

WESTERN REGION BURN DISASTER CONSORTIUM



BURN MASS CASUALTY OPERATIONS PLAN

PRODUCED IN COOPERATION WITH:



TABLE OF CONTENTS

INTRODUCTION	3
Overview.....	3
Purpose	3
Scope	3
Legal Authorities	3
Background	4
Western Burn Region	4
Burn Mass Casualty Incidents	4
Assumptions	5
CONCEPT OF OPERATIONS	6
The First 24 Hours	6
Notifications	6
Activations	6
Western Region Burn Bed Census.....	6
Initial Patient Coordination	7
The Ongoing Response	8
Roles & Responsibilities.....	8
Western Region Burn Coordination Center	10
Organizational Structure	10
Operational Overview	11
Patient Transfer Coordination	11
Resource Request Coordination	14
Clinical Support to Non-Burn Facilities	15
Facility Medical Care Operations.....	16
Anti-Discriminatory Policies	16
Patient Documentation & Privacy	16
Patient Care Resources.....	17
Burn Equipment & Supplies	17
The 96 Hour Plan	17
Burn Crisis Standards of Care Guidelines	18
Pediatric Considerations & Resources.....	19
Behavioral Health	20
Family Reunification	20
Fatality Management	21

WRBDC BURN MASS CASUALTY OPERATIONS PLAN

Transportation	21
All Patient Transfers	22
Air Transports	22
Deactivation & Recovery	23
RESOURCES	24
APPENDIX	25
A. Acronyms	26
B. WRBDC Burn Disaster Bed Census	27
C. WRBCC Job Action Sheets	29
D. WRBDC BMCI Patient Medical Data Form	31
E. Crisis Standards of Care Burn Triage Tables	33
F. WRBCC Mobile Task Force Go-Bags	35
G. HIPPA and Disasters: What Emergency Professionals Need to Know	37
H. Wound Care Supply Guideline for Burns	43
I. Prolonged Care of a Burn Patient in a Non-Burn Facility (96 Hour Plan)	44
J. Pediatric Planning Recommendations	60
K. Pediatric Equipment & Supplies	61
L. Behavioral Health Tips & Resources	63
M. Pediatric Psychological First Aid	65
N. Family Reunification Resources	67
O. COVID-19 Transportation Guidelines	74
P. WRBDC Facility Data Sheet	76
Q. WRBDC BMCI Patient Tracking Sheet	82
R. WRBCC Physician On-Call Schedule	84

Acknowledgments & Disclaimer:

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

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

INTRODUCTION

OVERVIEW

PURPOSE

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

SCOPE

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

LEGAL AUTHORITIES

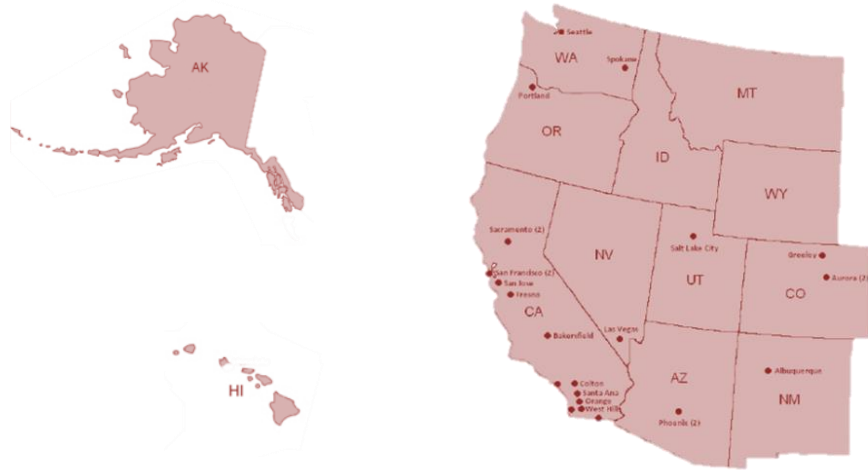
The response strategies and processes described herein are not legally binding, and there is no legal obligation to participate. However, participation by hospitals, healthcare systems and their partners is encouraged to ensure the best possible patient outcomes for all those treated in the Western Region.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

BACKGROUND

WESTERN BURN REGION

The Western Region Burn Disaster Consortium consists of 27 burn centers (13 verified, on the map at right) who have joined together to support response efforts for one another throughout the Western United States. The American Burn Association (ABA) has designated the following member states:

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



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

BURN MASS CASUALTY INCIDENT

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

tiered approach beginning with the local community hospital and engaging a broad array of state, regional and national stakeholders, depending on the scope of the incident.

ASSUMPTIONS

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

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

CONCEPT OF OPERATIONS

THE FIRST 24 HOURS

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

1. NOTIFICATIONS

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

2. PLAN & COORDINATION CENTER ACTIVATIONS

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

3. WESTERN REGION BURN BED CENSUS

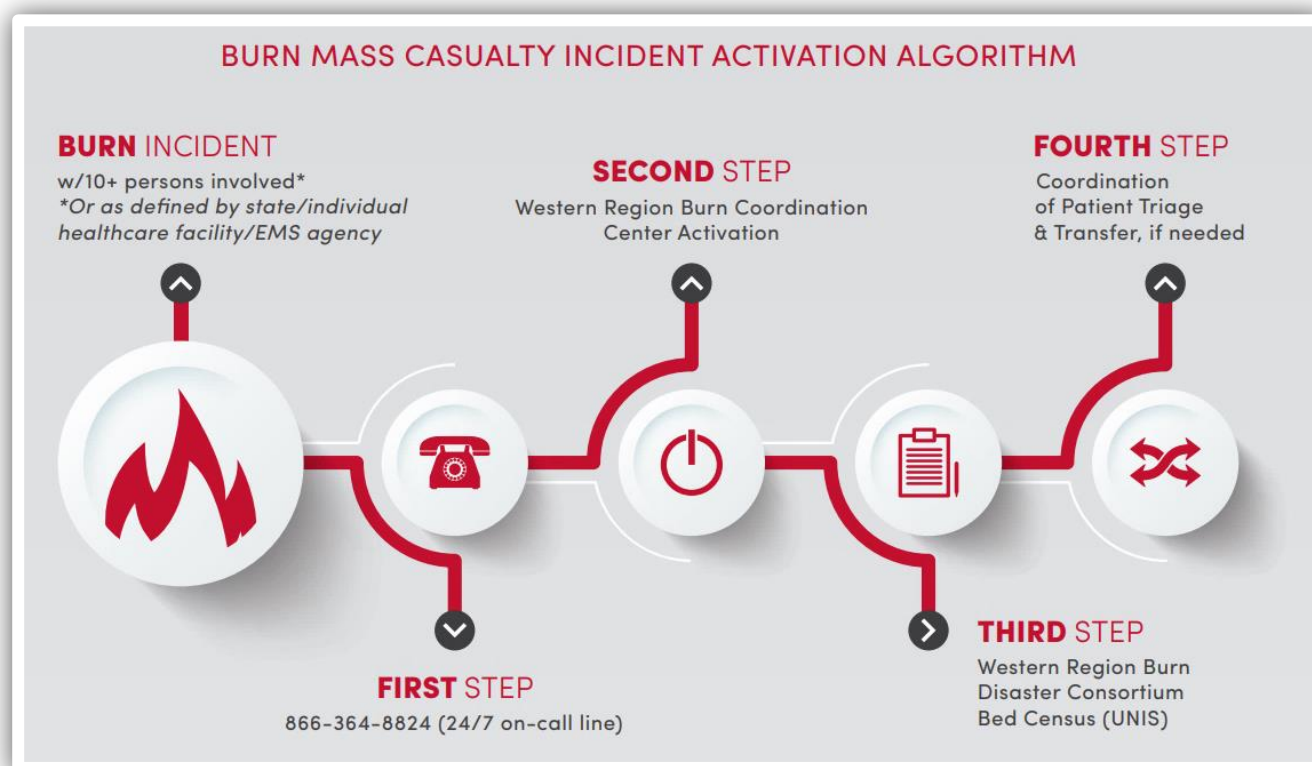
The Coordination Center will conduct Western Region burn bed census counts using the Utah Notification and Information System (UNIS) Burn Provider Group, or via email or Smart Sheets that will be sent to all regional providers. (**NOTE:* if the disaster is located in Utah and infrastructure damage occurs rendering communication technologies unusable, disaster efforts will be initiated by the Colorado Mass Notification System). Bed census counts will be conducted immediately, and again at 24 hours post-incident. Bed census counts are inclusive

of surge capacity, and consider individual burn center capability. The WRBCC will use the WRBDC Burn Disaster Bed Census spreadsheet (Appendix B) to record and share bed counts, a document that is regularly utilized for exercises and real-world events.

Regional Burn Surge Availability. There are around 453 total burn beds in the region, with approximately 150-180 available on an average day. Including surge estimates, this would leave 200 beds potentially available for a BMCI. There are two facilities within the WRBDC that take only pediatrics, Shriners Hospital for Children in Northern California and Children's Hospital Colorado. Kapi'olani Medical Center in Hawaii does not have designated burn beds, however it can accept burn patients as physicians also work at Straub Hospital Burn Center. Most burn centers care for both adult and pediatric patients with only two exceptions. Out of 453 total beds, approximately 422 could be used for either adult or pediatric patients.

4. INITIAL PATIENT COORDINATION

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



THE ONGOING RESPONSE

ROLES & RESPONSIBILITIES

Local organizations and agencies within the impacted jurisdiction will have primary responsibility for response, including initial triage and casualty distribution. Suggested response roles for local, state and national stakeholders and partner agencies are summarized in the table below. These roles were adapted from the [ASPR TRACIE Mass Burn Event Overview \(Resources\)](#), and are found in the [96 Hour Response Plan \(Appendix I\)](#).

PARTNER	RESPONSE ROLES
EMS Local Healthcare Coalition Public Health (PH) Emergency Management (EM)	- Rescue, transport, and distribute casualties to appropriate local facilities in accordance with established burn center MCI protocols. - Request/mobilize any coalition/regional caches of burn supplies. - Activate coalition coordination mechanisms and any burn-specific plans. - Coordinate local lists of casualties and clinical information. - Triage/prioritize patients for forward movement to specialty centers in accordance with established BMCI protocols and /or expert input. - Coordinate with burn experts to determine appropriate destinations for patients that cannot be accommodated in the local healthcare system with assistance from state and ABA. - Assure that appropriate clinical information is relayed between the referring and receiving facilities during the transfer process. <u>Secondary Roles:</u> - Coordinate information with state/federal ABA partners.
Closest ABA Burn Center	- Provide patient care. - Activate facility and regional surge capacity plans to accommodate multiple patients. - Liaison between local response and regional ABA coordinating center. <u>Secondary Roles:</u> - Assist with patient triage for forward movement. - Support facilities providing care for burn patients in the area via telephone or telemedicine and/or request support from WRBDC coordination center. - Ensure burn surge facilities use existing resources (96 Hour Plan).
State PH/EM	- Support local jurisdiction with state-level coordination and requests for assistance (e.g., state and federal declarations). - Assure that patient triage, tracking, and transport needs are addressed. - Make request for burn care assets, including dressings and other materials from the Strategic National Stockpile (SNS). - Engage Emergency Management Assistance Compact (EMAC) assets to provide inter-state support for transportation, staff, or other logistics.

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

WESTERN REGION BURN COORDINATION CENTER

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

ORGANIZATIONAL STRUCTURE

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

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

OPERATIONAL OVERVIEW

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

Immediate / First 24 Hours:

- **Partner Notification** – notify ABA leadership and WRBDC members of the BMCI, and enlist help as necessary.
- **Burn Bed Census** – conduct bed census counts immediately and at 24 hours post incident to identify available burn beds for patient transfer.
- **Assistance Requests** – request assistance (including resources, transferring and/or care of patients) from region member facilities, EMS, and/or adjacent regions.
- **Situational Awareness** – provide updates to WRBDC members, partners and all other appropriate agencies, including bed census reports and incident action plans (IAPs) or situation reports as necessary.
- **Technical Assistance** – assist the affected local burn center and/or non-burn facility by providing expert advice or telemedicine as requested.
- **Bed Matching** – assist with bed matching, i.e. finding the right bed and facility for each patient requiring transfer coordination.

Ongoing Response

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

Demobilization

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

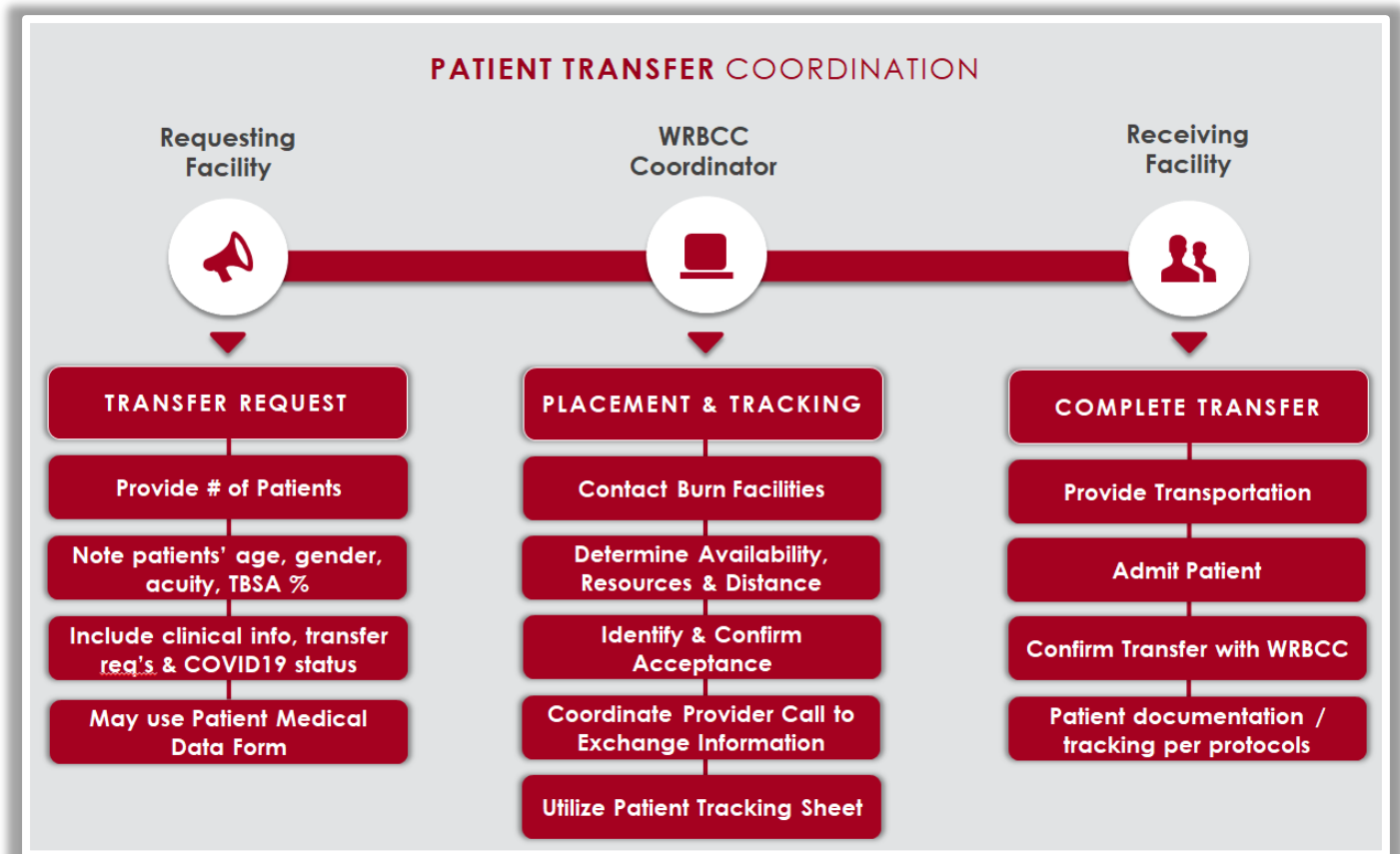
PATIENT TRANSFER COORDINATION

If secondary distribution of patients to burn specialty centers is requested, a WRBCC representative, utilizing existing hospital system transfer systems, will facilitate transfers between

hospital systems, based on clinical acuity and hospital capacity, to enable a more equitable distribution of burn patients when systems are in contingency care.

The primary purpose of patient transfers facilitated by the WRBCC in collaboration with local authorities is to decompress overwhelmed healthcare facilities by enabling an equitable distribution of patients. Assistance will be provided to affected non-burn facilities, local burn center and state public health in determining appropriate patient destinations (right patient to right bed and facility), while being mindful of family units.

The following steps outline the process for patient transfers coordinated through the Western Region Burn Coordination Center.



1. Requesting Facility Communicates Patient Transfer Request to the WRBCC

The request for burn patient transfer can be made by the requesting facility calling the WRBCC Coordinator, who will activate an online or telephone conference with WRBCC members. The requesting facility will provide the following information to the WRBCC:

- The number of patients requiring transfer
- Each patient's COVID-19 status (positive, negative, unknown)

- Each patient's age, gender, acuity and estimated total body surface area (TBSA) of injury, language and/or effective communication needs and level of care needed.
- Additional pertinent clinical information, including requirements for transfer (e.g., oxygen, intravenous medications/drips, cardiac monitoring, other special equipment, weight for aeromedical transfers, life sustaining treatment information).

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

2. WRBCC Facilitates Patient Placement & Tracking

After receiving pertinent patient information, the WRBCC Coordinator will contact burn receiving facilities to determine the most appropriate placement of patients. Patient placement decisions will be based on bed availability information and facility levels of care, in consultation with the WRBCC Physician. Additional decision-making information is found on the WRBDC Facility Data Sheet (Appendix P), which details all facilities in the Western Region Burn Disaster Consortium including adult and pediatric bed availability, staffing, level of care, and additional features including helipad and telemedicine capabilities. The WRBDC Mileage Chart (Resources) further helps in decision making by noting commercial flight time and ground transport mileage between all Western Region facilities. If Crisis Standards of Care are implemented, by governor declaration or other state protocol, the patient CSC Burn Triage Tables (Appendix E) may be utilized by a physician at the point of care in collaboration with a burn provider to assist in decision making.

Once a burn receiving facility has been identified and confirms acceptance of the patient(s), the WRBCC will coordinate a clinical provider call between the requesting facility and receiving facility to exchange patient information and determine transportation requirements. Patient information will be exchanged using the WRBDC BMCI Patient Medical Data Form (Appendix D). Telemedicine and digital images of the patient's burns will be utilized, if existing infrastructure allows, ensuring an accurate total body surface area (TBSA) is calculated and placement is appropriate.

WRBCC personnel will utilize the WRBCC BMCI Patient Tracking Sheet (Appendix Q) to document and track all patient transfers. This sheet records important patient data needed for transfer, as well as receiving facility information.

3. Receiving Facility Completes and Confirms Successful Patient Transfer

The Transportation Guidelines found in this document will be followed to ensure the safety of both transporter and patient. Transport of patients will be handled by the EMS and supporting agencies, according to existing plans and protocols. If the transferring facility has transportation procedures within the healthcare system, these may also be utilized.

Once the patient has been transferred and admitted, the receiving facility will contact the WRBCC to confirm the completion of the process. The WRBCC will document the transfer and its completion on the WRBCC BMCI Patient Tracking Sheet (Appendix Q).

RESOURCE REQUEST COORDINATION

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

Tiered Resource Request Process:

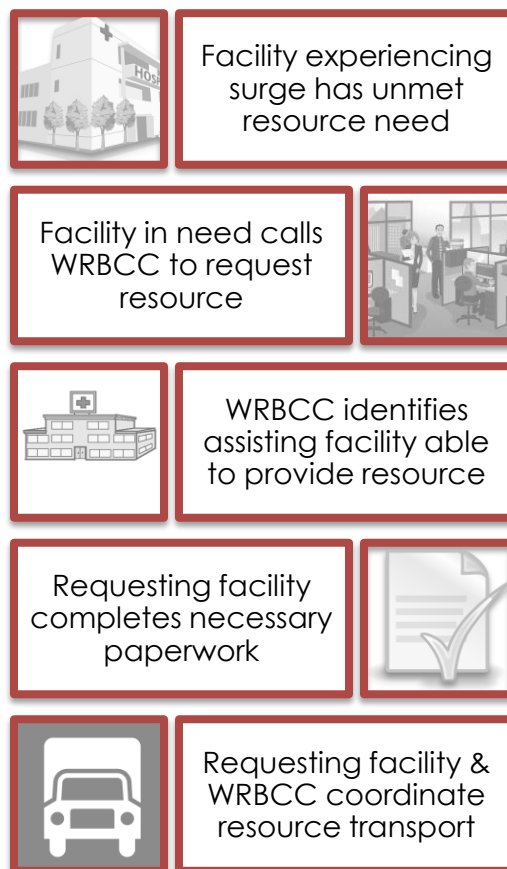
1. *Healthcare Facility / System* – when an unmet resource need exists, the facility will first utilize existing channels within its hospital system to acquire the needed item(s). If the system cannot meet the request, the local jurisdiction ESF 8 desk and/or regional healthcare coalition coordinator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

2. *Local ESF 8 / State ESF 8* – Local ESF 8/HCC will initiate efforts to obtain the needed item(s) by contacting facilities in their jurisdiction. If unmet, the request is then sent to the State ESF 8. ESF 8 and/or healthcare coalition coordinators will make arrangements for any available resources to be sent to the requesting facility.

Note that scarcity of resources may prompt prioritization recommendations to be established by local and state health officials, shared with hospitals through disaster communication channels.

3. *Regional WRBCC* – if the resource need is unable to be met from the healthcare system or from healthcare coalitions or local and state emergency support, the facility may request resource assistance from the WRBCC.

The WRBCC will assist in identifying another facility that is able to provide the resource. The requesting facility is responsible for completing



any necessary paperwork, and will work with the WRBCC to coordinate transportation of the resource.

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

CLINICAL SUPPORT TO NON-BURN FACILITIES

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

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

- Maximizing **Real-time telehealth provider support** for critical care, utilizing burn providers who are credentialed in multiple states. Telemedicine capabilities are currently available in multiple hospitals in the region, as listed on the WRBDC Facility Data Sheet (Appendix P). Providers who wish to practice in multiple states, including via telemedicine, can visit the Interstate Medical Licensure Compact website for licensure requirements (www.imlcc.org).
- Where telemedicine is not available, **image storing and forwarding**, accompanied by provider- to- provider discussions, may be utilized to effectively determine extent of patient's burns and provide assistance for triage and treatment courses.
- **Mobile Task Force deployment**, in collaboration with local and state partners, is a final potential option. The Task Force would likely include a Burn Physician or Advanced Practice Clinician, a registered nurse, and assistive personnel, all trained in burn treatment and response. Upon arrival at an impacted non-burn facility, these individuals would deliver just-in-time training to facility staff to enable them to provide specialized burn care. Most equipment and supplies would be provided by the impacted facility, but some basic personal and medical supplies force members may want to take with them are listed in the Mobile Task Force Go-Bag (Appendix F).

FACILITY MEDICAL CARE OPERATIONS

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

ANTI-DISCRIMINATORY TREATMENT POLICIES

The purpose of this document is to provide the best possible care to all burn victims following a mass casualty event. Difficult decisions, such as patient transfers and allocation of resources, will be objective and based on factors related only to the likelihood and magnitude of benefit from the medical resources. Factors that have no bearing on the likelihood or magnitude of benefit, including race, disability, gender, sexual orientation, gender identity, ethnicity, ability to pay, socioeconomic status, perceived social worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources, are not to be considered by providers making allocation decisions. For more information on laws governing these practices, please refer to the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act.

PATIENT DOCUMENTATION & PRIVACY

Patient Tracking. Healthcare facilities will follow routine and/or disaster protocols for tracking patient movement within their hospital system. More uncommon patient movement, including transfers from a facility to a destination facility outside of the hospital system or state, may be facilitated by the WRBCC, in collaboration with state and regional partners. The WRBCC BMCI Patient Tracking Sheet (Appendix Q) will be utilized by the coordination center to ensure consistency across the region in patient tracking efforts. Facilities may utilize their own patient tracking forms, if applicable, or those provided by the Hospital Incident Command System (HICS) which can be found online at <https://emsa.ca.gov/hospital-incident-command-system-forms-2014/>. *Note: in the near future, the WRBDC will be developing a burn-specific patient tracking form for facility use, patterned after the HICS forms, for inclusion in an updated version of this plan.*

Patient Care Documentation. Hospitals will utilize their existing or normal medical records to document patient assessment and medical care given to burn victims. The WRBDC BMCI Patient Medical Data Form (Appendix D) may be used to record details of the extent and depth of the burn. This form may be utilized for patient transfers, and to accompany the patient to the recipient facility. The WRBCC will support Burn Center efforts to collect comprehensive burn patient data from all treating healthcare facilities. This data may be

submitted to the ABA burn database according to established protocol by burn centers who receive burn patients, to be used for educational and research purposes.

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

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

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

PATIENT CARE RESOURCES

The WRBDC has put together an extensive collection of burn resources for non-burn and burn facilities. Training resources and planning documents aid in preparing facilities for a burn mass casualty incident, and guidelines to be followed during a response. In addition to being available online at <http://crisisstandardsofcare.utah.edu>, nearly all of these resources are also available as an app on smartphones and other devices (search for the “Burn CSC” app). This allows instantaneous in-field access to evidence based information on burn and soft tissue injury to assist in delivery of care. The following sections describe some of these resources in more detail, many of which are included in full or in part in the *Appendix*, and the *Resources* section of this plan provides information on accessing them.

BURN EQUIPMENT & SUPPLIES

Non-burn facilities who wish to know the supplies and equipment to have on hand for the treatment of a burn patient can refer to the Wound Care Supply Guideline for Burns (Appendix H). For pediatric patients, these basic burn supplies in addition to Pediatric Equipment and Supplies (Appendix K) are also important to have available. Please note that these lists are not exhaustive, and are meant to be a supplement to standard supply cart items and personal protective equipment a facility would typically provide.

THE 96 HOUR PLAN

A mass casualty incident with a significant number of burn-injured patients creates unique challenges due to the scarcity of burn centers and the complexity of the initial care required. Medical management poses unique challenges to healthcare professionals, many of whom will have limited amounts of knowledge and expertise in burn care. In acknowledgement of

this, the Western Region Burn Disaster Consortium has developed multiple resources to assist non-burn centers to care for those with burn injuries and ensure best practices will still be implemented, despite the constraints of a large-scale incident.

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

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

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

BURN CRISIS STANDARDS OF CARE GUIDELINES

An overwhelming public health emergency, such as a burn mass casualty incident, may greatly impact the availability of appropriate hospital beds, staff and resources. Providers may not be able to provide the same level of care that they otherwise would like to, given shortages or other difficulties resulting from the disaster. The purpose of the Burn Crisis Standards of Care Guidelines (*Resources*) is to guide the allocation of patient care resources and assist with patient care priorities during such an event. Application of these resources and guidelines will depend on physician judgment at the point of patient care or regional CSC decision-making bodies if activated. The guidelines, developed by the Utah Hospital Association (UHA) Crisis Standards of Care Workgroup, include the following:

- Adult and Pediatric initial management
- Fluid resuscitation
- Wound management
- Pain medication
- Physical therapy
- Radiation injury
- COVID19 considerations
- CSC Burn Triage Decision Tables (*Appendix E*)

PEDIATRIC CONSIDERATIONS & RESOURCES

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

- Calculation of the total body surface area (TBSA) involved in the burn is critical, as this will help determine fluid management and whether or not the patient requires transfer to a burn facility. Refer to the pediatric "Rule of Nines" in the 96 Hour Plan, Module 1 (Appendix I).
- When considering administering oral pain medications start with the smallest dose possible, and note that a patient will never be pain-free. Pediatric pain medication management guidelines can be found in the Initial Management Guidelines for the Pediatric Burn Patient (Resources).
- Monitoring glucose levels in pediatric burn patients is critical – too low or too high can be dangerous. Pediatric patients have a higher metabolic rate than normal, and higher glucose requirements. Critically-ill patients can experience stress-induced hyperglycemia and insulin resistance, which are associated with skin graft failure and infection.
- When it is necessary to secure an airway for a pediatric patient, note the significant anatomical and physiological differences compared with adults that make mask ventilation, direct laryngoscopy, and endotracheal intubation more difficult. These differences include:
 - A child's tongue is larger in proportion to the mouth than an adult's
 - A child's epiglottis is floppier and u-shaped
 - Vocal cords have an upward slant versus a horizontal slant
 - The trachea is narrow and less rigid in a child
 - The lungs have less capacity
- There are also differences in handling psychological needs for children in disasters, who tend to exhibit different emotional responses and have different needs for understanding and healing from trauma as compared to adults. Specific information and guidelines can be found in the Pediatric Psychological First Aid (Appendix M).

Burn-specific pediatric resources can be found in the Initial Management Guidelines for the Pediatric Burn Patient, part of the Burn Crisis Standards of Care Guidelines (Resources), and include primary assessment, intervention and care, fluid infusion and pain medication management.

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

Additionally, the Western Regional Alliance for Pediatric Emergency Management (WRAP-EM) was founded with the goal of developing a “coordinated, collaborative and sustainable regional pediatric disaster planning and response capability.” This group has put together an extensive collection of pediatric preparedness and response resources which support the significant pediatric-specific needs encountered by both initial care in place and the subsequent movement of children following a burn event: <https://wrap-em.org/index.php>.

BEHAVIORAL HEALTH

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

In a large-scale disaster scenario, psychological first aid is an evidence informed approach, whose purpose (according to The American Psychological Association) is to “assess the immediate concerns and needs of an individual in the aftermath of a disaster”. Psychological First Aid advocates that mental health clinicians and emergency response workers work to understand the victims world view, project a sense of calm, normalize feelings and reactions, provide information needed to de-escalate acute distress and provide education to the individual or family regarding “next steps” to take. Behavioral Health Tips & Resources (Appendix L), which includes brief tips as well as several resources for Psychological First Aid and Aftercare Support, is attached to this plan, along with Pediatric Psychological First Aid guidelines (Appendix M).

FAMILY REUNIFICATION

The process of reuniting family members with those who went missing during a BMCI, including burn victims, is the responsibility of local emergency management and first responders. Healthcare facilities may be asked to provide special assistance to law enforcement, mass care authorities, the Red Cross or others to facilitate reunification. Hospitals can serve as a

natural reunification site, since family members and friends are likely to check facilities for individuals who have gone missing. Setting up a reception site within or nearby the facility can be helpful in connecting patients with loved ones. A great planning resource for this purpose is the “Hospital Reception Site Planning Guide,” developed in the western region by the Coyote Crisis Collaborative of Arizona. The plan and several additional resource documents are available online at <https://coyotecampaign.org/documents/>. Some helpful documents from this guide have been adapted and shared in the Appendix, with the intent to assist healthcare facilities with their own planning. Family Reunification Resources (Appendix N) include:

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

FATALITY MANAGEMENT

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

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

TRANSPORTATION

A significant limiting factor in a regional response may be the availability of emergency medical services transport (ambulances). EMS support and coordination is essential to the logistical goals of this effort. Note that patient transfer coordination will include step-down transfers and assistance to local authorities as needed for family reunification efforts. EMS regulations differ widely by jurisdiction, therefore, patient movement will occur in accordance with local protocols and in collaboration with appropriate state, national, and federal agencies. To expedite safe, efficient and appropriate transfer of burn patients, the following guidelines should be adhered to. Note that supplementary COVID19 Transportation Guidelines (Appendix O) are attached to this plan.

ALL PATIENT TRANSFERS

- Whenever possible an Advanced Life Support (ALS) /critical care capable vehicle shall be used to transport a critical burn patient.
- Hospitals needing to transfer patients to a local Burn or Trauma Center should employ their normal private sector EMS transport contracts.
- An individual facility may make arrangements directly or request assistance from local ESF 8, regional Healthcare Coalition (HCC), according to local emergency management plans and protocols.
- Local ESF 8 desks, regional HCCs, and Emergency Medical Resource Centers (EMRC) will utilize internal policies and procedures to solicit assistance from private sector EMS, and public safety Fire and EMS for immediate help.
- If local transport resources have been exhausted, and/or if patient(s) need to be transported to another state within or outside of the region, transport request can be made directly to the WRBCC.
- Prior to transporting any patients, facility acceptance for the patient(s) should be confirmed by the WRBCC.
- The requesting facility should notify the WRBCC of what transportation arrangements have been made.
- The facility or agency arranging air or ground transportation should coordinate with the NOAA National Weather Service for current or future weather conditions. Information can be provided for local and on-route forecast conditions, including wind speed, temperature, pressure and inclement weather.
 - Western Region Operations Center Duty Officer (Salt Lake City, Utah), 801-524-7907, wr.roc@noaa.gov
- Additional transportation guidelines have been developed for COVID-19 (Appendix O).

AIR TRANSPORTS

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

DEACTIVATION AND RECOVERY

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

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

RESOURCES

WRBDC Resources:

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

<http://crisisstandardsofcare.utah.edu>

Search for the "Burn CSC App" on smart devices

WRBDC Coordinators:

24/7 Disaster Line: 866.364.8824

Annette Newman (Matherly), MS, RN CCRN
Community Outreach / Burn Disaster Coordinator
University of Utah Health Burn Center
Office: 801.585.2076
Cell: 435.901.1425
Email: Annette.Matherly@hsc.utah.edu

Kevin M. McCulley
Preparedness & Response Director
Bureau of EMS and Preparedness
Utah Department of Health
Office: 801.273.6669
Cell: 801.641.1295
Email: kmcculley@utah.gov

Additional Resources:

- American Burn Association
<http://ameriburn.org/>
- ASPR TRACIE Healthcare Emergency Preparedness Information Gateway
<https://asprtracie.hhs.gov>
- Western Regional Alliance for Pediatric Emergency Management (WRAP-EM)
<https://wrap-em.org/index.php>

APPENDIX

A.	Acronyms	26
B.	WRBDC Burn Disaster Bed Census	27
C.	WRBCC Job Action Sheets	29
	WRBCC Coordinator	29
	WRBCC Medical Control	30
D.	WRBDC BMCI Patient Medical Data Form	31
E.	Crisis Standards of Care Burn Triage Tables	33
F.	WRBCC Mobile Task Force Go-Bags.....	35
G.	HIPPA and Disasters: What Emergency Professionals Need to Know	37
H.	Wound Care Supply Guideline for Burns	43
I.	Prolonged Care of a Burn Patient in a Non-Burn Facility (96 Hour Plan)	44
	Module 1: Initial Assessment & Management	44
	Module 2: 0-48 Hours	48
	Module 3: 48-96 Hours	52
	Module 4: Transfer & Transport	56
J.	Pediatric Planning Recommendations	60
K.	Pediatric Equipment & Supplies	61
L.	Behavioral Health Tips & Resources	63
M.	Pediatric Psychological First Aid	65
N.	Family Reunification Resources	67
	Hospital Incident Command System (HICS) Chart	67
	Definitions.....	68
	Hospital Reception Site Equipment & Supply List	70
	Family & Friends Intake Form.....	72
	Child Identification Form.....	73
O.	COVID-19 Transportation Guidelines	74
P.	WRBDC Facility Data Sheet	76
Q.	WRBCC BMCI Patient Tracking Sheet.....	82
R.	WRBCC Physician On-Call Schedule.....	84

A. ACRONYMS

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

B. WRBDC BURN DISASTER BED CENSUS



Burn Medical Coordination Center Western Regional Burn Disaster Consortium (WRBDC) Burn Disaster Bed Census



Incident _____

Reported by: _____ Report #: _____ Date: _____ Time: _____

Burn Medical Coordination Center: **866-364-8824** 24 Hour Burn Hot-Line: **801-581-2700**

Burn Centers		Adult Open Beds				Surge Hours		Pediatric Open Beds				Surge Hours			Total Patients	
						Actual Disaster						Actual Disaster				
		02 Hours	Green	Yellow	Red	12 Hours	24 Hours	Adults Beds	02 Hours	Green	Yellow	Red	12 Hours	24 Hours		Peds Beds
Arizona																
1	Arizona Burn Center at Maricopa Medical Center, Phoenix															
2	Banner University Medical Center, Tucson															
California																
3	Bakersfield Memorial Hospital, Bakersfield															
4	The Hirschman Burn Center at Arrowhead Regional Medical Center, Colton															
5	Community Regional Leon S. Peters Burn Center, Fresno															
6	Southern California Regional Burn Center at LAC & USC Medical Center, LA County															
7	UCI Regional Burn Center, Orange															
8	Firefighters Burn Institute Regional Burn Center, Sacramento															
9	Shriners Hospitals for Children - Northern California, Sacramento															
10	UCSD Regional Burn Center, San Diego															
11	Bothin Burn Center, Saint Francis Memorial, San Francisco															
	San Francisco General Hospital - Burn Unit															
12	Santa Clara Valley Medical Center Regional Burn Center, San Jose															
13	Orange County Burn Center, Santa Ana															

14	Torrance Memorial Medical Center, Torrance															
15	The Grossman Burn Center, West Hills															
Colorado																
16	University of Colorado Hospital Burn Center, Aurora															
17	Children's Hospital Colorado, Aurora															
18	Western States Burn Center, Greeley															
19	Swedish Medical Center, Englewood															
Hawaii																
20	Straub Clinic and Hospital Burn Unit, Honolulu															
Idaho																
21	Eastern Idaho Regional Medical Center, Burn & Reconstructive Centers of Idaho, Idaho Falls															
Nevada																
22	Lions Burn Center-UMC, Las Vegas															
23	Sunrise Hospital and Medical Center, Las Vegas															
New Mexico																
24	New Mexico Regional Burn Center, Albuquerque															
Oregon																
25	Oregon Burn Center, Portland															
Utah																
26	University of Utah Burn Center, Salt Lake City															
Washington																
27	University of Washington Regional Burn Center, Seattle															
		Adult Open Beds				Surge Hours		Pediatric Open Beds					Surge Hours			
						Actual Disaster							Actual Disaster			
	TOTAL AVAILABLE BURN BEDS:	02 Hours				12 Hours	24 Hours	Adults Beds	02 Hours				12 Hours	24 Hours	Peds Beds	Total Patients

Definition of Patient Condition	Green (minor): <10% TBSA 2nd/3rd Degree Burn. No Inhalation Injury, not intubated, normotensive GCS >14	Yellow (serious): 10-20% TBSA 2nd/3rd Degree Burn. Suspected Inhalation Injury or potentially requiring intubation, normotensive GCS >14	Red (critical): >20% TBSA 2nd/3rd Degree Burn. Burns with multiple trauma, burns with definitive airway compromise
Priority Patients	Pediatrics are defined as anyone under the age of 14 years old	Priority for red patients/patients with a head injury will be transferred to a level 1 or 2 facility	

C. WRBCC JOB ACTION SHEETS

WRBCC COORDINATOR COORDINATION CENTER – JOB ACTION SHEET

Immediate/First 24 Hours Activities	Done	Date	Time
Partner Notification – notify ABA leadership and WRBDC members of the BMCI, and enlist help as necessary.	☐		
Burn Bed Census – conduct bed census counts immediately and after 24 hours to identify available burn beds for patient transfer.	☐		
Assistance Requests – request assistance (including resources, transferring and/or care of patients) from region member facilities, EMS, and/or adjacent regions.	☐		
Situational Awareness – provide updates to WRBDC members, partners and all other appropriate agencies, including bed census reports and incident action plans (IAPs) or situation reports as necessary.	☐		
Initial Patient Coordination – assist the affected local burn center and state public health in determining appropriate patient destinations and transportations	☐		
Ongoing Response Activities	Done	Date	Time
Bed Matching – assist with bed matching, ie finding the right bed and facility for each patient requiring transfer coordination.	☐		
Patient Information - facilitate the exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations.	☐		
Patient Tracking - assist with the tracking of patient movement including arrival at destination centers.	☐		
Situational Awareness – continue to provide updates to all partners, including bed census reports and incident action plans (IAPs) or situation reports as necessary.	☐		
Resource Requests - facilitate requests for tissue bank products, graft equipment or other specialized supplies.	☐		
Federal Partner Coordination - facilitate staff and supply needs with ASPR Regional Emergency Coordinator (REC).	☐		
Demobilization	Done	Date	Time
Incident Conclusion - establish when the BMCI has concluded, in collaboration with state and regional partners.	☐		
After Action - identify any post-incident system needs and initiate the After Action Report process.	☐		



WRBCC MEDICAL CONTROL COORDINATION CENTER – JOB ACTION SHEET

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





D. WRBDC BMCI PATIENT MEDICAL DATA FORM

MRN: _____

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

Patient Identification	Name: _____ DOB: _____ Age: _____ Sex: M/F Weight: _____ kg/lb Burn Date: _____ Burn Type: _____ TBSA: _____ Mechanism of Injury: _____ Inhalation injury: Y/N Intubated: Y/N Fluid Resuscitated: Y/N Peripheral IV: ☐ Central Line ☐ A-Line Escharotomy: ☐ Fasciotomy: ☐
Contact Information	Referring Hospital: _____ Referring Physician: _____ Contact Number: _____ Accepting Hospital: _____ Accepting Physician: _____ Contact Number: _____ Telemedicine Completed: Y/N Notification: ☐ Spouse/S.O. ☐ Parent ☐ Other: _____ Name: _____ Contact Number: _____
Patient Information	Code Status: Full code/No code: ☐ DNR ☐ DNI ☐ Advanced directives: Is Document Present: Y/N Traumatic Injuries: Y/N Type: _____ Last Vital Signs: HR: _____ RR: _____ B/P: _____ Temp: _____ O2 sat: _____ Diabetic: Y/N last meal: _____ Insulin Drip: Y/N Last Blood Sugar (date, time & value): _____ Tetanus Booster: Y/N (Last Date of Tetanus): _____ Critical Meds- MAR Attached: Y/N (if not attached: include medication, dose, route & time given): _____ Critical Labs: _____ Pertinent DX Exams: _____
Organ Systems	Neuro: Dx: _____ GCS: _____ PERRLA: _____ Pulmonary: Dx: _____ ETT Size: _____ Depth: _____ FiO2: _____ Vent Settings: _____ Chest tube: _____ ABG: _____ COVID19 Status: ☐ Positive + ☐ Negative - ☐ Person Under Investigation (PUI) Cardiovascular: Dx: _____ Rhythm/ Ectopy: _____ Vasoactive Drips: _____ Renal: Dx: _____ Foley: Y/N Volume last hour _____ ml Dialysis: Y/N Last Dialysis(Date/Time): _____ GI: Dx: _____ NPO: Y/N Reason: _____ Feeding Tube: Y/N
Sending Facility	Time & Date Departed: _____ Equipment Sent with Patient: ☐ IV Pumps: _____ ☐ Monitor: _____ ☐ Pulse Oximeter: _____ Ventilator/CPAP/BIPAP: _____ Other: _____ Items Sent with the Patient: _____
Receiving Facility	Time & Date Arrived: _____ Received by: _____ Receiving Facility MR#: _____ Equipment Received with Patient: _____ Items Received with patient: _____



WRBDC BMCI PATIENT MEDICAL DATA FORM

MRN: _____

Interpreter: Y / N Language: _____

Sign Language: Y / N

COVID19 Status:

Positive + / Negative - / PUI

Past Medical History: _____

Allergies: _____

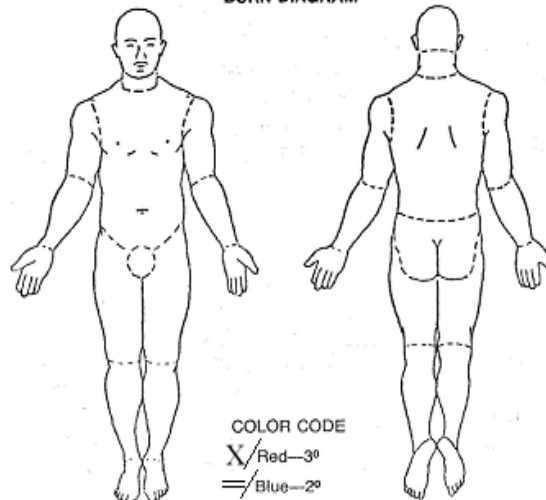
Medications: *(include dose, route & time given)* _____All Continuous IV infusions: *(include rate & dose)* _____Feeding Tube: *(include formula type & rate)* _____

Labs:

Na	Cl	BUN	Gluc	WBC	Hgb	Hct	Plt	Mag _____	Phos _____
K	CO2	Creat							

Narrative Summary of Care: _____

BURN DIAGRAM



E. CRISIS STANDARDS OF CARE BURN TRIAGE DECISION TABLE

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

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

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

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

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

CSC BURN TRIAGE DECISION TABLE, CONT.

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

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

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

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



F. WRBCC MOBILE TASK FORCE GO-BAGS

BURN COORDINATION CENTER - BURN MASS CASUALTY INCIDENT

PHYSICIAN

Front Pocket - Resources

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

Second pocket - Personal Supplies

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

Main Pocket

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

REGISTERED NURSE (R.N.)

Front Pocket - Resources

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

Second pocket - Personal Supplies

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

Main Pocket

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

Patient Assessment

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

ASSISTANT

Front Pocket - Resources

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

Second pocket - Personal Supplies

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

Main Pocket

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

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

Updated September 11, 2017

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

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

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

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

What is HIPAA and the Privacy Rule?

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

Covered entities:

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

Business associates:

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

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

Does HIPAA Apply to Me or My Organization?

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

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

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

When Can PHI Be Shared?

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

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

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

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

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

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

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

Covered entities can disclose needed PHI without individual authorization:

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

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

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

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

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

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

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

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

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

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

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

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

Does the HIPAA Privacy Rule Permit Disclosure to Law Enforcement?

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

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

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

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

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

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

For More Information

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

For more information on HIPAA and Public Health:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html>

For more information on HIPAA and Emergency Preparedness and Response:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/index.html>

General information on understanding the HIPAA Privacy Rule may be found at:

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html>

H. WOUND CARE SUPPLY GUIDELINE FOR BURNS

Taken from the Utah Crisis Standards of Care Guidelines, Appendix B: Burn Crisis Standards of Care.

Suggested wound care supplies for the treatment of ten patients with 50% TBSA burns for three dressing changes.

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

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

I. 96 HOUR PLAN

Module 1 - Initial Assessment & Management

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained. Utilization of all levels of care are equal to best care, even in a resource-rich environment.

Essential Care This is the minimum care given to patients based on your available resources.

No Access to Advanced Airway/Respiratory Supplies

Primary Survey – Airway & Breathing

- ☐ Assess for early signs of upper airway burns
- ☐ Monitor for changes in mental status, hypoxia, hoarse voice or stridor
- ☐ Open airway using manual maneuvers or airway adjuncts (nasopharyngeal (NPA)/ oropharyngeal airway (OPA))
- ☐ Administer high flow oxygen using a non-rebreather mask or via nasal cannula or mask
- ☐ Maintain patient in sitting or head elevated position to minimize upper airway edema
 - Consider spinal precautions
- ☐ Use walking wounded to Bag Valve Mask (BVM) ventilate if necessary

Circulation

- ☐ Monitor for signs of shock

Deficits

- ☐ Monitor for changing level of consciousness

Exposure

- ☐ Remove all clothing
 - Decontaminate patient if chemical exposure

Secondary Survey

- ☐ Perform head-to-toe assessment
- ☐ Obtain patient history
- ☐ Document essential information
- ☐ Resuscitate with salt-containing fluids
- ☐ Priority should be given to:
 - Adults with burns $\geq 20\%$ TBSA injury
 - Pediatric patients with burns $\geq 10\%$
 - Associated trauma with blood loss
- ☐ Use Oral Resuscitation Therapy (ORT) if IV access is unavailable
 - Up to 20% TBSA
 - Consider in up to 40% TBSA
 - Sips every five minutes, at least four cups/hr. (1 liter)
 - Wait 10 minutes after vomiting
- ☐ Use rectal infusion therapy if ORT restricted/no IV
 - Tap water or saline up to 400 ml/hr.
- ☐ Adjust fluids based on heart rate, capillary refill and mental status
- ☐ Minimize patient exposure time
- ☐ Warm the room

- ☐ Avoid cold surfaces
- ☐ Keep patient warm and dry, do not use wet dressings or wet blankets
- ☐ Wrap in a space blanket/plastic wrap/large plastic bag/aluminum foil if clean dry blankets are not available
- ☐ Measure patient temperature every four hours
- ☐ If temperature is $<37^{\circ}\text{C}$ (98.6°F)
 - Consider having patient lie close to family member to gain heat
- ☐ Evaluate the patient for pain and anxiety
- ☐ Assess with a standardized metric
 - Under austere conditions a pain level goal of 6-8/10 may be considered
- ☐ Non-pharmacologic interventions:
 - Elevate burned extremities
 - Decrease external stimuli
 - Do not use excessive pressure when handling wounds
 - Use hypnosis and/or virtual reality if available
 - Use family/friends for support
- ☐ Use all your resources so patients do not die from a correctable cause (e.g., use laymen to bag ventilate)
- ☐ Focus efforts on the moderate (30-60%) burns rather than the minor or severe
- ☐ Consider treating some severe as expectant if appropriate
- ☐ Call for resources (transportation, supplies, disaster plan activation, or just advice) early
- ☐ Do not forget the basics in the first hours – airway, fluids, analgesia
- ☐ Transfer patients as soon as possible to make room for more

Better Care

Better care builds on essential care and is based on available resources.

Some Access to Advanced Airway/Respiratory Supplies

Primary Survey – Airway and Breathing

- ☐ Apply cooled humidified oxygen to minimize upper airway edema
- ☐ Maintain airway and provide ventilation using
 - Laryngeal Mask Airway (LMA) / High Flow Nasal Cannula / CPAP
- ☐ Bag Mask Valve (BVM) ventilation performed by providers
- ☐ Begin IV fluid resuscitation
- ☐ Primary Survey initial start rates:
 - 0-5 years: 125 cc/hr.
 - 6-13 years: 250 cc/hr.
 - 14 years and older: 500 cc/hr.

Secondary Survey

- ☐ Document history and physical on patient record
- ☐ Calculate TBSA and adjust fluid rate:
 - Body weight in kg x % TBSA burns x 2-4 ml of Lactated Ringers or isotonic crystalloid over 24 hrs.
 - Administer 50% during the first eight hours following the burn
- ☐ May use a pre-calculated Parkland Formula fluid infusion chart to begin resuscitation
- ☐ Use two clean dry blankets to cover the patient
- ☐ Measure patient temperature every two hours

- ☐ If temperature is <37° C (98.6° F):
 - Use warm IV fluid if possible
 - Use forced air warming blanket if available
- ☐ Consider oral routes of medication delivery in small (<20% TBSA injury)
- ☐ Consider NSAIDs, acetaminophen, gabapentin and benzodiazepines
- ☐ Use weight-based, incremental dosing with appropriate frequency to obtain adequate relief
- ☐ Use standardized pain scale metrics to quantify pain and anxiety level
- ☐ Be prepared to use any medication available for pain treatment
 - Think outside the box
- ☐ Consider how resources can be conserved
 - Adapt strategies or substitute medications to make what you have go further
- ☐ Do not withhold more resources than you have to (proportionality)
- ☐ Re-evaluate as the situation evolves

Best Care Best care builds on better and essential care and is based on available resources.

Access to Advanced Airway/Respiratory Supplies

Primary Survey – Airway & Breathing

- ☐ Intubate at the first signs of airway edema: hoarseness, stridor, or progressive voice change
- ☐ If insufficient ventilators
 - Use walking wounded to bag patient
 - Assess whether T-piece blow-by oxygen directly attached to the ETT may be sufficient
 - Use transport ventilators in those with minimal airway needs
 - Consider ventilator sharing in those with similar injuries
- ☐ Consider nasopharyngeal endoscopy or video-assisted laryngoscopy in airway assessment
- ☐ Consider bougie-assisted endotracheal intubation/intubating bronchoscope in edema obscuring landmarks
- ☐ Perform cricothyrotomy in patients with edema who cannot be intubated

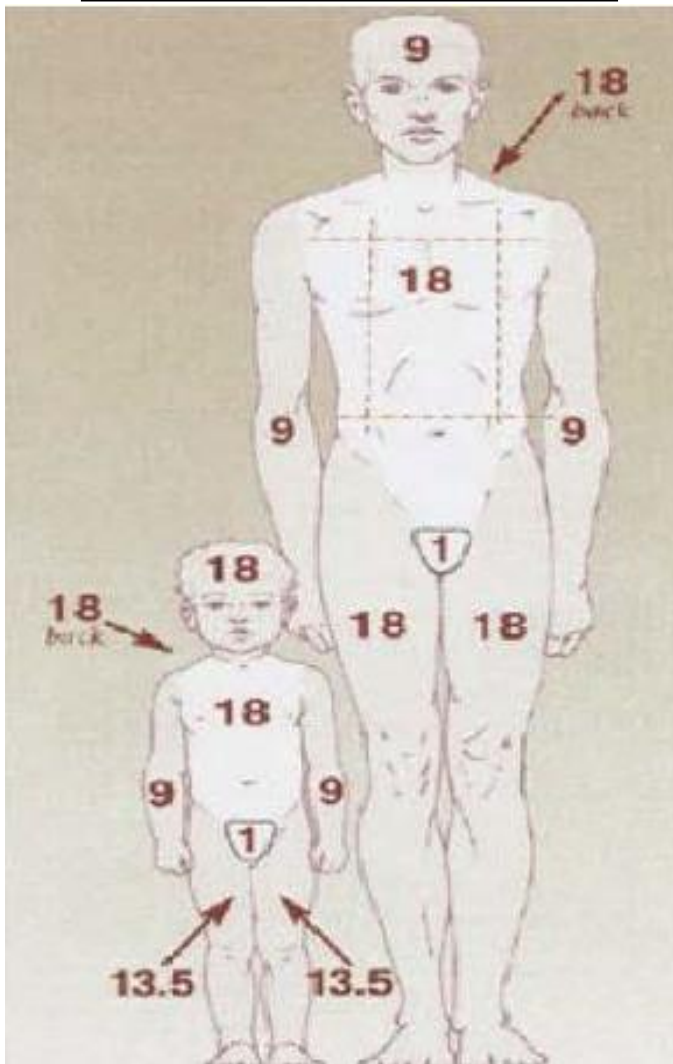
Secondary Survey

- ☐ Burn Center consult via telemedicine or other available method
- ☐ Use Lactated Ringers
 - If unavailable another isotonic crystalloid can be used
- ☐ Dextrose containing fluids should NOT be used for burn resuscitation
 - Exception in the very young who require a glucose source in addition to resuscitation fluid
- ☐ Perform ongoing patient temperature evaluation
- ☐ If temperature is <37° C (98.6° F) treat according to Evidence Based Warming Strategies in Trauma
 - Radiant warmer
 - Humidified ventilation
 - Circulating water garment
 - Consider body cavity lavage, continuous arteriovenous warming, extracorporeal membrane oxygenation/bypass
- ☐ Intravenous opioids are the appropriate initial treatment for acute burn pain
 - Unless the injury is minor

- ❑ Consider the Intraosseous route
- ❑ Consider use of IV benzodiazepines to alleviate anxiety and augment pain control
- ❑ Use standardized metrics to quantify pain and anxiety level
 - Lower pain levels of 2-4/ 10 are desired
- ❑ Consult with a burn center and distribute patients to burn/burn surge facilities
- ❑ Follow local and regional burn coordination mechanisms for movement of patients and supplies
- ❑ Use transfer vehicles/aircraft to bring supplies and personnel when appropriate

Additional Guidelines

Rule of Nines



Rule of Palms

**Patient's hand = 1%
Total Body Surface Area**



Examples of Oral Rehydration Solutions

- One Liter of clean water/one teaspoon of table salt (3 g)/three tablespoons of sugar (36 g or nine sugar cubes)
- Sports drinks such as Gatorade® or PowerAde®

96 HOUR PLAN - MODULE 2

0 to 48 Hours

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained. Utilization of all levels of care are equal to best care, even in a resource-rich environment.

Essential Care This is the minimum care given to patients based on your available resources.

No Access to Advanced Airway/Respiratory Supplies

- ☐ Frequent respiratory assessment and communication with provider
- ☐ Provide oxygen via nasal cannula or mask
 - Oxygen saturation of 90-92% is acceptable
- ☐ Open airway using airway adjuncts (nasopharyngeal (NPA)/oropharyngeal airway (OPA))
- ☐ Suction secretions as needed
- ☐ Maintain patient in sitting or head elevated position
 - Consider spinal precautions
- ☐ Estimate each patient's burn size (TBSA %)
 - Do not include first degree burns in the TBSA % estimate
 - Use "Rule of Nines" for large burns
 - For smaller burns, patient's palm (including fingers) is approximately 1% TBSA
- ☐ Resuscitate with salt-containing fluids
 - Adults with burns $\geq 20\%$ TBSA injury
 - Pediatric patients with burns $\geq 10\%$
- ☐ Use Oral Resuscitation Therapy (ORT) if IV access is unavailable
 - Up to 20% TBSA
 - Consider in up to 40% TBSA
- ☐ Use rectal infusion therapy if ORT restricted/no IV
 - Tap water or saline up to 400 ml/hr.
- ☐ Adjust fluids based upon heart rate, capillary refill and mental status
- ☐ Elevate burned extremities
- ☐ Monitor pulses hourly
 - Cut hole in dressings if wounds are wrapped
- ☐ Educate about why burns are painful
- ☐ Differentiate between pain and anxiety
- ☐ Assess with a standardized metric:
 - Every four hours
 - Pre- and post-intervention assessment
 - Under austere conditions a pain level goal of 6-8/10 may be considered
- ☐ Use non-pharmacologic interventions
 - Elevate burned extremities
 - Cover the injured areas
 - Minimize mechanical handling and cleaning
 - Hypnosis

- Virtual reality
- ☐ Emphasis on acute and severe pain if resource-limited
- ☐ Provide adequate pain control and anxiolysis if possible
- ☐ Avoid scrubbing motions when cleaning
- ☐ Use only enough pressure to remove loose debris
 - Do not try to scrub off intact eschar
- ☐ Have patients with small burns (<10% TBSA injury) wound care performed by self/friend/ family
- ☐ If lack of supplies or personnel leave wounds open (open technique)
 - Still requires careful and ongoing wound evaluation
- ☐ Perform dressing changes in a clean environment
 - Use clean water
 - Perform hand hygiene
- ☐ Select most appropriate, available topical or solution
- ☐ Reassess wounds with each dressing change
- ☐ Use oral intake of meals and supplements to support burn injuries $\leq 20\%$ TBSA
 - Supplements may include any local option with calories and protein

Better Care Better care builds on essential care and is based on available resources.

Some Access to Advanced Airway/Respiratory Supplies

- ☐ Maintain airway and provide ventilation using
 - Laryngeal Mask Airway (LMA) / High Flow Nasal Cannula / CPAP
- ☐ Bag Mask Valve (BVM) ventilation performed by providers
- ☐ Debride the wound
- ☐ Have a second practitioner confirm the TBSA % calculations
- ☐ Oral Resuscitation Therapy (ORT) drinking "schedule" to meet targets
 - Sips every five minutes
 - Wait 10 minutes after vomiting
 - At least four cups/hr. (1 liter)
- ☐ Collect urine output in a graduated container
- ☐ Use IV or IO access for larger or more complicated burns
 - Large bore IV
 - Avoid circumferentially burned extremity
- ☐ Use Doppler flow meter for hourly pulse checks
- ☐ Perform escharotomy
 - If unable to palpate distal pulses
 - Evacuation is delayed
- ☐ Use frequent small to moderate doses of analgesics and anxiolytics if available
- ☐ Preferential use of oral agents in small (<20% TBSA injury) burns
- ☐ Use non-opioid medications as adjuncts
- ☐ Use of wound dressings in deep partial and full thickness burns (closed technique)
- ☐ Identify and train a wound care team
- ☐ Use nutritional supplementation for patients with burns
 - $\geq 20\%$ TBSA
 - Facial burns
 - Those requiring mechanical ventilation

- ☐ Consider a feeding tube if resources allow
 - Gastric or enteral
- ☐ Use clean local resources when no commercial products are available

ORT examples

- One Liter of clean water/one teaspoon of table salt (3 g)/three tablespoons of sugar (36 g or nine sugar cubes)
- Sports drinks such as Gatorade® or PowerAde®

Best Care Best care builds on better and essential care and is based on available resources.

Access to Advanced Airway/Respiratory Supplies

- ☐ Secure Endotracheal Tube (ETT):
 - ETT securement device
 - Tape (non-burned face only, if no other options)
 - Twill tie (burned face)
 - Hold ETT when moving patient and verify depth unchanged
- ☐ Perform chest x-ray
- ☐ Place nasogastric tube
- ☐ Ensure continuous sedation
- ☐ Complete the Lund and Browder chart
- ☐ Burn Center consult via telemedicine or other available method
- ☐ Use LR or other isotonic crystalloid
- ☐ Calculate using Parkland formula
- ☐ Titrate based on urine output or other available monitoring techniques
- ☐ Do not use dextrose containing solutions for resuscitation
 - Exception would be very young patients requiring a glucose source
- ☐ Perform escharotomy if circumferential 3rd degree burn
- ☐ Burn Center consult via telemedicine or other available method
- ☐ Use IV agents for pain management
 - Titrated based upon effect and patient vital signs
- ☐ Standardized metrics for pain scale
 - Lower pain levels of 2-4/10 are desired
- ☐ Multimodal plan to control
 - Background pain
 - Breakthrough and procedural pain
- ☐ Use of durable silver dressings
 - Decreases need for pain control and clean environment for wound care
 - Preserves personnel time and effort
- ☐ Provide 50-60% of caloric goal in the first week after injury

Additional Guidelines

Burn Estimate and Diagram**Burn Injury Guidelines for Care**

Area	Birth-1 yr.	1-4 yr.	5-9 yr.	10-14 yr.	15 yr.	Adult	2nd	3rd	TBSA% Total
Head	19	17	13	11	9	7			
Neck	2	2	2	2	2	2			
Ant. Trunk	13	13	13	13	13	13			
Post. Trunk	13	13	13	13	13	13			
R. Buttock	2.5	2.5	2.5	2.5	2.5	2.5			
L. Buttock	2.5	2.5	2.5	2.5	2.5	2.5			
Genitalia	1	1	1	1	1	1			
R. U. Arm	4	4	4	4	4	4			
L. U. Arm	4	4	4	4	4	4			
R. L. Arm	3	3	3	3	3	3			
L. L. Arm	3	3	3	3	3	3			
R. Hand	2.5	2.5	2.5	2.5	2.5	2.5			
L. Hand	2.5	2.5	2.5	2.5	2.5	2.5			
R. Thigh	5.5	6.5	8	8.5	9	9.5			
L. Thigh	5.5	6.5	8	8.5	9	9.5			
R. Leg	5	5	5.5	6	6.5	7			
L. Leg	5	5	5.5	6	6.5	7			
R. Foot	3.5	3.5	3.5	3.5	3.5	3.5			
L. Foot	3.5	3.5	3.5	3.5	3.5	3.5			
TOTAL									

Cause of

Burn _____

Additional injuries _____

Date of Burn _____

Time of Burn _____

Age _____

Sex _____ Weight _____

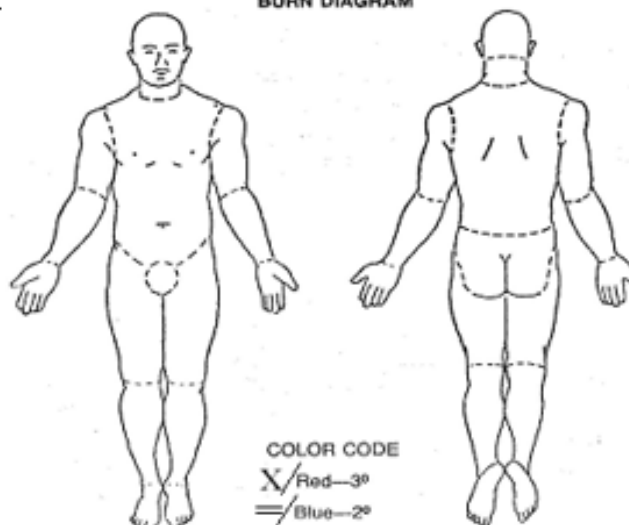
_____ Kg

Height _____ cm

Date of assessment _____

Time of assessment _____

Assessed by _____

BURN DIAGRAM

96 HOUR PLAN - MODULE 3

48 to 96 Hours

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained. Utilization of all levels of care are equal to best care, even in a resource-rich environment.

Essential Care This is the minimum care given to patients based on your available resources.

- ☐ Practice basic infection control concepts
- ☐ Do not give prophylactic antibiotics
- ☐ Meeting >3 of the following should trigger concern for infection:
 - Temp >39°C (102.2° F) or <36 °C (96.8° F)
 - Progressive tachycardia >110 bpm
 - Tachypnea >25 breaths per minute not ventilated or >12 L/minute ventilated
 - Thrombocytopenia <100,000 three days after initiation of resuscitation
 - Hyperglycemia >200 mg/dl, >7 units of insulin/hour or >25% increase in insulin requirements over 24 hours
 - Feeding intolerance >24 hours
- ☐ Reinforce burn pain education
- ☐ Continue to differentiate between pain and anxiety and provide psychological support
- ☐ Continue to assess with a standardized metric:
 - Every four hours
 - Pre-and post-intervention assessment
 - Under austere conditions a pain level goal of 6-8/10 may be considered
- ☐ Continue to use non-pharmacologic interventions
 - Elevate burned extremities
 - Cover the injured areas
 - Minimize mechanical handling and cleaning
 - Hypnosis or Virtual reality if available
 - Use family/friend for psychological support
- ☐ Emphasis on patients with acute and severe pain if resource-limited
- ☐ Determine overall health status of each patient
- ☐ Identify patients who are in shock or developing organ failure
- ☐ Repeat burn wound mapping to estimate true %TBSA
- ☐ Repeat triage
- ☐ Arrange priority transfer of critical patients to a higher level of care with burn surgery capability
- ☐ Continue to maintain organ perfusion with maintenance fluids for others
- ☐ Watch for and treat infectious complications.
- ☐ Continue to provide basic wound care with topical antimicrobials/silver dressings, etc.
- ☐ Reassess clinical status of remaining patients
- ☐ Use the burn triage table to guide decisions
 - Patients re-triaged as expectant should be those who will most benefit from palliative care
 - Promoting comfort should be the highest priority
- ☐ Assess immediately available resources

- ☐ Discuss future expected resources
- ☐ Ensure decisions are made equitably using evidence-based data
- ☐ Involve the family and patient in discussions

Better Care Better care builds on essential care and is based on available resources.

- ☐ If infection criteria is met:
 - Culture patient
 - Evaluate wounds/all sources of potential infection
 - Initiate broad-spectrum antibiotics
- ☐ Follow up of cultures, antibiotic stewardship and de-escalating antibiotics as able is paramount
- ☐ Discontinue antibiotic use:
 - If cultures are negative
 - If no source is identified
- ☐ Use frequent small to moderate doses of analgesics and anxiolytics if available
- ☐ Preferential use of oral agents in small (<20% TBSA injury) burns
- ☐ Use non-opioid medications as adjuncts
- ☐ Consider using non-typical medical adjuncts such as cannabis
 - If resources are limited
 - Benefits must outweigh the risks
- ☐ Arrange priority transfer of the following:
 - All burns who will require extensive burn surgery (>10% TBSA)
 - Burns to anatomically important areas (face, genitals, hands, etc.)
- ☐ Ensure family, patients and staff have access to psychological specialists
- ☐ Provide access to spiritual support
- ☐ Provide patient and family privacy
- ☐ Use a hospital palliative care team if available

Best Care Best care builds on better and essential care and is based on available resources.

- ☐ If infectious source is identified:
 - Obtain source control
 - Treat per infectious guidelines
- ☐ Use IV agents for pain management
 - Titrated based upon effect and patient vital signs
- ☐ Standardized metrics for pain scale
 - Lower pain levels of 2-4/ 10 are desired.
- ☐ Multimodal plan to control
 - Background pain
 - Breakthrough and procedural pain
- ☐ Prioritize patients
- ☐ Transfer those requiring definitive burn wound coverage. (i.e., skin grafting)
- ☐ Burn Center consult via telemedicine or other available method
- ☐ Initiate "airway rounds" by select providers
- ☐ Employ a deliberate system of ventilator allocation by a ventilator triage team
- ☐ Consider ventilator sharing with like patients
- ☐ Transfer to an alternative care site (e.g. Hospice or long term care site)

Additional Guidelines

CRISIS STANDARDS OF CARE BURN TRIAGE TABLES. The following crisis standards of care guidelines are to be implemented only when numbers of seriously ill patients greatly surpasses the capability of available care and normal standards of care can no longer be maintained. Application of these guidelines will require physician judgement at point of care. Use of these guidelines may require governor approval, depending on state protocols. These tables do not account for other coexisting conditions or concomitant trauma, which should also be considered in transfer or triage decisions.

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

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

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

OUTPATIENT: Survival and good outcome expected without requiring initial admission.

VERY HIGH: Mortality ≤10%, anticipated length of stay ≤ 4-21 days, 1-2 surgical procedures.

HIGH: Mortality ≤10%, anticipated length of stay ≥14-21 days, multiple surgical procedures.

MEDIUM: Mortality 10-50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures.

LOW: Mortality 50-90%, even with provision of prolonged, intensive resources.

EXPECTANT: Mortality ≥90%, even with prolonged aggressive care.

Burn Estimate and Diagram

Burn Injury Guidelines for Care

Area	Birth-1 yr.	1-4 yr.	5-9 yr.	10-14 yr.	15 yr.	Adult	2nd	3rd	TBSA% Total
Head	19	17	13	11	9	7			
Neck	2	2	2	2	2	2			
Ant. Trunk	13	13	13	13	13	13			
Post. Trunk	13	13	13	13	13	13			
R. Buttock	2.5	2.5	2.5	2.5	2.5	2.5			
L. Buttock	2.5	2.5	2.5	2.5	2.5	2.5			
Genitalia	1	1	1	1	1	1			
R. U. Arm	4	4	4	4	4	4			
L. U. Arm	4	4	4	4	4	4			
R. L. Arm	3	3	3	3	3	3			
L. L. Arm	3	3	3	3	3	3			
R. Hand	2.5	2.5	2.5	2.5	2.5	2.5			
L. Hand	2.5	2.5	2.5	2.5	2.5	2.5			
R. Thigh	5.5	6.5	8	8.5	9	9.5			
L. Thigh	5.5	6.5	8	8.5	9	9.5			
R. Leg	5	5	5.5	6	6.5	7			
L. Leg	5	5	5.5	6	6.5	7			
R. Foot	3.5	3.5	3.5	3.5	3.5	3.5			
L. Foot	3.5	3.5	3.5	3.5	3.5	3.5			
TOTAL									

Cause of

Burn _____

Additional injuries _____

Date of Burn _____

Time of Burn _____

Age _____

Sex _____ Weight _____

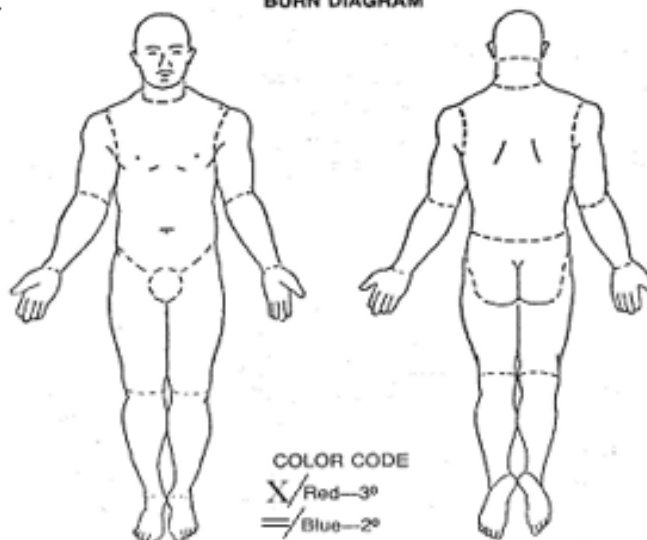
_____ Kg

Height _____ cm

Date of assessment _____

Time of assessment _____

Assessed by _____

BURN DIAGRAM

96 HOUR PLAN - MODULE 4

Transfer & Transport

Use these Quick Reference Sheets to identify, prepare and package patients for transfer.

The following Crisis Standards of Care recommendations are to be implemented only when numbers of seriously ill patients greatly surpass the capability of available care and normal standards of care can no longer be maintained.

Essential Care This is the minimum care given to patients based on your available resources.

- ☐ Obtain/Estimate each patient's age
- ☐ Estimate each patient's burn size (TBSA %)
 - Do not include first degree burns in the TBSA % estimate
 - Use "Rule of Nines" or Palmar method
- ☐ Using the All Burn Triage Table, determine triage category of all patients
- ☐ Consider transfer of patients in the following priority order:
 - Medium, High and Very High are most likely to benefit from specialized care
 - Low category patients have a mortality rate of 50-90% even with prolonged, intensive resources
 - Expectant category patients have > 90% mortality
- ☐ Arrange transport based on priority ordering and other factors
 - Determinations regarding which specific patients should be transported and in which order, will ultimately rest with the practitioner's judgement
- ☐ Variables, in addition to the All Burn Triage Table category, should be considered including:
 - Degree of injury
 - Comorbid factors
 - Facility capabilities
 - Time, distance and transportation methods
- ☐ Classify as dead all patients who are pulseless and apneic
 - Terminate resuscitative measures
 - Relocate decedent away from treatment areas to preserve family privacy and protect belongings

If the number of critical patients, outnumbers available personnel or resources

- ☐ Withhold or terminate care in apneic patients after repositioning airway -
- ☐ Provide palliative or comfort care to all patients who have a pulse and spontaneous respirations and who are classified as expectant using the "All Patients – Burn Triage Table"

No Access to Advanced Airway/Respiratory Supplies

- ☐ Maintain patient in sitting or head elevated position
 - Consider spinal precautions
- ☐ Provide oxygen via nasal cannula or mask
 - Oxygen saturation of 90-92% is acceptable
- ☐ Maintain open airway using airway adjuncts (nasopharyngeal (NPA)/oropharyngeal airway (OPA)
- ☐ Frequent respiratory assessment and communication with provider

No Access to Intravenous (IV) Supplies

- ☐ Use Oral Resuscitation Therapy (ORT) if IV access is unavailable and less than 20% TBSA
 - Consider in burns up to 40% TBSA

Non-pharmacologic Interventions

- ☐ Elevate burned extremities
- ☐ Decrease external stimuli
- ☐ Do not use excessive pressure when handling wounds
 - Support burned extremities from underneath rather than gripping
 - Use flat surface of hands / forearms rather than fingertips
- ☐ Measure patient temperature in preparation for transport
- ☐ If $<36^{\circ}\text{C}$ (96.8°F)
 - Minimize patient exposure time
 - Warm the room
 - Avoid cold surfaces
- ☐ Keep the patient warm and dry
 - If clean, dry blankets are not available wrap patient in a space blanket/plastic wrap/large plastic bag/aluminum foil for insulation and warmth
- ☐ Do not use wet dressings or wet blankets
- ☐ If $<36^{\circ}\text{C}$ (96.8°F) consider risk vs benefit of delaying transport until patient temperature rises
- ☐ If $>40^{\circ}\text{C}$ (104°F) administer antipyretic medication and consider delaying transport until temperature is below 40°C (104°F). Consider adding external cooling if no response to antipyretics.
- ☐ If between 36°C (96.8°F) - 40°C (104°F) continue preparations for transport
- ☐ If between 39°C (102.2°F) - 40°C (104°F) consider administering antipyretic medication for patient comfort
- ☐ Protect patient from cold/wet weather when moving to transport vehicle
- ☐ Cover with two blankets or improvised cover such as plastic wrap/aluminum foil/plastic bag If unable to measure temperature during transport
- ☐ Ensure all patient(s) receive a medical screening exam, appropriate triage and stabilization
 - Within the capability and capacity of the facility)
 - Primary goal is to minimize the risk of patient(s) deterioration during transport
- ☐ Ensure receiving facility agrees to accept the patient
 - In the event of a national emergency or crisis, a community-wide written protocol designating specific entities (i.e. trauma destination policy) may be relied on for pre-established referrals
- ☐ Ensure patient(s) handoff communication tool has a unique identifier, pre-burn estimate of weight, estimation of % TBSA and the name of accepting hospital and physician
 - This may be provided via triage tag, hospital cover sheet, and summary sheet or provider notes
- ☐ Ensure verbal report is given to the transport team consisting of:
 - A summary of patient's initial condition
 - Medical treatments and therapies administered
 - Patients' response to the medical care provided
- ☐ Package all medical records, lab results and x-rays available at the time of transport, and send with patient(s) to receiving hospital

Better Care Better care builds on essential care and is based on available resources.

- ☐ Have second practitioner confirm the TBSA % calculations
- ☐ Identify patients who have inhalation injuries and comorbidities
- ☐ Comorbidities with significant impact are:
 - Renal disease, obesity, liver disease, HIV/AIDS, pulmonary disorders, alcohol abuse, CHF, metastatic cancer and peripheral vascular disorders
- ☐ Use the Inhalation Injury and Non-Inhalation Injury Burn Triage Tables to determine triage category of all patients
- ☐ Wounds are cleaned and TBSA% re-evaluated by second practitioner

If the number of critical patients, outnumber available personnel or resources

- ☐ Deliver palliative or comfort care to patients who:
 - have a pulse and spontaneous respirations and are classified as expectant using the "Inhalation Injury and Non-Inhalation Injury Burn Triage Tables"

Some Access to Advanced Airway/Respiratory Supplies

- ☐ Maintain airway using:
 - Laryngeal Mask Airway (LMA)
- ☐ Provide oxygenation/ventilation using
 - High Flow Nasal Cannula/CPAP
 - Bag Mask Valve (BVM) ventilation

Some Access to Intravenous (IV) Supplies

- ☐ Initiate peripheral IV access
 - Large bore IV
 - Avoid circumferentially burned extremity
 - Avoid infusion distal to burned tissue

Pharmacological Interventions

- ☐ Oral medications may be considered when oral intake is not contraindicated, however, assess for possible adverse effects including, but not limited to, airway compromise
- ☐ We recommend that ketamine be preferred over morphine for Intramuscular (IM) analgesia
- ☐ Measure temperature during transport every 4 hours
- ☐ If < 36.0° C (96.8° F) use available active warming means to achieve normothermia
 - Warm transport vehicle / warm blankets / heating blankets / warm IV fluids
- ☐ If >39° C (102.2° F) remove blanket, consider administering antipyretic medications for patient comfort
- ☐ If >40° C (104° F) and unresponsive to medications consider adding cold air-conditioning and wetting sheets with saline
- ☐ If between 36° C (96.8° F) and 39° C (102.2° F) cover patient with a blanket
- ☐ Send a copy of patient's initial medical record & face sheet
- ☐ Ensure verbal report is given from referring physician to receiving physician
- ☐ Ensure essential elements of patient care are recorded on a standardized, pre-printed handoff communication tool (such as the BMCI Patient Medical Data Form)

Best Care Best care builds on better and essential care and is based on available resources.

- ☐ Burn Center Consult via telemedicine or other available method

If the number of critical patients, outnumbers available personnel or resources

- ☐ Transfer expectant patients to identified alternative care sites
 - Hospices, long term care facilities

Access to Advanced Airway/Respiratory Supplies

- ☐ Secure Endotracheal Tube (ETT)
 - ETT Securement device
 - Tape (non-burned face only, if no other options)
 - Twill Tie (burned face)
 - Hold ETT when moving patient
 - Note depth of tube and verify unchanged after movement
- ☐ Provide continuous sedation during transport

Access to Intravenous (IV) Supplies

- ☐ Central Line Access if requirements exceed safe capacity of peripheral IV
- ☐ Intravenous or intraosseous pain medication administration
 - Consider possible adverse effects
- ☐ Measure temperature during transport every 2 hours
- ☐ Ensure a BMCI Patient Medical Data Form is completed for each burn patient transferred
- ☐ Ensure any medical equipment accompanying the patient (IV Pumps, ventilators, monitors, etc.) are notated on patient chart by item, brand, BMET service tag number and serial number

Additional Guidelines

- See "Rule of Nines", Module 1
- See "Rule of Palms", Module 1
- See Burn Triage Tables, Module 3

J. PEDIATRIC PLANNING RECOMMENDATIONS

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

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

K. PEDIATRIC EQUIPMENT & SUPPLIES

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

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

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

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

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

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

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

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

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

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

L. BEHAVIORAL HEALTH TIPS & RESOURCES

Psychological First Aid advocates that clinicians and emergency response workers work to understand the victims world view, project a sense of calm, normalize feelings and reactions, provide information needed to de-escalate acute distress and provide education to the individual or family regarding "next steps" to take.

1. In a burn disaster scenario, the mental health clinician or EMS worker would start with **creating a sense of safety**: "your loved one is being cared for by the medical team", "we are moving you/your loved one to someplace safe where they can get the care they need", "I am here to work with the team to get you information in real time and to ensure that the victim/family is safe".

2. The next step involves asking the victim or family what they know about their situation (medical condition, condition of home, etc.); "tell me what you know at this time". This would provide an opportunity to **clarify misconceptions or misinformation**. Correct information should be provided in a very basic manner, staying only one or two steps ahead of the moment. For example: "the information that we have right now is...", "we are still gathering very basic information and the important thing for you to know is....", or "in the next hour or so, you should expect....". Information should be presented in a calm manner, false promises and platitudes should be avoided and a sense of safety should be re-enforced. It may be necessary to calmly state "as a reminder, you are at _____ Hospital, in the care of Dr. _____".

3. **Normalization of feelings** would include statements grounded in psycho education. "You may notice that your thoughts are racing and it is difficult to focus. You may notice that your stomach is tight or a band headache is developing. It might be difficult to remember all the information being provided to you. These are all normal responses to traumatic events".

4. The victim or family would then be provided with **very basic self-care tools** to help them through the immediate future. For example, a notebook for taking notes, breathing, re-framing tools, choosing a family spokesperson to address the community or communicate with friends/family, drinking water, and walking around a bit can all help empower people experiencing a stress response.

5. The victim or family would then be provided with **education regarding "next steps"**; staying away from hypothesizing, overwhelming or very detailed/specific information. It is important to not make promises that cannot be 100% assured or to make outcome predictions that may give false hope or expectations.

The simple steps of clarifying misinformation, normalization of feelings, and providing psychoeducation regarding simple and concrete strategies for self-care in the moment, and providing basic information on what to expect next all aid in reducing acute stress responses by increasing a sense of control and de-escalating physiological responses to trauma/stress.

Once initial psychological first aid has been provided (this can be done in 5-10 minutes in its simplest form and then layered upon), obtaining important information on the victim in the form of a crisis assessment should be completed. This information would include basic demographic information (name, date of birth), identification of the patient's next of kin/medical decision maker, identification of a family spokesperson, contact information, immediately relevant information regarding psych history drug use, legal issues and the patient's strengths. Ending on asking the patient or family to focus on strengths lends to a resiliency building approach and reminds people that they do have the skills to do hard things. It is important to remember that the medical team will obtain a relevant medical history.

Information on Psychological First Aid can be found at:

- <https://www.apa.org/practice/programs/dmhi/psychological-first-aid/resources>
- <https://learn.nctsn.org/course/index.php?categoryid=11>
- https://www.who.int/mental_health/publications/guide_field_workers/en/
- https://relief.unboundmedicine.com/relief/view/PTSD-National-Center-for-PTSD/1230010/all/Introduction_and_Overview
- <https://learn.nctsn.org/course/index.php?categoryid=11>

Information on Aftercare Support can be found at:

- <https://www.phoenix-society.org/>
- <https://www.samhsa.gov/dtac/recovering-disasters>
- <https://www.samhsa.gov/dtac/recovering-disasters>
- <https://www.psychiatry.org/patients-families/coping-after-disaster-trauma>
- <https://www.cdc.gov/childrenindisasters/children-disaster-help.html>
- <https://www.collabforchildren.org/sites/default/files/downloads/Trauma%20Guide%20from%20IBM%20-%20Adults%20-%20English.pdf>

M. PEDIATRIC PSYCHOLOGICAL FIRST AID

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

Children will respond to trauma and disasters differently than adults, and there will be large range in responses, depending upon the child's age, sociocultural background and personality. Some may have overt reactions in the acute phase while others may not manifest symptoms for many weeks or months.

Goals

- Re-create sense of safety
- Provide for basic needs (food, clothing, medical care)
- Ensure that survivors are safe and protected from reminders of the event
- Protect them from on-lookers and media
- Help them establish a "personal space" and reserve privacy and modesty

Encourage social support

- Help survivors connect with family and friends (most urgently, children with parents).
- Educate family and friends about survivor's normal reactions and how they can help.

Re-establish sense of efficacy

- Give survivors accurate, simple information about plans and events.
- Allow survivors to discuss events and feelings, but do not probe.
- Encourage them to re-establish normal routines and roles when possible.
- Help resolve practical problems.
- Discuss self-care and strategies to reduce anxiety and offer relaxation techniques.
- Encourage survivors to support and assist others.

Some children are more likely to have **emotional reactions** to the events, such as:

- Children who witnessed the event firsthand or whose parent, relative or friend was killed or injured.
- Children who are displaced from their home or schools.
- Children with a past history of emotional problems.
- Children with a past history of trauma, either as a victim or witness to violence or abuse.
- Children with an adult in their life who is having difficulty with their emotions, a witness to violence or a victim of domestic violence.

It is helpful to know age-specific reactions, however, and to know what interventions may be beneficial.

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 from parents and siblings
- Encourage expression through play, drawing, puppet shows, and storytelling
- Limit media exposure such as watching television
- Set gentle but firm limits on acting out behavior
- Provide structured activities and chores

Preadolescents and adolescents (12-17 years)

- May withdraw, resist authority, become disruptive and begin to experiment with high-risk behaviors, such as alcohol or drug abuse.
- Preadolescents and adolescents may develop vague physical complaints.
- May abandon chores, schoolwork, and other responsibilities.

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

Suggested Engagement Script

5. 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?”
6. 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?”
7. 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?”
8. 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?”

Additional Engagement Items

- 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?”
- 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.”
- 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.
- 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?”

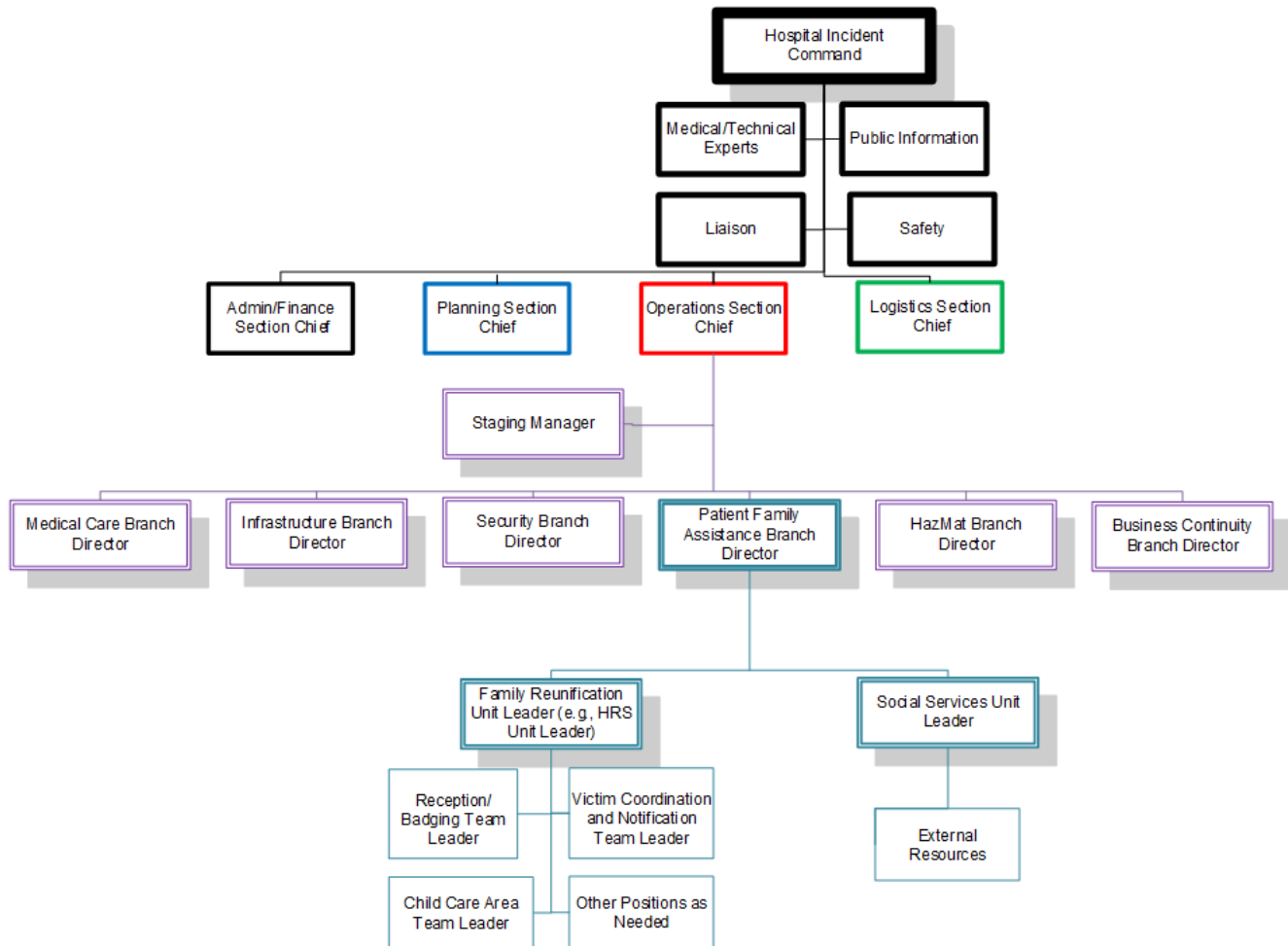
It is advisable to refer to local psychiatric referral centers and other resources accessed during NON-disaster situations to identify pediatric mental health practitioners. Additionally, prehospital personnel should have hotline numbers readily available:

- National Suicide Prevention Lifeline
1-800-273-TALK
- Substance Abuse and Mental Health Services Administration (SAMHSA) Helpline
1-800-662-HELP
- Workplace Helpline
1-800-WORKPLACE, www.workplace.samhsa.gov/helpline

N. FAMILY REUNIFICATION RESOURCES

The following resources were adapted from the Hospital Reception Site Planning Guide, developed by the Coyote Crisis Collaborative from Arizona and accessible online at <https://coyotecampaign.org/documents/>.

HOSPITAL INCIDENT COMMAND SYSTEM (HICS) CHART



Functions of the Family Reunification Unit:

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

FAMILY REUNIFICATION RESOURCES

DEFINITIONS

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

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

FAMILY REUNIFICATION RESOURCES

HOSPITAL RECEPTION SITE EQUIPMENT & SUPPLY LIST

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

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

FAMILY REUNIFICATION RESOURCES

FAMILY & FRIENDS INTAKE FORM

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

FAMILY REUNIFICATION RESOURCES

CHILD IDENTIFICATION FORM

Name of child: _____

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

Address, if available: _____ Phone: _____

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

Eye color: _____ Hair color: _____

Distinguishing Marks _____

Name of accompanying adult:

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

Relationship to child: _____

Accompanying adult treated for illness or injury? Yes___ No___

Admitted? Yes___ No___ If so, where? _____

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

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

O. COVID-19 TRANSPORTATION GUIDELINES

MAKE TRANSPORT DECISIONS QUICKLY

- It is critical that transport decisions regarding Burn injured COVID-19 patients are made quickly to avoid further decompensation and deterioration of patient's condition.

CONSIDER ADVANCED LIFE SUPPORT & AIR AMBULANCE

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

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

LIMIT RISK OF DISEASE SPREAD

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

COORDINATE TRANSFER TIME

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

SHORTEN TRANSPORT TIMES

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

- Ground transport should likely only be used for those taking 30-60 minutes if possible, otherwise air transport may be more appropriate.

NOTIFY DISPATCH OF COVID-19 STATUS

- When speaking with dispatch, please advise them this is a patient with known COVID-19 or person under investigation (PUI).
- Notify dispatch of all the necessary medical equipment, ventilators, medication pumps, personal protective equipment (PPE), etc.

COORDINATE AIR AMBULANCE TRANSPORTS

- All potential air ambulance transports need to be communicated to the WRBCC and other applicable agencies.
- As numbers of COVID positive and critically ill patient's increase, undoubtedly air ambulances will be stretched thin, resulting in increased wait times for transfer by air ambulance.

SECURE THE AIRWAY PRIOR TO TRANSPORT

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

NOTIFY DISPATCH ASAP OF PPE REQUIRED

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

MINIMIZE TRANSPORTING CREW EXPOSURE

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

P. WRBDC FACILITY DATA SHEETS

Facility Name	Helipad	Total Unit Beds	Predicted Surge (50% above baseline)	Adult	Pediatric	Dedicated Rehab beds	Facility Phone Number	Total Burn or Plastics MD/PA/NP	Disaster Contact	Telemedicine Capabilities	Designated Trauma Level 1	Designated Trauma Level 2	Designated Trauma Level 3
Arizona Rotor Wing 50 / Fixed Wing 23													
Arizona Burn Center at Maricopa Medical Center	YES	44	66	x	x	No rehab beds in house	Bed desk- 602 694- 4600 Main Operator 602-344-5726	4 Burn MDs, 5 PA, 1 NP	John Schaper (480)612-1250 john.schaper@mihs.org Lynne Schaper 480-612-1251 lynn.schaper@mihs.org	•Hard-wired and internet •HD Sony & Polycom telemedicine/conferencing codecs+Tandberg Video Bridge •Isolated network •Lease Vidyo licenses	13	0	7
Banner University Medical Center, Tucson	yes	12 ICU beds, 24 step down trauma / burn beds	54	x	x	No	(520)694- 0111	2 Burn MDs, other trauma & critical care surgeons, 5 trauma PA / NPs	Andrew Brady Andrew.Brady@bannerhealth.com phone 602.747.3827	Yes	yes		
California Rotor wing 98 / Fixed wing 23													
Bakersfield Memorial Hospital	Yes	7	10	x	Has PICU, BC takes pediatrics	No	661-323-2876	3 MD, 2 PA	Nurse Manager Amber Lizotte cell 661 333-3133 email amber.lizotte@dignityhealth.org	Yes, InTouch	13	44	14
The Edward G. Hirschman Burn Center at Arrowhead Regional Medical Center	Yes	14	21	x	x	No	909-580-2100	2MD, 1 NP	Scott Smith. RN, Emergency Coordinator smithw@armc.sbcounty.gov Cell: 760-995-6345	Store and forward of digital images			

WRBDC BURN MASS CASUALTY OPERATIONS PLAN: **APPENDIX**

Community Regional Leon S. Peters Burn Center	Yes	10	15	x	x	Yes	559-459-4220	4 Burn MD's, 3 NP's	Joseph Penn RN, Director for Burn Services. cell # is – (559) 284-9754, Office: (559) 459-4209, E-mail: jpenn@communitymedical.org				
Southern California Regional Burn Center at LAC & USC Medical Center		10 med/surg, 10 ICU	30	x	x		323-409-7991		Warren Garner, MD / W: (323)409-7759 cell phone / wgarner@surgery.usc.edu	Scanning pictures			
UCI Regional Burn Center		8	12	x	x		714-456-5304			Store and forward of digital images			
Firefighters Burn Institute Regional Burn Center UC Davis Medical Center	YES	12	18	x		Hospital has a rehab	916-734-3636	4 Burn MDs, 1 Plastic MD, 1 NP	Leonard Sterling cell (916)-412- 2028 , work 916 734-7073, pager (USA mobility) 916 816 0630 lesterling@ucdavis.edu, Marianne MacLachlan mmaclachlan@ucdavis.edu, Cell: 916-501-6738 Office: 916-734-3686	NO			
Shriners Hospitals for Children - Northern California		25	38		x		916-453-2111 (ICU)		Robin Bartlett, rbartlett@shrinenet.org				
UCSD Regional Burn Center	YES	18	24	x	x	NO	619-543-6502	2 MDs (soon 3)	Suzette Jernagen, sjernagen@ucsd.edu , work 619 543-2581	Yes use zoom platform			
Bothin Burn Center at Saint Francis Memorial Hospital	NO	16	24	x	x	Hospital has an acute rehab	415-353-6255	3 Burn MDs	Nursing Director Karl Frank 719 651-6399 karl.frank@dignityhealth.org	Designated cell phone for pictures			

WRBDC BURN MASS CASUALTY OPERATIONS PLAN: **APPENDIX**

Santa Clara Valley Medical Center Regional Burn Center	YES	8	12	x	x	YES	408-885-6666	4 Burn MDs	Yvonne Louise Karanas / 650-996-6677 / yvonne.karanas@hhs.scc.gov.org or ykaranas@gmail.com Emiko Rivera cell: (408) 835-6539 Emiko.Rivera@hhs.sccgov.org David Fernandez Hospital Emergency Preparedness Manager email Fernandez, David david.fernandez@hhs.scc.gov.org	No	Yes, adult	Yes, pediatric				
Orange County Global Medical Center	Yes	7	11	x	x	No	714-953-2377	3 Burn MDs	Rebecca Brown (714)953-2377, cell 714 721-8708, rebecca.brown@kpchealth.com	No		x				
Torrance Memorial Medical Center		12	18	x	x		310-517-4622		Vimal Murthy MD	No (working on picture scanning)						
The Grossman Burn Center- West Hills	YES	25 med/surg, 8 ICU	37/12	x	x(med/surg only)	No rehab beds in house	818-676-4177	3 plastic / reconstructive MDs, 1 pediatrician, 1 PA	Burn Clinical Manager Shurene (Dunbar) Larson, email Shurene.dunbar@hcahealthcare.com work 818-676-4355, Cell: 810-358-4502	Yes						
2802 level 1 beds / 4288 level 2 beds (total 7090)											Colorado		Rotor wing 19 / Fixed wing 10			
University of Colorado Hospital Burn Center	YES	19	29	x		Dedicated 36 bed general rehab floor, OK for low acuity burn	(720)848-7583	3 Burn Attendings	Patrick Conroy/ cell 303-880-1799/office 720-848-6632/patrick.conroy@uchealth.org Clinton Andersen Work 720-848-6095, Cell 303-419-0888 Clinton.andersen@uchealth.org	Picture Scanning and Telemedicine	5 / Yes	11 / NA	25 / NA			

WRBDC BURN MASS CASUALTY OPERATIONS PLAN: **APPENDIX**

Children's Hospital Colorado	YES	12	18		x	13	(303)549-4636	1 burn MD, 1 burn NP, 4 burn RNs	Director Emergency Management Sarah Lorenz, Manager Sarah.Lorenz@childrenscolorado.org Phone: (720) 777-8070 cell (303) 520-9882	Yes	Pediatric Level 1	NA	NA
Burn and Reconstructive Center at Swedish Medical Center	YES	8 icu Adult and 6 ICU pediatric beds	21	X	X		855-863-9595	3 Burn/Plastic Surgeons, 5 Physician Assistants (14 Add'l Burn Surgeons, 75 Add'l APPs thru Burn & Recon. Ctrs of America)	Benson Pulikkottil MD, Burn Medical Director (cell) 845-216-1506, Access number: 855-863-9595	Yes	Yes		
Western States Burn Center	YES	10	15	x			(970) 810-6099	2 Burn MDs, 1 NP (another MD on back up if needed)	Rebecca Garber (970) 810-4540, Rebecca.Garber@bannerhealth.com	Vidyo live format and image store and forward			
Hawaii Rotor wing 6 / Fixed wing 14													
Straub Clinic and Hospital Burn Unit	No	7	12	x	x (at Kapiolani Hospital)	Rehab beds at Pacific Hospital	808-522-3731, 808 522-4000	3 Plastics MDs	Safety Officer Shane Correa shane.correa@straub.net. Barry King, Security Manager, barry.king@straub.net	Yes	1	2	1
Kapi'olani Medical Center for Women & Children													

Idaho													
Eastern Idaho Regional Medical Center Burn and Reconstructive Centers of Idaho	YES	6 Adult ICU / 4 step down / 6 pediatric ICU	24	5	4		Burn CN C(208)881.1757 burn ICU front desk 208.529.7855	5 Burn MDs, 1 plastics, 2 NP,	Jim Howard Disaster & Emergency Preparedness Coordinator jim.howard@hcahealthcare.com O-208.529.6223 C-208.520.1080 Bed Access-208.529.6096	Yes	0	4	2
Nevada Rotor Wing 10 / Fixed Wing 13													
Lions Burn Center-UMC	YES	16	24	x	x	no	702-383-2268	5 burn MDs		No	1	2	1
Sunrise Hospital and Medical Center	YES	12	18	x	x	yes	Burn Center 702 961-6470 Referral center 855 863-9595 Clinic number 702 961-7552	4 Burn MD, 6 PA		No	1		
New Mexico Rotor wing 17 / Fixed wing 8													
New Mexico Regional Burn Center	YES	6	9	x	X	no	505-272-2721	1 Plastic/ reconstructive MD 1 PA	PALS (Physician Access Line) 505-272-2000 (24/7)	NO	1	0	6
Oregon Rotor wing 17 / Fixed wing 8													
Oregon Burn Center	YES	16	24	x	x	Rehab unit at Legacy Good Samaritan hospital	503-413-4232	4 Burn MDs, 1 NP	Curtis Ryun cell (503)317-5724 cryun@lhs.org (in addition to the main unit number)	no telemed on the unit, but use a system called RITA PICS that is used by all of the hospitals in the area	2	4	15

973 Level 1 beds/ 272 Level 1 pediatric beds / 950 Level 2 beds (total 2195) Utah Rotor wing 18 / Fixed wing 4													
University of Utah Burn Center	YES	15	23	x	x	no (hospital has a rehab unit or use outside facility as needed)	801-581-2700	3 burn MDs, 3 burn NPs, 4 burn PA	Annette Matherly cell (435)901-1425 Annette.Matherly@hsc.utah.edu	•Polycom system for incoming calls or IP address •Telemedicine bridge •Intouch laptop/robot system for Idaho, Grand Junction CO, Nevada • Vidyo for some sites. - Store & forward w/ encryption.	3	5	3
Level 1 beds 413 Level 2 beds 1400 adult and 200 pediatric Washington Rotor wing 13 / Fixed wing 10													
University of Washington Regional Burn Center	YES	40	60	x	x	Adult rehab beds 24	206-744-3140	6 Burn MDs, 1 NP, 1 PA	Carolyn Blayney Program Operations Manager /cell 206-450-3294/blayney@uw.edu/ Jo Tate Program Manager/cell 253-381-4337/jotate@uw.edu	Can be via desktop or mobile devices, use the zoom meeting app (ZOOM#206-744-5666). Email for videoconferencing is clpcc@uw.edu	1	7	24



Q. WRBCC BMCI PATIENT TRACKING SHEET For Use in the Coordination Center

STATE:

FACILITY NAME:

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

FACILITY NAME:

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

STATE:
FACILITY NAME:

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

FACILITY NAME:

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



R. WRBCC BURN PHYSICIAN ON-CALL SCHEDULE

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