



NYC REMSCO/REMAC Operational Advisory

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The Regional EMS Council (REMSCO) of NYC is responsible to coordinate EMS in NYC. The Regional Emergency Medical Advisory Committee (REMAC) of New York City is responsible to develop, approve and implement prehospital treatment and transport protocols for use within the five boroughs of the City of New York. Both the REMSCO and the REMAC of New York City operate under the auspices of Article Thirty of the New York State Public Health Law.

A new process has been developed that identifies when and how EMS agencies on the scene of a Mass Casualty Incident (MCI)¹ shall notify and provide information to FDNY EMS. The process allows FDNY EMS to categorize MCI levels based on severity, and determines where FDNY EMS will direct patient transport.

Four (4) levels of MCIs: Level A (moderate), Level B (significant), Level C (major), and Level D (catastrophic) Each level connects with a pre-determined number of patients that a specific hospital can accept, dependent on the severity of the MCI.

The process is:

1. If non-911 EMS personnel arrive on scene of an incident that is or has the potential to become a Mass Casualty Incident **prior** to arrival of a municipal or other 911-contracted ambulance agency, this information should be communicated immediately to FDNY by contacting Emergency Medical Dispatch at (347) 250-6334 -or- 6335. This phone will be picked up by the EMD Citywide Dispatcher.
2. FDNY EMS will coordinate the MCI and direct the transport of patients to specific hospitals.
3. FDNY EMS will communicate with hospitals and provide notification of in-coming transports.

Agency leadership is responsible to share this Advisory with all EMS personnel and agency dispatchers.

[ATTACHED: NYC REMAC Coordination of Prehospital Resources Protocol](#)

¹ The Coordination of Prehospital Resources Protocol (attached), developed at the request of the NYS Commissioner of Health, states, 'MCIs are generally defined as five (5) or more patients with the potential need for extraordinary resources. However, the criteria for the definition of MCIs are not primarily dependent upon the number of patients. The Regional Emergency Medical Services Council of New York City and FDNY should include all EMS Agencies participating in MCIs into MCI planning, and should coordinate training in MCIs for all participating EMS Agencies.'

COORDINATION OF PREHOSPITAL RESOURCES PROTOCOL

INTRODUCTION

The purpose of this protocol is to set forth New York City Regional guidelines for the coordination of prehospital resources at the scene when multiple Emergency Medical Service (EMS) Agencies are present. An EMS Agency is any NYS DOH or REMAC of New York City approved ambulance or first response service, including municipal, hospital, volunteer or commercial entities, authorized to provide patient care and/or transport in NYC.

The protocol addresses who has the authority to determine:

- who will provide patient care;
- who will accompany the patient;
- which ambulance(s) will provide transport;
- the appropriate destination(s); and
- the need for additional resources.

1. PARTICIPATION GUIDELINES

All providers must properly and reasonably identify themselves and their certification levels. The provider must provide his/her name, organization name, and provider number (shield or NYS DOH certification number). Written identification (i.e., patch, agency ID tag, etc.) is preferable to avoid confusion.

All providers present at an incident must function as part of a response by the EMS Agency with which they are affiliated and remain within their scope of training and practice.

The EMS Agency must be authorized to provide prehospital care within the New York City region and operate under regionally approved protocols specific to the agency's approved level(s) of care.

2. RESPONSIBILITY FOR PATIENT CARE

The prehospital emergency care provider with the highest level of certification who first establishes patient contact at the scene assumes responsibility for providing initial patient care. S/he retains responsibility for patient care, until relinquished to a prehospital emergency care provider as determined by patient condition/medical necessity, mutual consent, operational necessity, or patient request.

If an ALS provider assumes patient care responsibility from a BLS provider, the BLS provider should assist in the delivery of patient care as requested until such time as the primary ALS care provider determines that assistance is no longer required.

A BLS provider must relinquish patient care to an ALS provider who requests it.

In cardiac arrest situations, CFR-D or EMT-B units will be considered a higher level of patient care provider over units not equipped with a defibrillator.

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When a patient requires ALS care and is on a BLS ambulance, and an ALS provider is present, the BLS unit shall assist the ALS provider and transport the patient with the ALS provider and equipment as soon as appropriate.

Under no circumstances should patients be transferred between units unnecessarily or transport be delayed.

3. COORDINATION OF PREHOSPITAL RESOURCES

The prehospital emergency care provider with the highest level of certification who first establishes patient contact at the scene assumes responsibility for decisions related to coordination of prehospital resources.

Higher level prehospital providers must assume responsibility for coordination of prehospital resources if they assume responsibility for patient care.

Responsibility for coordination of prehospital resources may be relinquished to later arriving prehospital providers based on mutual consent.

When a NYC "911 System" participating EMS Agency is not the first EMS Agency on the scene and is not acting in the role of primary care provider, it shall act as an operational resource for:

- Information regarding hospital diversions, specialty referral center bed availability and other specialized resources; and
- Incident scene safety (e.g., environmental conditions, crowd/traffic control in the absence of NYPD, potentially dangerous patient or family member to self and/or others).

FDNY shall be responsible for coordination of prehospital resources in situations involving:

- Multiple Casualty Incidents (MCIs);
- Unscheduled MEDEVAC transports;
- Hazardous Materials (HAZMAT) and/or Weapons of Mass Destruction (WMD) situations which require decontamination;
- Fires/Crimes in progress; or
- Unusual public health or safety emergencies.

At the point that FDNY assumes operational responsibility for coordination of prehospital resources, incident command procedures are in effect, incorporating all participating EMS Agencies and resources into the response, as appropriate.

4. MULTIPLE CASUALTY INCIDENTS (MCIs)

MCIs are generally defined as five (5) or more patients with the potential need for extraordinary resources. However, the criteria for the definition of MCIs are not primarily dependent upon the number of patients.

The Regional Emergency Medical Services Council of New York City and FDNY should include all EMS Agencies participating in MCIs into MCI planning, and should coordinate training in MCIs for all participating EMS Agencies.

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5. **PATIENT TRANSPORTATION**

The provider who is responsible for patient care will determine who accompanies the patient and, except in MCI's, the appropriate destination, in accordance with state and regional protocol. In all practical circumstances the number of individuals in the patient compartment, excluding the patient, shall not exceed four (4). However, the provider who is responsible for patient care makes the ultimate decision regarding who is in the patient compartment.

6. **IMPLEMENTATION/EVALUATION**

Each EMS Agency shall develop guidelines, policies and procedures to ensure the implementation of this protocol, including continuing education in the use of the protocol. Complaints shall be first addressed agency to agency, secondly to the Regional EMS Council/REMAC Quality Assurance Committee. Evaluation of the effectiveness of the protocol shall be ongoing as part of each EMS Agency's QA processes and integrated into system-wide QA activities pursuant to Article 30 of the New York State Public Health Law.