 and ICS-400.

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Development Leadership Team will identify specialized medical training for various aspects of the
EMS D.A.R.T. response to events such as structural search & rescue events, Active Shooter Events, CBRNE events, Transportation Incidents, and Mass Evacuation events.

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Development Leadership Team will identify one Triage System and identify training on utilization of the system.

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Team Development Leadership Team will partner with GA DPH/Health Protection Division/Office of Emergency Preparedness to ensure all EMS agencies participating in D.A.R.T. will be utilizing the state approved patient tracking system.

- NW GA/Region 1 EMS Disaster Medical Assistance Taskforce Development (D.A.R.T.) Development Leadership Team will work with state and local EMA/DPH-EP Partners to develop additional training and funding opportunities

**Standard Operating Guidelines (SOG):**

This Standard Operating Guideline (SOG) addresses the Georgia Department of Public Heath/Health Protection Division/Office of EMS & Trauma (DPH/HPD/OMEST), Region 1 EMS Council/Regional Trauma Advisory Committee tasked, multi operational period mission profile of the EMS Rapid Response Strike Team (EMS-RRST) components of the EMS Disaster Assistance Response Taskforce (EMS-DART). This document will address both regional and intra-regional, operational periods (<24 hours) and (24-72 hour) mission profiles for mutual aid response. See Addendum 1 Operational Guidelines

**Purpose:**

This SOG is designed to ensure the uniform and orderly deployment of the EMS-RRST component of the EMS-DART across all 10 EMS regions of Georgia that develop a taskforce as part of their Regional Trauma Advisory Committee.

**Planning Assumptions:**

In order to ensure consistency and brevity this SOG makes the following assumptions:

1. This document is to be considered a living document which may be updated from time to time as new information becomes available. The most current copy will be maintained by the Regional EMS Office, Regional EMS-DART Commander and Deputy Commanders and the District Health Office EP/EOC designated for the respective Regional EMS office. A copy of ten regional plans will
be kept at the DPH State Operations Center (SOC) and will be posted on the Georgia Office of EMS & Trauma website.

2. The term “region” or “regions” will be utilized throughout this document and refers to the ten EMS regions as defined by the state. Instances where this does not apply will be noted as such.

3. The term "EMS Rapid Response Strike Team" should be considered to mean a geographical group of designated Ambulances, with a minimum of 3 to 5 personnel on each unit that will be ready to respond upon activation to an unscheduled event with a goal of 30-60 minutes of request.

4. The term "EMS Disaster Assistance Response Taskforce" should be considered as all EMS-R.R.S.T.’s from one EMS Region within the state. The actual number of ambulances and personnel will vary by region and EMS agencies participating in each region. Therefore this document will not define how many ambulances and personnel each EMS D.A.R.T. will include.

5. Each EMS regions EMS-D.A.R.T. should have pre-identified Emergency Medical Service (EMS) agencies for deployment as part of the state mass transportation plan.

6. Each Ambulance (ground and/or air) and each Medical First Responder Service participating shall be licensed, and in good standing, by the Department of Public Health/Health Protection Section/Office of EMS & Trauma to become a deployable asset and must maintain the license to remain deployable.

7. Each EMS regions EMS-D.A.R.T. will have executed appropriate MOU’s with partnering agencies and personnel to allow for a Regional and State tasked mission.

8. Each EMS regions EMS-D.A.R.T. will have identified, partnered with, and trained a public safety communications/dispatch center with 24/7 operations to serve as the initial contact number for deployment of the EMS-R.R.S.T.’s or EMS-D.A.R.T. The EMS-D.A.R.T. 24 hour contact number should be published to the State’s disaster response entities, including but not limited to: , Regional EMS Director, EMS-DART Commander and Deputy Commanders, District Health Departments EP Director, DPH EOC, SOC Manager, etc. This communications center should have a list of initial and fall back contacts as well as notification policies regarding that region’s EMS R.R.S.T. / EMS-D.A.R.T. deployment process.

9. Each EMS regions EMS-D.A.R.T. will identify and implemented systems or technologies, previously available or novel, with redundancies, designed for the notification of EMS-R.R.S.T.’s members’ deployment, both at the partnering agency and team member level.

10. Each EMS Region will pre-identify the EMS Rapid Response Strike Teams (EMS-R.R.S.T.), ensuring each has the appropriate equipment and training to serve in that role.
11. Upon activation of the EMS-R.R.S.T. the team(s) will deploy units which are fully mission capable and able to be self sustained for a period of at least 12 hours and up to 72-hours.

12. Team members are expected to be trained in National Incident Management System (NIMS).

13. FEMA typing is acknowledged; to support common terminology, in regards to ambulances staffing and will be based on Basic (BLS) or Advanced Life Support (ALS). Georgia also recognizes other levels of licensure to include Neonatal, Air (Helicopter) and Medical First Responder. FEMA's "Ambulance Task Forces" which is identified as five (5) Ambulance Strike Teams with Leaders & a Group Supervisor; however, will not apply to the Georgia EMS-D.A.R.T. as the composition and tasks of EMS-R.R.S.T.’s and EMS-D.A.R.T. may be more or less than the defined numbers of an AST/ATF. No “rules” are set in this document regarding the EMS-RRST personnel licensure composition, although the recommendation to each region is that the FEMA Type II Strike Teams (ALS-EMS-R.R.S.T.) are preferable to FEMA Type IV (BLS-EMS-R.R.S.T.).

14. Memorandums of Agreement (MOAs) are to be established between responding agencies and the appropriate agency/organization supplying resources and/or reimbursement.

**EMS-Rapid Response Strike Team (EMS-R.R.S.T.) Composition:**

The EMS-R.R.S.T. component should be made up of at least one ambulance for each county that the team encompasses. Each EMS-R.R.S.T. will operate under the direction of an EMS-R.R.S.T. Commander who will respond in a separate vehicle. All vehicles in the EMS-R.R.S.T. must have common communications capabilities. To expand on this capability, it is the recommendation that all vehicles in the EMS-R.R.S.T. share common communications with each other and the rest of the Regional EMS-D.A.R.T.

Each Ambulance of the EMS-R.R.S.T. will respond with at least 3 to 5 personnel who have meet the training requirements of the EMS-D.A.R.T. In addition to the Georgia Office of EMS & Trauma required equipment this unit will also have the currently required EMS-R.R.S.T. equipment on it.

The EMS-R.R.S.T. primary function of response is to provide initial medical triage and treatment and support local personnel in providing care to those found injured/ill and to the rescue personnel. The extra on board personnel will be assigned to duties deemed necessary. The ambulance with 2 personnel may be geographically located to the operational area to support the type of operation as needed. This approach to what is commonly referred to as a "Strike Team" provides medical personnel to support responder operations, and reduces the number of ambulances required to support those operations. Therefore, allowing more ambulance to be available for transportation duties under most operational circumstances.

Additionally, utilization of licensed Medical First Responder agencies will provide an additional pool of licensed EMS personnel to support triage, treatment, staging, transport, or other medical care support without taking needed ambulances out of the transportation capability.

One final aspect of the EMS-R.R.S.T.’s is that they will include some personnel specially trained for specific event responses. Those events could include Active Shooter calls that require a cadre of SWOT/Tactical
Medics trained to support Law Enforcement Operation in Hot/Warm Zones. Other like events could be Hazardous Materials, Wilderness, Specialized Collapse events, etc. that require medical personnel specifically trained to provide medical care in hostile environments to support GASAR, SWAT, or other such specialized response teams statewide.

Specialty ambulances, (bariatric capable, Critical Care Transport (CCT), or Neonatal Transport units, Helicopters, etc.) may all have high and specific value to the EMS-D.A.R.T., given the mission profile. However, due to the rarity and wide variation of capabilities of these types of apparatus, it is not the recommendation of this SOG to pool or designate them as any specific type of specialty team. Each Region will include these units, to include unit type; agency and city/county located in, as part their regional EMS Resource lists so that they can be deployed when situations dictate.

EMS-Disaster Assistance Response Taskforce (EMS-D.A.R.T.) Composition:

The EMS-D.A.R.T component will be made up of at least all EMS-RRST’s for each EMS Region that the team encompasses. Each EMS-D.A.R.T., under the direction of an EMS-D.A.R.T. Commander (Regional EMS Director, or their designee) who will coordinate the activation, will be required to assemble and respond to a request for deployment. The total number of ambulances and personnel of the EMS-D.A.R.T. will be dependent on the mission. If the event is a mass casualty, the units of the EMS-R.R.S.T.’s may include 3-5 personnel. However, if the mission is that of a mass transportation event, such as a coastal evacuation, the number of personnel on each ambulance could be only 2-3.

Each EMS-D.A.R.T. may vary in size, like the EMS-R.R.S.T.’s, due to an unequal number of counties, and the total number of licensed Ambulance services in each region.

Training

The Education sub-subcommittee of the Region 1 EMS-D.A.R.T. Development Leadership Team has determined that the role of the Georgia Regional EMS Rapid Response Strike Teams (EMS-R.R.S.T.) and the EMS Disaster Assistance Response Taskforce (EMS-D.A.R.T.) are to bridge the gap between the Ambulance Strike Team (AST) and the Technical aspect of USAR/Tactical/Hazmat/etc specialized teams. Each member will receive newly designed training to the awareness level of each specialized discipline. This will meet the needs of the medics participating on the teams. The sub-committee has identified the following areas to focus on.

Overview of DART Program

- Vision/Mission
- Roles & Responsibilities
- Organization Chart
- DART Equipment
- Activation/Deactivation

Tactical -

- Initial Response protocol and process (Based on Hartford II Consensus)
• Collection point process (triage/treatment)

SAR -
• Awareness - Trench/Confine Space/Collapse/Rope/Swift Water (Ask GSAR if they need Ops level for confined space/collapse)
• Crush Injury management
• Dehydration
• Environmental - Hypo/hyperthermia

Hazardous Materials -
• -Toxicology – Medical Management of Contaminated Patients

Wilderness Medic
• Overview of how ground search functions
• Personal safety and survival

Specialized Burn Care
• Developed by the J.M. Still Burn Center

Job Action Sheets and Reimbursement Guidelines

Dealing with Distressed Citizens during a Disaster

Tabletop Exercise
• Main scenarios with one major inject per strike team

The Education sub-committee designed the course based on our expertise in the above areas by creating a course goal, enabling objectives, and a course outline to be reviewed and approved by the leadership team. The course should consist of web-based and direct delivery components as to reduce cost and offer flexibility to members in meeting the training requirements. This course as developed is 16 hours in total contact time to include a Table Top Exercise. We worked with other public safety stakeholders to identify technician and /or operations level training needs for more specialized sub-groups. These could include additional medical care training for license EMS personnel who are current and/or future members of GSAR, Law Enforcement Tactical Medics, and Hazardous Materials teams.

Each member of the EMS-R.R.S.T. will be required to have training designated by this plan within 18 months of the initial course offerings.

EMS-RRST personnel will be required to have the following training to participate as a member;

Required of all personnel statewide
• IS 100.b, (Web-based) (Required)
• IS 200.b, (Web-based) (Required)
• IS 700.a, (Web-based) (Required)
• IS 800.b, (Web-based) (Required)
- Hazardous Materials Awareness (HMA) (Required)
- Infectious Disease Management (Required)
- SALT/MUCC Triage - online class (Web-based and included in DART Course)
- Approved Trauma Class (PHTLS/ITLS/ATT, or equivalent etc) (Required)
- Specialized training to the Awareness Level for SAR/Tactical/Hazmat/Wilderness responses (EMS-D.A.R.T. Course to be designed)

Preferred courses statewide based on funding availability
- Basic Disaster Life Support (BDLS) (preferred)
- Advanced Burn Life Support (ABLS) (preferred)

Optional Courses recommended for EMS personnel if they choose to take them on their own, or in conjunction with other funding sources.
- Tactical Combat Casualty Care (TCCC)
- NAEMT Safety Course
- Urban Search and Rescue Medic Training (USAR Medic)
- Advanced HazMat Life Support (AHLS) or equivalent
- Disaster Medical Assistance Team (DMAT)
- Advanced Disaster Life Support (ADLS)

EMS-R.R.S.T. Team Leaders will be required to have the following training in addition to the training above for that of the team members;
- ICS 300
- ICS-400

EMS-D.A.R.T. Commanders will be asked to have training above and beyond those of the EMS-R.R.S.T. Team Leaders to include;
- Disaster Planning
- Plans and forms administration

The EMS-D.A.R.T. course will be a competency based, awareness-level course that introduces concepts and principles to licensed EMS professionals working on an ambulance for the management of injuries and illness caused by disasters and public health emergencies. The primary focus of the EMS-D.A.R.T. course is to apply the principles and concepts of urban search and rescue team medical support, tactical operations medical care and support, mass-casualty patient management triage and tracking systems, traumatic and explosive events, nuclear -radiologic -biological and chemical events and wilderness search and rescue operation. The course addresses the role which these teams of EMS professionals would perform under a disaster response operation. This will apply whether it is a natural or man-made situation. We will also include training for the EMS providers’ role during Active Shooters/Terroristic shooting events, hazardous materials incidents, large scale wilderness events, and the like.
The EMS-D.A.R.T. program designed addresses the identified gaps between our everyday EMS provider and those of technical rescue specialist, such as those from the fire service and law enforcement, that address high risk operations. The training program will be designed to reach a high volume number of participant via a web-based deliver system LMS (Learning Management System). The Georgia Office of EMS & Trauma has provided a LMS to its providers for free for over 5 years and we are looking at expanding the system and changing our current LMS to a hosted LMS to provide a broader base of users. This approach will allow other states, territories and the federal government the opportunity to receive the didactic component live or virtual and designate live training/exercises to practice the skill sets.

Our leadership team and educators whom contribute to development of the program will gladly assist our partners in any jurisdiction, region, state or territory with conducting the training.

The Educational Goal of the EMS-D.A.R.T. Program is to provide EMS Responders designated as members of the Regional EMS-D.A.R.T. and local EMS R.R.S.T. the needed knowledge to effectively function during a disaster related response with other non-medical responders whose roles may differ greatly from that of triage, treatment and transportation of the sick and/or injured.

Enabling Objectives:

- Understand the role of the Federal Response Plan, the National US&R Task Force System, The National Disaster Medical System and the medical entities with which the teams may interact.

- Understand the post disaster environment and its health and safety concerns.

- Understands the US&R confined-space environment and demonstrate the ability to function in a safe and effective manner.

- Demonstrate a working knowledge of the medical problems experienced in collapsed structure victims and the adaptations necessary to manage these and more common problems when in the confined-space and austere post-disaster environments.

- Effectively and efficiently cooperate with the Search, Rescue, and Technical Teams to maximize salvage of patients.

- Understand the role of the Medical Team in keeping other disaster personnel healthy and functional under austere and stressful conditions.

- Describe the procedures necessary for personnel protection in a hazardous materials exposure.
• List what each component of the ABCDE Assessment stands for

• Define Toxidrome

• Discuss the common management criteria for treating any contaminated patient.

• Describe the EMS Responders Role and Responsibility during a Active Shooter event

Team members will be expected to complete the above courses within 12-18 months of being approved by their service to participate. We will also ask that the EMS R.R.S.T. Team Leaders and members to go back to their services and provide in-services for their peers in their roles during disaster events. We also would expect them to do training with the their local Fire/Law Enforcement and EMA on activations of the plan, especially addressing the specialized training and drills with local Law Enforcement such as active shooter awareness, incident response, and workplace violence. With their local hospitals when doing JCHO or Coalition drills. With Fire/Rescue services to practice events such as Trench, Confined Space, etc training. These activities enhance inter-agency cooperation which is imperative during mass casualty events as well as build valuable relationship long before any event may occur.

**Equipment Requirements**

**Personal kits (Fanny type or equivalent)**

In addition to what the EMS-D.A.R.T. Field Bag the EMS R.R.S.T. members carry from their designated units, they should carry the following in a personal gear bag that is always ready to go when activated. Equipment might include:

- 1 - Gear Bag
- PPE (Nitrile gloves, mask, eye protection-Safety type)
- 1 personal care kit (PCK) that includes personal medications, sunscreen, insect repellant, and/or contact lens supplies, feminine hygiene, Lip Balm, etc
- Reinforced Toe Work Boots (OSHA Compliant)
- Spare Socks
- Work Gloves
- Bandana or equivalent
- Flashlight, UL rated intrinsically safe
- hydration items/water bottle (camel pack optional)
- Personal protection clothing
- Anaphylaxis meds (Epi Pen, Benadryl, Primatene Mist, etc) for those with known allergies
- NSAID, Aspirin, GI Meds (Pepto, Imodium etc)
- USAR/Caving Helmet Eye/Ear protection (– optional – Must be the same brand, model # and color of those supplied in the DART Field Bags)
- EMS DART Work Shirts, Hats, etc. (– optional – If made available for purchase)

**Equipment for EMS-D.A.R.T. Field Bags**
We will place three to four EMS-D.A.R.T. Field Bags on each designated EMS R.R.S.T. unit. The equipment will be sufficient to address any initial treatment to found victims and provider injuries until we get an ALS ambulance to them. The following is the equipment each gear bag will have:

EMS-D.A.R.T. Field Bag (Three on each EMS-RRST designated unit)
- USAR/Caving Helmet Eye/Ear protection
- Trauma Shears/Scissors
- Stethoscope
- Thermometer - oral, electronic
- Thermometer - oral, hypothermic
- N95n Masks
- Respirator
- Airways - NPA, OPA
- Small pocket mask,
- Collapsible BVM
- Suction, potable with tonsilar tip
- Eye Patches, (cotton individually wrapped)
- Alcohol wipes (box 100-200 individually wrapped)
- Swabs, cotton sterile long wrapped pair
- Jelly, Lubricant, single use packets
- Tongue depressors, sterile, individually wrapped, box
- Elastic Bandages - 3" -4 and 6" -4 (ace wrap type)
- Triangular bandages (4)
- 4" roll gauze, (6) individually wrapped
- heavy duty 2" tape (2) (e.g. compression type tape)
- Moldable Splints - SAM type (2)
- Multi-Trauma Dressing 12x30 (2)
- Trauma Dressing - 5x9 or equivalent (4)
- Sponges, Sterile, 4x4 (2) 25 pack
- Tape 1" silk (4)
- Tape 2" Cloth (2)
- Blister Dressing - 4x3 Mole Skin (3 packs)
- Vaseline Gauze, (6) individually wrapped
- Hemostatic dressing - (6) Quik Clot gauze or equivalent
- Assorted band aids
- 2 tourniquets (CAT or equivalent)
- Chest decompression kit
- 2-3 open chest seal - (occlusive Dressing or HALO)
- Glucometer and strips (1 box/bottle)
- Mini-Pulse Ox
- Blanket, Mylar Survival Blankets (2)
- Chemlight stick (4)
- Hand sanitizer
- Headlamp (1) (helmet Mountable
- Clipboard, Metal
- Patient Contact Forms
- Markers, Felt tip, black permanent
- 5.11 EMS Blue Field Deployment Back Pack

Portable programmable multi-channel radio - Each EMS R.R.S.T. will have five field programmable portable radios. One radio will be assigned to each EMS R.R.S.T. bag and one in the ambulance with the crew to assure that they are able to communicate between themselves and other EMS-D.A.R.T. Members including, Triage, Transport, Staging and Command. Each of the EMS R.R.S.T. Commanders and the Regional EMS-D.A.R.T. Commander will have one.

Definitions

**Mass Care incident** is defined for the purpose of this publication as any event; planned or unplanned that results in the need to provide medical care to patients outside of traditional hospital settings. Broadly, incidents are divided into planned events (special events—like a sporting event or political protest) and unplanned incidents (such as terrorism, earthquakes, natural disasters, or weather related triggering mechanisms).

**EMS-Rapid Response Strike Team (EMS-R.R.S.T.)** is a group of four or more ambulances comprised of 3-5 personnel per unit from a pre-determined geographical locale, equipped to respond to a request for deployments to any regional request within one hour of the request. The team will have capabilities to support GSAR Operations for Search & Rescue Operations, provide immediate triage and medical care, and provide transportation services as deem necessary. The team may be all ALS, all BLS, or a combination. **Replaces (FEMA Definition) Ambulance Strike Team** is a group of five ambulances of the same type with common communications and a leader. The RRST may be all ALS or all BLS.

**EMS-Disaster Assistance Response Taskforce (EMS-D.A.R.T.)** is the combinations of three or more, EMS-R.R.S.T.’s ambulances and personnel, under the direction of the Regional EMS-D.A.R.T. Commander, Deputy Commanders or Regional OEMS&T Program Director, to provider coordinated assets for support
and response to any all-hazards response with common communication capabilities, equipment and protocols. The EMS-D.A.R.T. will be self-sufficient for 12-hour operational periods up to 72 hours. **Replaces (FEMA Definition)** Ambulance Task Force is any combination of ambulances, within the span of control, with common communications and a designated leader.

**All Hazards Approach** - EMS Disaster Assistance Medical Taskforce(s) will prepare for responses to any and all hazards. The incidents could include, but are not limited to natural disaster responses such as flood, hurricanes, tornadoes, etc., man-made disasters such as mass shooting incidents, hazmat incidents, explosions, building collapse, trench incidents, etc., wilderness incident, and major transportation incidents such as multi-vehicle incidents, air passenger crashes, etc., pandemics and any other incidents as deemed necessary.

**Resource Typing** is the categorization and description of resources that are commonly exchanged in disasters via mutual aid, by capacity and/or capability. Through resource typing, disciplines examine resources and identify the capabilities of the resource’s component.

**Resource Type**
- **ALS - P** - Unit with all personnel GA Licensed Paramedics
- **ALS - A** - Unit with a mix minimum mix of personnel consisting of no more that 50% of personnel at the GA Licensed EMT-Intermediate or Advanced EMT and the remain 50% or greater being GA Licensed Paramedics.
- **BLS - A** - Unit with a mix minimum mix of personnel consisting of no more that 50% of personnel at the GA Licensed EMT(Basic) level and the remaining 50% or greater being GA Licensed EMT-Intermediate or Advanced EMT.
- **BLS -B** - Unit with GA Licensed EMT (Basic) and or EMT-Intermediates making up the personnel.
- **Specialty Transportation Unit** - Any unit with special needs (Neonatal/Critical Care) transportation ability and/or mass care transportation (Disaster Buses) capable of handles special medical needs and transportation.
- **Specialty Support Services** - Any unit capable of provides mobile command and control services or equipment replenishment services (Mobile Command Vehicles, Task Force Command Vehicles, Medical Equipment Trailers, etc).
- **Air Medical Support Unit** - Air Medical Helicopters capable of providing advanced medical care and transportation services.

**Incident Type** categorized by five types based on complexity.
- **Type 1 Incident** – most complex, requiring national resources to safely and effectively manage and operate.
- **Type 2 Incident** – regional and/or national resources are required to safely and effectively manage the operations.
- **Type 3 Incident** – occurs when capabilities exceed initial attack, the appropriate ICS positions should be added to match the complexity of the incident.
- **Type 4 Incident** – Resources vary from a single module to several single resources.
- **Type 5 Incident** – One or two single resources with up to six personnel.
**EMS Rapid Response Team Unit Leader** - A designated person with specialized training and leadership skill sets that is the main point of contact for each county EMS R.R.S.T. Unit. Each EMS R.R.S.T. Unit Leader will report to the EMS Rapid Response Team Commander for their respective geographic team.

**EMS Rapid Response Team Commander (Team Leader)** - A designated person with specialized training and leadership skill sets that is the main point of contact and coordinator of a pre-determined geographically located EMS R.R.S.T. Each EMS R.R.S.T. Commanders will serve as a Deputy Commanders to the Regional EMS-D.A.R.T.

**EMS Disaster Assistant Response Taskforce Commander** - A designated person with specialized training and leadership skill sets that is the main point of contact and coordinator of the Regional EMS-D.A.R.T. in conjunction with the Regional OEMS&T Program Director or their designee.

**Incident Management Team** - is a comprehensive resource team to either augment ongoing operations through provision of infrastructure support, or when requested, transition to an incident management function to include all components/functions of a Command and General Staff. An IMT:

- Includes command and general staff members and support personnel
- Has statutory authority and/or formal response requirements and responsibilities
- Has pre-designated roles and responsibilities for members (identified and able to be contacted for deployment)
- Is available 24/7/365

Each Regional IMT will consist of the regions EMS-D.A.R.T. Commander, all Regional EMS R.R.S.T. Commanders and the Regional OEMS&T Program Director or their designee.

**Regional Hazard Analysis**

After Action Reports from the 2011 and 2013 tornado responses indicated a large training and capability gap of EMS providers responding to these types of events. On March 14, 2002 a 115 vehicle motor vehicle crash occurred on I-75 in Catoosa County. The large scale EMS Response also showed gaps in coordinating triage, treatment, and transport of multiple victims. That event led to several training courses around the region to address those gaps, and reducing the ‘cowboy’ affect.

Northwest Georgia’s EMS Region 1 is comprised of 16 counties and spans 5439 square miles serving a population of 1,105,044. It borders three states, North Caroline and Tennessee to the north and Alabama to the west down to where I-20 intersects the state line. There are 3 major mountain ranges, 4 main valleys, 5 major rivers and 4 interstate Highways, (I-75, I-24, I-59 and I-20) Several County's are in the flight path to Hartsfield International Airport to the south and Chattanooga Regional Airport to the north. The northern most counties (6) are within the 50 mile radius of Sequoyah Nuclear Plant in Soddy Daisy TN. EMS resources in this region consist of 17 different 911 EMS agencies, 4 non-emergency BLS providers and two air ambulance services. Collectively they provide care within the region as needed.

Based on the GEMA Regional Preparedness and Capabilities Assessment 2013 - the 16 counties of NWGA/Region 1 EMS are included in the 21 county GEMA Area 6 analysis.
**#1 Threat/Hazard/Context** includes Natural Disasters: Tornado - late at night with no warning, daytime during commutes and/or school transport, any storm event in a heavily-populated areas.

**#2 Threat/Hazard/Context** includes Human caused hazardous materials release: in heavily populated areas, and those which require evacuation – especially at night.


For **Planning** the assessments of capabilities are as follows based on a scale of 1-7:
- Planning 2, Organization 3, Equipment 4, Training 3, Exercise 3

For **Threats and Hazard Identification** the assessment of capabilities are as follows based on a scale of 1-7:
- Planning 2, Organization 4, Equipment 5, Training 5, Exercise 3

For **Critical Transportation** the assessments of capabilities are as follows based on a scale of 1-7:
- Planning 2, Organization 2, Equipment 2, Training 2, Exercise 2, and for

For **Mass Care** the assessments of capabilities are as follows based on a scale of 1-7:
- Planning 2, Organization 4, Equipment 2, Training 4, Exercise 4.

The average EMS provider working on an ambulance specifically needs extensive training on Mass Care and Disaster Response. Georgia EMS-D.A.R.T. will address and fill the needs of those gaps.

**Command Structure**

The Lead Agency for activation and deployment of the Region 1 EMS-DART or any RRST’s will be the sole responsibility of the Region 1 Office of EMS and Trauma Regional Director or their designee when not available. (see Addendum 2 _ Job Action Sheet)

Each RRST will have a Commander, who will be responsible, their respective teams. When notified by the Regional EMS Director, each RRST Commander will notify their respective agencies for their team that they have been activated and advise the service of the rendezvous point to meet at. Then RRST Commander will then lead the team in a convoy style to the designated Staging Area for that particular event. Once at Staging, the entire RRST members will check in, have their portable radios, checked and
given frequency assignments. Then await instructions from EMS Sector Command (see Addendum 2 _ Job Action Sheet)

Each RRST Unit (service level) will assign a person as unit leader for their personnel during each deployment. This person will report to the RRST Commander for that team. (see Addendum 2 _ Job Action Sheet)

**Staging Officer** - Each event shall constitute the need for a designated staging area for the EMS Personnel, Resources and the RRST’s. The Staging Officer will check in each person, unit and resource and log that resource.

The Staging officer will coordinate with each RRST Commander the location of the Comm L or Comm T to verify each radio is operational and the frequency(s) being used. No RRST unit or personal shall be deployed unit this is accomplished. (see Addendum XX _ Job Action Sheet !!!)

**Triage Officer** - Each operation will require a Triage Officer at one or more locations as needed. This person(s) will be responsible for implementing the approved Triage Protocol and notifying the Transportation Officer with the needs and urgencies so they may assign units to these patients and assign a location for destination.

(see Addendum XX _ Job Action Sheet !!!)

**Transportation Officer** - The Transportation Officer will be responsible for the dissemination of patients to the appropriate medical care facility by the right means, in a timely manner based on their triage status and transportation resource availability (see Addendum XX _ Job Action Sheet !!!)

**Patient Tracking and Triage Protocols**

All EMS Services participating with a designated RRST will be required to participate in the Georgia Department of Public Health, Health Protection Section Patient Tracking Program. Research indicates that using these devices on a daily basis increases the user's ability to properly use the device under real world disaster and mass casualty events.

- **PATIENT TRACKING DEVICE** *(still not available to Region 1 Services in December 2015, therefore we will add is and when they do come available to us)*

For accountability reasons, it is necessary to track patient flow through the incident scene. We, as emergency responders, have a responsibility to account for where we send our patients so they can be reunited with their families.

With the introduction of electronic Patient Tracking Devices (PTD) we will be able to track patient progress within the incident scene, through the transport recorder position and ultimately to the receiving facility. The data collected by the PTD allows us to provide a more detailed patient treatment record to the receiving facility and will allow for easier reunification of families.
The PTD is designed to mirror the information gathered on the COG Disaster Tag. Information is organized into a single record by scanning the barcode attached to the Disaster Tag. This information is then visible to command and receiving facilities as well as any providers who may ultimately provide care to the patient, in near real time.

The more information about the patient (vital signs, medications, allergies, age, name, etc.) that can be obtained in the Treatment Area the better, but it is important that providers not focus on inputting information and neglect patient care. It is well understood that in a busy Treatment Area, there may not be enough personnel or time to input large amounts of information.

By placing PTDs in strategic locations within the incident and scanning the barcodes, it is possible for the IC to track patient flow and evaluate the progress of the incident.

Another option would be to use the iOS/Android app, or the Windows 8 app that is being developed on a compatible smart phone, laptop or tablet instead of the handheld device.

- **TRIAGE PROTOCOL**

Mass casualty triage is a critical skill. Although many systems exist to guide providers in making triage decisions, there is little scientific evidence available to demonstrate that any of the available systems have been validated. Furthermore, in the United States there is little consistency from one jurisdiction to the next in the application of mass casualty triage methodology. There are no nationally standardized categories or color designations. SALT Triage is the product of a CDC Sponsored working group to propose a standardized triage method. The guideline, entitled SALT (sort, assess, life-saving interventions, treatment and/or transport) triage, was developed based on the best available science and consensus opinion. It incorporates aspects from all of the existing triage systems to create a single overarching guide for unifying the mass casualty triage process across the United States. SALT is compliant with the Model Uniform Core Criteria for Mass Casualty Triage currently contemplated as the proposed national standard for all mass casualty triage systems.

On July 8, 2013 all of the members of Federal Interagency Committee on EMS (members: DOT, DOD, HHS, DHS, and FCC) concurred with the following statement “The FICEMS recommends that state and local Emergency Medical Services (EMS) systems improve their mass casualty incident triage capabilities through adoption of triage protocols and systems that are based on the Model Uniform Core Criteria. Federal resources may be used to support development of capabilities which improve EMS system preparedness for mass casualty triage.”

The full text of their implementation plan is available at (this also includes a list of the members of FICEMS):


- **SALT Mass Casualty Triage On-line Training (see Addendum 4)**
This on-line training program consist of a 22 minute video, links to articles on SALT Mass Casualty Triage and a downloadable powerpoint set for teaching SALT Triage to others. The program has a short 5 question quiz that upon successful completion will result in a certificate of completion.

There are two course versions that are identical, the only difference is the type of completion certificate that is awarded. One without CME (Free) and one with a CME certificate ($5 US). The free version contains the contact hour information on the certificate sufficient to claim credit for many professional organizations / licenses. The CME certificate program has specific language needed for the awarding of CME Credit and is typically used by Physicians and PAs. In some cases, profession organizations will exchange a CME certificate for CEUs without any additional approval process.

If you are a first time user of this system you will need to create your account using the "First Time Here" link on the right side of the page and verify your email address. If you have not received the email within a few minutes be sure to check your spam folder for the email.

SALT Triage On-line Training (No CME - FREE)
SALT Triage On-line Training (CME Version $5 US)

Communications Section

Initial activation of the EMS-D.A.R.T. would be by notification from the local EMS Director, EMA Director or 911 centers to the Metro Atlanta Ambulance Service Communications Center at 707-693-8480. Metro will then notify the Region 1 Regional EMS Director or their designee. Metro will then activate the DART members/service notification via the 21st Century notification system (or subsequent systems that may replace it). The Region 1 Regional EMS Director or their designee will then make contact with the Incidents EMS Command for a brief report of resources needed. After determining the needs of the incidents, the Region 1 Regional EMS Director or their designee will make contact with the Rapid Response Strike Team Leaders (R.R.S.T.) for instructions on:

- status of availability
- location of event
- estimated time of assembly
- and, staging location for the event.

The EMS R.R.S.T. Leaders will contact their EMS Services to obtain the availability and status of their EMS R.R.S.T. unit. The EMS R.R.S.T. Leader will also state where those units are to meet to respond together as a ‘strike team’. The EMS R.R.S.T. Commanders will also be the primary contact for communications and instructions with the Region 1 Regional EMS Director or their designee, Regional EOC or their designee.

Activation of the EMS DART should occur after the initial mutual aid requests that would normally be activated in a mutual aid event. However, in a known mass damage/casualty event, the initial request for activation could come simultaneously with the mutual aid requests.
Activation of the EMS-D.A.R.T. services/members will occur through 21st Century notification system (or subsequent systems that may replace it). Each person identified by their respective services for notification will simultaneously receive a region wide text/email/and recorded phone call notifying them that an incident has occurred in Region 1 (or another region or state requesting resources).


When personnel arrive at their base location where the EMS D.A.R.T. unit and equipment is located, they shall obtain access to the secured D.A.R.T. Field Deployment bags (3), the gray truck portable radio box, and the Region 1 EMS D.A.R.T. magnetic signs and put them in the ambulance responding in. The crew should consist of the normal 2 person EMS Crew and 3 additional personnel contained on this one unit.

The magnetic DART sign shall be place on the cab doors, even if they cover services logos, etc as to easily allow the unit to be identified as a DART unit.

Once the crew is assembled, truck ready and the crew receives instruction for the R.R.S.T. Leader, they shall respond in a safe and appropriate manner to the rendezvous point established by the R.R.S.T. Leaders. Once the arrive at the designated locale, the R.R.S.T. Leader will lead them convoy style to the incidents designated staging area.

Radios -

Each Service will have three (3) D.A.R.T. Field Deployment bags and one gray plastic DART Unit Radio box. Upon deployment one member of the team shall open the gray box, remove the radio, battery clamshell and pack of sealed batteries (AA/AAA) and placed the batteries in the clamshell and then the clamshell in the radio. Turn the radio on and assure that it powers up. If the R.R.S.T. provides a designed channel for the team’s operation response, then tune to that channel.

Each D.A.R.T. Field Deployment bag contains 1 pre-programmed, field programmable portable radio that does not have the battery attached. Also in the bag with the radio a AA/AAA battery clamshell and an unopened pack of batteries. Once the team arrives at the staging area, they shall report to the appropriate DART communication person (CommL/CommT) or their R.R.S.T. Leader for the activation of and assembly of the battery clamshell and the operational channel.

Radios should not be removed from the bags nor any seals broken on the bags until instructed to by the strike team leaders for said team.

The radio frequency will be assigned during operational periods to allow the team members to communicate with their ambulance, staged geographically to them, and their R.R.S.T. Leader. Cell phone number should also be shared between members and R.R.S.T. leaders as a back up to radio communications.
Etiquette

All radio communications shall be brief, to the point and limited to pertinent information and requests. We will use common vocabulary and avoid any use of codes, signals, etc as to remove ambiguity. Any questions about utilization of radio, cell phones, etc shall be directed to the appropriate R.R.S.T. Leader.

Radio Call Signs

David Foster (or R1 EMS Director)_ Region 1 EMS Director
R1 EMS Director or Designee - once on-scene -- DART Command
R.R.S.T. Leaders -
- DeWayne Wilson or designee - DART Strike Team 1 Leader
- Courtney Taylor or designee - DART Strike Team 2 Leader
- Danny West of designee - DART Strike Team 3 Leader
- Carlton Firestone - DART Strike Team 4 Leader

Services units

Strike Team 1
1. Angel EMS DART 1(second unit would be DART 11)
2. Dade Co DART 1
3. Puckett DART 1
4. Walker Fire DART 1
5. Redmond DART 1

Strike Team 2 -
1. Gordon EMS DART 2
2. Hamilton EMS DART 2
3. Floyd DART 2
4. Redmond DART 2
5. Murray DART 2
6. AMTRAN DART 2

Strike Team 3
1. Cherokee DART 3
2. Fannin DART 3
3. Gilmer DART 3
4. Pickens DART 3
5. Hope DART 3

Strike Team 4 -

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1. Ambucare DART 4
2. Metro DART 4
3. Bartow DART 4
4. Redmond DART 4
5. Floyd DART 4

Mass Transportation Component

Natural and man-made disasters have the potential to occur at any time throughout the state and may require a significant segment of the population to be evacuated from those impacted areas. This may involve evacuations for all possible hazards. Hazard analysis for GA indicates that hurricanes pose the greatest threat to the state and would impact a large percentage of the state’s population. Current hurricane disaster modeling indicates the potential that a substantial portion of the population in the coastal evacuation zones will need transportation to evacuate from those areas. This population may be general population, people considered to have special needs who reside in a non-institutional setting, or people residing in hospitals, nursing homes, personal care homes, assisted living and hospice facilities. Although state and local governments have plans to assist the population, there are a finite number of assets readily available to assist in the case of a major mass evacuation operation. To meet the projected numbers of evacuees, the State of Georgia will augment government assets with contractor and Georgia EMS-D.A.R.T. supplied vehicle support. Additionally, state and local governments have plans to assist the population in evacuating in other than hurricane disasters, i.e., planning for mass evacuations resulting from any natural or man-caused catastrophic event. As with hurricane disaster modeling, catastrophic event planning suggests a substantial portion of the population lacks transportation and the State of Georgia will assist mass evacuations with contractor and Georgia EMS-D.A.R.T. supplied vehicle support.

EMS Services participating in the regional EMS-D.A.R.T. program, having a designated EMS R.R.S.T. unit, are encouraged to submit a contract with GEMA (Georgia Emergency Management Agency) for Contract for Vulnerable Population Coastal Evacuation Transportation Services (Contact GEMA for current contract) for no less than their designated EMS R.R.S.T. unit. EMS Services can contract with GEMA for additional resource if they so choose, however they will only be required to submit a contract for their designated EMS R.R.S.T. unit.

Infectious Disease Precautions & Exposure Management for EMS D.A.R.T. Personnel

Purpose
To provide guidelines and procedures for EMS pre-hospital personnel, to reduce risk of infectious disease exposure to themselves and patients, and to evaluate and report suspected exposures to communicable diseases.

A. Although the presence of disease-causing agents may or may not be known, these agents may be present in body fluids and substances. Even apparently healthy persons may carry and be capable of transmitting disease.

B. Precautions identified in this policy are intended to provide pre-hospital personnel with information to safely care for all patients, regardless of disease status.

Exposure Risk Reduction

A. Pre-hospital Personnel. Pre-hospital personnel shall:

1. Follow employer’s policies/procedures for infection control to protect both patients and themselves.

2. **Use standard precautions for all patient contacts.** Additional barrier precautions are to be used based on the potential for exposure to body fluids and substances.

3. Wash hands, prior to and following patient contact at a minimum, regardless of the use of gloves or other barrier precautions. Thorough hand washing with soap and water is the most effective infection control activity for pre-hospital personnel. Waterless hand sanitizers are an option if soap and water are not available.

B. Provider Agency. Each provider agency shall:

1. Comply with all federal, state, and local regulations regarding infectious disease precautions.

2. Establish and maintain a written exposure control plan designed to eliminate or minimize employee exposure. This plan shall include a procedure to be used if an employee is possibly exposed to a communicable disease and this plan shall be made easily accessible.

3. Designate an infection control officer to evaluate and respond to possible infectious disease exposure of provider agency’s pre-hospital personnel.

4. Make available equipment, supplies and training necessary for pre-hospital personnel to reasonably protect themselves and their patients against infectious disease exposure.
C. Receiving Facility. Receiving hospitals should have staff procedures for:

1. Assisting possibly exposed pre-hospital personnel in assessing the significance of the exposure, and the need for and provision of prophylaxis.

2. Obtaining the appropriate testing to determine whether or not the source patient is infected with a communicable disease.

Exposure Definition

A significant communicable disease exposure is defined by criteria set by the Centers for Disease Control (CDC) and the Local Public Health Department and may include:

A. Contact with patient’s blood, bodily tissue, or other body fluids containing visible blood on non-intact skin (e.g. open wound; exposed skin that is chapped, abraded, affected with a rash) and/or mucous membranes (e.g., eye, mouth).

B. Contaminated (used) needle stick injury.

C. Unprotected mouth-to-mouth resuscitation.

D. Face-to-face contact in areas with restricted ventilation with patients who have airborne and or droplet transmissible diseases (e.g. Influenza, Measles, Chickenpox, Pertussis, Tuberculosis or Meningitis).

E. If extent of exposure is in question contact your local Public Health Department for additional guidance.

Center for Disease Control Recommendation

In the event of a possible infectious disease exposure and you are not sure what the particular guidelines are for a specific disease, contact your local or district public health office for guidance. If unable to contact Public Health, contact the CDC for guidance.

CDC recommendations should be used for follow up/treatments following a potential or significant exposure. Provider agencies, designated officers, occupational injury treatment centers, and emergency department staffs are expected to coordinate efforts to ensure prompt treatment for affected pre-hospital personnel.

RESPONSIBILITIES IN A CASE OF SUSPECTED EXPOSURE

A. Individual that may have been exposed shall:

1. Notify the RRST Unit Team Leader or RRST Commanders to report possible exposures during a deployment operation.
2. If the member have been deactivated before suspecting an exposure, then contact his or her employer’s Infection Control Officer/Designated Officer as soon as possible to determine the extent of the exposure and if follow-up recommendations including prophylaxis are required.

3. Refer to employer’s internal notification requirements and internal policy for direction and advice on reporting, evaluation and treatment.

B. Employer of the individual who may have been exposed should:

1. Assess the potential exposure to determine if the exposure meets the definition as defined above.

2. Assure the individual with a suspected exposure is instructed to report immediately to an emergency department, or other health treatment facilities for risk assessment and determination of need for prophylactic treatment.

Memorandum of Understanding/Agreement (MOU/MOA)

Each participating service will agree to the terms of the attached MOU/Contract and be held accountable for all assets provided to them under the terms of said MOU/Contract (See Addendum 5)

Each participating service will sign a MOU with the agency/organization receiving grant funding to process the DART related equipment and supplies, for the purpose of receipt, security, and loss protection of said equipment.

An additional MOU for deployment related purposes may occur at a later time as we explore the regulatory and statutory requirement of this project.

BIS Assessment

National Association of State Emergency Medical Services Officials
EMS Incident Response and Readiness Assessment (EIRRA)

*Scoring descriptions in parentheses are meant to be examples to assist in arriving at a score. It is understood that few examples will be an exact match of the situation

<table>
<thead>
<tr>
<th>100 PERSONNEL</th>
<th>200 INFRASTRUCTURE</th>
<th>300 Emergency Care System</th>
<th>400 PUBLIC AWARENESS &amp; NOTIFICATION</th>
<th>500 EVALUATION</th>
<th>600 MASS CASUALTY PLANNING</th>
<th>700 GOVERNANCE</th>
<th>Total BIS Score</th>
</tr>
</thead>
</table>

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The above table is the scoring results for the assessment conducted on the 16 county region of Region 1 EMS and is not indicative of any particular county, but all collectively.
See Addendum XX for Full Tables and Individual Scoring

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**Addendum 1 - Operational Guidelines**

**Overview**

The mission of the NW GA EMS D.A.R.T. is to provide a sustainable EMS Taskforce to the counties of Region 1, GEMA Area 6, the state of Georgia and our neighboring states in times on mass casualty events which overwhelm them. Each participating service will send one designated ambulance with a crew of 5 personnel (minimum of 3) when requested as part of one of four (4) strike teams. The unit will respond to a designated location to meet with all other strike team units determined by the strike team leader (ST
Commander). The strike team will then respond to the incident convoy style to the events DART Staging area.

Response of EMS R.R.S.T. units from Region 1 EMS Services.

When personnel arrive at the service location where the EMS D.A.R.T. unit and equipment is located, they shall obtain access to the secured D.A.R.T. Field Deployment bags (3), the gray truck portable radio box, and the Region 1 EMS D.A.R.T. magnetic signs before responding in. The crew should consist of the normal 2 person EMS Crew and 3 additional personnel contained on this one unit.

The magnetic DART sign shall be placed on the cab doors, even if they cover services logos, etc as to easily allow the unit to be identified as a DART unit.

Once the crew is assembled, truck ready and the crew receive instructions for the R.R.S.T. Leader (Strike Team Commander), they shall respond in a safe and appropriate manner to the rendezvous point established by the R.R.S.T. Leaders. Once they arrive at the designated locale, the R.R.S.T. Leader will lead them convoy style to the incidents designated staging area.

**Roles and Responsibilities**

Once deployed, the team may be active for up to 96 hours. Each person is encouraged to create and keep ready a “Go Bag” contain one or more NW GA EMS DART T-shirt(s) extra clothing and personal items. (See GO BAG handout from DART Course).

Once the team has arrived at the incident, members will be given assignments as needed. This could include providing medical support and deployment with a GSAR Strike Team, Law Enforcements, HazMat Unit, Wilderness Search/Rescue Team, Triage, Treatment, Staging or other duties as dictated by the event.

Each unit members will answer to their strike team commanders, or their designee as determined by the event’s needs.

**Communications Section**

Initial activation of the EMS-D.A.R.T. would be by notification from the local EMS Director, 911 center or EMA Director to the Metro Atlanta Ambulance Service Communications Center at 707-693-8480. Metro will then notify the Region 1 Regional EMS Director or their designee. Metro will then activate the DART members/service notification via the 21st Century notification system (or subsequent systems that may replace it). The Region 1 Regional EMS Director or their designee will then make contact with the Incidents EMS Command for a brief report of resources needed. After determining the needs of the incidents, the Region 1 Regional EMS Director or their designee will make contact with the Rapid Response Strike Team Leaders (R.R.S.T.) for instructions on:
• status of availability
• location of event
• estimated time of assembly
• and, staging location for the event.

The EMS R.R.S.T. Leaders will contact their EMS Services to obtain the availability and status of their EMS R.R.S.T. unit. The EMS R.R.S.T. Leader will also state where those units are to meet to respond together as a ‘strike team’. The EMS R.R.S.T. Commanders will also be the primary contact for communications and instructions with the Region 1 Regional EMS Director or their designee, Regional EOC or their designee.

Activation of the EMS DART should occur after the initial mutual aid requests that would normally be activated in a mutual aid event. However, in a known mass damage/casualty event, the initial request for activation could come simultaneously with the mutual aid requests.

Activation of the EMS-D.A.R.T. services/members will occur through 21st Century notification system (or subsequent systems that may replace it). Each person identified by their respective services for notification will simultaneously receive a region wide text/email/and recorded phone call notifying them that an incident has occurred in Region 1 (or another region or state requesting resources).

- Radios

Each Service will have three (3) D.A.R.T. Field Deployment bags and one gray plastic DART Unit Radio box. Upon deployment one member of the team shall open the gray box, remove the radio, battery clamshell and pack of sealed batteries (AA/AAA) and placed the batteries in the clamshell and then the clamshell in the radio. Turn the radio on and assure that it powers up. If the R.R.S.T. provides a designed channel for the teams’ operation response, then tune to that channel.

Each D.A.R.T. Field Deployment bag contains 1 pre-programmed, field programmable portable radio that does not have the battery attached. Also in the bag with the radio a AA/AAA battery clamshell and an unopened pack of batteries. Once the team arrives at the staging area, they shall report to the appropriate DART communication person (CommL/CommT) or their R.R.S.T. Leader for the activation of and assembly of the battery clamshell and the operational channel.

Radios should not be removed from the bags nor any seals broken on the bags until instructed to by the strike team leaders for said team.

The radio frequency will be assigned during operational periods to allow the team members to communicate with their ambulance, staged geographically to them, and their R.R.S.T. Leader. Cell phone number should also be shared between members and R.R.S.T. leaders as a back up to radion communications.
-Etiquette

All radio communications shall be brief, to the point and limited to pertinent information and requests. We will use common vocabulary and avoid any use of codes, signals, etc as to remove ambiguity.

Any questions about utilization of radio, cell phones, etc shall be directed to the appropriate R.R.S.T. Leader.

-Radio Call Signs

David Foster (or R1 EMS Director)_ Region 1 EMS Director
R1 EMS Director or Designee - once on-scene -- DART Command
R.R.S.T. Leaders -
- DeWayne Wilson or designee - DART Strike Team 1 Leader
- Courtney Taylor or designee - DART Strike Team 2 Leader
- Danny West of designee - DART Strike Team 3 Leader
- Carlton Firestone - DART Strike Team 4 Leader

-Services units

Strike Team 1
6. Angel EMS DART 1(second unit is DART 11)
7. Dade Co DART 1
8. Puckett DART 1
9. Walker Fire DART 1
10. Redmond DART 1

Strike Team 2 -
7. Gordon EMS DART 2
8. Hamilton EMS DART 2
9. Floyd DART 2
10. Redmond DART 2
11. Murray DART 2
12. AMTRAN DART 2

Strike Team 3
6. Cherokee DART 3
7. Fannin DART 3
8. Gilmer DART 3
9. Pickens DART 3
10. Hope DART 3
Strike Team 4 -

6. Ambucare DART 4
7. Metro DART 4
8. Bartow DART 4
9. Redmond DART 4
10. Floyd DART 4

- Response
Once activated, each RRST unit will respond per the instruction of their respective RRST Commander. They will rendezvous with the RRST Commander and other RRST units before responding on to the events staging area. No unit will respond directly to any event. Once they arrive at the events staging area they will await their assignment from their RRST Commander.

- Taskforce Briefings
As soon as the taskforce personnel arrive at the identified area to establish a base of operation (BoO), a briefing should be conducted for all personnel. After the taskforce supervisory personnel have had an opportunity to convene, they should outline their strategy and delegate specific responsibility for each issue. This is extremely important in order to ensure that the taskforce operates as a cohesive unit and that goals are clearly understood by all members. A review of the following issues should be addressed:

  Incident situation reporting.
  Taskforce objectives.
  Tactical assignments.
  Taskforce support layout and requirements (BoO).
  Communications plan, frequencies, and radio designations.
  Medical treatment and evacuation procedures for taskforce personnel.
  Process for ordering supplies and equipment through IMT.
  Incident stress management considerations.
  Shift assignments and rotations.

- Safety
Each unit will exercise extreme caution while responding and deployed. Many of these events pose additional hazards that EMS Personnel do not encounter on a daily basis therefore they must be ever vigilant of their surrounding and environment. This applies to the response to the event, response during the event, and operational assignments.

- Reporting
Each EMS DART member will refer to their Job Action Sheet for their assignments for reporting and accountability.
The EMS DART Commander, in conjunction with the local authorities will create the EMS Incident Action Plan for each operational period. Each patient transported will still require a patient care report (ePCR) and a comprehensive verbal report to the receiving facility. Using the Patient Tracking System devices should allow for a more accurate reporting process between each person that encounters the patient from triage to receiving faculty.

If a member suffers a traumatic injury, it must be reported to the IMT as soon as possible. The injured person should be treated and transported to a medical facility if necessary without delay. An occupational disease must be reported to the taskforce or IMT management as soon as the person first becomes aware of the condition.

- **Sustainability**

EMS Services are usually required well past the initial event deployment. Some RRST Units may be released after a 12-36 hrs hour deployment, and returned to their respective services. Some units will need to remain to support recovery operations for an unspecified period. In these incidents, their respective EMS Services may be requested, to send in relieve personnel to allow for recuperation of initial response units. Once we start deactivations of the operation, some personnel beyond the normal two people on an ambulance, may be released, while retaining two members for non-critical support of stand by operations.

- **Support to other disciplines**

The roles of EMS DART personnel are to provide a specialized group of personnel who are trained in disaster medical services who will provide dual purpose roles. The first role will be patient care and transportation services. The second role will be to provide medical support to specialized units for search, rescue, tactical, or other operations requiring a medical support team. This approach will allow for support to the operations, without reducing the number of ambulances available to provide transport services.

- **Equipment Cache Management**

All DART equipment cache assigned to the EMS Service must be procured from a secure, environmental controlled area at said service, with seals intact, and loaded onto the ambulance prior to deploying. Items expended, lost, damaged, or intentionally left for the local jurisdiction must be identified and reported to the EMS DART Commander.

- **Restocking**

Gordon Co EMA and Cherokee Fire & Emergency Services have vehicles which we can place restocking supplies for the EMS DART.

- **Rest and Rehabilitation**

Upon return to the base of operation (BoO) every attempt will be made through the proper channels to find quarters for all task force personnel to provide rest and rehabilitation time.
- Scheduling and Work Period Rotations

The EMS RRST Commander and other supervisory personnel will need to determine how to deploy task force personnel at the start of mission operations. It may be most appropriate and advantageous to commit all taskforce personnel to the support of rescue/tactical effort or it may be better to commence with setting up, medical triage area(s), Treatment areas, Staging and Transport areas in anticipation of an influx of various levels of patients. While time is of the essence to effect successful live victim extrications and treatment, the full-scale commitment of personnel must be balanced by a review of the present and anticipated search and rescue operational support. Within a matter of hours of initial personnel deployment, the EMS RRST Commander and other supervisory personnel must begin some moderate to long term planning. The work schedule will be incident driven, based upon the general conditions present. The following depicts one possible deployment model:

- First 8-12 hrs - All personnel and resources establish or support ongoing triage, treatment and transport operations. Support search and rescue operations, tactical operations, of other such needs based on the incident type.
- Hours 12-24 - Provide relief for one half of personnel for release back to their respective services with fresh personnel for said service, or to provide feeding/sleeping opportunities.
- Hours 24 and beyond, - continue to provide support to the other agencies and needed in 12 hour operational periods. Rotate personnel with those who have rested, and those that have come from their respective services, to relieve their peers. Continue to provide medical stand-by until relieved by the incident commander to allow the local EMS agency to return to its normal daily operations. Provide backup to the local EMS if system is still overloaded from the event.

- Code of Conduct

Each member of the EMS DART will adhere to the following

- No transportation/use of illegal drugs/alcohol.
- No firearms allowed.
- Normal radio protocol used/traffic kept to a minimum.
- Know your chain of command/who you report to.
- Limit procurement of equipment.
- Do not take things without authorization.
- Act professional.
- Remain ready even when unassigned.
- Recreation limited to unassigned hours.
- Maintain/wear safety gear/clothing.
- Wear proper uniform.
- Your actions reflect your organizations and the Regional EMS System

- EMS DART MEDICAL PROCEDURES

This specialized medical team is trained, organized, staffed, and equipped to provide sophisticated and prolonged pre-hospital and specialized emergency medical care, throughout the course of a mission. It is
recognized that both serious injuries and illnesses may be encountered and will require treatment. The medical personnel are also responsible for minimizing health risks, intervening in extended incident stress syndrome, and treating taskforce personnel exposed to hazardous materials. Special protocols will apply for disaster medical care.

- **TREATMENT PRIORITIES**
  The treatment priorities for the task force medical team are:
  
  - First - triage and treatment of any injured or ill patient encountered as part of the response.
  - Second - treatment of S&R, Tactical or other operational personnel who the RRST member is assigned to support.
  - Third - treatment of victims directly encountered by the taskforce.

  It is the intent of the medical team to be the lead supporting medical resource to local medical systems at the disaster site. In exceptional incidents the NDMS may be the primary providers of general medical care to disaster victims. It is recognized that the EMS RRST’s, being medically sophisticated, will be supported by an equally capable transport team to manage all patients for transport to definitive care facilities. Some patients may be passed off to air medical resources with even greater scopes of practice as warranted by the triage, transport, TSEC criteria and resource availability of certain medical specialty services needed by the patient’s condition.

- **Deactivation**
  All units and personnel will remain deployed until released by the EMS DART Commander. Should an event of illness or injury occur that requires the release of any team member it will occur with the decision of the RRST Unit Leader or RRST Commander. Any such events shall be reported up the chain of command as soon as possible.

- **Post Incident Documentation**
  Each event will require post incident documentation based on the event type. These can include state or federal reimbursement documentation, local EMS Resources and personnel verification, information for a Hot Wash and/or Incident After-Action Plan, etc.

  **Addendum 2 – Job Action Sheets**

**Job Action Sheet**
Command Section
EMS Branch Director
D.A.R.T COMMANDER

**Mission:** Organize and directs the Northwest Georgia Region I EMS Disaster Assistance Response Taskforce Operations (D.A.R.T.). Gives overall strategic direction for the Region 1 EMS D.A.R.T. Supports activities, including emergency response and recovery for the Task Force.
**Reports to:** Incident Commander or State of Georgia Emergency Operations Center’s ESF # 8 Desk.

**Supervises:** D.A.R.T. Strike Team Leaders (R.R.T. Commanders)

**Upon Activation of the District EOC (DOC):** Reports promptly to the EOC when notified; presents proper identification for entrance into the EOC.

**Upon Notification from a Service/County:** when notified that an event has occurred, they may activate the EMS D.A.R.T. prior to District EOC activation and Deploy to the scene EMS Commander Center.

- Notifies the State EMS Director if needed.
- Notify the appropriate DPH District Office EP Director or designee to request DOC activation if needed.
- Initiate the Incident Briefing Form (ICS 201).
- Activates the Task Force via notification of Regional EMS Disaster Assistance Response Taskforce (D.A.R.T.) Rapid Response Team Leader(s) R.R.T. Commanders)
- Using information on hand, estimates duration of incident.
- Briefs all D.A.R.T. Team Leaders of the nature of the problem, immediate critical issues and initial plan of action. Incident Briefing Form( ICS Form 201)
- Designate time for next briefing.

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**Operational Duties**

- Ensure that the approved IAP is communicated to all D.A.R.T Command Staff and Communicate IAP to state level authorities as needed.
- Conducts Safety Briefing
- Authorize resources as needed or requested by D.A.R.T. Command Staff.
- Conduct regular briefings with D.A.R.T. Command Staff and Section Chiefs to identify needs and Situational updates.
• Evaluates overall D.A.R.T. Task Force operational status, and ensure critical issues are being addressed.

Demobilization

• Approve the plan developed by the Demobilization Unit Leader and approved by the Planning Section Chief for the gradual demobilization of the D.A.R.T. Task Force according to the progression of the incident.
• Authorize D.A.R.T. Task Force Leaders (R.R.T. Commanders) to demobilize positions and return staff to day to day operations.
• Conduct D.A.R.T. Staff debriefings to identify accomplishments, response activities, and improvement issues as well as cost and recovery efforts.
• Participates in event Hot Wash, After Action Report and Improvement Plan development
• Approves D.A.R.T. After Action Report and Improvement plan
• Approves needed revisions to D.A.R.T. EOP, Job Action Sheets, operational procedures, records and/or other related items.
• Approves Post-incident media briefings and public health updates

Job Action Sheet Operations Section
EMS Branch

EMS DART Rapid Response Strike Team Commander

Mission: Supervises and Coordinates the units of their Rapid Response Strike Team. Contact Services with instructions on where to rendezvous when activated.
Position Reports to: EMS DART Commander -

Qualifications: Georgia Certification as a, CT or Paramedic
NIMS Courses ICS 100, 200, 700, 800, HazMat Awareness,
PHTLS/ITLS, Basic Disaster Life Support, D.A.R.T. course
minimum.

Disclaimer: You are being assigned to the Region I EMS Task Force (D.A.R.T.) as an extension of your current EMS employer. This is a voluntary assignment upon recommendation of your employer. Deployment is at the sole discretion of your employer! While deployed with the Region I EMS DART you are under direct supervision of the EMS Commander regardless of their service affiliation.

Upon Activation:

- Report to designated team assembly point.
- Receive briefing from the EMS DART Commander or their designee
- Obtain copy of Job Action Sheets.
- Put on position identification. (i.e. EMS DART Vest)
- Deploy with EMS Task Force in provided transportation to a designated staging area or incident location. DO NOT SELF DEPLOY IN PERSONAL TRANSPORTATION.

Operational:

- Arrive at assigned site when notified and check in with Lead Medical Manager.
- Read this entire Job Action Sheet.
- Obtain situation briefing from the EMS DART Commander
- Don position identification vest
- Appoint and brief staff, as needed:
- Insure the establishment of communications with EMS Command and RRST units
- Assign RRST assignments as needed in conjunction with EMS DART Commander.
- Establish communications with EMS DART EMS Commander
- Request additional ambulances as required via EMS DART Commander
- Evaluate and request necessary resources, as needed
- Maintain Unit/Activity Log (ICS Form 214)
- Secure operations when advised
• Forward reports and records to EMS DART Commanders when requested

• Will confer with DART or Local Medical Control physician if further consultation/evaluation regarding injuries/illness or exposure is needed.

• If there is a potential security threat, assure that Law Enforcement has personnel to secure the area as needed.

• Direct all media inquiries to the Public Information Liaison assigned to the clinic.

Demobilization

When orders are received via radio or face to face to stand down:

• Assure all team members as accounted for

• Verify all units have their field bags, portable radios, and other EMS DART Assigned equipment are back on their units.

• Check out with EMS DART Commander.

• Identify issues for debriefing report.

• Participate in stress management and Hot Wash.

• Participate in other briefings and meetings as required.

• Upon on return to Home Base completely fill out the Time sheet (ICS Form 252) sign and give to EMS Task Force Leader (R.R.T. Commander).

• When released by the EMS Task Force Leader (R.R.T. Commander) check with your EMS Employer/Supervisor for your next assignment.

Documents/Tools

• Identification Vest and EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag)

• Triage Tags compatible with scannable patient tracking device(s)

• ICS Form 252 – Time Sheet

• EMS Task Force Vest

• Radio
Job Action Sheet Operations Section
EMS Branch
EMS Task Force Team Member
(R.R.T. Unit Team Member)

**Mission:** To provide emergent pre-hospital treatment and or transport as part of a EMS Task Force in the event of a disaster or mass causality event to a designated area, county or state.

**Position Reports to:** EMS Strike Team Leader (R.R.T. Team Leader)

**Qualifications:** Georgia Certification as an EMT or Paramedic
NIMS Courses ICS 100, 200, 700, 800, HazMat Awareness, PHTLS/ITLS, Basic Disaster Life Support, D.A.R.T. course minimum.

**Disclaimer:** You are being assigned to the Region I EMS Task Force (D.A.R.T.) as an extension of your current EMS employer. This is a voluntary assignment in upon recommendation of your employer. Deployment is at the sole discretion of your employer! While deployed with the Region I EMS task force you are under direct supervision of the EMS Team Leader regardless of their service affiliation.

**Upon Activation:**

- Report to designated team assembly point.
- Receive briefing from the EMS Task Force Leader.
- Obtain copy of Job Action Sheets.
- Put on position identification. (i.e. EMS Task Force Vest)
- Take handheld radio from D.A.R.T. Field Gear Bag to Communication Officer and have tuned to appropriate channel. Conduct radio test when instructed to do so.
- Obtain EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag) and PPE (if indicated) from your unit.
- Deploy with EMS Task Force in provided transportation to a designated staging area or incident location. DO NOT SELF DEPLOY IN PERSONAL TRANSPORTATION.
Operational:

- Each R.R.T. will rendezvous with the R.R.T. Team Leader (R.R.T. Commander) at a designated location to respond together to the events Staging Area.
- Upon arrival at the events Staging Area wait for assignment from the EMS R.R.T. Commander before leaving Staging Area. DO NOT SELF-DEPLOY from Staging Area.
- Duties could include assignment to a SAR/Tactical Team, Triage, Treatment and Transport or to provide daily EMS Services to the affected area.
- Additional duties could include Shelter Support, Hospital Care or support staff for a deployed state or federal team.
- Remain in constant communication with the EMS R.R.T Team Leader (R.R.T. Commander) through the Communications Officer.
- Provide pre-hospital emergency care to the sick and injured to your level of training if assigned.
- Follow orders of Transportation Officer on scene if involved in Transport or evacuation of patients.
- Requests for EMS transportation resources (buses, shuttles, ambulances, mass causality vehicles must be made through the EMS Task Force Leader (R.R.T. Commander) to the EMS Section Commander
- Requests for air lift medical evacuation from patient care areas are made through the EMS Task Force Leader (R.R.T. Commander) to the EMS Section Commander.
- Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.

Demobilization

When orders are received via radio or face to face to stand down:

- Immediately report to the Staging Area for further instructions.
- Take the battery out of all Radio equipment and secure in the D.A.R.T. Field Gear Bag.
- Return equipment and supplies to the EMS Task Force Leader (R.R.T. Commander) for re-supplying and sealing before placing back on your unit.
- Brief EMS Task Force Leader (R.R.T. Commander) on recommendations for procedure changes, accomplishments and issues.
- Participate in stress management and Hot Wash.
- Participate in other briefings and meetings as required.
- Upon on return to Home Base completely fill out the Time sheet (ICS Form 252) sign and give to EMS Task Force Leader (R.R.T. Commander).
• When released by the EMS Task Force Leader (R.R.T. Commander) check with your EMS Employer/Supervisor for your next assignment.

Documents/Tools
• Identification Vest and EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag)
• ICS Form 252 – Time Sheet
• EMS Task Force Vest
• Radio

Job Action Sheet
EMS Branch
EMS COMMUNICATIONS UNIT LEADER
(D.A.R.T. Communications Officer)

Mission: Organize and coordinate external EMS communications connectivity.

Qualifications: ICS NIMS: 100, 200, 700, 800 and prefer 300 and 400.
911 Operators with Class 2 Radio License
Amateur radio license, Comm-L or Comm-T certification.

Position Reports to: EMS Task Force Leader (D.A.R.T. Commander)

Immediate (Operational Period 0-12 Hours)

• Receive appointment and briefing from the EMS Task Force Leader. (D.A.R.T. Commander)
• Obtain Communication Equipment from Task Force Leader. (D.A.R.T. Commander)
• Outline Communication Action Plan and review with EMS Task Force Leader (D.A.R.T. Commander) for approval.
• Inventory and assess all available on-hand radios.
• Verify Radio functionality, and proper programing of each radio in the D.A.R.T. Field Gear Bag as R.R.T. units arrive at Staging Area.
• Set up and maintain communication equipment and provide ongoing communication support for the EMS Task Force (D.A.R.T.).
• Initiate the Incident Communications Log (ICS Form 205).
• Determine radio channels for response and make radio assignments.
• Prepare for radio checks from personnel that are assigned hand-held radios and other portable communications equipment.
• Assess status of all on-site communications equipment, including two-way radios, satellite phones and inter and intra-net connectivity.
• Initiate repairs per the standard operating procedures.
• Evaluate status of internal and external telephone/fax systems and report findings to EMS Task Force Leader (D.A.R.T. Commander).
• Request the assistance of amateur radio personnel to assist with communications, if indicated.
• Document all communications (internal and external) on an Incident Message Form (ICS Form 213).

Operations:
• Responsible for all radio communication of the EMS Task Force (D.A.R.T.) between each Task Force Team member (R.R.T Unit) and the EMS Task Force Team Leader (R.R.T. Commander) and the EMS Branch Director (D.A.R.T. Commander).
• Establish communications with the County EOC.
• Establish communication by radio or phone with EMS Branch Director (D.A.R.T. Commander).
• Expand communication network capability and equipment as required to meet the needs of the EMS Task Force (D.A.R.T.) response.
• Ensure communication equipment maintains proper functioning.
• If primary communications systems fail, establish mechanism to communicate with EMS Task Force (D.A.R.T.)
• Receive and archive all documentation related to internal and external facilitates communication systems.
• Advise EMS Task Force Leader (D.A.R.T. Commander) immediately of any operational issue you are not able to correct or resolve.
• Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.

Demobilization/System Recovery Time Initial
• Ensure return/retrieval of communication equipment.
• Ensure that all radios and battery operated equipment is serviced and recharged.
• Advises EMS Task Force Leader (D.A.R.T. Commander) on lessons learned and procedural/equipment changes needed.
Upon deactivation of your position, brief the EMS Task Force Leader (D.A.R.T. Commander) on current problems, outstanding issues, and follow-up requirements.

Upon deactivation of your position, ensure that Operational Logs (ICS Form 214) and all documentation are submitted to the EMS Task Force Leader (D.A.R.T. Commander).

Submit comments to the EMS Task Force Leader (D.A.R.T. Commander) for discussion and possible inclusion in the after-action report; topics include:

- Review of pertinent position descriptions and operational checklists
- Recommendations for procedure changes
- Section accomplishments and issues
- Participate in after-action debriefings.

Documents/Tools

- ICS Form 205 – Incident Communications Log (Internal and External)
- ICS Form 207 – Incident Management Team Chart
- ICS Form 213 – Incident Message Form
- ICS Form 214 – Operational Log
- Telephone directory
- Radio/satellite phone
- PC with internet access, if available

Job Action Sheet Operations Section  
EMS Branch  
**EMS D.A.R.T. EMS STAGING Officer**

**Mission:** To supplement local EMS Staging Operations or fulfill the ICS EMS Staging Officer Position as indicated. Organize and manage the deployment of supplementary pre-hospital resources, including personnel, vehicles, equipment, supplies, and medications.

Reports to: The DART ENS Staging Officer is appointed by the D.A.R.T. Transportation Officer. Once the appointment is made the position reports to the D.A.R.T. Commander.

---

Date: __________ Start: __________ End: __________ Position Assigned to: ________________ Initial: __________

Position Reports to: Operations Section Chief once appointed.
Immediate (Operational Period 0-2 Hours) | Time | Initial
---|---|---
Receive appointment and briefing from the DART EMS Team Leader. Once appointed position reports to the local Operations Section Leader Obtain Staging Unit Job Action Sheets. | | |
Read this entire Job Action Sheet and review incident management team chart (ICS Form 207). Put on position identification. | | |
Determine need for and appropriately appoint Staging Team Leaders, distribute corresponding Job Action Sheets and position identification. Complete the Branch Assignment List (ICS Form 204). | | |
Document all key activities, actions, and decisions in an Operational Log (ICS Form 214) on a continual basis. | | |
Identify an appropriate area to serve as Staging Area for the receipt and distribution of personnel and equipment resources. | | |
Coordinate delivery of needed resources to requesting area:  
- Personnel  
- Vehicles  
- Equipment and supplies  
- Medications | | |
Regularly report Staging Area status to Operation Section Chief. | | |
### Immediate (Operational Period 0-2 Hours)

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- Assess problems and needs; coordinate resource management.
- Evaluate on-hand equipment, supply, and medication inventories and staff needs in collaboration with Logistics Section Supply Unit Leader; report status to Operations Section Chief and Supply Unit.
- Meet with the Operations Section Chief and Logistics Section Chief, as appropriate to discuss plan of action and staffing in all activities.
- Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.

### Intermediate (Operational Period 2-12 Hours)

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- Brief the Operations Section Chief frequently.
- Continue coordinating delivery of needed personnel, equipment/supplies, medications, and facility support services, working with the Logistics Section and Operations Section Branch Directors, as needed.
- Ensure prioritization of problems when multiple issues are presented.
- Coordinate use of external resources.
- Develop and submit a Staging Area action plan to the Operations Section Chief when requested.
- Ensure documentation is completed correctly and collected.
- Advise the Operations Section Chief immediately of any operational issue you are not able to correct or resolve. Make notification of resource problems encountered to the Logistics Section Chief, as appropriate.
- Ensure staff health and safety issues being addressed; resolve with the Safety Officer.
### Extended (Operational Period Beyond 12 Hours)

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<tr>
<th>Action</th>
<th>Time</th>
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<tr>
<td>Continue to monitor the Staging Team’s ability to meet workload demands, staff health and safety, resource needs, and documentation practices.</td>
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<td>Coordinate assignment and orientation of external personnel sent to assist.</td>
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<td>Work with the Operations Section Chief and Logistics Section Chief, as appropriate on the assignment of external resources.</td>
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<td>Rotate staff on a regular basis.</td>
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<td>Document actions and decisions on a continual basis.</td>
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<td>Continue to provide the Operations Section Chief with periodic situation updates.</td>
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<td>Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.</td>
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<tr>
<td>Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Employee Health &amp; Well-Being Unit Leader. Provide for staff rest periods and relief.</td>
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<tr>
<td>Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.</td>
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### Demobilization/System Recovery

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<th>Action</th>
<th>Time</th>
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<tr>
<td>As needs for Staging Area decrease, return staff to their normal jobs and combine or deactivate positions in a phased manner, in coordination with the Demobilization Unit Leader.</td>
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<td>Assist the Operations Section Chief and Branch Directors with restoring EMS resources to normal operating condition.</td>
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<tr>
<td>Ensure the return/retrieval of equipment/supplies/personnel.</td>
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### Demobilization/System Recovery

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<th>Demobilization/System Recovery</th>
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<td>Debrief staff on lessons learned and procedural/equipment changes needed.</td>
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<td>Upon deactivation of your position, brief the Operations Section Chief on current problems, outstanding issues, and follow-up requirements.</td>
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<td>Upon deactivation of your position, ensure all documentation and Staging Unit Operational Logs (ICS Form 214) are submitted to the Operations Section Chief.</td>
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<td>Submit comments to the Operations Section Chief for discussion and possible inclusion in the after-action report; topics include:</td>
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<td>- Review of pertinent position descriptions and operational checklists</td>
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<td>- Recommendations for procedure changes</td>
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<td></td>
<td></td>
<td>- Section accomplishments and issues</td>
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<td></td>
<td>Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.</td>
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</table>

### Documents/Tools

- Incident Action Plan
- ICS Form 204 – Branch Assignment List
- ICS Form 207 – Incident Management Team Chart
- ICS Form 213 – Incident Message Form
- ICS Form 214 – Operational Log
- County emergency operations plan
- Incident organization chart
- Radio/satellite phone
Job Action Sheet Operations Section
EMS Branch
EMS DART Transportation Officer

Mission: Responsible for the coordination of patient transportation and maintenance of records relating to the patient’s identification, condition, and destination. The Patient Transportation function may be initially established as a Unit and upgraded to a Group based on incident size or complexity.

Position Reports to: EMS DART Commander -

Qualifications: Georgia Certification as an Intermediate '85, AEMT, CT or Paramedic
NIMS Courses ICS 100, 200, 700, 800, HazMat Awareness, PHTLS/ITLS, Basic Disaster Life Support, D.A.R.T. course minimum.

Disclaimer: You are being assigned to the Region I EMS Task Force (D.A.R.T.) as an extension of your current EMS employer. This is a voluntary assignment upon recommendation of your employer. Deployment is at the sole discretion of your employer! While deployed with the Region I EMS DART you are under direct supervision of the EMS Commander regardless of their service affiliation.

Upon Activation:

- Report to designated team assembly point.
- Receive briefing from the EMS DART Commander or their designee
- Obtain copy of Job Action Sheets.
- Put on position identification. (i.e. EMS DART Vest)
- Take handheld radio from D.A.R.T. Field Gear Bad to Communication Officer and have tuned to appropriate channel. Conduct radio test when instructed to do so.
- Obtain EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag) and PPE (if indicated) from your unit.
- Obtain a Patient Tracking Scanning device
- Deploy with EMS Task Force in provided transportation to a designated staging area or incident location. DO NOT SELF DEPLOY IN PERSONAL TRANSPORTATION.

Operational:

- Arrive at assigned site when notified and check in with Lead Medical Manager.
• Read this entire Job Action Sheet.
• Obtain situation briefing from the Treatment Unit Leader
• Don position identification vest
• Obtain situation briefing from Medical Group Supervisor or Medical Branch Director.
• Don position identification vest
• Appoint and brief staff, as needed:
  • Insure the establishment of communications with hospital(s).
  • Designate Transportation Section Ambulance Staging Area(s).
  • Establish and identify ambulance-loading areas
  • Direct the off-incident transportation of patients
  • Develop ambulance ingress and egress traffic pattern and coordinate with Law Enforcement Group Supervisor
  • Assure that patient information and destination are recorded.
  • Establish communications with EMS DART Staging Officer
  • Request additional ambulances as required via EMS DART Commander
  • Coordinate the establishment of the Air Ambulance Helispots with the EMS DART Commander
  • Maintain written records of patients, ambulance units, and receiving facilities
  • Coordinate with GA TCC for available service lines to assure not overloading areas hospitals.
  • Provide patient information for transmission to the receiving facilities
  • Evaluate and request necessary resources, as needed
  • Maintain Unit/Activity Log (ICS Form 214)
  • Secure operations when advised
  • Forward records and reports to Medical Group Supervisor or Medical Branch Director
  • Forward reports and records to EMS DART Commanders when requested
  • Will confer with DART or Local Medical Control physician if further consultation/evaluation regarding injuries/illness or exposure is needed.
• If there is a potential security threat, assure that Law Enforcement has personnel to secure the area as needed.

• Direct all media inquiries to the Public Information Liaison assigned to the clinic.

**Demobilization**

*When orders are received via radio or face to face to stand down:*

• Prepare Transportation Staging and Loading Area(s) for termination or hand off to replacement.

• Assist with the tear down and clean up of the area.

• Check out with EMS DART Commander.

• Identify issues for debriefing report.

• Participate in stress management and Hot Wash.

• Participate in other briefings and meetings as required.

• Upon on return to Home Base completely fill out the Time sheet (ICS Form 252) sign and give to EMS Task Force Leader (R.R.T. Commander).

• When released by the EMS Task Force Leader (R.R.T. Commander) check with your EMS Employer/Supervisor for your next assignment.

**Documents/Tools**

• Identification Vest and EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag)

• Triage Tags compatible with scannable patient tracking device(s)

• ICS Form 252 – Time Sheet

• ICS Form 214 - Unit/Activity Log

• EMS Task Force Vest

• Radio
Mission: Assess patients for disease/illness or exposure to disease/illness before entering the emergency clinic. Direct appropriate patients to Medical Evaluation as needed. May consult with physician on-call if necessary for appropriate diagnosis and screening.

Position Reports to: EMS DART Commander

Qualifications: Georgia Certification as a Paramedic
NIMS Courses ICS 100, 200, 700, 800, HazMat Awareness, PHTLSITLS, Basic Disaster Life Support, D.A.R.T. course minimum.

Disclaimer: You are being assigned to the Region I EMS Task Force (D.A.R.T.) as an extension of your current EMS employer. This is a voluntary assignment upon recommendation of your employer. Deployment is at the sole discretion of your employer! While deployed with the Region I EMS DART you are under direct supervision of the EMS Commander regardless of their service affiliation.

Upon Activation:

- Report to designated team assembly point.
- Receive briefing from the EMS DART Commander or their designee
- Obtain copy of Job Action Sheets.
- Put on position identification. (i.e. EMS DART Vest)
- Take handheld radio from D.A.R.T. Field Gear Bag to Communication Officer and have tuned to appropriate channel. Conduct radio test when instructed to do so.
- Obtain EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag) and PPE (if indicated) from your unit.
- Deploy with EMS Task Force in provided transportation to a designated staging area or incident location. DO NOT SELF DEPLOY IN PERSONAL TRANSPORTATION.

Operational:

- Arrive at assigned site when notified and check in with Lead Medical Manager.

- Read this entire Job Action Sheet.
• Obtain orientation and familiarize yourself with the area

• Review educational materials and familiarize self with disease/illness symptoms and signs of exposure.

• Guide and assist in setting up the clinic operation and ensure appropriate supplies and documents are available.

• Screen patients for signs of illness according to questions on the script.

• Direct patients to appropriate evaluation location for treatment.

• Screen patients for contact with a rash illness or other form of exposure in the last 3 weeks. (When appropriate)

• Will confer with DART or Local Medical Control physician if further consultation/evaluation regarding injuries/illness or exposure is needed.

• If there is a potential security threat, assure that Law Enforcement has personnel to secure the area as needed.

• Direct all media inquiries to the Public Information Liaison assigned to the clinic.

Demobilization

When orders are received via radio or face to face to stand down:

• Prepare Triage station for termination or hand off to replacement.

• Assist with the tear down and clean up of the area.

• Check out with EMS DART Commander.

• Identify issues for debriefing report.

• Participate in stress management and Hot Wash.

• Participate in other briefings and meetings as required.

• Upon on return to Home Base completely fill out the Time sheet (ICS Form 252) sign and give to EMS Task Force Leader (R.R.T. Commander).

• When released by the EMS Task Force Leader (R.R.T. Commander) check with your EMS Employer/Supervisor for your next assignment.
Documents/Tools
- Identification Vest and EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag)
- Triage Tags compatible with scannable patient tracking device(s)
- ICS Form 252 – Time Sheet
- EMS Task Force Vest
- Radio

Job Action Sheet Operations Section
EMS Branch
EMS DART Treatment Officer

Mission: Responsible for treatment and re-triage of patients assigned to Immediate Treatment Area.

Position Reports to: EMS DART Triage Officer -

Qualifications: Georgia Certification as a Intermediate '85, AEMT, CT or Paramedic

- NIMS Courses ICS 100, 200, 700, 800, HazMat Awareness, PHTLS/ITLS, Basic Disaster Life Support, D.A.R.T. course minimum.

Disclaimer: You are being assigned to the Region I EMS Task Force (D.A.R.T.) as an extension of your current EMS employer. This is a voluntary assignment upon recommendation of your employer. Deployment is at the sole discretion of your employer! While deployed with the Region I EMS DART you are under direct supervision of the EMS Commander regardless of their service affiliation.

Upon Activation:
- Report to designated team assembly point.
- Receive briefing from the EMS DART Commander or their designee
- Obtain copy of Job Action Sheets.
• Put on position identification. (i.e. EMS DART Vest)
• Obtain a portable radio from EMS D.A.R.T. Communications Leader
• Obtain a Patient Tracking Scanning device
• Deploy with EMS Task Force in provided transportation to a designated staging area or incident location. DO NOT SELF DEPLOY IN PERSONAL TRANSPORTATION.

Operational:
• Arrive at assigned site when notified and check in with Triage Officer
• Read this entire Job Action Sheet.
• Obtain situation briefing from the Triage Officer
• Don position identification vest
• Coordinate location of all Treatment Areas
• Request or establish Medical Teams as necessary.
• Make requests for supplies and personnel through EMS DART Commander
• Assign treatment personnel to patients received in the Immediate Treatment Area.
• Ensure appropriate treatment of patients in the Immediate Treatment Area.
• Assure the patients are prioritized for transportation.
• Coordinate transportation of patients with Transportation Officer.
• Notify Transportation Officer of patient readiness and priority for transportation.
• Assure that appropriate patient information is recorded via Patient Tracking Device.
• Maintain Unit/Activity Log (ICS Form 214)
• Forward reports and records to EMS DART Commanders when requested
• Will confer with DART or Local Medical Control physician if further consultation/evaluation regarding injuries/illness or exposure is needed.
• If there is a potential security threat, assure that Law Enforcement has personnel to secure the area as needed.
• Direct all media inquiries to the Public Information Liaison assigned to the clinic.
Demobilization

When orders are received via radio or face to face to stand down:

- Prepare Treatment Area(s) for termination or hand off to replacement.
- Assist with the tear down and clean up of the area.
- Check out with EMS DART Commander.
- Identify issues for debriefing report.
- Participate in stress management and Hot Wash.
- Participate in other briefings and meetings as required.
- Upon on return to Home Base completely fill out the Time sheet (ICS Form 252) sign and give to EMS Task Force Leader (R.R.T. Commander).
- When released by the EMS Task Force Leader (R.R.T. Commander) check with your EMS Employer/Supervisor for your next assignment.

Documents/Tools

- Identification Vest and EMS Task Force Jump Kit (D.A.R.T. Field Gear Bag)
- Triage Tags compatible with scannable patient tracking device(s)
- ICS Form 252 – Time Sheet
- ICS Form 214 - Unit/Activity Log
- EMS Task Force Vest
- Radio

Addendum 3 – SALT Triage Schematic
Addendum 4 – DART COURSE OUTLINE

AGENDA
Day 1 - 0800-1700

0800-Welcome & Sign In
0810-Module 1 - DART Overview - Intro
0905-Module 2 - Operations and DART Personnel Roles
1000-1010 BREAK 10 Mins
1010-Module 3 - Communication
1100-Module 4 - The Behavioral Aspect of People Exposed to Disasters and how to interact
12-Lunch (On your own)
1300-Module 5 - SALT/Triage National Course Video
1400-Module 6 - Austere Environment
1300 BREAK 10 Mins
1310-Module 7 - Tactical Operations

Day 2 - 0800-1700

0800 - Sign in
0810 - Module 8 - Medical Management of the Contaminated Patient
0905 - Module 9 - Mass Burn Care - Field Management
1000 BREAK 10 Mins
1010 - Module 10 Search & Rescue Guidelines
1200 - Lunch (on your own)
1300 - Table Top exercise
1600 - Course Review / Question & Answers
1630 - Course Evaluations - Distribution of DART Shirts and Decals.

Certificates will be emailed to each person who completes the course

Addendum 5 – BIS Assessment
The following assessment is based on the NASEMSO Assessment document and is only based on the sixteen county Region 1 EMS area. It does not include a statewide assessment or any individual county.
National Association of State Emergency Medical Services Officials  
EMS Incident Response and Readiness Assessment (EIRRA)

*Scoring descriptions in parentheses are meant to be examples to assist in arriving at a score. It is understood that few examples will be an exact match of the situation.*

**EMS Incident Response and Readiness Assessment (EIRRA) Tables**

100 PERSONNEL  
**Benchmark:** There are sufficient numbers, types and distribution of prehospital emergency medical and support personnel who are well-trained and supported for responding to mass casualty incidents. EMS personnel operate within a culture of safety, and are supported with high quality medical directors who have an integral role in mass casualty response.

### 101. Human Resource Availability

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Scoring* (0-5)</th>
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<tbody>
<tr>
<td><strong>101.1. Patient Care Personnel (BLS)</strong> - Basic Life Support levels of EMS personnel (first/emergency responders, Basic EMTs) are available in, sufficient numbers throughout the area being evaluated.</td>
<td>5 There is comprehensive coverage of BLS personnel (full time, comprehensive Basic-EMT coverage of the area). 5</td>
</tr>
<tr>
<td><strong>101.2 Patient Care Personnel (ALS)</strong> Advanced Life Support levels of personnel (Advanced (ALS) Advanced Life Support personnel are available in.</td>
<td>There is comprehensive ALS coverage. (There is a paramedic on every responding unit with Critical Care Ground/Air Medical response available.) 5</td>
</tr>
<tr>
<td><strong>101.3 Rescue/Extrication Personnel</strong> - Rescue/extrication personnel are available in.</td>
<td>There is comprehensive coverage of rescue/extrication personnel. 5</td>
</tr>
<tr>
<td><strong>101.4 Vehicle Operators</strong> - Vehicle operators (those identified in disaster plan, e.g., school bus, transit drivers) are available, have been familiarized with their support role, and are included in an activation plan.</td>
<td>There are limited numbers of vehicle operators who can assist in a MCI. (Vehicle operators have been identified but they are not necessarily familiar with their role.) 3</td>
</tr>
<tr>
<td><strong>101.5 Specialized Technicians</strong> Specialized Technicians (type identified in disaster plan, e.g.,</td>
<td>There are limited numbers/types of specialized technicians in the area. (Adequate number of specialized technicians identified, but not well distributed in specialty or location. There is no plan for 3</td>
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specialized extrication, high angle rescue, hazmat) are available for use in a mass casualty incident and a plan is in place to activate the resource. activating them.

| 101.6. CERT Members – Community Emergency Response Team (CERT) members/volunteers are available (or other localized response corps personnel). | There are a substantial number of CERT volunteers in the area. |
| 101.7. Bystanders – Emergency personnel have an established plan for effective use of on scene bystanders. | Not known |

102. Education and Training

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<tr>
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<tr>
<td><strong>102.1. Incident Command Training</strong> – All emergency personnel, including medical directors, are trained in Incident Command.</td>
<td>Emergency personnel receive minimal (basic) Incident Command training. Medical Directors are not required to receive incident command training. 2</td>
</tr>
<tr>
<td><strong>102.2. Mass Casualty Training</strong> All EMS personnel, including medical directors, are trained in the effective management of mass casualty scenes.</td>
<td>Emergency personnel receive minimal (basic) mass casualty training. Medical directors are not required to receive mass casualty training. 2</td>
</tr>
<tr>
<td><strong>102.3. Disaster Exercises - All emergency personnel, including medical directors, participate in disaster exercises.</strong></td>
<td>Emergency personnel and medical directors conduct limited disaster exercises (every 2 years). 2</td>
</tr>
<tr>
<td>**102.4. Unique Patient Communication Needs - EMS personnel, including medical directors, are trained in the use of alternative communication methods (diagrams, devices, translation service, emergency</td>
<td></td>
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<tr>
<td></td>
<td>There is no training in the use of alternative communication methods. 1</td>
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</table>
102.5. Special Needs Patient Training  - All EMS personnel, including medical directors, are trained in the care of multiple special needs children and other special needs patients. Emergency personnel have minimal resources and training for treating special needs patients (e.g. one class every 4 or so years; medical directors are rarely involved).

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<tr>
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<tr>
<td><strong>103. Personnel Safety &amp; Support</strong></td>
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<tr>
<td><strong>103.1. Safety Requirements</strong> - Safety policies are established for EMS personnel, such as appropriate use of lights and sirens response; determining scene safety before approaching; using BSI precautions; practicing safety in traffic zones, etc.</td>
<td>There are substantial safety policies for EMS personnel. (Policies are written and current, and have general compliance.)</td>
</tr>
<tr>
<td><strong>103.2 Mutual Aid</strong> - Mutual aid plans and agreements are established.</td>
<td>There is a comprehensive mutual aid resource system. (Comprehensive plans and agreements exist.)</td>
</tr>
<tr>
<td><strong>103.3 Post Incident Stress Management</strong> - Responders and those in support roles (dispatchers, etc.) have access to stress management resources following a MCI.</td>
<td>There are limited post incident resources available (some have access to trained individuals; others rely on obtaining professional help as needed).</td>
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<tbody>
<tr>
<td><strong>104. Medical Direction</strong></td>
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</tr>
<tr>
<td><strong>104.1. Medical Direction Availability</strong> - EMS services have medical direction provided by licensed physician</td>
<td>There is substantial medical direction provided to EMS services (e.g. substantial medical director involvement with EMS services, including online, offline and on-scene)</td>
</tr>
<tr>
<td><strong>104.2. Medical Director MCI Involvement</strong> - EMS medical</td>
<td>There is a limited amount of medical director involvement (e.g. standard set of medical protocols for MCIs are available and some</td>
</tr>
</tbody>
</table>
directors are engaged in all aspects of mass casualty response (protocols, planning, exercising, scene response, after action reviews).

| 200 INFRASTRUCTURE | Benchmark: The emergency infrastructure includes the necessary communications, transportation, equipment and information sharing technology resources for assuring the best possible emergency response to mass casualty incidents. |

| 201 Public Safety Answering Points (Primary and Secondary) |

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<tr>
<td><strong>201.1. Emergency Dispatcher Availability</strong> – Emergency dispatchers are sufficiently available to fully staff all primary and secondary (EMS) public safety answering points (PSAPs).</td>
<td>There is substantial availability of emergency dispatchers. PSAPs are fully staffed for normal shift activity. 4</td>
</tr>
<tr>
<td><strong>201.2. Emergency Medical Dispatch (EMD)</strong> – Emergency medical dispatch protocols are used in the PSAP responding to EMS calls. (This can be the primary PSAP or secondary PSAP--also known as EMS call center or emergency medical dispatch center). EMD programs consist of 3 parts: 1) Triage of incoming calls to determine level of response—may or may not involve tiered response; 2) Providing pre-arrival instructions to caller; 3) Quality Assurance or ongoing evaluation by medically trained personnel to monitor effectiveness.</td>
<td>EMD is used in to a limited extent in the PSAP/EMS call center (some components of an EMD program are in place). 3</td>
</tr>
<tr>
<td><strong>201.3. Ability to Determine Caller Location</strong> (including comprehensive. (PSAP is Phase I and Phase II compliant. Calls can</td>
<td>5</td>
</tr>
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</table>
**from wireless or telematic device** – Public safety answering points (PSAPs) are served by Enhanced 911 (E911) and are Phase I and Phase II compliant. Note: Phase I ensures the PSAP has call back number of a wireless caller and can identify cell tower from which call originated. Phase II includes Phase I features plus ability to identify location of wireless caller within 125 meters 67% of time and selective routing based on the coordinates.

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<tr>
<th>201.4. EOC and PSAP Integration – The Emergency Operations Center(s) and Public Safety Answering Point(s) are integrated so that there is minimal delay in response activation and comprehensive coordination in a large scale incident.</th>
<th>There is substantial integration of the EOC and PSAP. (They have integrated response plans and exercise together.)</th>
</tr>
</thead>
</table>

| **202 Communications Resources/Systems and Other Information** | **Scoring* (0-5)** |
| Indicator | |
| 202.1. Early Hospital Notification – An organized system for early notification of hospitals in the event of a mass casualty incident is in place | There is a limited system in place for early notification of hospitals in the event of a mass casualty incident. (The EOC is activated and has a process for contacting hospitals to notify them and request availability of services.) |
| 202.2. Specialized Resource Knowledge – Specialized resource knowledge is available in MCIs through a system of continually updated resource lists. The EOC and PSAP share the lists to allow for rapid deployment of | There is a limited system for specialized resource knowledge management. (Resource lists are maintained but may not be frequently updated; they are not readily available to the PSAP.) |
critical materials and to ensure accuracy of the information.

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<tr>
<th>202.3. Hospital Bed Status Monitoring – An effective hospital bed status monitoring system is in use.</th>
<th>There is a substantial system for hospital bed status monitoring on a regional or statewide basis (e.g. all hospitals have access, but some use it more effectively than others. The information is available to dispatch).</th>
<th>4</th>
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<tr>
<th>202.4. Regional Communications and Dispatch Coordination - Planning and cooperation among the communications centers in the area have resulted in effective dispatch coordination. Regional plans have been tested with full scale exercises and revised as necessary</th>
<th>There is substantial regional planning for dispatch coordination. (Ongoing activity that includes establishing event coordination and joint tabletop of limited functional exercises.)</th>
<th>4</th>
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<tr>
<th>202.5. Medical Coordination Center (Regional Call Center) - A plan is in place for rapid deployment of a medical coordination center to serve as a communication center for relaying accurate information to callers in a major incident.</th>
<th>There is a minimal plan for deployment of a medical coordination center in a major incident. (There have been discussions about the need and how it would operate, but plans have yet to be finalized.)</th>
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### 203 Communications Hardware

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<tr>
<td><strong>203.1. Two Way Radios</strong>&lt;br&gt;There are ample numbers of programmed, two-way radios for use by emergency responders in a major incident.</td>
<td>There is a substantial supply of functioning two-way radios for use in a major incident. (In addition to the two-way radios installed in most emergency response units and portables assigned to most individual responders, there are extra radios for use in a major incident.)</td>
</tr>
<tr>
<td><strong>203.2. Wireless Phones</strong>&lt;br&gt;Emergency responders are equipped with cell phones and there is good wireless phone coverage in the area.&lt;br&gt;Note: The National Communications Service offers Wireless Priority Service (WPS) for wireless phones</td>
<td>Most responders have cell phones and there is substantial wireless coverage in the area. (There is good quality wireless coverage throughout the area by multiple collaborative carriers.)</td>
</tr>
</tbody>
</table>
that may be used in emergencies when the wireless networks may be overloaded.

| 203.3. Satellite Phones – Satellite phones are available for use in situations where wireless coverage is limited. | Satellite phones are minimally available. (There are a few satellite phones available but access to them in rapid deployments can be challenging.) | 2 |
| 203.4 HAM Radios – HAM radios and operators are available for use if needed in a mass casualty incident. | There are substantial plans for use of HAM radios and operators in a large scale incident. (There are a number of HAM operators who are trained and have participated in exercises. Some additional HAM radios are available.) | 4 |
| 203.5 Radio Interoperability and Reliability - The area is served by a reliable and interoperable radio communication system. | The radio communication system is limited in reliability and interoperability (full coverage, but not always interoperable with other EMS, public safety systems, or hospitals). | 3 |
| 203.6 Next Generation Communications – Planning is underway for utilizing high capacity wireless and broadband networks for greater communications capabilities, including onscene video and specialized patient or resource tracking. | There are limited efforts to include new communications technologies but limited budgets and time restrict these efforts to a time available basis ancillary to general MCI planning. (New ideas are being incorporated but not as an integrated element of the response planning.) | 3 |

### 204 EMS Personnel and Patient Transportation

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<tr>
<td><strong>204.1 Basic Ground Ambulance</strong> - The area is served by state regulated, responsive ground BLS emergency ambulance, 24 hours a day, 7 days a week.</td>
<td>The area has limited BLS ground ambulance coverage on a 24/7 basis. The area has ambulance service, but they are often understaffed and frequently rely on mutual aid.</td>
</tr>
<tr>
<td><strong>204.2 Advanced Ground Ambulance</strong> - The area is served by state-regulated, responsive ALS ground emergency ambulance, 24 hours a day, 7 days a week.</td>
<td>The area has comprehensive ALS ground ambulance coverage on a 24/7 basis. Only in catastrophic incidents are they understaffed or heavily rely on mutual aid for ALS coverage.</td>
</tr>
<tr>
<td><strong>204.3 Critical Care Ground</strong></td>
<td>The area has minimal critical care ground ambulance service on a</td>
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</tbody>
</table>
Ambulance - The area is served by state-regulated, responsive critical care ground emergency ambulance, 24 hours a day, 7 days a week. 24-hour, 7 days a week basis.

204.4 Air Ambulance - The area is served by responsive air emergency ambulance service, 24 hours a day, 7 days a week that is well integrated into the EMS system. There is comprehensive access to air ambulance service that is fully integrated into the EMS system. (Coverage is such that one is always available, with a limited wait, barring weather problems.) 5

204.5 Specialty Patient Transportation Vehicles – There is access to additional specialty patient transportation vehicles that can be used in a mass casualty incident. There is limited access to additional specialty patient transportation vehicles. (Planning has addressed; resources are available on intermittent or limited basis.) 3

204.6 Non-Transport “First Responder” vehicle – First Responder (non-patient transport) vehicles are well integrated into the EMS system. There is substantial integration of first response vehicles into the EMS system. (While there is good coverage and integration, few are staffed at the ALS level.) 4

205 Transportation Operations

<table>
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<tbody>
<tr>
<td>205.1 Route Access – EMS agencies have evaluated and planned access to/from route locations where highway mass casualty incidents may occur.</td>
<td>There has been minimal evaluation of/planning for access to various routes where MCIs could occur. (Problem locations have been identified, but no further planning has occurred.) 2</td>
</tr>
<tr>
<td>205.2 Access Control - EMS agencies have evaluated and planned how to manage/reroute traffic and onlookers to keep the scene safe during a highway MCI.</td>
<td>There has been minimal planning for traffic management during a highway MCI. 2</td>
</tr>
<tr>
<td>205.3 Vehicle and Personnel Staging – Effective staging procedures for personnel and vehicles have been developed</td>
<td>Minimal staging procedures for personnel and vehicles are in place. (There is an informal plan in place that is communicated when needed.) 2</td>
</tr>
</tbody>
</table>
and exercised.

### 205.4 Designated Landing Zones

Pre-determined helicopter landing zones have been established. There are communication and coordination procedures for helicopters, which are well known by emergency responders.

There are minimal pre-determined landing zones and communication and coordination procedures in place for helicopter landings. (General, informal landing zone locations have been discussed and a procedure for contacting air medical services is known.)

### 205.5 Transport of Special Equipment and Supplies

Planning and exercising have been completed for transport of any special equipment or supplies (blood, medications, etc.) needed in MCIs.

Substantial planning has been completed for transport of special equipment/supplies. (Needs for have been identified with access plans in place; occasionally exercised and practiced.)

### 206 Equipment

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<tbody>
<tr>
<td><strong>206.1 Patient Care Equipment Caches</strong> - EMS agencies have well-stocked patient care equipment caches readily available in the event of a MCI.</td>
<td>EMS agencies have substantial caches of patient equipment (generally well stocked and accessible within a few hours notice.) 4</td>
</tr>
<tr>
<td><strong>206.2 Equipment/Supply Caches</strong> – Caches of equipment and supplies (fuel, blankets, cots, generators, etc.) are readily available in the area.</td>
<td>There is substantial access to equipment/supply caches in the area. (Caches are well-stocked and dispersed, but personnel lack familiarity with contents and/or accessing caches). 4</td>
</tr>
<tr>
<td><strong>206.3 Vehicle Extrication</strong> – Vehicle extrication equipment allowing safe extrication on newer model cars is readily available. Crews are well trained on its use.</td>
<td>There is comprehensive vehicle extrication equipment in the area. (Highest generation of equipment enabling safe extrication on newer model cars is available and is part of organized dispatch system for activation and transport. Crews are trained and regularly practice extrication operations, and are coordinated with ambulance personnel.) 5</td>
</tr>
<tr>
<td><strong>206.4 Towing and Recovery</strong> - Towing and recovery resources can be readily accessed.</td>
<td>There is substantial access to towing and recovery resources. (A variety of towing/recovery resources available. Towing/recovery services not consistently included in exercises.) 4</td>
</tr>
<tr>
<td><strong>206.5 Personnel Safety</strong> –</td>
<td>A limited assortment of personnel safety equipment is available to 3</td>
</tr>
</tbody>
</table>
Personnel safety equipment is readily available to all providers (reflector vests, helmets, gloves, extrication protective clothing, goggles, etc).

**206.6 Care in Place** – Plans have been developed and resources (staff and equipment) are available to provide “care in place” in lieu of transport to hospital.

| 207 Technology/Intelligence Sharing for Situational Awareness/IntelliDrive |
|-----------------------------|-----------------|
| Indicator                   | Scoring* (0-5)  |
| **207.1 Route availability/GPS** – EMS has ready access to route availability through electronic navigation systems. | EMS has substantial access to GPS or other electronic navigation systems. (Most vehicles or personnel are equipped with navigational devices.) 4 |
| **207.2 Congestion** – EMS has access to information on traffic congestion. | There is limited access to information on traffic congestion (e.g., typical congestion locations and times are known; real time anecdotal congestion information can sometimes be obtained from others in the area). 3 |
| **207.3 Other incidents** - EMS has access to information on other incidents occurring in the area. | There is limited access to information on other incidents occurring in the area (e.g. some dispatch centers notify responders; some anecdotal communication from other responders). 3 |
| **207.4 Remote Weather Information Systems (RWIS)** - Technology (remote weather stations, roadway sensors) is in place to relay weatherrelated road information (snow, ice, fog, flood) to allow for planning alternate routes. The weather information is transmitted to EMS, either by the PSAP or other means. | There are minimal remote weather information systems in the area. (Only a few locations monitored and the information is not easily accessed by EMS.) 2 |
| **207.5 Advanced Automatic Crash Notification (AACN)** - Telematic device data from crashed passenger vehicles | AACN data are not transmitted directly to the area PSAP, and when a telematics service provider contacts the PSAP, only location information is obtained by the PSAP staff. 1 |
can be transmitted directly to public safety answering points and “translated” into indicators of predicted injury severity.

207.6 Automatic EMS Vehicle Location Identification - Automatic vehicle location (AVL) technology utilizes transmitters on each vehicle that provide location information via communications devices or satellite so that PSAP and incident command staff can see the real time location of all area vehicles on a geographic display.

The system has comprehensive capability to display EMS vehicle locations as a result of automatic information retrieval. It is updated on a real time basis; portable devices are available to provide to neighboring services that may respond to a mass casualty incident.

300 Emergency Care System

Benchmark: The emergency care system has adequate availability of well-prepared emergency response teams and medical facilities, including a well-developed specialty care system. The emergency care system is prepared for mass casualty incidents, and able to meet unique communication needs of patients.

301 Medical Facilities

<table>
<thead>
<tr>
<th>Indicator</th>
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</thead>
<tbody>
<tr>
<td><strong>301.1 Availability</strong> - There is adequate availability of medical facilities in the area being evaluated.</td>
<td>There is substantial medical facility coverage (e.g. good hospital coverage but sometimes EDs closed due to overcrowding). 4</td>
</tr>
<tr>
<td><strong>301.2 Transport Time</strong> – Transport time to medical facilities in the area is satisfactory.</td>
<td>The majority of the medical facilities that would be used are within 30 minutes from the scene. 4</td>
</tr>
<tr>
<td><strong>301.3 MCI Preparedness</strong> - Medical facilities have plans and personnel are well-prepared for mass casualty incidents (they regularly review the plan, exercise and conduct post incident reviews)</td>
<td>Medical facility personnel complete a substantial amount of training for mass casualty incidents (completed plan, exercised, and completed post incident review within past 2 years) 4</td>
</tr>
</tbody>
</table>
for MCIs; personnel receive MCI training).

### 302 Specialty Care Systems

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Scoring* (0-5)</th>
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<tbody>
<tr>
<td><strong>302.1 Specialty Care Systems</strong> - A well-developed system of regionally designated hospitals and specialty care centers is available.</td>
<td>A comprehensive specialty care system is available in the area (designated trauma system with ample level 1 and 2 hospitals, burn centers and pediatric trauma centers).</td>
</tr>
</tbody>
</table>

### 303 Mass Casualty/Disaster Support Teams

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<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td><strong>303.1 MCI Support Teams</strong> - Mass casualty/disaster support teams are available (EMS Strike Teams, State or Regional Medical Assistance Teams, Hospital Go Teams, Incident Management Teams, National Guard).</td>
<td>A substantial system of mass casualty support exists (several mass casualty support teams are available, but more is needed for full coverage).</td>
</tr>
</tbody>
</table>

### 304 Alternate (Temporary) Care Facilities

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<tr>
<th>Indicator</th>
<th>Scoring* (0-5)</th>
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</thead>
<tbody>
<tr>
<td><strong>304.1 Alternate Care Facilities</strong> - There is an established plan for temporary use of alternate care facilities in the event of a mass casualty incident.</td>
<td>A comprehensive plan is in place for temporary use of alternate care facilities (facilities are identified and well dispersed, planning is updated and exercises completed regularly).</td>
</tr>
</tbody>
</table>

### 305 Unique Patient Communication Needs

<table>
<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td><strong>305.1 Patient Communication</strong> - The ability to meet unique patient communication needs in a mass casualty incident is available (foreign language interpreters, sign language interpreters, medical translator tools).</td>
<td>There is minimal access to language interpretation services (some language interpretation service via telephone).</td>
</tr>
</tbody>
</table>
**Benchmark:** There is an effective public awareness and notification system in place, which includes preincident education of the public as well as notification during the incident.

### 401 Pre-incident – Public Awareness/Education

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<thead>
<tr>
<th>Indicator</th>
<th>Scoring* (0-5)</th>
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</thead>
<tbody>
<tr>
<td><strong>401.1 Mile markers</strong> <em>(or other location identification devices)</em> - Mile markers are posted at regular intervals on roadways to assist in identifying incident location.</td>
<td>A substantial number of roadways in the area have mile markers or other location identification devices. 4</td>
</tr>
<tr>
<td><strong>401.2 Drivers: Maintain Awareness of Your Location</strong> - “What’s your location” public education programs are utilized to remind drivers to maintain location awareness in the event of an emergency (using road signs, mile markers, landmarks, etc.).</td>
<td>There is minimal formal public education for awareness of location (a few billboards or signs in some areas). 2</td>
</tr>
<tr>
<td><strong>401.3 9-1-1: The Only Number You Need to Know</strong> – Public campaigns on 9-1-1 are undertaken to educate the public to call 9-1-1 in all emergencies.</td>
<td>There is limited formal public information to educate the public to call 9-1-1 in all emergencies (billboards/signs and some public service announcements, but not plentiful or often). 3</td>
</tr>
<tr>
<td><strong>401.4 Bystander Care</strong> - Training on what to do if in or when encountering a crash is made available to the public.</td>
<td>There is minimal formal public training on what to do if in or when encountering a crash (a class is available on sporadic basis). 2</td>
</tr>
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</table>

### 402 During Incident—Public Notification

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<tbody>
<tr>
<td><strong>402.1 Notifications to Transportation Systems</strong> - Notification systems or procedures are in place to ensure that transportation systems that use the same route (school buses, transit, rail) are informed in the case of an incident.</td>
<td>There are limited procedures for notifying transportation systems that may be affected by the incident (some formal procedures, but improvement needed). 3</td>
</tr>
</tbody>
</table>
402.2 Road Closure Notifications - Road closure notifications are expanded to hospitals on either side of the closure (even if not anticipating patient transport).

There is a minimal, non-formal procedure for notifying affected hospitals of road closures due to an incident.

402.3 Community Alert Messaging Systems – A community alert system is in place. This would include systems that alert the public by sending voice, text and image via multiple devices -- landline, cell phone, email, message board, siren (e.g. Reverse 911, CodeRED, MyStateUSA, etc.)

A substantial portion of the public can be notified of the incident via a community alert messaging system (several types of alerting systems in place).

402.4 Highway Alerting System - Dynamic Message, EAS and other highway alerting systems, especially on the other side of geopolitical boundaries, are available for use in a mass casualty incident.

A minimal number of principle roadways in the area have highway alerting systems in place (fewer than 10% of roadways).

402.5 Media Engagement – The media is engaged in alerting and educating the public in a mass casualty incident.

A limited number of media outlets have been engaged in planning for alerting and educating the public in a MCI, but further work is needed.

500 EVALUATION

Benchmark: There is an effective evaluation system providing for a thorough review of the performance of emergency responders at mass casualty incidents. The system includes robust and reliable electronic information systems which capture valuable patient and provider data. The data from the systems can be accessed and analyzed, ideally through electronic linkages, to determine the need for changes to improve response in the future. After Action and clinical patient record reviews are conducted following a Multiple Casualty Incident. Performance improvement plans are created, implemented and tested.

501 Information Systems

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| 501.1 Prehospital Medical Records – Prehospital medical records (EMS run reports or patient care records) are collected electronically in a NEMSIS compliant system and are uploaded to State EMS Office. | There is a comprehensive patient care record system. (Records are collected electronically, by NEMSIS-compliant system, starting at point-of-care, and are uploaded to state EMS office.) | 5 |
| 501.2 Patient Tracking Records – Electronic record exists with unique identifier and progressive tracking for each patient. | There is a limited electronic patient tracking system (limited use of use of electronic tracking system; more training and exercising needed before fully functional). | 3 |
| 501.3 PSAP/Dispatch Data and Logging Records – Dispatch records are provided from the PSAP for analysis of the incident. | There are substantial dispatch records available. (PSAP/Dispatch records are electronic/digital. Voice recordings available.) | 4 |

502. Post Incident Review

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<tr>
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<tbody>
<tr>
<td>502.1 After Action Review – There is a process in place to conduct a formal After Action Review of incidents.</td>
<td>There is a substantial process in place to conduct After Action Reviews. (Process is formalized, has an established format and includes multiple disciplines.)</td>
</tr>
<tr>
<td>502.2 Clinical Performance Improvement Process - There is a process in place to conduct a formal clinical review of care provided to MCI patients by EMS.</td>
<td>There is minimal process in place to conduct clinical reviews. (Medical director/QI reviews of EMS run reports.)</td>
</tr>
<tr>
<td>502.3 System Improvement Plan - There is a formal process in place to develop system improvement plans based on the After Action and Clinical Performance reviews.</td>
<td>There is a limited process in place to develop improvement plans based on after action and clinical reviews. (Formal improvement plans developed, plans are minimally or not shared with crews/implemented.)</td>
</tr>
</tbody>
</table>
**600 MASS CASUALTY PLANNING**

**Benchmark:** Mass casualty planning has been thorough and is well documented. Planning addresses incident/unified command, a uniform triage system, transportation/destination determination planning, specials risks/hazard vulnerability, multiple fatality management, inventory, resource management (sustainability), rehabilitation services, and exercises.

### 601 Incident/Unified Command

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<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td><strong>601.1 Leadership Participation</strong> – Leadership from area-wide medical facilities, emergency and public health agencies participate in MCI/disaster planning councils.</td>
<td>A comprehensive planning process involving leadership of the key agencies is ongoing. There is a formal planning council comprised of agency leadership that meets regularly. 5</td>
</tr>
<tr>
<td><strong>601.2 Multi-jurisdictional Agreements</strong> – Joint powers or other formal agreements delineate “who’s in charge, and who participates” in unified command, and address scope, jurisdiction, and authority.</td>
<td>There are substantial multi-jurisdictional agreements for MCIs in place. (Most agencies have entered into agreements; roles are mostly delineated.) 4</td>
</tr>
<tr>
<td><strong>601.3 Rural Issues</strong> - Plans acknowledge rural limitations of human resource shortages and outline alternate approaches to “textbook” leadership assignments.</td>
<td>The plans address rural limitations on a limited basis. (Some suggestions for human resource shortages and alternate leadership assignments are provided.) 3</td>
</tr>
<tr>
<td><strong>601.4 Incident Management Team Integration</strong> - Regional or state level incident management teams (IMTs) are available and integrated into local command plans and practice.</td>
<td>There is substantial planning for integrating Incident Management Teams into local plans and practice. Further work is needed for optimum performance. 4</td>
</tr>
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</table>

### 602 Uniform Triage System

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<tr>
<th>Indicator</th>
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</thead>
<tbody>
<tr>
<td><strong>602.1 Uniform Triage System/Tags</strong> – A uniform triage system, which includes</td>
<td>A limited uniform triage system, including a system for patient tags, is identified in the plan. It does not address portable patient care record issues. Mutual aid partners are not included/addressed. 3</td>
</tr>
</tbody>
</table>
on-patient documentation (tag) and portable patient care record issues, has been addressed in the plan; it includes mutual aid partners.

### 603 Transportation and Destination Determination Planning

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<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td><strong>603.1 Transportation and Destination Determination</strong> - Prehospital, hospital, and trauma system (if any) have all been involved in transportation and destination determination planning.</td>
<td>There has been comprehensive transportation and destination determination planning by prehospital, hospital and the trauma system representatives. Decisions are well-documented in the plan. 5</td>
</tr>
</tbody>
</table>

### 604 Special Risks/Hazard Vulnerability

<table>
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<tbody>
<tr>
<td><strong>604.1 Special Risks/Hazard Vulnerability</strong> - Special risks/hazard vulnerability (e.g. routes with heavy truck traffic, hazardous materials, implications for road closure) are addressed in MCI planning.</td>
<td>There has been comprehensive planning for special risks/hazard vulnerability. (Plans address hazard vulnerability.) 5</td>
</tr>
</tbody>
</table>

### 605 Multiple Fatality Management

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<th>Indicator</th>
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<tbody>
<tr>
<td><strong>605.1 Multiple Fatality Management</strong> - Management of multiple fatalities has been addressed in the plan.</td>
<td>A substantial amount of planning for mass fatality management has been done. (Resources have been identified, and some agreements in place.) 4</td>
</tr>
</tbody>
</table>

### 606 Inventory Resource Management (Sustainability)

<table>
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<tbody>
<tr>
<td><strong>606.1 Inventory Resource Management</strong> - Planning includes a system to sustain inventory of renewable resources (e.g. replacing expired/used medical supplies, equipment)</td>
<td>There is minimal planning to replace supplies and equipment. (Limited rotation plan in place to avoid expiring medical supplies, but no additional plans to replace supplies/equipment used at an incident.) 2</td>
</tr>
</tbody>
</table>
in order to maintain the readiness of MCI supply caches. (Replacement may come from rotation of supplies in caches or purchase of new supplies with designated funding sources.)

### 607 Rehabilitation Services

<table>
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<tr>
<th>Indicator</th>
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</thead>
<tbody>
<tr>
<td><strong>607.1 Rehab Services</strong> - Planning addresses rehabilitation support services (e.g. food, water) to support responders and patients in a longer term incident.</td>
<td>The MCI plan minimally addresses rehab support services. (Some local resources are identified as possibilities but no definitive plans made.)</td>
</tr>
</tbody>
</table>

### 608 Exercises

<table>
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<tr>
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<tbody>
<tr>
<td><strong>608.1 Exercises</strong> – MCI planning includes regularly scheduled exercises. Unified command and regional/state incident management teams (IMTs) are integral component of exercises.</td>
<td>There is substantial planning for disaster exercises. This includes drills and tabletops, with unified command and regional/state IMTs; full scale exercises have not been conducted.</td>
</tr>
</tbody>
</table>

### 609 Highway Mass Casualty Playbook

<table>
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<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td><strong>609.1 Comprehensive Area Disaster Plan</strong> – The comprehensive area disaster plan (developed and managed by the county or regional emergency manager) specifically and adequately addresses highway MCIs.</td>
<td>The comprehensive area disaster plan substantially addresses highway MCIs. (Provides substantial information for responding to large scale highway incidents, but needs further work, e.g., exercises, etc).</td>
</tr>
<tr>
<td><strong>609.2 Highway Mass Casualty Multi-agency Plan</strong> – Multiagency plan includes all agencies likely to respond to a</td>
<td>There is a limited highway mass casualty multi-agency plan (EMS, fire, law enforcement, and towing/recovery included; does not address attention to responder safety, quick clearance at scene.)</td>
</tr>
</tbody>
</table>
highway MCI (beyond EMS/Fire/law enforcement). It addresses responder safety, quick clearance and interoperable communications.

<table>
<thead>
<tr>
<th>609.3 EMS Agency-Specific Plan</th>
<th>There is a minimal highway MCI plan specifically for EMS (a brief section on EMS included in a multi-agency plan).</th>
</tr>
</thead>
<tbody>
<tr>
<td>609.4 SOP/SOGs</td>
<td>There are minimal standard operating procedures/guidelines appropriate for highway MCIs (a few basic SOPs).</td>
</tr>
<tr>
<td>609.5 Checklists/Guides</td>
<td>There are minimal task-specific checklists useful for highway MCIs (e.g. quick reference cards for HAZMAT, but little else).</td>
</tr>
</tbody>
</table>

### 700 GOVERNANCE

**Benchmark:** In the case of mass casualty incident response, the roles and lines of authority are clearly defined among governing bodies, including local, tribal, state, federal and international. Funding mechanisms are available for preparation and post-incident reimbursement. Effective and well-understood procedures for communicating with elected officials are in place.

#### 701 Regulatory Roles

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<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>701.1 Regulatory Roles</td>
<td>The roles and lines of authority among governing bodies in mass casualty incidents are limited in definition. (Roles and authority are predefined, but are not executed accordingly in an incident.)</td>
</tr>
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</table>
### 702 Funding

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<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>702.1 Pre-incident Funding (Preparedness) - Funding is available for mass casualty response planning, exercising and other costs of preparedness.</td>
<td>There is limited funding available for mass casualty planning, exercising and preparedness. (There is some funding assistance but the majority of costs are not covered.) 3</td>
</tr>
<tr>
<td>702.2 Post Incident Funding (Response and Recovery) - Funding is available to reimburse for mass casualty response costs.</td>
<td>Substantial funding is available for mass casualty response and recovery. (Funds are available to cover much, but not all costs.) 4</td>
</tr>
</tbody>
</table>

### 703 Intergovernmental Considerations

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<thead>
<tr>
<th>Indicator</th>
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<tbody>
<tr>
<td>703.1 Intergovernmental Considerations - There are minimal plans and procedures for mass casualty incidents that have intergovernmental implications. (Only basic guidelines have been developed and are not well known among emergency responders. No agreements are in place with other governments.)</td>
<td>There are minimal plans and procedures for mass casualty incidents that have intergovernmental implications. (Only basic guidelines have been developed and are not well known among emergency responders. No agreements are in place with other governments.) 2</td>
</tr>
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### 704 Elected Officials

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<tbody>
<tr>
<td>704.1 Elected Officials - Written procedures are in place for communicating with elected officials in a mass casualty incident.</td>
<td>There are no procedures in place for communicating with elected officials in a mass casualty incident. 1</td>
</tr>
</tbody>
</table>
Addendum 6 - Memorandum of Understanding/Agreement (MOU/MOA)

Memorandum of Understanding

Contract Number: xx-xxxx

This is a Equipment Agreement of the Georgia Department of Public Health, District 1.1 (or) Northwest Georgia EMS Systems Inc) on behalf of Northwest Georgia EMS Advisory Council/Regional Trauma Advisory Committee for the Northwest Georgia EMS Disaster Assistance Response Taskforce project (EMS DART)

Between

Name of supplying entity (D1.1 or NWGAEMS System Inc) (Party A)

And

Name of EMS Service (Party B)

I. Purpose and Scope

The purpose of this Memorandum of Understanding (MOU) is to clearly identify the roles and responsibilities of each party as they relate to the distribution and receipt of equipment, training and supplies for response to disasters within the sixteen county delivery area of Region 1 EMS and participating EMS Services of the Northwest Georgia EMS Disaster Assistance Response Taskforce project.

The EMS DART project is intended to provide specially trained personnel and equipped EMS units for response to any type of hazard which the local EMS Services resources are overwhelmed. The mission is to support the local entity and not to take over the EMS functions in any such event. To support this goal, Party A and Party B will provide educational opportunities to eligible EMS Services personnel as described in the EMS DART Plan under the Training Section. Party A will seek funding streams and provide said equipment, training and supplies as they come available.
II. MOU Term

The term of this MOU Agreement is the period within which the project responsibilities of this agreement shall be performed. There is no ending term for this project as it is fluid and ongoing.

III. Party A Responsibilities

Party A shall undertake the following activities during the duration of the MOU term:

1. Seek funding sources for the EMS DART Project
2. Ensure adherence to applicable federal and state laws and regulations and program guidelines to adhere to the funding sources requirements.
3. Provide equipment, training and supplies through various means
4. Provide training and technical assistance opportunities to Party B on disaster preparedness and response practices as funding becomes available

IV. Party B Responsibilities

Party B shall undertake the following activities during the duration of the MOU term:

1. Upon acceptance of any equipment and supplies for the EMS DART project, will provide a secure, environmentally controlled, location where the designated EMS DART unit is located so that personnel can quickly access and load the EMS DART Field Bags and Equipment onto the unit when deployed.
2. Will immediately report any lost, stolen or damaged EMS DART equipment or supplies to the Regional EMS Director upon discovery of such issues.
3. Will replace any lost, stolen or damaged EMS DART equipment of supplies at their own expense via the same vendor which the original equipment of supplies where obtained to assure consistency with other EMS DART units within the region, as long as the damage was the result of a deployments by the Region 1 EMS Office.

4. Will notify the Regional EMS Director when the designated unit for the EMS DART program is being replaced due to aging, damage or other replacement issues. The new designed unit will then become identified by its state of Georgia EMS Vehicle Identification Designation (VID) number with the state database.

5. Will display the one EMS DART logo on each side and the rear of the designated EMS unit to assure rapid identification of the unit when deployed.

6. Will call in the appropriately trained personnel to assemble and respond to an event when activated so that the unit will be responding to the designated location with 30-60 minutes of activation.

7. Will notify the regional EMS Office of any changes in personnel who are to be contacted to for activation when those changes occur to assure accuracy in the agencies contacts for disaster deployment.

V. Parties A and B Agree to the Following Provisions:

1. Documentation Approval and Acknowledgements

Upon receipt of EMS DART equipment and supplies, each party will sign this MOU acknowledging said receipt of supplies from Party A and received by Party B who in turn agrees to the terms of acceptance, security and deployment stated in Sect IV.

VI. Funding
1. **Party A** will continue seek funding sources in conjunction with the Regional EMS Office to provide training, equipment and supplies which will be used to enhance the EMS DART program.

2. **Party B** will notify the Regional EMS Office if they discover potential funding sources that may be appropriate for support of the EMS DART program.

**VII. Modification and Termination**

1. This agreement may be cancelled or terminated without cause by either party by giving (30) calendar days advance written notice to the other party. Such notification shall state the effective date of termination or cancellation and include the return of all equipment and supplies provided in good condition to Party B from Party at the time of termination.

2. Any and all amendments must be made in writing and must be agreed to and executed by the parties before becoming effective.

**VIII. Effective Date and Signature**

This MOU shall be effective upon the signature of **Party A** and **Party B** authorized officials. It shall be in force until one of the parties either executes a request for termination as described in Section VII or Party B ceases operation for any reason.

Signatures and dates

[Authorized signature from **Party A**]  [Authorized signature from **Party B**]
Addendum 7 – Region 1 Disaster Contacts

Region 1 Office of EMS & Trauma
EMS Services Emergency Contacts - 2015
When a Mutual Aid Request for Ambulances comes from any EMS Providers in the 16 County Northwest Georgia EMS Region that exceeds the normal request for occurrences such as MVC’s, or small scale responses of 2-3 additional units from a single EMS Provider then the requesting agency and/or 911 center shall contact the Region 1 EMS Program Director for assistance in requesting and coordinating these additional EMS Resources.

Last Update – December 2, 2015

Region 1 Office of EMS & Trauma
EMS Services Emergency Contacts - 2014

The following is the Region 1 OEMS Disaster Response and Requests for Mutual Aid Plan. This plan should be followed for all Region 1 EMS Services, PSAP’s and other entities requesting a large scale EMS Mutual Aid Response

Disaster Coordination

1. *It shall be the responsibility of each designated EMS Provider to have a written plan which addresses at a minimum the names, telephone number, and responsibility of key individuals within a geographic territory that may be utilized during a disaster situation. A copy of this plan must be supplied to the PSAP by the designated EMS Provider for use during a disaster. This plan should be filed with the Regional EMS Office and updated as necessary.*

2. *The disaster plan should specify how the service activities should be coordinated if the disaster is confined to the zone and no other outside resources are needed. The disaster plan should also specify how outside resources should be obtained and coordinated if the disaster is confined to the zone and outside resources are needed. **Disasters that involve***
multiple zones [counties] shall contact the Metro Atlanta Ambulance Service
Communications Center at 707-693-8480.

MAAS Communications Center will contact the Region 1 EMS Director or their designee @
David T. Foster III, MLS, Paramedic- Regional EMS Director
Office (706) 295-6176
State Cell (404) 989-4231
Personal Cell (423) 304-1027
Home Phone (706)-861-7128

3. If the disaster is declared by the Governor or his/her representative, all laws, rules,
regulations and policies regulating ambulance services are null and void until the all
clear is declared (i.e. requirement to transport patients in a licensed vehicle). Providers
are expected to make every attempt to adhere to these laws, rules, regulations and
policies whenever possible even in a disaster situation.

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<tbody>
<tr>
<td>4.</td>
<td>Bartow County -</td>
<td>Bartow County EMS</td>
</tr>
<tr>
<td>5.</td>
<td>Catoosa County -</td>
<td>Angel EMS</td>
</tr>
<tr>
<td>6.</td>
<td>Chattooga County -</td>
<td>Redmond EMS</td>
</tr>
<tr>
<td>7.</td>
<td>Cherokee County -</td>
<td>Cherokee County Fire &amp; Emergency Services</td>
</tr>
<tr>
<td>8.</td>
<td>Dade County</td>
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</tr>
<tr>
<td></td>
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</tr>
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<td>Fannin County -</td>
<td>Fannin County Fire/EMS</td>
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<td>10.</td>
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<td>County</td>
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<td>Redmond EMS</td>
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<td>AMTRAN</td>
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<td>Gilmer County</td>
<td>Gilmer County Fire and EMS</td>
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<tr>
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<td>Hope Ambulance Service</td>
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<tr>
<td>13</td>
<td>Gordon County</td>
<td>Gordon EMS</td>
</tr>
<tr>
<td>14</td>
<td>Haralson County</td>
<td>Ambucare</td>
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<td>15</td>
<td>Murray County</td>
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<tr>
<td>16</td>
<td>Paulding County</td>
<td>Metro Atlanta Ambulance</td>
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<td>17</td>
<td>Paulding County</td>
<td>Paulding County Fire</td>
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<td>19</td>
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<td>20</td>
<td>Walker County</td>
<td>Puckett EMS</td>
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<td>21</td>
<td>Whitfield County</td>
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<td>22</td>
<td>Chattanooga, TN –</td>
<td>Georgia Licensed Services</td>
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<tr>
<td></td>
<td>a. Life Guard</td>
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<tr>
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<td>b. Puckett EMS</td>
<td></td>
</tr>
</tbody>
</table>

Bartow County
Bartow Co. EMS
Emergency Contacts

**Bartow EMS Office:**  770-387-5160

**Kevin Garren, Director**
Work- 770-607-6205  
cell- 404-606-5660  
Home 770-663-7568  
garrenk@bartowga.org

**Brandon Duncan, Captain**
Work- 770-387-5160  
cell- 678-758-6670  
duncanb@bartowga.org

**Marty Teems, Captain**
Work- 770-387-5160  
Cell- 678-725-8225  
teemsm@bartowga.org

**Matt Moore, Captain**
Work-770-387-5160  
Cell-770-546-8213  
moorem@bartowga.org

**Shift Captains**
Office  770-387-5160  
Cell  404-392-5137

---

**Catoosa County**  
**Angel EMS**  
337 South Cedar Lane
Emergency Contacts

W. DeWayne Wilson, Director/President/CEO
Office: (706)861-1234
Cell: Nextel - (423) 593-0782
Direct Connect – 148*29*27611
Cell: I-Phone (423)488-3022
Home: (706) 858-5900
Email: wccoroner@aol.com
Email: dwilson@angelems.net

Lana G. Duff - Operations Manager
Office: (706)861-1234
Cell: Nextel - (423) 593-9408
Home: (706)861-6297
Email: lduff@angelems.net
Email: lanaduff@comcast.net

On Duty Shift Supervisor
Office: (706)861-1234
Cell: Nextel – (423)421-1449
Direct Connect – 148*29*2602
Cell: I-Phone (423) 580-9594

If you have problems reaching any of the above,
Contact the Angel EMS Dispatch center anytime at (706) 861-1234 and the dispatcher will make contact with the person you are requesting as soon as possible

Chattooga County
Redmond EMS
Emergency Contacts

**Robert Early** – Director
Robert.Early@HCAhealthcare.com
Home - 706-290-8590
Work Cell - 706-252-5660
Personal Cell - 706-346-3044

**Sherry Peace** - Floyd County DC
Sherry.Peace@hcahealthcare.com
Work - 706-252-0822
Home - 706-235-0144
Work Cell - 706-252-1584

**Herbert Dodd** - Chattooga County
Herbert.dodd@redmondems.org
Work Cell - 706-844-8354

Redmond Regional Dispatch 24/7 - 706-295-2000
Danny West, Cherokee County EMS Chief
Office: 678-493-4127
Cell: 678-614-8949 (best)
Email: dwest@cherokeega.com

Tim Prather, Cherokee County Fire Chief
Office: 678-493-4000
Cell: 770-894-3020
Email: tprather@cherokeega.com

Eddie Robinson, Training Chief
Office: 678-493-4000
Cell: 678-614-1519
Email: erobinson@cherokeega.com

Cherokee County 911 Dispatch Center
678-493-4080

Dade County
Dade County Emergency Services

Emergency Contacts
Alex Case – EMA Director
706-657-4111 – Office
423-718-2111 – Mobile
706-398-2200 - home
ACase@dadcounnty-ga.gov

Dade County EMS – E-911 Dispatch 706-657-4111 24/7

Puckett EMS

Shane Garrison - Vice President
C: 770-833-5974
O: 423-894-4407
F: 877-630-8668
Puckett Dispatch: 423-894-1800 or 770-222-1988
shanegarrison@puckettems.com

Chattanooga, TN
Steve Puckett, President
C: 770-833-5976
stevepuckett@puckettems.com

Shane Garrison, Vice President
C: 770-833-5974
shanegarrison@puckettems.com

Dispatch: 423-894-1800  Fax: 877-630-8668

Fannin County
Fannin County Fire/EMS

Emergency Contacts
Robert Graham, Fannin County Fire/EMS Director
Office: 706-632-1958
Cell: 706-851-4830
Home: 706-455-0463
PSAP - 706-632-6022
Email: rgraham@fannincountyga.org

Darrell Payne, Fannin County Fire/EMS, Deputy Director
Office: 706-632-4755
Cell: 706-455-0558
Home: none
Email: dpayne@fannincountyga.org

Floyd County
Floyd Emergency Medical Services
Administrative and Education Center
500 Riverside Parkway
Rome, Georgia 30161
Emergency Contacts

M. L. Bud Owens, Director
Cell: 706-331-4173
Email: bowens@floyd.org

Major Robbie Hill, Operation manager
Cell: 678-873-8596
Email: rhill@floyd.org

Captain William Channell Special Operations and fleet Coordinator
Cell: 770-547-8206
Email: wchannell@floyd.org

Captain Connie Chandler
706-252-0001
Schandler@floyd.org

Captain Andy Fairel
706-331-7124
afairel@floyd.org

Floyd County
Redmond EMS
Emergency Contacts

Robert Early – Director
Robert.Early@HCAhealthcare.com
Home - 706-290-8590
Work Cell - 706-252-5660
Personal Cell - 706-346-3044

Sherry Peace - Floyd County DC
Sherry.Peace@hcahealthcare.com
Work - 706-252-0822
Home - 706-235-0144
Work Cell - 706-252-1584

Herbert Dodd - Chattooga County
Herbert.dodd@redmondems.org
Work Cell - 706-844-8354

Redmond Regional Dispatch 24/7 - 706-295-2000

AMTRAN

Emergency Contacts
Dispatch: (706)291-0043

Mike Bolyard, Owner
mike@amtraninc.com
Cell (678)898-5856

Matthew Joiner, Chief Operations Officer
aj@amtraninc.com
Cell (678)234-1637

Gilmer County
Gilmer County Fire and EMS

Emergency Contacts

Page 172 of 203
Scott Stephens - EMS Operations Captain  
Cell: 770-891-4413  
Email: sstephens@gilmercounty-ga.gov

Tony Pritchett- Director  
706-889-6896 or 706-273-8349  
Email: tpritchett@gilmercounty-ga.gov

Ben Daniel- Assistant Chief  
Cell: 706-669-1295

Headquarters Fire/EMS-  
706-635-1333

911 Center- 706-635-8911

Hope Ambulance Service

Jackie Ellington – C.E.O.  
Cell: 706-889-8199  
tricounty@ellijay.com

Pete Martin – Director  
Cell: 706-889-8174  
hopeambulance1@gmail.com

Day Shift Supervisors  
Cell: 706-889-2326  
hopeambulance2@gmail.com

Station 1  
Main: 866-213-1275  
Fax: 706-273-7476

Gordon County  
Gordon EMS

Emergency Contacts
Courtney Taylor, Director
Office: 706-602-7800 x2387
Cell: 770-608-1993
Email: courtney.taylor@ahss.org

Donald Bowen, Deputy Director
Office: 706-602-7800 x2079
Cell: 706-483-1578
Home: 706-625-6985
Email: donald.bowen@ahss.org

Stacy Koonce, A shift Captain
Office: 706-624-5045
Cell: 706-233-3241

Marcy Fountain, A shift Lieutenant
Office: 706-624-5045
Cell: 815-718-3185

Jennifer Henderson, B shift Captain
Office: 706-624-5045
Cell: 706-271-7285

Michael Payne, B shift Lieutenant
Office: 706-624-5045
Cell: 706-979-0605

Mark Bramblett, C shift Captain
Office: 706-624-5045
Cell: 706-506-0369

Marcus Desmond, C shift Lieutenant
Office: 706-624-5045
Cell: 706-537-0377

Haralson County
Ambucare EMS
1196 Hightower Road
Emergency Contacts

ON DUTY CAPTAIN : (678)215-2799

Chief Bill Hightower, Owner/CEO
Office   (770)537-1946      Funeral Home: (770)537-2375
Cell:  (770)537-7620
Home:  (770)537-3093
E-Mail:  BH1196@aol.com

Captain Carlton Firestone, B-Shift Supervisor, Training and Education Coordinator
Office   (770)537-1946
Cell:  (770)324-0085
E-Mail:  MedicCF3@aol.com

Captain Joe Fuller, C-Shift Supervisor, Logistics and Resources Coordinator
Office (770)537-1946
Cell: (256)201-0980
E-Mail:  JoeFuller05@gmail.com

Captain Ken Worsham, A-Shift Supervisor, Durable Medical Resource Coordinator
Office   (770)537-1946
Cell:  (770)6394974
E-Mail:  WorshamKen@gmail.com

Captain Gary Blackmon, Day Truck Supervisor, Vehicle Maintenance Coordinator
Office (770)537-1946
Cell: (770)6394974
E-Mail:  GBlackmon@gmail.com

Susan Hightower, Office and Human Resources Manager
Office (770)537-1946
Cell: (770)537-7560
Home: (770)537-3093
E-Mail:  Susan.Hightower@ambucare.com  or Ambucare@aol.com

Haralson County E-911 Center (770) 646-0077

Murray County
Murray Medical EMS
Emergency Contacts

Murray 911 Center non-emergency numbers:
706-695-7938 or
706-695-6222
706-517-3718 Fax

Larry Ballew, Director
Office: 706-517-2089
Cell: 706-260-6702
Home: 706-695-3222
lballew@murraymedical.org

Kevin Ballew, Supervisor
Office: 706-517-3723 or 706-517-2098
Cell: 706-217-5916
Home: 706-695-5103
kballew@murraymedical.org

Doug Douthitt, Supervisor
Office: 706-517-3723 or 706-517-2098
Cell: 706-271-8410
Home: 706-695-1374
ddouthitt@murraymedical.org

Paulding County
Metro Atlanta Ambulance Service
Emergency Contacts
Metro Atlanta Ambulance Service
Dispatch is 770-693-8480

Karen Robinson
Operations Manager
Cell: 404-597-5540.
Email: Karen.Robinson@maas911.com

Shift supervisor number is
404-664-0879

Lee Oliver as alternate contact
Cell: 478-951-6140
Office: 770-693-8471
Email: Lee.Oliver@maas911.com

Dave O’Neill
Communications Manager
Cell – 404-392-9992
Office – 770-693-8478
Email – dave.oneill@maas911.com

Pete Quinones
President/CEO
Office: 770-693-8445
Cell: 770-815-7169
Fax 770-590-8617
Email: pete.quinones@maas911.com

Paulding County Fire – (No Ambulances – 1st Responder Only)
Main office address
PCFD Administration/Station 2
535 Seaboard Ave. Hiram, Ga. 30141
Office Main number 770-222-1160
Office fax number 770-222-7131

Joey Pelfrey - Fire Chief/EMA Director
Office direct number 678-383-3428
Cell number 404-867-2881
jpelfrey@paulding.gov

Greg Elsberry - Deputy Chief- Paulding County Fire
Office direct number 678-383-3437
Cell number 404-545-0134
gelsberry@pauling.gov

Kevin New – Division Chief
Office direct number 678-383-3427
Personal cell number 678-409-6638
knew@paulding.gov
Emergency Contacts

**Sloan Elrod - Director**
- Office: (706)-253-8950
- Cell: (770)-894-7496
- Home: (706)-253-1111
- Email: selrod@pickenscountyga.gov

**Beth Feininger – Training Officer**
- Cell# 404-693-4014
- Email jaspurrcats@yahoo.com

**Captain on Duty:**
- Office: (706)-253-8965
- Cell: (770)-894-1919

**24 Hour Dispatch Center:**
- Main: (706)-253-8911
- Alt #: (706)-253-8943
Emergency Contacts

**Robert Early – Director**
Robert.Early@HCAhealthcare.com
Home - 706-290-8590
Work Cell - 706-252-5660
Personal Cell - 706-346-3044

**Sherry Peace - Floyd County DC**
Sherry.Peace@hcahealthcare.com
Work - 706-252-0822
Home - 706-235-0144
Work Cell - 706-252-1584

**Herbert Dodd - Chattooga County**
Herbert.dodd@redmondcems.org
Work Cell - 706-844-8354

Redmond Regional Dispatch 24/7 - 706-295-2000

---

Walker County
Will Pitt – North GA Operations Chief
C: 423-463-2318
O: 423-894-4407
F: 877-630-8668
Puckett Dispatch: 423-894-1800 or 770-222-1988
WilliamPitt@puckettems.com

Shane Garrison - Vice President
C: 770-833-5974
O: 423-894-4407
F: 877-630-8668
Puckett Dispatch: 423-894-1800 or 770-222-1988
shanegarrison@puckettems.com

Chattanooga, TN
Steve Puckett, President
C: 770-833-5976
stevepuckett@puckettems.com

Shane Garrison, Vice President
C: 770-833-5974
shanegarrison@puckettems.com

Dispatch: 423-894-1800  Fax: 877-630-8668
Emergency Contacts

**Scott Radeker** – Director
Cell - 423-667-9865
Home- 706-375-3770
Office - (706) 278-9211
Email- sradeker@hhcs.org

**Captain Ed Cuthbert**
Cell- 706-483-6738
Email- ecuthbert@hhcs.org

**Lieutenant Jason Reed**
Cell- 706-463-1134
Email- jreed@hhcs.org

**Captain Christie Tankersley**
Cell- 706-463-0114
Email- ctankersley@hhcs.org

**Lieutenant Zach Downs**
Cell- 423-503-4224
Email- zdowns@hhcs.org

**Captain Lee Duman**
Cell- 706-463-1340
Email- lduman@hhcs.org

**Lieutenant Chris Tieck**
Cell- 706-280-3533
Email- ctieck@hhcs.org

Chattanooga, TN – Georgia Licensed Services
Emergency Contacts
Chattanooga, TN
Steve Puckett, President
Office - 678-504-1701
C: 770-833-5976
stevepuckett@puckettems.com

Shane Garrison, Vice President
Office - 678-504-1702
C: 770-833-5974
shanegarrison@puckettems.com

**Puckett EMS**
Dispatch - 423-894-1800 or 770-222-1988
Fax: 877-630-8668
Cell - 770-833-0349

**LifeGuard Ambulance of Tennessee**
Chattanooga Dispatch – 423-499-9500

The dispatcher can make any initial call in sending units for mutual aid. If for any reason I am unavailable, the dispatcher @ 423-499-9500 can assist in getting the person who can approve for longer or more aid past an initial response.

**Cindy Dycus**
C: 423-421-1385
cindy.dycus@lifeguardambulance.com

**Addendum 8 - EMS Assets List**

**Bartow Co-**
<table>
<thead>
<tr>
<th>County</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Bartow Co</td>
<td>1 EMS Rapid Response Unit - Bartow EMS</td>
</tr>
<tr>
<td>Catoosa Co</td>
<td>2 EMS Rapid Response Unit - Angel EMS</td>
</tr>
<tr>
<td></td>
<td>1 EMS Mobile Command Center - Angel EMS</td>
</tr>
<tr>
<td></td>
<td>3 EMS Disaster Buses - Angel EMS</td>
</tr>
<tr>
<td></td>
<td>1 meter Mobile Hughes Net Satellite Disk - Angel EMS</td>
</tr>
<tr>
<td></td>
<td>4 – Satellite Phone - Angel EMS</td>
</tr>
<tr>
<td></td>
<td>1 – F350 Ford Specialty Response Unit</td>
</tr>
<tr>
<td>Cherokee Co</td>
<td>1 EMS Rapid Response Unit (CCFES)</td>
</tr>
<tr>
<td>Chattooga Co</td>
<td>1 EMS Rapid Response Unit (Redmond EMS)</td>
</tr>
<tr>
<td>Dade Co</td>
<td>2 EMS Rapid Response Units (1 from Dade Co Emergency Services and 1 from Puckett EMS)</td>
</tr>
<tr>
<td>Fannin Co</td>
<td>1 EMS Rapid Response Unit (Fannin Fire/EMS)</td>
</tr>
<tr>
<td></td>
<td>1 – Disaster Medical Trailer – 100 pt capable (DPH EP D1.2 @ Fannin Co Fire)</td>
</tr>
<tr>
<td>Floyd Co</td>
<td>3 EMS Rapid Response Unit (Floyd EMS, Redmond EMS &amp; AMTRAN)</td>
</tr>
<tr>
<td></td>
<td>1 - Disaster Bus (Floyd EMS)</td>
</tr>
<tr>
<td></td>
<td>1 – Disaster Medical Trailer – 100 pt capable (DPH EP D1.1 @ Floyd EMS)</td>
</tr>
<tr>
<td>Gilmer Co</td>
<td>2 EMS Rapid Response Unit (Gilmer Fire/EMS &amp; HOPE Ambulance Service)</td>
</tr>
<tr>
<td>Gordon Co</td>
<td>1 EMS Rapid Response Unit (Gordon EMS)</td>
</tr>
<tr>
<td></td>
<td>1 Mobile Care Center (Gordon EMA)</td>
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<tr>
<td></td>
<td>1 Ford F250 – Special Operation Unit – Gordon EMS</td>
</tr>
<tr>
<td>Haralson Co</td>
<td>1 – EMS Rapid Response Unit (Ambucare)</td>
</tr>
<tr>
<td></td>
<td>1 – Disaster Medical Trailer – 100 pt capable (DPH EP D1.1 @AMBUCARE)</td>
</tr>
<tr>
<td>Murray Co</td>
<td>1 EMS Rapid Response Unit (Murray EMS)</td>
</tr>
<tr>
<td>Paulding Co</td>
<td>1 EMS Rapid Response Unit (Metro Atlanta)</td>
</tr>
<tr>
<td>Pickens Co</td>
<td>1 EMS Rapid Response Unit (Pickens Fire/EMS)</td>
</tr>
<tr>
<td>Polk Co</td>
<td>2 EMS Rapid Response Unit (One unit each - Floyd EMS &amp; Redmond EMS)</td>
</tr>
<tr>
<td>Bartow Co</td>
<td>1 EMS Rapid Response Unit</td>
</tr>
<tr>
<td>Walker Co</td>
<td>1 EMS Rapid Response Unit (Puckett EMS)</td>
</tr>
</tbody>
</table>
ADDENDUM 9 - Pediatric Management Guideline for Disaster Response

Children make up 25% of the U.S. population, yet in a recent survey of EMS agencies, only 13% have pediatric-specific mass casualty incident (MCI) plans. There are 1,313 hospitals in the U.S., of which 55%
are children’s hospitals. And only 5% of U.S. adult hospitals have adequate resources to deal with pediatrics.

We forget children are a distinct group, at a distinct stage of development, with unique physical, psychological and communication needs. Even within the subset of pediatrics there are various considerations and needs based on age, ranging from babies to preteens. They have significantly higher mortality rates in disasters compared to adults, and that mortality rate increases even more in children less than 5 years old. Although there are many factors that contribute to these rates, our lack of sufficient preparation for children in disasters is certainly a factor.

**Pediatric Physiology**

What is it about children that makes them so susceptible to the physiological effects of disasters? Children’s heads are proportionally much larger than their bodies, making them more susceptible to head injuries from blunt trauma. Children’s organs are also proportionally larger, and not as well protected by the rib cage and abdominal musculature as in adults. They also have faster respiratory rates and heart rates, putting them at higher risk for airborne chemical and biological agents since their bodies absorb toxins at a much faster rate. Some of the toxic agents cause vomiting and diarrhea, which dehydrates children more rapidly than adults, since children have smaller reserves. Some of the molecules are heavier than air and settle close to the ground where children are more likely to be inhaling them, since they’re shorter. Kids also have a proportionally greater body surface area for their body mass, which allows them to take in more toxins more rapidly by that route as well. And due to their higher metabolic rate, they have a different response to both the toxins and the medications you may use to treat them.

More than just the physical differences, children also have different mental and psychological needs, especially in a disaster setting. They lack a sense of self-preservation, and don’t have the cognitive skills or physical ability to react appropriately to signs of danger or instructions for help. They have fewer coping skills than most adults, don’t always understand what’s happening and, as anyone with children knows, don’t always follow directions well. Despite all of that, children have great potential for resiliency when treated appropriately.

**Psychological:**

From a Mental or Behavioral Health standpoint Pediatric victims of disaster have unique psychological needs. There will inevitably be fear and panic, and it is therefore important to establish a method of rapid psychological assessment. Pay attention to children’s emotional state—a calm child is much more cooperative than a screaming one. Remember that children won’t always be with their parents/caregiver when disaster strikes. You may need to take a few extra seconds to calm a child in order to get them to cooperate, but this will pay off in the long run, as the child will be more cooperative afterward.

The event isn’t over until you’re through the recovery phase. Children continue to be susceptible to environmental problems—respiratory disease, contaminated water, malnutrition and dehydration—and abuse. The stress hormones released can have profound impact on both the child’s immediate health, as
well as their long-term development; the psychological impact will certainly have long-lasting implications as well. The majority of secondary deaths in children under 5 years old are preventable.

Mental health is a major factor during all phases, but especially during recovery. Kids are viewed as high-value targets by terrorists; as the emotions of children go, so goes the rest of their community. Children are extremely sensitive to the attitude and psychological state of the adults around them. If the adults are fearful and upset, most children will be too, which just serves to make the adults even more upset.

Kids affect overall mental health of the community, so addressing their emotional response is crucial. Get children out of “bad” environments and back to normal as quickly as possible by establishing some kind of routine for regular meals and sleeping time. The structure will be beneficial to the child and to the whole community.

Communications Interventions by Age Range

Preschool age (1-5 years of age) and school age (6-12 years)

- Children may regress to an earlier behavioral stage: they may revert to thumb sucking and bedwetting, become afraid of strangers, and cling to parents.
- Children may become disobedient, hyperactive, aggressive, or they may withdraw.
- Changes in eating and sleeping habits are expected, and they may complain of multiple body aches and pains.

Interventions:
- If possible, attempt to avoid separation.
- Encourage expression through play, drawing, puppet shows, and storytelling.
- Limit media exposure.
- Set gentle but firm limits on acting out behavior.
- Provide structured activities and chores.

Preadolescents and adolescents (12-17 years)

- Preadolescents and adolescents may develop vague physical complaints and may abandon chores, schoolwork, and other responsibilities. They may also withdraw, resist authority, become disruptive in the classroom, and begin to experiment with high-risk behaviors, such as alcohol or drug abuse.

Interventions:
• Encourage discussion of experiences among peers, but do not force them to talk about their feelings. Listening to them is critical!

• Providing structured activities and involvement in community recovery work may be beneficial.

**Psychological First Aid**

Psychological First Aid ([www.samhsa.gov](http://www.samhsa.gov)) is an evidence-based approach to help victims cope in the aftermath of a disaster. The primary objective of Psychological First Aid is to create and sustain an environment of 1) safety, 2) calm, 3) connectedness to others, 4) self-efficacy or empowerment, and 5) hope.

In speaking to children and adolescents, the following steps are recommended (a script is provided, as well):

1) **Contact and engagement** – “My name is _______ and I am here to try to help you and your family. I am a _______ worker here, and I am checking with people to see how they are feeling. May I ask your name?”

2) **Safety and comfort** – “Do you need anything to drink or eat? Is your family here with you? Do you have a place to stay? We are working hard to make you and your family safe. Do you have any questions about what we’re doing to keep you safe?”

3) **Stabilization (if needed)** – “After bad things happen, your body may have strong feelings that come and go like waves in the ocean. Even grown-ups need help at times like this. Is there anyone who can help you feel better when you talk to them? Can I help you get in touch with them?”

4) **Information gathering** – “May I ask some questions about what you have been through? Can you tell me where you were during the disaster? Did you get hurt? Is your family safe? How scared were you? Is there anything else that you are worried about?”

5) **Practical Assistance** – “It seems like what you are most worried about right now is ____________. Can I help you figure out how to deal with this?”

6) **Connection with Social Support** – “You are doing a great job letting grown-ups know what you need. It is important to keep letting people know how they can help you. That way, you can make things better.”

7) **Information on Coping** – “It’s normal for kids to feel scared after bad things happen. You will probably start to feel better soon. If you like, I can tell you some ways to help you feel better. You can also call 800-854-7771 (hotline staffed by mental health professionals trained in disaster response) any time to talk to people who can help you.”

8) **Other support** - Provide direct referrals to a) county mental health services or those through private insurance, b) Red Cross and FEMA, as appropriate.
9) Continuity in Helping Relationships – Facilitate referrals: “May I help make some calls to people who can help you?” and if feasible, “I’d like to check in with you again to see how you are doing. How may I contact your parents later?”

It is advisable to refer to local psychiatric referral centers and other resources accessed during NON-disaster situations to identify pediatric mental health practitioners.

### Pediatric Mental Health Checklist

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
<th>In Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pediatric local mental health practitioners have been identified, and a relationship has been established with them.</td>
<td></td>
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<tr>
<td>2. Resources, hotlines, etc. for use in disasters have been identified, and the list is readily available.</td>
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<td></td>
<td></td>
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<tr>
<td>3. Training has been provided to hospital staff in Psychological First Aid.</td>
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</tbody>
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### Decontamination:

It’s a natural instinct to rush to hold and comfort children immediately after an incident, but remember they may be contaminated initially in a chemical or biohazard incident. You’ll need an altered decontamination protocol, more communication, more personnel to help with all the children who can’t follow directions, and specialized, smaller equipment. Set up a pediatric-specific decontamination station, with higher volume/lower pressure warm water. Consider family stations, which will both keep families together and provide additional adult staff to help get the children through the process. Remember that you may need isolettes, warmers and smaller gowns for the children after they’ve been decontaminated. Because children have a larger body surface area, they’re at greater risk for hypothermia, so it’s important to get them covered again quickly.

### PATIENT MANAGEMENT

**SALT Triage with the Pediatric Assessment Triangle**
Step 1: Sort

SALT begins with a global sorting of patients, prioritizing them for individual assessment. Patients who are able to walk to a designated area should be assigned last priority for individual assessment. Those who are unable to walk should be asked to wave (i.e., follow a command) or be observed for purposeful movement. Those who do not move (i.e., are still) and those with obvious life or limb-threatening injuries should be assessed first since they are the most likely to need life saving interventions.

Group Sorting

- Priority 1: Still/Obvious life threat
- Priority 2: Wave/Purposeful movement
- Priority 3: Walk

Step 2: Assess

Use the PAT to help assess children in disasters or MCIs. The PAT is an easy tool for the rapid, initial assessment of any child, but is especially important in Priority 1 patients who cannot walk or show purposeful movement. The PAT is the general assessment approach to children, which is taught by the PEPP Course (Pediatric Education for Prehospital Professionals), and by all American pediatric life support courses. It allows the prehospital professional engaged in field triage during a disaster or MCI to develop a general impression of patient’s status with only visual and auditory clues. By using the PAT at the point of first contact with the patient, the prehospital professional can immediately establish a level of severity, determine urgency for life support, and identify the general type of physiologic problem. Continued use of the PAT gives the prehospital professional a way to track response to therapy and reassess triage priority and also to determine timing of transport. Furthermore, it allows for communication among medical professionals about the child’s physiologic status and for accurate radio reporting.

There are three components of the PAT that together reflect the child’s overall physiologic status: (1) appearance; (2) work of breathing; and (3) circulation to skin. The PAT is based on listening and seeing, and does not require a stethoscope, blood pressure cuff, cardiac monitor, or pulse oximeter. The PAT can be completed in less than 30 seconds and is designed to systematize a time-honored process of "across the room assessment"—an intuitive process that experienced pediatric providers do instinctively.

The PAT
The three components of the PAT provide an accurate initial picture of the child's underlying cardiopulmonary status and cerebral function. While the PAT may not lead to a diagnosis, it will help identify the general category of the physiologic problem and establish triage status and urgency for treatment and/or transport. The PAT does not replace vital signs and the ABCDEs, which are part of the hands-on triage assessment.

**Appearance**

**Characteristics of Appearance**

The child's general appearance is the most important factor in determining the severity of the illness or injury, the need for treatment, and the response to therapy. Appearance reflects the adequacy of ventilation, oxygenation, brain perfusion, body homeostasis, and central nervous system (CNS) function. There are many characteristics of appearance; the most important are summarized in the "tickles" (TICLS) mnemonic: tone, interactiveness, consolability, look/gaze, and speech/cry.

**Techniques to Assess Appearance**

Assess the child's appearance from a few steps away. This is the first part in the PAT. Techniques for assessment of a conscious child's appearance include observing from a distance, allowing the child to remain in the caregiver's lap or arms, using distractions such as bright lights or toys to measure the child's ability to interact, and kneeling down to be at eye level with the child. An immediate "hands-on" approach may cause agitation and crying, and may complicate the assessment. Unless a child is unconscious or obviously critically ill, get as much information as possible by observing the child before touching or taking vital signs.

**Characteristics of Work of Breathing**
In children, work of breathing is a more accurate indicator of oxygenation and ventilation than respiratory rate or chest sounds on auscultation: the standard measures of breathing effectiveness in adults. Work of breathing reflects the child’s attempt to compensate for abnormalities in oxygenation and ventilation and therefore it is a proxy for the effectiveness of gas exchange. This component of the PAT requires listening carefully for abnormal airway sounds and looking for signs of increased breathing effort. It is another "hands-off" evaluation method that does not require a stethoscope or pulse oximeter.

**Techniques to Assess Work of Breathing**

The second part of the PAT is assessing work of breathing. Begin by listening carefully from a distance for abnormal airway sounds. Next, look for key physical signs. Note if the child has abnormal positioning, especially the sniffing posture or tripoding. Next, have the caregiver uncover the chest of the child for direct inspection or have the child undress on the caregiver’s lap. Look for intercostal, supraclavicular, and substernal retractions, and note if there is head bobbing in infants. After examining for retractions, inspect for nasal flaring. This stepwise process is critical for gathering accurate information. Once an infant or child begins to cry, assessment of work of breathing may be impossible.

Children may have increased work of breathing because of abnormalities anywhere in their airways, alveoli (air sacs), pleura (membrane surrounding the lungs and lining the walls of the pleural cavity), or chest wall. The type of abnormal airway sounds gives an important clue to the anatomic location of the illness or injury process, whereas the number and type of physical signs of increased work of breathing helps in determining the degree of physiologic stress.

Combining assessment of appearance and work of breathing can also help establish the severity of the child's illness or injury. A child with a normal appearance and increased work of breathing is in respiratory distress. An abnormal appearance and increased work of breathing suggests respiratory failure. An abnormal appearance and abnormally decreased work of breathing implies impending respiratory arrest.

**Circulation to Skin**

**Characteristics of Circulation to Skin**

The goal of rapid circulatory assessment is to determine the adequacy of cardiac output and core perfusion, or perfusion of vital organs. The child's appearance is one indicator of brain perfusion, but abnormal appearance may be caused by other conditions unrelated to circulation, such as brain injury or intoxication. For this reason, other signs of adequacy of perfusion must be added to the evaluation of appearance to assess the child's true circulatory status.

An important sign of core perfusion is circulation to skin. When cardiac output is inadequate, the body shuts down circulation to nonessential anatomic areas such as skin and mucous membranes in order to preserve blood supply to the most vital organs (brain, heart, and kidneys). Therefore, circulation to skin
reflects the overall status of core circulation. Pallor, mottling, and cyanosis are key visual indicators of reduced circulation to skin and mucous membranes.

**Techniques to Assess Circulation to Skin**

The third part of the PAT is evaluating circulation to skin. Be sure the child is exposed long enough for visual inspection, but not long enough to become cold. A cold child may have normal core perfusion, but abnormal circulation to skin. Cold circulating air temperature is the most common reason for misinterpretation of skin signs, and a young infant if undressed may become hypothermic quickly, even at normal ambient temperatures.

Inspect the skin and mucous membranes for pallor, mottling, and cyanosis. Look at the face, chest, abdomen, and extremities, and then inspect the lips for cyanosis. In dark skinned children, circulation to skin is sometimes more difficult to assess, and the lips, mucous membranes, and nail beds may be the best places to look for pallor or cyanosis.

**Using the PAT to evaluate severity**

The PAT provides a general impression of the pediatric patient. The intent is to provide an instant picture of the child’s physiologic status. By combining the three components of the PAT, the pre-hospital professional can recognize serious illness or injury and select the most important actions: how fast to intervene, what type of general and specific treatment to give, and how to triage and transport.

The PAT has two important advantages. First, it allows the examiner to quickly obtain critical information about the child’s physiologic status before touching or agitating the child. This allows a triage prioritization in disaster or MCI situations. Second, the PAT helps set priorities for the rest of the hands-on initial assessment, when possible. The PAT takes only seconds, and it helps to identify the need for life-saving interventions, and blends into the next phases of triage or of hands-on physical assessment. The three components of PAT—appearance, work of breathing, and circulation to skin can be assessed in any order, unlike the ordered ABCDEs of resuscitation.

**Step 3: Perform lifesaving interventions**

After quickly using the PAT to form a general impression, do a primary assessment and follow the ABCDEs as they apply to infants and children. Perform limited rapid lifesaving interventions (LSI) with the primary assessment:

- Open the airway through positioning or basic airway adjuncts (no advanced airway devices should be used)
- If the patient is a child, consider giving 2 rescue breaths
- Chest decompression
- Control major hemorrhage through the use of tourniquets or direct pressure
- Use auto injector antidotes
Note: LSI should only be performed within the responder’s scope of practice and only if the equipment is immediately available.

Prioritize treatment and/or transport by assigning patients to one of five categories:

- **Minimal**: Patients with mild injuries that are self-limited and can tolerate a delay in care without increasing mortality risk. Designate as “minimal” with the color **green**.

- **Immediate**: Patients who do not obey commands, or do not have a peripheral pulse, or are in respiratory distress, or have uncontrolled major hemorrhage. Designate as “immediate” with the color **red**.

- **Expectant**: Patients who have injuries incompatible with life given the currently available resources. Designate as “expectant” with the color **gray**.

- **Dead**: Patients who are not breathing after life-saving interventions are attempted. Designate as “dead” with the color **black**.

- **Delayed**: Remaining patients who do not fit the above categories. Designate as “delayed” with the color **yellow**.

This prioritization process is dynamic and may be altered by changing patient conditions, resources, and scene safety. Continued reassessment of all patients is critical.

In general, treatment and/or transport should be provided for immediate patients first, then delayed, and then minimal. Expectant patients should be provided with treatment and/or transport when resources permit. Efficient use of transport assets may include mixing categories of patients and using alternate forms of transport. Some patients may only require treatment at the scene and not need transport.  
*See Schematic on Next page*
SALT Triage Combined With Pediatric Assessment Triangle

Still/Obvious Life Threat
Assess 1st

Step 1: Sort
Global Sorting

Wave: Purposeful movement
Assess 2d

Able to Walk:
Assess 3d

Step 2: Assess/Reassess
Individual Assessment using PAT
If immediate life-saving intervention is needed, proceed immediately to Step 3.

Step 3: Life-Saving Interventions
- Open airway. For child, consider two rescue breaths
- Control major hemorrhage
- Chest decompression
- Auto injector antidotes

Improvement? If yes, return to PAT

Pediatric Assessment Triangle

Appearance
Obeys commands?

Breathing
Respiratory distress?

Circulation
Peripheral pulse?

No

No pulse or respiration

DEAD

Minor injuries?

Likely to survive given current resources?

Injuries incompatible with life?

MINIMAL

IMMEDIATE

EXPECTANT

ALL OTHER PATIENTS TRIAGED AS DELAYED
**ADDENDUM 10 - Communications Plans**

- **LEAVE ON CHANNEL MODE TO SHOW NAME**
- **On/Off/Volume**
- **LED Indicator**
- **Two-bank display, up/down arrow indicates which channel bank**
- **Switches modes Channel-Name**
- **Frequency-switch**
- **Switches channel banks from top to bottom bank**
- **Battery Release**
- **Push to Talk Button**
- **Mic-Jack**
- **Keypad Lock**
- **Channel Select Up/Down**

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NW GA EMS D.A.R.T. ACTIVATION FOR EMA/911 Centers in Region 1

What is the DART?

Northwest Georgia Emergency Medical Services and the Region 1 Office of EMS & Trauma have been working a state and national pilot project for the past 2 plus years. This approach changes how EMS providers respond to disasters collectively in the early onset of the event. This new asset from EMS is called the EMS D.A.R.T., which stands for Disaster Assistance Response Taskforce.

- **Global**
  Typically EMS requests come through the local 911 centers to agencies that have written mutual aid agreements. This usually is from services that border the agencies geographic boundaries and can respond quickly. Then if additional ambulances are needed then someone from 911, EMA, or the local EMS calls the local EMA, Public Health, the Regional EMS Director for GA OEMS or even GEMA to request these assets. As discovered during our responses to, reviews of the responses during the hot washes and included in the After Actions Reports (AAR) for EMS during the 27 April, 2011 and 31 January, 2013 Tornado responses in Dade, Walker, Catoosa, Bartow and Gordon counties, these requests can be dangerously delayed through the normal channels for assets. One such request was sent through the proper channel of local EMA, GEMA, and Public Health to Region 1 OEMS. The request was finally received 4 hours after he was on the scene of the 2nd tornado in Dade Co, and already had his staff in the District Health Office of 1.1 EOC call all Region 1 Services for asset availability. Therefore the request had been fulfilled and additional units staged around the region due to multiple lines of storms consistently hammering the region on 27 April, 2011. The results of these event and the AAR showed that EMS will be requested to provide not only medical to the injured and displaced early in the event, but will be requested by multiple agencies to provide medical support for their operations throughout the operational periods of any event.

- **Specifics**

  The results of these events lead to a small group of EMS personnel and GSAR 6 Leadership exploring how EMS could support and fulfill the Medical Section of the GASR plan for GSAR 6. As we looked at the Statewide GSAR plan for medical the group decide to explore what other states were doing. We reviewed plans from 12 states and FEMA/HHS to see if we could find a best practices that would address our findings and needs from the 27 April, 2011 AAR. We found small inclusive sections of a few plans where the states version of GSAR included a robust EMS contingency and personnel with limited EMS transport units. However nothing that was housed; funded or operationalized by the state or regional EMS Agencies in these states. What most states had was an adopted plan of Ambulances Service Taskforce (AST) plan for FEMA. This plan basically is to evacuate and re-populate citizens in the event of a foreseen event such as
epidemic outbreak or hurricane type evacuations. However these plans are impractical in an unforeseen, unpredictable sudden event. Therefore, after reviews of the AAR, these plans, and discussing the GSAR medical support, the decision was made to put together a leadership team with representatives from local Hospital, Private, County and Fire based EMS providers, Fire Service, Law Enforcement, EMA, State and District Public Health, GA OEMS, GEMA and the Trauma Care Network. This group was given the ideas of the original group and after 8 months of meetings and collaborating, developed a general guidelines document to guide the plans further development.

The plan calls for each participating service to designate one ambulance (though they don’t have to send that exact unit) as their D.A.R.T. Unit. This unit will be capable of transporting the crew of five (5) personnel and not just two (2) along with the EMS D.A.R.T. Field deployment bags as part an organized strike team geographically located within the said region.

Furthermore the region, which consists of sixteen (16) counties, was divided into 4 counties each to create four (4) strike teams. Each Strike Team will consist of units from its area and will respond together under the direction of a designated strike team leader to any EMS D.A.R.T. activation. This approach provides not only transport capabilities, but additional personnel as well. Usually the first few ambulances in a disaster will either set up command, triage and treatments staff, which could take out the first three (3) to five (5) ambulances ability to transport out of that capability as they personnel from those units will be performing other roles, which will lead to that ambulance being parked until additional personnel can get there to staff it. Or they may just grab the first patient or two (2) they see and leave with them for the closest hospital.

Then as the operation expands, and begins getting organized, there are multiple needs to EMS personnel. They include, but are not limited to manning care/aid stations, working triage/ patient staging and transportation area(s), supporting partner agencies such as fire/rescue to do Search & Rescue functions, law enforcement for medical screening of large crowds, standing-by for public utilities while they restore the areas services, and more.

Therefore, the leadership group felt that to truly address our findings, that each EMS unit needs to have no less than three (3) and no more than five (5) EMS providers respond on each designated DART unit. Also, each unit needs to have specialized field deployment medical bags that contained basic life support supplies and equipment as well as one advanced airway technique. This ALS airway procedure is needle chest decompression that only a License Paramedic can perform, but is deemed as a single lifesaving attempt under the adopted SALT Triage for the state and this taskforce.

The Leadership group then turned the program over to the education group who developed a specialized sixteen (16) hour course that focuses on conceptual development, operations, activation, USAR, Tactical, Wilderness, Mass Burn and Contaminated patients care and mass care. As of Nov 10th, 2015, two (2) courses have been taught and 192 personnel from all the regions 911 services and 3 non 911 services have been trained and all services equipped for responding to such events.

**Criteria for activating the DART (Mutual Aid then DART)**
NW GA EMS D.A.R.T. does not replace your first line mutual aid of EMS. You will still make those requests initially. One of the simplest ways to explain DART Activations is to think of it you would the GSAR Asset. It is available to assist with additional medical manpower and transportation needs, support the medical section of the GSAR Plan (at least currently for EMS Region 1 and GEMA Area 1 - formerly 6). It is an asset to expand upon and provide long-term EMS assets from 1-96hr, however it can extend that time as deemed needed by local EMS/EMA and the OEMS EMS Regional Director.

**Who can activate the DART (EMS Command or EMA)**

Activation of the NW GA EMS D.A.R.T. can come from the Local EMS Commander of the operation or the Incident Commander of a Unified Command Center with Local EMS Command input. Or it can come directly from the Local EMA Director or designee. If the request comes from anyone but the Local EMA, then they must be immediately notified that the DART Asset has been requested as to not have duplication in requests and so they are included in the request decision for this asset.

Initial activation of the EMS-D.A.R.T. would be by notification from the local EMS Director, 911 centers or EMA Director to the Metro Atlanta Ambulance Service Communications Center at 770-693-8480. Metro will then notify the Region 1 Regional EMS Director or their designee.

When a call is received the Communication Officer shall obtain the following information;

- location of event
- Nature of event (i.e. Tornado, Flooding, Law Enforcement event, etc.)
- The caller’s name, title and call back number
- Contact person for EMS Command at the event
- Call back numbers for EMS Commander
- Any additional information they feel pertinent to the event.

Metro will then activate the DART members/service notification via the 21st Century notification system (or subsequent systems that may replace it).

Once the call has been made to the DART Commander and Mass Notification activated, then the communication center will pass this info on to the GEMA/HS State Warning point at 1-800-879-4362 or 404-635-7000 and advise them that the NW GA EMS D.A.R.T. has been activated and to where. GEMA may request additional information. They can be directed to contact the DART Commander for that incident... or Tim Reeves GEMA Area 1 Coordinator.

**911 roles and interagency collaboration**

As during any time of need, 911 operation centers are the first line of notification and event activation. It is the desire of the GA EMS DART project and its partners, including 911 centers that the request for the NWGA EMS DART asset should not come directly through the local 911 center. However, 911 operators, whom will most likely be overwhelmed from the deluge of callers during such events, may...
realize early on that their local and mutual aid ambulances resources may be quickly overwhelmed. If they feel it appropriate they should, if at all possible, have a supervisor or other available personnel reach out to the local EMS commander and EMA Director to help with making the decision for DART to be a medical priority and get the request in to the Metro Atlanta Ambulance Service Communications center as soon as possible.

This document is a collaborative effort of EMS, EMA and 911 Representatives from Region 1.
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Kevin New - Paulding County Fire & Rescue - NW GA EMS D.A.R.T. Communications Officer
David Foster – GA Office of EMS & Trauma – Region 1 Director
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