SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 8000
Effective Date: September 2, 2014
Supersedes: January 15, 2011

MULTI-CASUALTY INCIDENT POLICY

I. PURPOSE

This policy supports the San Francisco Emergency Medical Services Multi-Incident Casualty (MCI) Plan. The MCI Plan identifies and delineates the structure and processes for the provision of emergency medical care by local EMS system participants during a MCI event of any size or magnitude.

The overall objective of the MCI Plan is to minimize the morbidity and mortality associated with large scale emergency patient care incidents occurring in San Francisco by ensuring the provision of rapid and appropriate emergency medical care to the most possible patients through a coordinated response system based on incident management principles.

II. AUTHORITY

A. Statutory authorities for the MCI plan include:
- California Health and Safety Code, Sections 1797.103; 1797.150-153; 1797.204; and 1797.220
- California Code of Regulations, Title 19, Division 2, Chapter 1
- California Code of Regulations, Title 22, Section 100167 (b) (2 - 3); 100168 (b) (4); and 100169 (a)
- California Code of Regulations, Title 22, Division 9, Section 100255
- California Government Code, Article 9, Section 8605
- California Master Mutual Aid Agreement
- California Emergency Services Act

B. The MCI Plan complies with the following standards or references the following partner plans:
- National Incident Management System (NIMS)
- City and County Emergency Response Plan, April 2008
- San Francisco Bay Area Regional Coordination Plan – Medical and Health Subsidiary Plan, March 2008
- Firescope Field Operations Guide, ICS 420-1, July 2007
- California Standardized Emergency Management System (SEMS)
- California Public Health and Medical Emergency Operations Manual, July 2011

III. POLICY

A. The San Francisco Emergency Medical Services MCI Plan is an approved policy and procedure of the Department of Emergency Management - EMS Agency. EMS provider

organizations shall comply with the operational roles and standards as defined in the MCI Plan. This includes all San Francisco ambulance providers, dispatch centers, hospitals and relevant Emergency Operations Center or departmental operations center command staff.

B. All San Francisco ambulance providers, dispatch centers, and hospitals shall develop, maintain and train staff on Emergency Response Plans for their organizations, and maintain disaster supplies and equipment that will allow for a minimum of 72-hours of self-sufficient operations.

IV. TRAINING and EXERCISES

A. All EMS provider organizations shall provide annual training and updates on the San Francisco Emergency Medical Services MCI Plan and participate in regular exercises of that plan with other EMS system participants.

B. EMS provider organizations shall provide training to relevant staff to ensure proficiency in the following:

1. First Receiver (Hospitals Only):
   a) Simple Triage and Rapid Treatment (START) and JUMPSTART
   b) Hospital Incident Command System
   c) Hospital Incident Command System Hazardous Materials Awareness
   d) Incident Command System (up to ICS 200 level)
   e) National Incident Management System (NIMS) IS-700 and IS-800
   f) Working knowledge of San Francisco EMS Agency Policies and Procedures
   g) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

2. All Field First Responders:
   a) Simple Triage and Rapid Treatment (START) and JUMPSTART
   b) California Standardized Emergency Management System (SEMS)
   c) Incident Command System (up to ICS 200 level)
   d) National Incident Management System (NIMS) IS-700 and IS-800
   e) Hazardous Materials First Responder Awareness
   f) Working knowledge of San Francisco EMS Agency Policies and Procedures
   g) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

3. Ambulance Strike Team Leader:
   a) Incident Command System (up to ICS 300 level)
   b) Ambulance Strike Team Leader Training (State EMS Authority course)
   c) Ambulance Strike Team Provider Training (State EMS Authority course)

d) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

4. On-Scene Command Staff:
   a) Incident Command System (up to ICS 400 level)
   b) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.
   c) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

5. Assigned EOC or DOC Command Staff:
   a) City and County Emergency Response Plan
   b) City Departmental Emergency Response Plans (any city DOC staff)
   c) Provider Emergency Operations Plan (any private provider DOC staff)
   d) MGT 313 (or equivalent) – Incident Management / Unified Command
   e) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

V. MCI PLAN UPDATES

The EMS Agency is responsible for updates of the San Francisco Emergency Medical Services MCI Plan through its regular policy and protocol public comment process. This policy will be updated as appropriate to support the MCI Plan.

VI. QUALITY IMPROVEMENT

A. The Medical Group Supervisor for a MCI will submit the MCI Summary Report along with a written narrative to the EMS Agency within 24 hours after the incident.

B. DEC will submit a MCI Post Event Report Form to the EMS Agency within 24 hours of the incident.

C. EMS provider organizations shall submit other incident or patient-related information *as requested* by the EMS Agency. Any submitted patient information must NOT contain specific patient identifiers in compliance with all applicable federal or state patient confidentiality requirements.

D. The EMS Agency will review all MCI Post Event Report Forms and MCI Summary Reports as part of our on-going Quality Improvement process. The EMS Agency may coordinate an inter-agency debriefing for significant MCIs. A representative from each department or agency with an active role in the MCI incident will attend the debriefing. The EMS Agency will follow up all in-person inter-agency debriefings with a written After Action Report / Plan of Correction.

MCI Date / Time:
CAD Incident Number:
Report Completed By:

Fax Copy within 24 hrs after MCI
to DEM - EMS Agency at (415) 552-0194

MCI SUMMARY REPORT TO EMS AGENCY V. July 2016

SCENE INFORMATION	
Call Sign:	
Location:	
Incident Type:	
Hazards:	
Staging:	
Access:	
Egress:	

COMMAND STAFF	
IC:	
MGS:	
Triage:	
Treatment:	
Staging:	
Transport:	

ESTIMATED NUMBER OF PATIENTS			
Red	Yellow	Green	Total

UNIT STATUS					
UNIT ALS / BLS	DISPATCH TIME	STATUS HOSP / CAN	TRANSPORTED # R	TRANSPORTED # Y	TRANSPORTED # G

HOSP STATUS					
HOSP STATUS	# AVAIL BEDS	STATUS HOSP / CAN	# TYPE # R	# TYPE # Y	# TYPE # G
CalPac					
Dav					
Kais-SF					
St Fran					
St Lukes					
St Mary					
SFGH					
UCSF					
Veteran					
Chinese					
CPMC-Cal					
UC-MB					
South Kais					
Seton					

LOCATION OF	
ICP:	**Transport:**
Triage:	**Staging:**
Treatment:	**Supply:**
Green Treatment:	**Rehab:**
Morgue:	

OTHER UNITS DISPATCH		
TYPE	# PTS	TIME
Bus		
Helicop		
RedCross		

SAN FRANCISCO

MCI PLAN

June 2016

POLICY REVISIONS SUMMARY 2016

#	Title	Action Taken	Details	Effective Date
8000	Multi Casualty Incident	Revision	Automatic (default) patient distribution table in section 3.10 has been changed to have Zuckerberg San Francisco General Hospital to take the first 10 (ten) Red trauma patients. Added UCSF Mission Bay Hospital to take the same patient load as other community hospitals, with a preference for pediatric MCI patients. New Appendix E has been added to reflect the patient tracking information needed for hospitals to complete within 24 hours of the conclusion of an MCI. Minor updates included: • Re-numbering Section 3 to correct a numbering error. • Changed “EMSystem” to “”Reddinet.” • EOC Operations Section – Human Service Branch renamed to “Health and Human Services Branch.” • Deleted old terminology (Metropolitan Medical Task Force) • Minor grammatical edits done to various sections. THER WERE NO OTHER CHANGES TO MCI PLAN CONTENTS	**June 24, 2016**

CONTENTS

PART 2: BACKGROUND

Section 2.1 Introduction

2.1.1 Objectives

The Department of Emergency Management - Emergency Medical Services (EMS) Agency Multi Casualty Incident (MCI) Plan (herein referred to as the "MCI Plan") identifies and delineates the structure and operations for the provision of emergency medical care during a MCI event of any size or magnitude. The intent of the MCI Plan is to ensure the provision of rapid and appropriate emergency medical care to the most possible patients through a coordinated response system based on incident management principles.

The primary objective is to minimize the morbidity and mortality associated with large scale emergency patient care incidents occurring in San Francisco. This plan is compliant with the State of California Firescope, the California Standardized Emergency Management System (SEMS), the federal National Incident Management System (NIMS), as well as local planning, policies and procedures related to MCI activities.

2.1.2 Plan Organization

The ***MCI Plan*** is subdivided into three parts:

- **Part 1 – Standard Operating Procedures** - A script for easy reference to the initial actions for responders.
- **Part 2 - Background** - Provides relevant background information about the structure and response operations. It is intended for training or for responders who are new to MCI responses.
- **Part 3 - Operations** - Describes in detail the activities that all EMS participants must follow during a general response to a MCI.

Part 3 – Operations is further subdivided into sections based on the various components and phases of a system-wide EMS MCI response. The use of discrete sections provides responders with the information they need in user-friendly format that does not require reading the entire plan. The intent of this format is to provide quick, clear information on specific response operations. It also fulfills the requirement for scalability since only portions of the plan may be required for a particular incident response operation

The **Annexes** describe special emergency medical response operations for scenario specific situations (e.g. bombings, contaminated scenes, etc.). The Annexes supplement the Core Plan and are intended to be used in tandem with the general response information in the Core Plan.

The **Appendices** provide reference information relevant to supporting a successful response operation. It includes guides to the various EMS resources, Field Incident Command System Position Descriptions, maps, glossary and etc.

2.1.3 Authorities, Standards and Guidelines

The following authorities, standards and guidelines provide compliance for the development and implementation of Plan:

Local

- The San Francisco Emergency Medical Services MCI Plan is an approved policy and procedure of the Department of Emergency Management - EMS Agency
- City and County Emergency Response Plan, April 2008

State

- Firescope Field Operations Guide, ICS 420-1, July 2007
- California Standardized Emergency Management System (SEMS)
- California Health and Safety Code, Sections 1797.103; 1797.150-153; 1797.204; and 1797.220
- California Code of Regulations, Title 19, Division 2, Chapter 1
- California Code of Regulations, Title 22, Section 100167 (b) (2 - 3); 100168 (b) (4); and 100169 (a)
- California Code of Regulations, Title 22, Division 9, Section 100255
- California Government Code, Article 9, Section 8605
- California Public Health and Medical Emergency Operations Manual, July 2011
- California Master Mutual Aid Agreement
- California Emergency Services Act

Federal

- National Incident Management System (NIMS)

2.1.4 Personnel Training and Competency Levels

All EMS providers should check with their respective training providers for the most current training requirements specific to their roles during a MCI response. At a minimum, this plan assumes that users of this plan will be familiar with and proficient in the following:

First Receiver (Hospitals Only):

- Simple Triage and Rapid Treatment (START) and JUMPSTART
- Hospital Incident Command System
- Incident Command System (up to ICS 200 level)
- National Incident Management System (NIMS) IS-700 and IS-800
- Working knowledge of relevant San Francisco EMS Agency Policies and Procedures

All Field First Responders:

- Simple Triage and Rapid Treatment (START) and JUMPSTART
- California Standardized Emergency Management System (SEMS)
- Incident Command System (up to ICS 200 level)
- National Incident Management System (NIMS) IS-700 and IS-800
- Hazardous Materials First Responder Awareness
- Working knowledge of San Francisco EMS Agency Policies and Procedures

Ambulance Strike Team Leader:

- Incident Command System (up to ICS 300 level)
- Ambulance Strike Team Leader Training (State EMS Authority course)
- Ambulance Strike Team Provider Training (State EMS Authority course)

On-Scene Command Staff:

- Incident Command System (up to ICS 400 level)

Assigned EOC or DOC Command Staff:

- City and County Emergency Response Plan
- City Departmental Emergency Operations Plans (any city DOC staff)
- Provider Emergency Operations Plan (any private provider DOC staff)
- (Recommended) MGT 313 – Incident Management / Unified Command

Section 2.2 Patients

2.2.1 Triage

Triage is a French word meaning “to sort.” It is used to identify patients that have the most immediate need for medical care vs. those that may wait. Triage is the primary tool used in determining the most appropriate allocation of available medical care resources in a large multi-casualty incident.

Field treatment and the eventual distribution of patients to receiving facilities are determined by the systematic triage of patients at the scene. The flow of the entire emergency medical

MCI response is driven by both the total number patients and their assigned triage levels. It is therefore crucial that First Responders do appropriate patient triage at the onset of every MCI – no matter how large or small the incident.

2.2.2 Required Triage Standard – START Triage and Jump START

The EMS Agency requires that field First Responders do **START Triage** during a MCI on all adult patients and **JUMP START** on all pediatric patients. Both systems are physiological assessment methods based on a simple mnemonic "**RPM" (R**espirations, **P**erfusion, **M**entation). **START** is an acronym for **S**imple **T**riage **a**nd **R**apid **T**reatment. Once the START triage evaluation is complete, the victims are labeled with one of four color-coded triage level categories:

Minor = walking wounded / can delay care for up to three hours

Delayed = serious non-life-threatening injury / can delay care for 1 hour

Immediate = life-threatening injury / requires immediate care

Deceased / Expectant = pulseless / non-breathing or imminent demise

Triage categories are an indication of the desired time to receive treatment. In a large scale incident, actual time to treatment may vary based on the availability of resources.

JumpSTART is based on the START physiologic triage system used for adults. However, JumpSTART system recognizes the key differences between adult and pediatric physiology and substitutes appropriate pediatric physiologic parameters at triage decision points. JUMP START is used for the following:

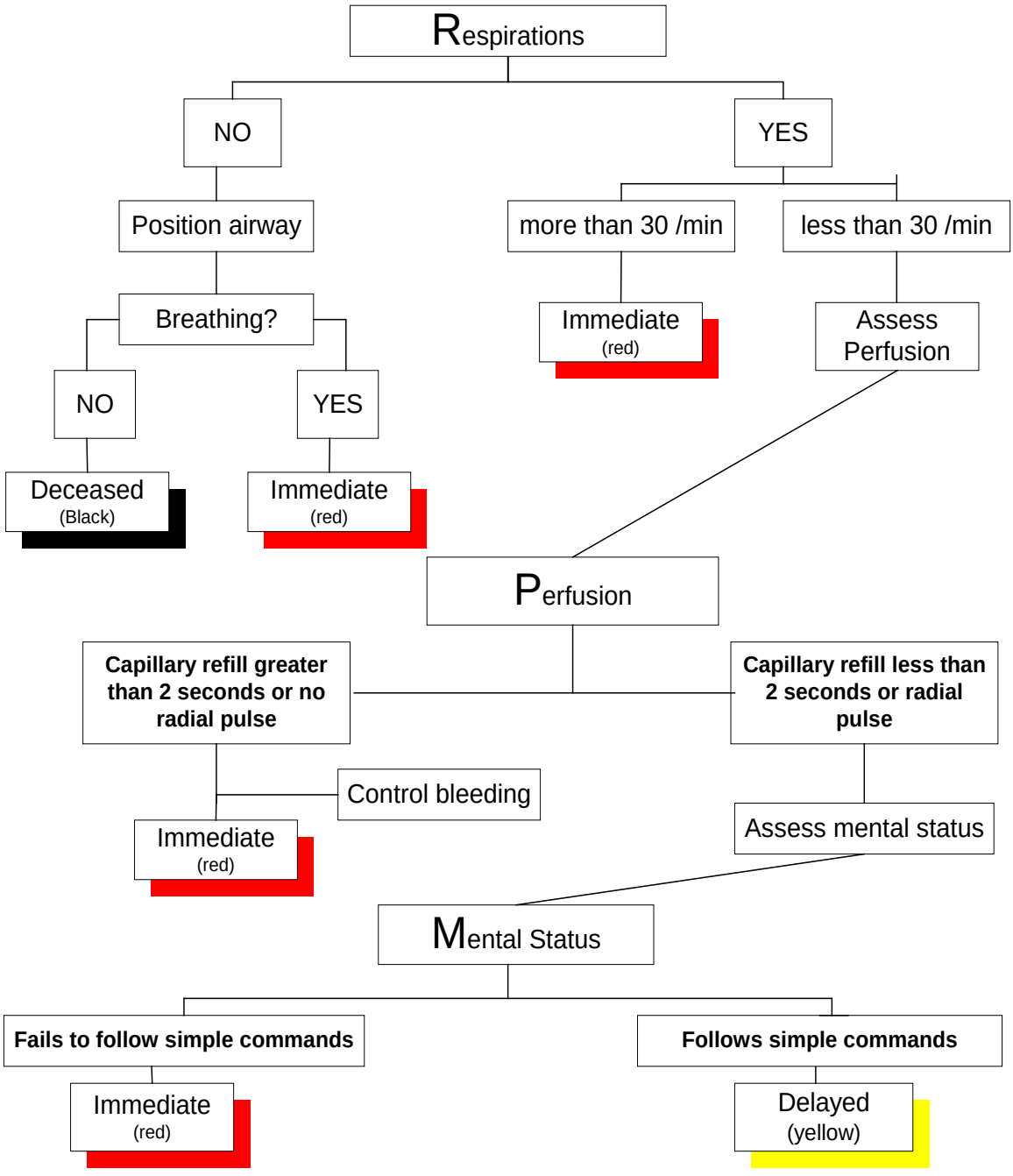
1. Children ages newborn to 8 years or,
2. When the patient appears to be a child or,
3. Whenever you can use a length-based (Broselow) resuscitation tape.

Both START Triage and JumpSTART Triage are designed for use in only disaster and multi-casualty situations, not for daily EMS or hospital triage. Refer to Figures 1 and 2 for the START and JUMP START Flow Charts.

Figure 1: START TRIAGE FLOW CHART

START: **S**imple **T**riage and **R**apid **T**reatment

1. Direct patients who are able to move to a certain area; triage as minor.
2. Begin triage: **START** with closest patient



Note: Once a patient reaches a triage level indicator in the algorithm, triage of this patient should stop and the patient tagged accordingly.

START TRIAGE STEPS

*Use the mnemonic "**RPM**"*
*(**R**espirations, **P**erfusion, **M**ental Status)*
to remember the assessment sequence.

1. MOVE WALKING WOUNDED
   - Direct patients who are able to walk to another area. Tag **GREEN.**

2. **R**ESPIRATIONS
   - If respiratory rate is 30/minute or less go to PERFUSION assessment.
   - If respiratory rate is over 30/ minute, tag **RED**.
   - If victim is not breathing, open the airway, remove any visible obstructions and re-position head to open airway. Re-assess respiratory rate.
   - If victim is still not breathing, tag **BLACK**.

3. **P**ERFUSION
   - Palpate radial pulse or assess capillary refill (CR) time.
   - If radial pulse is present or CR is 2 seconds or less, go to MENTAL STATUS assessment.
   - No radial pulse or CR is greater than 2 seconds, tag **RED**.
   - Control any major external bleeding at this point.

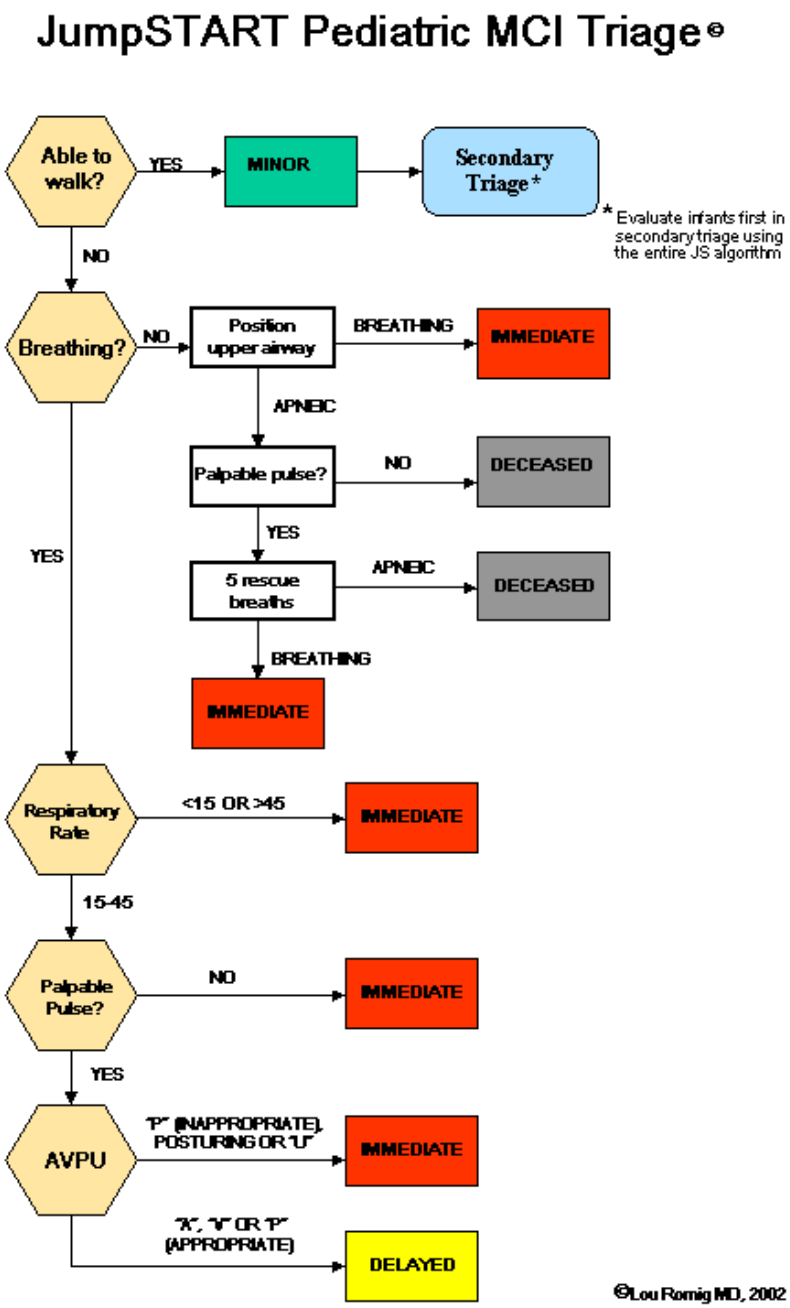
4. **M**ENTAL STATUS
   - Assess ability to follow simple commands and orientation to time, place and person.
   - If the victim does not follow commands, is unconscious, or is disoriented, tag **RED**.
   - If the victim follows simple commands tag **YELLOW.**

***SPECIAL CONSIDERATIONS**:*

- Stop at any point in the RPM assessment when a **RED** triage level is identified.
- Tag **YELLOW** obvious significant injuries (e.g. burns, fractures).
- Correct only life-threatening issues (e.g. airway obstruction, severe hemorrhage) during initial triage.

Figure 2: JUMP START TRIAGE FLOWCHART*

*See www.jumpstarttriage.com for additional information.



2.2.3 Other Considerations for Patient Triage

START Triage and JUMP START are the first triage systems used in the MCI Triage Area, followed by Trauma Triage Criteria in the designated Treatment and / or Transport Area(s). Other clinical considerations should be factored into the determination of an appropriate triage level and destination for their medical care depending on the provider training, availability of personnel, and if the situation safely allows for it. Below is a list of all triage criteria, injury scoring systems and clinical considerations that may be applicable during the MCI triage process:

- START Triage and JUMP START
- Trauma Triage Criteria
- Glasgow Coma Scale
- Burn Rule of Nines
- Significant Medical Complaints
- Special Circumstances (Hazmat exposure)
- Special Populations:
  - Age Extremes
  - Pregnant
  - Medically Fragile

2.2.4 Required Triage Tags and Patient Records

First Responders must use a triage tag to label triaged patients by the severity of their injury. Triage tape is permitted in the Triage Area, but should be replaced by a tag in the Treatment or Transport Area(s). atient identifying information, vital signs, treatment, and destination should be written on the triage tags when the time and situation permit it. EMS patient care records may be used if adequate personnel resources are available and the patient is held at the scene for an extended period of time.

2.2.5 Deceased Care

Deceased patients must be labeled as **Deceased** with the triage tag. Deceased patients require no further care and may be left in place while responders attend to other viable patients. Responders should notify the San Francisco Medical Examiner to assume responsibility for the disposition of deceased patients.

Efforts should be made to treat deceased patients with respect, and to cover or move them as resources and the situation permits. If the incident is a crime scene, the Medical Examiner or SFPD must approve moving deceased patients. When moving a body, Responders should do the following:

1. Fill out information on identifying information on the triage tag or attach a morgue tag or other label directly to the body. Include:
    - Date, time and location body found,
    - Name/address of decedent, if known,
    - If identified, how and when,
    - Name/phone of person making identity or filling out tag, and
    - Note any contamination

2. Personal effects must remain with the body at all times. If personal effects are found and thought to belong to a body, place them in a separate container and tag. Do not assume any loose effects belong to a body.

3. Place the body in a disaster body bag or in plastic sheeting and securely tie to prevent unwrapping. Attach a second exterior tag to the sheeting or pouch.

4. Move the properly tagged body with their personal effects to a separate, safeguarded location, preferably with refrigerated storage.

Section 2.3 Medical Group Organization

2.3.1 Medical Group Positions

EMS MCI field operations are the responsibility of the ICS Operations Section – Medical Group. Firescope defines the fifteen positions that comprise the Medical Group. Below briefly describes the roles and responsibilities for each Medical Group position. Detailed position descriptions for all Medical Group personnel are found in the Appendices.

1. Medical Branch Director – Has overall command of EMS field Operations in a full branch response. Responsible for the implementation of the Incident Action Plan within the Medical Branch. Reports to Operations Chief. Supervises Medical Group Supervisor(s) and Transportation function (Unit or Group). Reports out casualty information to the Operations Chief.

2. Medical Group Supervisor (MGS) - In charge of the Medical Group EMS field operations in an initial and reinforced level of response. Reports to the Medical Branch Director. Supervises Triage, Treatment and Transport Unit Leaders and Medical Supply Coordinator. Reports out casualty information to the Medical Branch Director.

3. Triage Unit Leader - Coordinates the triage of all patients. Reports to MGS. Supervises Triage Personnel / Litter Bearers and Morgue Manager.

4. Triage Personnel – Responsible for triaging patients and assigning them to appropriate Treatment Areas. Reports to Triage Unit Leader.

5. Morgue Manager - Responsible for Morgue Area functions. Reports to Triage Unit Leader.

6. Treatment Unit Leader - Coordinates on scene emergency medical treatment of all victims. Reports to MGS. Supervises Treatment Dispatch Manager, Immediate Treatment Manager, Delayed Treatment Manager and Minor Treatment Manager.

7. Immediate Treatment Area Manager – Responsible for treatment and re-triage of patients assigned to the Immediate Treatment Area.

8. Delayed Treatment Area Manager – Responsible for treatment and re-triage of patients assigned to the Delayed Treatment Area.

9. Minor Treatment Area Manager - Responsible for treatment and re-triage of patients assigned to the Minor Treatment Area.

10. Treatment Dispatch Manager – Coordinates movement of patients from Treatment Area to Transport Area. Reports to Treatment Unit Leader.

11. Patient Transportation Unit Leader (or Group Supervisor) - Oversees the coordination of patient transport vehicles and hospital destinations. Supervises Ground Ambulance Coordinator, Air Ambulance Coordinator and Medical Communications Coordinator. At his / her discretion, may add additional positions in Patient Transportation Unit to coordinate transportation to out-of-county destinations.

12. Ground Ambulance Coordinator - Coordinates ground ambulances. Reports to Transportation Unit Leader.

13. Air Ambulance Coordinator - Establishes and coordinates helispots and air medical operations with the Air Operations Group. Reports to Transportation Unit Leader.

14. Medical Communications Coordinator - Maintains medical communications with the Patient Distribution Group and selects the mode of transport and patient destination based upon patient need using patient condition information provided by the Treatment Dispatch Manager. Reports to Transportation Unit Leader.

15. Medical Supply Coordinator – Coordinates medical supply requests and maintains stock. Reports to MGS.

2.3.2 Organization of the Medical Areas

Locations of the medical areas (Triage Area, Treatment Area, etc.) shall be determined by the Medical Group Supervisor. Selection of the locations will factor in the following considerations:

- Safe distance from the scene and hazards.
- Upwind from any noxious fumes.
- Adequate space for patient care, personnel, and in-coming / out-going vehicles.
- Environmental controls, if possible (out of wind, rain or extreme heat/cold).

The Medical Group Supervisor or his/her designee will oversee the designation and set up of specific medical areas until delegated to the Unit Leaders for each area listed below:

Triage Area – Location for the triage of patients.

Treatment Area – Location for the treatment of patients. In a small incident, on Treatment Area may be set up with patients grouped together according to triage levels (Immediate, Delayed and Minor). For larger incidents, separate Immediate, Delayed and Minor Treatment Areas are established.

Patient Transport Area – Location for loading patients into transporting vehicles. Ideally, the loading area should be adjacent to the treatment area(s) and in-line with the one way traffic from the Ambulance Staging Area. When a one-way traffic pattern is not possible due the topography or building density, scene personnel should improvise (e.g. create a patient gurney shuttle using firefighters, etc.).

Ambulance Staging Area – Location for in-coming ambulances and other EMS personnel or equipment to report in and await assignment to the MCI response. In a small incident, the Ambulance Staging Area may be combined with the incident Staging Area for other response vehicles and personnel. In larger incidents, it may be a separate location.

Morgue Area – Location for holding the deceased.

Section 2.4 San Francisco Alert Levels

San Francisco uses a classification scheme for MCI Levels that is similar to the one used by the California's Disaster Medical System. The progressive MCI Levels for San Francisco are important because they determine an alert level that is communicated to all EMS participants that corresponds to a specific set of actions they should take to respond to the MCI incident**. It is important to note that the cut off points for the number of victims needed to call either a**

Level 1, 2 or 3 MCI alert is flexible. Section 3.4 of this Plan describes the operation use of the MCI alert levels. The chart on the next page describes the San Francisco alert levels followed by examples of types of incidents that would trigger those alerts.

ALERT LEVELS

Level	Definition	Purpose	Example
MCI YELLOW ALERT	Incident with a potential for multiple casualties	"Heads Up" about a situation that may become a MCI.	Large residential building is on fire, but no victims have yet been identified.
LEVEL 1 MCI (RED) ALERT	MCI with **6 - 50 victims** of any triage level.	Notifies local EMS system about a MCI with 6 – 50 victims.	Bus accident with 15 patients all triaged as YELLOW.
LEVEL 2 MCI (RED) ALERT	MCI with **51 - 100** victims of any triage level. Requires resources from or distribution of casualties to neighboring counties.	Notifies local EMS and disaster system and Regional Mutual Aid System about a MCI with 51 – 100 victims.	Mass transit accident with 95 victims. Must send trauma patients to SFGH and Trauma Centers in nearby counties.
LEVEL 3 MCI (RED) ALERT	MCI with **101 or more** victims of any triage level. Requires resources from or distribution of casualties throughout the State or federal response system.	Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about MCI with > 101 victims. Assumes infrastructure is essentially intact, but has numerous disruptions.	High magnitude earthquake with hundreds of casualties. Example: 1989 Loma Prieta Earthquake
LEVEL 4 MCI (RED) ALERT	Catastrophic disaster with significant infrastructure damage, and unknown number of injuries and deaths. Requires significant, long-term support from State and Federal governments.	Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about a catastrophic disaster. Recovery outlook is long-term.	San Francisco 1906 earthquake and fire.
LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION	Disruption of normal 911 operations due to: 1) Extreme 911 call volume causing ambulance shortage, AND/ OR 2) Hospital(s) issue closes it to 911 ambulances.	"Heads Up" about disruption to the medical 911 system. EMS and hospital providers may be requested to report about their resources (number of ambulances / hospital beds / etc.).	Extreme weather generates hundreds of medical 911 calls resulting in ambulance shortages and saturation of hospital emergency departments.

Section 2.5 Standard Operating Procedures

The classification of an incident level determines the corresponding alert and activation level that the Department of Emergency Management – Division of Emergency Communication (DEC) sends to EMS provider organizations. The alert levels correspond to **Standard Operating Procedures** which are defined as scripted participant actions in response to a MCI. Standard Operating Procedures are similar to ***Job Action Sheets (aka Job Checklists* or *Position Descriptions)*** that individual field personnel or EOC / DOC command staff follow during a disaster response. The difference though is that Standard Operating Procedures apply to the response actions of an *entire EMS provider organization* (e.g. a hospital or an ambulance provider company).

The purpose of the alert levels and corresponding Standard Operating Procedures is to improve the speed, efficiency and overall coordination of the initial operational response to a MCI. An alert initiates the start of a Standard Operating Procedures that is followed in the first hour(s) to days of a MCI response until an Incident Command is organized and able to create and distributes an Incident Action Plan with response objectives that are specific to the incident. The details for each alert level are listed in **Part 1 – Standard Operating Procedures** of this plan.

Section 2.6 EMS Provider Agency Roles and Responsibilities

2.6.1 Primary Agencies

San Francisco Fire Department: Provides fire suppression, hazmat services and ALS ambulances and BLS First Responder in the San Francisco EMS System. The SFFD field role in a MCI is to provide emergency medical care at the scene, transport victims to receiving facilities and to fill any position within the field ICS structure, especially positions within the field medical branch. SFFD operates mobile Multi-Casualty Units that can quickly bring additional emergency medical supplies to a scene.

The SFFD Departmental Operations Center provides command, coordination and support for their suppression and EMS units during a MCI.

ALS Ambulance Providers: Advanced Life Support (ALS) Ambulance Providers (American Medical Response, King American Ambulance, Bayshore Ambulance, Pro-Transport 1, and NorCal Ambulance) provide emergency ALS level ambulance services and ALS inter-facility transport services.

ALS Ambulance Providers' role in a MCI is to provide emergency medical care at the scene, transport victims to hospital or other alternate treatment sites (if in use and authorized) and to fill any position within the field ICS structure, especially positions within the medical branch.

BLS Ambulance Providers: Private Basic Life Support (BLS) Ambulance Providers (American Medical Response, King American Ambulance, Bayshore Ambulance, St. Joseph's Ambulance, ProTransport-1, NorCal Ambulance and Falck Ambulance) provide BLS inter-facility transport services in the San Francisco EMS system.

BLS Ambulances Providers' may have a direct role in a MCI field response by providing emergency medical care at the scene, transporting victims to hospital or other alternate treatment sites (if in use and authorized) and filling any position within the field ICS structure, especially positions within the medical branch. BLS may also provide back- up ambulance "surge capacity" to the day-to-day EMS System if an incident(s) requires all available ALS resources. Alternative uses of the BLS providers during a large MCI are only authorized by the EMS Medical Director in consultation with the Director of Health/Health Officer and management at each BLS provider company.

Air Medical Service Providers: Offer on scene emergency medical care and air evacuation of patients. REACH, Stanford Lifeflight and CalSTAR provide services for San Francisco EMS and throughout most of Northern California. During an MCI, air medical services are primarily used to transport the most critically injured patients to out-of-county trauma centers.

General Acute Care Hospitals: Provides emergency medical care and definitive medical treatment to patients. Their role is the same during MCI event within the limits of their capacity to "surge" their staff and internal resources. Hospitals may "stabilize and transfer" if the patient's medical needs require specialty services not available at that hospital or if they are at capacity and cannot offer an available bed or staffed treatment space.

Department of Emergency Management: Provides various emergency management functions and consists of two divisions: Division of Emergency Communications (911) and the Division of Emergency Services (DES).

- **Division of Emergency Communications (DEC):** Responsible for receiving 911 calls and dispatching police, fire, and EMS services. The primary role of DEC during a MCI is to notify and alert of key response personnel, and to dispatch and track field response resources including mutual aid resources and initially staff the Patient Distribution Group.
- **Division of Emergency Services (DES):** Responsible for developing citywide emergency plans, activating the City's Emergency Operations Center (EOC) and preparing citizens for all-hazards events (i.e. earthquakes, terrorism, and tsunamis). During an MCI, DES

may activate the City's EOC to support overall MCI operations and request emergency declarations from the Mayor.

- **EMS Agency:** The San Francisco EMS Agency is in under DES. The EMS Agency is responsible for planning, coordinating, and evaluating emergency medical services for San Francisco. During a MCI or medical disaster, the EMS Agency fulfils diverse roles, including serving as the Medical Health Operational Area Coordinator, modifying or creating EMS policy or protocols to meet changing situational needs, activating or staffing the DPH Department Operations Center, or the City Emergency Operations Center.

Department of Public Health: Provides various public health related functions and direct medical services. DPH divisions involved in emergency support include:

- **Public Health Emergency Preparedness and Response**: Responsible for planning, and coordinating the public health response and hospital disaster preparedness.
- **Communicable Disease Control and Prevention Section:** Provides community monitoring for communicable diseases, conducts epidemiological investigations, and provides communicable disease control and prevention information to medical professionals and the community that may include: infection control protective measures, prophylaxis or treatment, identification of the type and source of an outbreak, and if necessary, issue isolation or quarantine orders.
- **Environmental Health Section**: Assures the safety of the food and water supplies. They also provide technical and scientific advice to the SFFD on the detection, identification, and handling of hazardous materials and management of hazardous situation. They are also responsible for approving the health-related safety issues for the mass shelters.
- **Behavioral Health Services:** Provides mental and substance abuse services. During a large MCI, they may provide the initial crisis mental health services for victims.

2.6.2 Supporting Agencies

In addition to the primary EMS System participants, there are other organizations that may work closely with the EMS System during a MCI or Mass Casualty Event:

San Francisco Police Department: Provides law enforcement to San Francisco. They also can provide SWAT, Explosive Ordinance Disposal, and other specialized law enforcement services. During an MCI, they may provide force protection, security for critical assets, and create cordons.

San Francisco Sheriff's Department: Provides protective and security service for City and County facilities and buildings, including San Francisco General Hospital, and the Department of Public Health Department buildings. They also can provide aerial surveillance or recognizance

using their air units. During an MCI, they may provide force protection, security for critical assets, and create cordons.

California Highway Patrol: Provides law enforcement to the State and Federal highways within San Francisco and provides protection and security for state facilities and buildings. During an MCI, they may provide force protection, provide security for critical assets, and create cordons.

Auxiliary Communication Service (ACS): Coordinated by the Dept of Emergency Management's Division of Emergency Services, ACS provides amateur radio operators with equipment for disaster response and large special events. In a MCI, ACS may provide amateur radio operators to field, hospital, and emergency operations centers or be used to replace or to augment communication capabilities.

San Francisco Office of the Medical Examiner: Investigates, and determines cause and manner of death for cases under the Office's legal jurisdiction. During a large MCI, the Medical Examiner's Office is responsible for identifying and handling decedents and their personal effects.

Section 2.7 Interagency Coordination

2.7.1 Scene Organization

NIMS and SEMS are based on the Incident Command System (ICS) and are used to provide the basic organizational structure for all incident operations including MCI field operations. ICS is designed to coordinate the efforts of all involved agencies at the scene of a large, complex, emergency situation, as well as the small day-to-day situation. The organizational structure of ICS may be expanded in a modular fashion based upon the changing conditions and/or size/scope of the incident.

ICS has been summarized as a "first-on-scene" organizational structure, where the first responder to arrive on scene assumes command until the incident is resolved or there is a formal transfer of command to a more-qualified individual arriving later.

The essential elements of ICS are:

- **Command:** Overall management and setting of objectives for the response.
- **Operations:** Direct control of tactical operations and the implementation of response objectives.
- **Planning:** Development of a plan for response operations.
- **Logistics:** Coordinates acquisition and distribution of resources.
- **Finance:** Purchases resources. Records what resources were involved in the response for purposes of reimbursement.

2.7.2 Single vs. Unified Command

The Incident Commander is responsible for the overall management and setting of objectives for the incident response. Depending on the size and duration of the MCI, the Incident Commander may directly supervise operations or delegate this responsibility to an Operations Section Chief. EMS Multi-Casualty Field Operations are within the responsibility of the Operations Section.

Single Command

Most incidents involve a single Incident Commander. In these incidents, a single person commands the incident response and is the final authority for decision-making. A single incident commander is chosen when a single agency has responsibility for an incident. The Incident Commander is usually the individual first on scene representing the public safety agency having primary investigative authority. There may be exceptions to this rule, based the characteristics of the incident.

In San Francisco, the following are examples for when a single command may be implemented. Any of these scenarios may evolve from a Single Command into a Unified Command.

- *San Francisco Fire Department* – Fires, rescues and EMS incidents.
- *San Francisco Police Department* – Crime related incidents, civil disorders, and most mass gatherings and pre-planned events.
- *San Francisco Department of Public Health* – Contagious diseases and other public health emergencies.
- *California Highway Patrol* – Accidents or incidents on all freeways, including right of way.
- *US Military/Department of Defense* - National Defense Areas including a military reservation or an area with "military reservation status" that is temporarily under military control, e.g., military aircraft crash site.
- *FBI* – Terrorist incidents. However, most consequence management functions will continue to be managed by local agencies, such as police and fire.
- *US Secret Service/US Department of Homeland Security* – Events that are designated as National Special Security Events.

Unified Command

Unified Command is used for larger incidents usually when multiple agencies are involved. A Unified Command functions as a single entity. Unified Command typically includes a command representative from the involved agencies with one person from that group designated to act as the *group spokesperson,* and not as an Incident Commander. Unified Command is used anytime an incident crosses jurisdictional boundaries or exceeds the responsibility of a single agency. It allows all agencies with responsibility for an incident to establish a common set of incident objectives, strategies, plans, and priorities to jointly execute the incident operations and maximize the use of assigned resources. Most significant incidents in San Francisco will involve unified command with San Francisco Fire and Police fulfilling lead roles. However, any of the above agencies may be involved in Unified Command.

2.7.3 Field Command - Single Site Incidents and Multi-Site Incidents

In **Single Site Incidents**, all MCI field operations are at one location usually under a single ICS command structure. **Multi-Site Incidents** are two or more related or unrelated MCIs regardless of type, occurring simultaneously within a single Operational Area.

The size and configuration of the ICS structure and command for a single site or multi-site incidents depends on various factors such as jurisdictional complexity, size of involved geographic area, span of control, logistical needs and potential for growth. Incident Complexes or Area Command are ICS structures and command for major incidents. An *Incident Complex* is two or more individual incidents located in the same general proximity assigned to a single Incident Commander or Unified Command to facilitate management. These incidents are typically limited in scope and complexity and can be managed by a single entity. *Area Command* is NOT used in the San Francisco Emergency Management structure.

In the ICS structure, EMS MCI field operations are under the responsibility of the Operations Section in the Medical Group. For single-site incidents that are small, only one Operations Section - Medical Group will be established. For larger incidents or multi-site incidents with more than one Operations Section - Medical Group, a Medical Branch with several Medical Groups will be established. The Medical Branch structure maintains the appropriate span of control to manage large patient incidents.

Section 2.8 In-County Coordination

For large or multi-site incidents, higher-level support facilities above the field level may be activated. These facilities provide logistical and administrative support or in some instances, set response priorities and objectives to ensure efficient use of resources. Activated facilities may include the Emergency Operations Center and / or Departmental Operations Centers.

2.8.1 Emergency Operations Center / Departmental Operation Centers

The Emergency Operations Center (EOC) is a facility space that provides centralized, city-wide coordination of emergency responses. It is staffed with personnel trained in emergency management and is equipped with a variety of systems and tools that aid in data collection and sharing, resource allocation, and other critical functions. The EOC coordinates information with city DOCs (if activated) and other governmental and non-governmental agencies in order to maintain a comprehensive situational analysis. It also serves as San Francisco's Multi-Agency Coordination Center (MACC), as described in NIMS, thereby ensuring that all response systems are interconnected and complementary rather than duplicative.

The EOC is activated when citywide multi-agency coordination is needed for an MCI event. The EOC provides:

- A central coordination point for multi-agency emergency management of the MCI (e.g., emergency operations, communications, damage assessment, media and public information).
- A single location to collect and disseminate information to create a common operating picture of San Francisco's citywide response activities.
- Facilitate actions necessary to protect residents and property of San Francisco during a citywide event.

Like the EOC, Departmental Operations Centers (DOCs) provide facility space for the centralized coordination of usually one emergency functions (e.g. fire, police, health, etc.). In San Francisco's local government, DOCs also serve as the disaster command centers for each city department or affiliated response agencies (e.g. American Red Cross).

2.8.2 EOC and DOC Support During a MCI

The EOC would rarely be activated during a Level 1 MCI Level since those incidents are usually handled only through a field response.

The EOC will be activated for MCI's requiring multi-city agency responses or out-of-county resources that occurs in MCI Levels 2 – 4. The decision to activate the EOC is done in consultation with the DEM Deputy Director or DEM Duty Officer. The City and County of San Francisco Emergency Response Plan describes in further detail the organization and command of the citywide response to large or complex disaster incidents. The same plan is followed for citywide organization and command of large or complex multi-casualty incidents.

A DOC may be activated when single-agency coordination is needed for a large emergency response. Depending on the nature, size and scope of a MCI, a single DOC or several DOCs may

be activated to support the response. If multiple DOCs are activated, the EOC also activates to provide centralized coordination for the response. DOCs contribute to citywide response efforts through communications and coordination with the EOC. Any of the city departmental DOCs may be involved in supporting a MCI response, especially in a large-scale event that covers several operational periods.

2.8.3 Role of EOC Operations Section – Health & Human Services Branch

The EOC uses the Incident Command System (ICS) organizational structure when activated. The Emergency Medical Services and Public Health Group are located in the Operations Section – Health & Human Services Branch within the EOC ICS structure. Roles during a MCI response may include:

- Provides overall medical-health system (includes all San Francisco hospitals and medical providers) coordination and establishes medical response priorities / objectives for large MCIs or disasters with a large medical-health impact.
- Provides operational and logistical support through other City Agencies or mutual aid requests for out-of-county resources through:
    - Assists patient distribution to out-of-county hospitals.
    - Receiving, tracking and fulfilling requests for medical resources.
    - Coordinating in-coming / out-going requests for medical mutual aid with Medical-Health Operational Area Coordinator (MHOAC).
- Collates and reports situational and response information for situational assessments and reporting within the city and to other local, regional, state and federal government and non-governmental agencies.
- Approves Medical-health related public information for the EOC Joint Information Center.
- Collates incident casualty counts from the field and hospitals.

The Department of Public Health DOC may be activated to assist with any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

2.8.4 Role of EOC Operations Section – Fire and Rescue Branch

SFFD EMS and / or private ambulance provider representatives may be located in the Operations Section – Fire and Rescue Branch within the EOC ICS structure (Suppression duties are not addressed in this plan.). EMS roles during a MCI response may include:

- Support for emergency medical responders at the scene.
- Establishment of field response priorities for large, complex or multi-site MCIs.

- Optimize deployment and use of SFFD resources and specialty teams and equipment including:
  - Ambulances
  - Mobile Mass Casualty Unit.
  - SFFD Hazmat Team.
  - SFFD Heavy and light rescue Teams.
- Coordination of in-coming / out-going EMS mutual aid with Medical-Health Operational Area Coordinator (MHOAC).
- Tracking and compiling field patient distribution to receiving facilities.
- Collection and reporting of EMS field situational and response information to the EOC Fire Branch.

The SFFD DOC may be activated to assist with any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

Section 2.9 Out-of-County Coordination - Medical Mutual Aid

Mutual Aid is defined as the voluntary provision of services and facilities by other agencies or organizations to assist each other when existing resources are inadequate or depleted. In California, mutual aid generally refers to aid that comes from outside the Operational Area.

Medical Mutual Aid is defined as the voluntary provision of medical services/equipment and medical facilities by other agencies or organizations to assist each other when existing medical resources are inadequate or depleted. Medical Mutual Aid is specific to supplementing / augmenting medical and health resources.

All medical mutual aid requests follow the SEMS and NIMS systems. Medical mutual aid is initiated when the surging of medical resources within San Francisco has been exhausted. It also may be used in medical incidents when it is determined that it may be faster to supplement or augment San Francisco resources from assets outside of the county. For example, San Francisco has several disaster medical field care clinics that may take several hours to set up, supply and staff. Patients would get to medical treatment in less time if they are sent to out-of-county medical facilities using the Medical Mutual Aid process.

In California, counties are grouped into six Mutual Aid regions by the state California Emergency Management Agency (CalEMA). The Medical-Health Mutual Aid system uses the same county groupings for its six Mutual Aid regions. San Francisco is in Region 2. Within a region, resources are distributed from the unaffected Operational Area to the affected one. There are three personnel roles that are unique to the Medical Mutual Aid system in California:

- **Medical Health Operational Area Coordinator (MHOAC**) – An individual appointed by a county Department of Health Director / local Health Officer who is responsible for coordinating medical-health services and resources within the Operational Area (County) in the event of a disaster or major incident where medical mutual aid is required.

- **Regional Disaster Medical Health Coordinator (RDMHC)** – The RDMHC is responsible for the coordination of medical and health mutual aid among the operational areas within a California mutual aid region during a disaster or other major event**.**

- **Regional Disaster Medical Health Specialist (RDMHS)** – The RDMHS is staff to the RDMHC and provides assistance for the coordination of medical and health mutual aid among the operational areas within a California mutual aid region.

In San Francisco, the MHOAC is the DEM EMS Agency Medical Director. Several Department of Public Health's physicians are the designated back-ups. The MHOAC is in the Operations Section – Health & Human Services Branch during activation of the citywide EOC. The Regional Disaster Medical Health Coordinator (RDMHC) is based at the Alameda County EMS Agency.

During Level 2 or 3 Incidents, the Medical-Health Operational Area Coordinator (MHOAC) and his/her designees coordinate all out-of-area medical mutual aid resource requests – whether they are in-coming or out-going. The MHOAC is responsible for coordinating disaster medical resources and communicating with the Region 2 - Regional Disaster Medical Health Medical Coordinator (RDMHC) all requests for medical supplies, personnel, and equipment. All requests that have no pre-agreement go through the MHOAC to the RDMHC. The RDMHC handles requests for resources if it can be fulfilled within their assigned region. If it cannot be fulfilled with their region, the RDMHC forwards the request to the State government. State government will obtain the requested resources from either non-adjacent mutual aid regions within the state or the federal government.

State agencies handle communications with federal disaster response organizations. In some instances, State and/or Federal government response agencies may automatically begin forward deployment of resources or provide them through their own supplies channels if there is advance notice of a major event (e.g. hurricanes). Details about state and federal entities involved in a disaster response are found in the California Public Health and Medical Emergency Operations Manual (July 2011). Operational details about the Medical Mutual Aid process are further described in Sections 3.17 -19 of this Plan.

PART 3: OPERATIONS

Section3.1 Introduction

The Department of Emergency Management - Emergency Medical Services (EMS) Agency MCI Plan identifies and delineates the structure and operations for the provision of emergency medical care during a MCI event of any size or magnitude. **MCI Plan Part 3 - Operations** details the specific activities that all EMS participants must follow during a general response to a MCI.

Section 3.2 Scene Management

3.2.1 Incident Command

All MCIs / disasters are managed using SEMS and ICS. The highest-ranking official of the first on-scene agency is the Incident Commander until relieved by a higher ranking, more qualified personnel. The Incident Commander is responsible for overall management of the incident. It is his/her responsibility to prepare the response objectives. The Incident Commander also determines:

- Alert level for the incident,
- Incident name (e.g. Shotwell Street Fire; Broadway Building Collapse),
- ICS structure,
- Radio call signs for Incident Command and Medical Group Supervisor,
- Location of command post,
- Staging location(s) for incoming units,
- Whether additional response resources are needed, and
- Requests for Dept Parking Transport or SFPD (or other law enforcement) to secure scene and perimeter.

A Unified Command Post with Fire/EMS, Police, or other agency may be utilized for multi-agency responses or at jurisdictional borders. If the scene is spread out over a large area, the Incident Commander will determine whether it is more appropriately managed as two separate incidents or as a single incident and its appropriate command structure.

3.2.2 Medical Branch / Medical Group

EMS MCI field operations are the responsibility of the ICS Operations Section – Medical Group. Only one Operations Section - Medical Group is established for small, single-site incidents. A Medical Group Supervisor is in charge of the Medical Group EMS field operations.

A Medical Branch with several Medical Groups may be established for large incidents or incidents at multiple sites. Overall command of EMS field operations in a full Branch response is delegated to the Multi-Casualty Branch Director. The Medical Group Supervisor or Multi-Casualty Branch Director will report to the IC or the Operations Chief if an Operations Section is activated.

Section 3.3 Initial Set Up of the Medical Group

3.3.1 First On-Scene

The **First on-Scene EMS unit's paramedics (or EMTs)** will report to the Incident Commander or Operations Chief. The First on-Scene EMS unit paramedic #1 (or EMT #1) will function as the Medical Group Supervisor until an EMS Officer arrives to assume the Medical Group Supervisor role. Paramedic #2 (or EMT #2) will be the Triage Unit Leader until relieved.

First on-Scene EMS units will do the initial medical assessment ("windshield assessment") of the scene to establish:

- Type of incident (trauma, medical, Hazmat or combination),
- Incident location and best ingress routes for ambulances.
- Estimated number of victims, and
- If additional response EMS resources are needed.

The assessment is communicated back to DEC who relays it to all responding agencies.

The **First on-Scene EMS Field Supervisory staff** duties include:

- Report to Incident Commander. Usual work site is at the Command Post with the Incident Commander.
- Receive Situation Report (Sit Rep) from Incident Commander and interim paramedic (or EMT) Medical Group Supervisor.
- Assume the role of Medical Group Supervisor.
- Set up the Medical Group or Branch. On large incidents, designate the paramedic or EMT who served as interim Medical Group Supervisor as an "Assistant. Medical Group Supervisor" who will assist with radios and incident management.
- Repeat the medical assessment of incident and work with Incident Commander to request additional resources and personnel if needed for triage and litter teams or patient transport.
- The Medical Group Supervisor monitors/utilizes the Tactical Channel to talk to Incident Commander and Medical Group Channel to talk to Medical Officers.
- If delegated by Incident Commander, Medical Group Supervisor will assume task of giving updates and requesting additional medical resources through DEC.

3.3.2 Second, Third and Subsequent On-Scene

Second on-Scene EMS units will report to Incident Commander or Medical Group Supervisor as directed. The Second-In Unit Paramedic (or EMT) #1 will be the Treatment Unit Leader and Paramedic (or EMT) # 2 will be the Transport Unit Leader until relieved by an EMS Officer. The Second EMS Field Staff On-Scene duties include:

- Report to Medical Group Supervisor to receive a Situation Report.
- 2nd EMS Field Supervisory Staff will normally be assigned the Transport Leader role.
- Utilize secondary Medical Channel (or cell phone) to talk to DEC to distribute patients to hospitals throughout City.
- The Incident Commander and / or Medical Group Supervisor can special call additional EMS Field Supervisory Staff to the scene, if required.

The **Third EMS Field Supervisory Staff On-Scene** duties include:

- Report to Medical Group Supervisor to receive a Situation Report.
- Determine if a Medical Branch with several Medical Groups will be established. Consult with Incident Commander who will make the final determination on the organization of the field medical response.
- 3rd EMS Field Supervisory Staff may serve as Medical Branch director, if established, or as an additional Medical Group Supervisor, or support Medical Group Supervisor, or Triage, Treatment or Transport Officers as directed by the MGS. Medical Branch Director or Medical Group Supervisor should be staffed with an experienced supervisor.

Subsequent ambulances will report to the Medical Group Supervisor who will direct the crews to the Treatment Area for staffing the Immediate, Delayed and Minor Treatment Areas.

Section 3.4 Alert Level Determination

The Incident Commander determines the appropriate alert levels based on the number of victims and if outside resources are needed to manage the incident. The lowest alert level to adequately meet the situational demands should be used.

A single alert level is issued for every incident. The alert level may be upgraded or downgraded at any time during the incident based on the direction of Incident Commander. It is important to note that the cut off points for the number of victims needed to call a Level 1, 2 or 3 MCI alert are flexible. For example, 30 pediatric trauma victims may require sending some of the victims to out-of-county destinations – a Level 2 MCI alert.

In a situation with more than one incident in progress, the incident that has the higher level of need will determine the alert issued. For example, Incident #1 is a Level 1 MCI Alert and Incident #2 is a Level 2 MCI Alert. The Incident Commander will select a Level 2 MCI Alert – the higher level of the two possible alerts.

Section 3.5 EMS, 911 Dispatch and Hospitals Communications

1. The Incident Commander on scene radios a Situation Report on the initial Control Channel to DEC (911 Dispatch) within the first 15 minutes that includes:

    - Yellow or Red Alert
    - If Red Alert – the alert level,
    - Location of Incident and Name of Command,
    - Type of Incident/Nature of Incident;
    - Hazards (if present),
    - Number of victims (estimated or actual number),
    - Command Post and Staging Locations,
    - Initial route of Ingress (best route to enter) and Egress, and
    - Additional and / or Specialized Resources if needed.

2. SFFD Officers located at DEC relays the initial situation report to hospital Emergency Departments via Reddinet and an open channel on B13/ B14*. A Reddinet bed poll is also initiated. The SFFD Rescue Captain may assists in some of these functions with support from the Lieutenant, Battalion Chief, and civilian supervisors.

3. During a MCI, all Emergency Department Charge Nurses are required to:
    - Monitor Reddinet and the 800 MHz radios for the duration of the MCI;
    - Input the number of available ED beds for Immediate (Red), Delayed (Yellow) and Minor (Green) patients **within the first 15 minutes or less;** and
    - Update the number of available ED beds as appropriate for the duration of the MCI.

4. SFFD Officer located at DEC radios on B15*, the information reported on Reddinet on the number and types of MCI patients that each hospital can take to the Medical Group Supervisor or Patient Transport Officer.

5. Medical Group Supervisor or Patient Transport Officer will radio back to the SFFD Officer located at DEC which hospitals will receive patients, how many, what type, and any special needs (pediatrics, hazmat). Updates will be provided every 30 minutes or anytime there is a significant change in the MCI incident.

6. SFFD Officer located at DEC radios by an open channel on B13 / B14* hospitals will receive patients, the number, type, and any special needs.

7. Hospitals will surge their operations as necessary to prepare for the receipt of the MCI patients.

8. SFFD Officer located at DEC will announce to hospitals, ambulances and other field providers when the alert is secured and the incident is closed.

**Radio channel designations may change based on operational needs.*

Section 3.6 Medical Branch / Group Operations

3.6.1 Medical Branch Director

A Medical Branch Director has overall command of EMS field operations if a full branch response is initiated. The Medical Branch Director may supervise several Medical Group Supervisors and reports to either the Incident Commander Operations Section Chief if an Operations Section is activated.

3.6.2 Medical Group Supervisor

The Medical Group Supervisor(s) ensures command and control of all activities within the Medical Group and the integration of those activities with the overall operational response. This includes assuring that adequate personnel and resources are available to the Medical Group to accomplish its assigned objectives.

3.6.3 Ambulance Staging Area

DEC will announce to all in-coming ambulance crews the location of the Staging Area when it is established. Initial supervision of this area may be assigned to the first unit arriving in the Staging Area.

In-coming crews will park in the Ambulance Staging Area and report to the Ambulance Staging Manager who will give them their assignments. If **NO** Ambulance Staging Manager is designated, crews will report into the Transport Unit Leader (or Medical Group Supervisor, if necessary). Crews will stay with their vehicles in the Ambulance Staging Area while awaiting assignment.

Transport vehicles will be maintained in a one-way traffic pattern towards the loading area, if possible. Law enforcement assistance may be used to establish traffic patterns to optimize the flow of patients out of the incident.

3.6.4 Triage Area / Triage Team Operations

Victims are usually be triaged where they lie. A separate Triage Area may be created if there is a hazard or if the physical location is not conducive for triaging patients.

Emergency medical care during the triage process is generally limited (e.g. establishing an airway, controlling hemorrhage, etc.). The deceased are also triaged and tagged. Deceased may be are left where they lie or moved to a separate Morgue Area if adequate resources are available to set it up. If the MCI is a crime scene, decedents are not moved without prior approval of the Medical Examiner or SFPD.

All patients are triaged and tagged in the triage area. "Immediate" patients must be transported to a hospital as soon as possible. Immediate patients may be moved to the Treatment Area if there is a delay in transport due to a lack of transportation units or a high number of victims.

For large incidents, the Triage Team Leader may sets up a physical "triage funnel" with tape, sawhorses, etc. through which all patients are routed to the Treatment Area. The Triage Funnel should be in close proximity to Treatment Area.

The Triage Team Leader is responsible for tallying and reporting the total number of victims and classifying the MCI type as trauma, medical, Hazmat or combination. Results of the tally are reported as total number of patients and their triage categories (e.g. "Total of 10 trauma patients: 2 Immediate, 4 Delayed, and 4 Minors. No decontamination needed."). The Triage Team Leader reports this information to the Medical Group Supervisor.

3.6.5 Treatment Area Operations

The Treatment Areas will be set up with equipment from the initial arriving ambulances. The SFFD Multi-Casualty Unit vehicles may supplement equipment as needed. EMT and paramedic personnel must staff all Treatment Areas. Walk-up volunteer medical personnel must be cleared through the chain of command before patient contact. The Treatment Unit Leader will check through the chain of command where to send walk-up volunteer medical personnel for clearance checks.

Once a patient is in the Treatment Area, treatment will consist of:

- Re-triaging patients.
- Checking and recording vital signs and chief complaint on the triage tag.

- Establishing and maintaining an airway and controlling hemorrhage.
- First aid, BLS and ALS level care depending on provider training, availability of personnel and resources, and only if the situation safely allows for it.
- Preparing patients for transport.

Current EMS policies for evaluating and releasing patients from the scene should be followed for any MCI patients who refuse care or transport at the scene.

3.6.6 Patient Transport Area

The Patient Transport Area matches patients needing transportation with vehicles and assigned destinations. Section 3.5 describes the communications between the field, DEC and the hospitals for determining available beds and notifying hospitals about in-coming patients. Communications between the field and DEC about patient care operations is handled by the Medical Group Supervisor or Patient Transport Officer. In a full branch response, a Medical Communications Coordinator reporting to the Patient Transport Officer may be designated for communications with DEC.

The Treatment Area personnel will provide to the Patient Transport Officer which patients are prioritized for transport. The Patient Transport Officer will choose an appropriate mode of transportation for the patient. Possible patient transportation options include:

- Ground Ambulance
- Air Ambulance
- At the discretion of the Transport Unit Leader, other vehicles (e.g. buses, wheelchair vans) may be substituted for ambulances as appropriate for the patients' condition.

The Patient Transport Officer will request medical transport vehicles directly through DEC. In a large MCI response, a Ground Ambulance Coordinator or Air Medical Coordinators may be used. All requests for transportation will include specific details such as number and description of transport units, e.g., "2 ALS ground ambulances, 1 BLS ground ambulance, and 1 ALS air ambulance".

Patients will be moved from the Treatment Area to the Patient Transport Area only when:

- The patient is "packaged" and ready to go,
- A hospital bed destination is identified, and
- The transport vehicle is ready to go.

The Patient Transport Officer (or Ground Ambulance Coordinator and the Air Medical Coordinator if used) are responsible for securing requested transport vehicle(s) and for maintaining "Patient Logs" of the patients leaving the scene via ground or air that includes:

1. Triage tag number
2. Triage Level
3. Patient name and age (if known)
4. Patient gender
5. Chief complaint
6. Type of transport
7. Name of transport provider and unit number
8. Destination
9. Date and time of departure

Patient distribution to San Francisco and Bay Area county hospitals will continue until there are no patients remaining at the scene or the hospitals are at capacity.

For large incidents, Delayed (Yellow) and Minor (Green) patients may be held at the treatment area. If patients are held at the treatment site for several hours to days, it will be designated with as a formal **Field Treatment Site** and adjust its operations accordingly with additional supplies, personnel and shelter provided through field cache and alternate care supplies. <u>All decisions to hold patients at the scene or establish Field Treatment Sites will be relayed through the Medical Group Supervisor to the Incident Commander for approval.</u>

3.6.7 Morgue Area

A temporary Morgue Area may be established when adequate resources are available and / if it is necessary to remove deceased patients from the impacted site. This area should be located away from the treatment area(s) and is the responsibility of the Medical Examiner. EMS personnel assistance may be required in the establishment of the field morgue.

3.6.8 Medical Supply Operations

A Medical Supply Area may be established for large, protracted incidents. The Medical Supply Coordinator requests, receives, distributes, tracks and maintains stock for medical supplies and equipment assigned to the Medical Group. The Medical Supply Coordinator reports to the Medical Group Supervisor. If the Logistics Section is established, the Medical Supply Coordinator will coordinate request through the Logistics Section Chief or the Supply Unit Leader. Otherwise, requests are funneled through the Medical Group Supervisor to the Incident Commander.

Resource requests are done by resource type and number when possible. MCI resource requests may consist of the following:

Transportation

- Ground or Air Ambulances
- Buses
- Strike Teams or Task Forces

Supplies and Equipment

- Medical Supplies Caches and Equipment Trailers

Personnel

- ALS or BLS Personnel
- Litter Bearers
- Strike Teams or Task Forces
- Californian Medical Assistance Teams (Cal-MAT – state)
- Disaster Medical Assistance Teams (DMAT - federal)

- Rescue Equipment
- Specialized Equipment

3.6.9 Termination
The Incident Commander will make the determination when the MCI response is completed and communicate the termination notice to DEC who relays it to the relevant response participants.

Section 3.7 Modified 911 EMS Responses

Minor and / or major modifications of the standard EMS responses may be necessary to maintain the sound operations of the entire EMS system during a sizeable MCI event. An example of a *minor* modification includes suspending diversion until the incident response is closed out.

Any decision to do a major modification of the standard 911 medical responses must be authorized by the EMS Agency Medical Director in consultation with the Director of Health, the SFFD Chief and the leadership of the affected EMS providers. Part 1 Standard Operating Procedures lists the potential modifications to EMS responses. Below lists examples of possible *major* modifications to EMS response that may be invoked during a MCI.

Potential Modified Responses during a Level 2 MCI Alert
- ALS ambulances dispatched only to Code 3 (Delta and Echo) calls.
- BLS ambulances dispatched to Code 2 (Alpha, Bravo, and Charlie) calls.
- First Responder dispatched to Code 2 ((Alpha, Bravo, and Charlie) calls.

Potential Modified Responses during a Level 3 MCI Alert
- BLS Ambulance dispatched to only Code 3 (Delta and Charlie) calls.
- First Responder dispatched to only Code 2 ((Alpha, Bravo, and Charlie) calls.
- No response to Code 2 (Alpha, Bravo, and Charlie) calls.

Section 3.8 Hospital Operations

All San Francisco hospitals will surge their patient care operations through their pre-planned activities to accommodate MCI patients. Hospitals may surge their internal capacity by setting up alternate care areas through the re-purposing of current patient care sites or by setting up disaster tents on the hospital property.

At no time should more than one hospital staff person communicate with the DEC about the receipt of MCI patients. **The Emergency Department Charge Nurse is the designated Point-of-Contact for all MCI Alerts.** This designation may be transferred to Hospital Command Center staff during large, protracted incidents extending for several operational periods.

Hospitals will communicate to DEC through the 800 MHz radio and Reddinet. If Reddinet is not functioning, DEC will directly contact hospitals via the 800 MHz radio for bed availability. Landline telephones may provide backup communications in the event the 800 MHz radio is not functional. Satellite phones may also be considered for backup communications.

Section 3.9 Overview Patient Distribution

The overall goal of patient distribution is to deliver MCI patients to appropriate and available treatment beds to meet their medical needs without overwhelming any one hospital with too many patients.

Patients will be distributed to hospitals through the combined use of: **1) Assigned Distribution** and **2) Managed Distribution.** Assigned distribution automatically assigns a fixed, minimum number of patients to each hospital in the initial phase of the MCI response. San Francisco hospitals MUST accept their automatically assigned minimum number of patients. If the total number of patients from an incident **exceeds** the total number assigned slots, then Managed Distribution will determine the hospital distribution for those patients.

Section 3.10 Assigned Patient Distributions

On the following page is the initial distribution plan for MCI patients to hospital by the Patient Transport Officer.

This list does NOT imply that patients must be sent to the hospitals according to any specific sequence. DEC or the Patient Transport Officer may make adjustments based on the MCI situation or reported hospital availability.

Assigned Distribution				
Hospital	**Immediate (Red) [1]**	**Delayed (Yellow) [1]**	**Minor (Green) [1]**	**ONLY Green [2]**
ZSFG Trauma Center	1st 10 (ten) major trauma	4	6	20
UCSF Parnassus Campus *)*	2	4	6	12
CPMC Pacific Campus	2	4	6	12
Kaiser	2	4	6	12
St. Francis Memorial	2	4	6	12
CPMC St Lukes	2	4	6	12
St. Mary's Medical Center	2	4	6	12
CPMC Davies	2	4	6	12
CPMC California St Campus *(Pediatric Preferred)*	2	4	6	12
UCSF- Mission Bay *(Pediatric Preferred)*	2	4	6	12
(Only Delayed + Minor) [3]				
Chinese Hospital	0	4	6	12
VA Medical Center	0	4	6	12
Seton – Daly City	0	4	6	12
South Kaiser – So. SF *)*	0	4	6	12
SUBTOTAL:	**28**	**56**	**84**	**168**
TOTAL:	**168**			

1. Hospitals may receive either a combination of Red, Yellow, Green patients or "*Only Green*"patients.
2. **"Only Green"** refers to bulk transport of minor (green) patients via a Muni or shuttle bus. In this situation, the hospital will receive "Only Green" patients due to the large number of patients who will arrive at the Emergency Department at the same time.
3. **"Only Delayed + Minor "**refers to hospitals who will receive Yellow and Green patients or Only Green.

Critical trauma patients may be distributed to regional Trauma Centers through the mutual aid process. The Medical Health Operational Area Coordinator (MHOAC) will notify the Regional

Medical Health Operational Area Coordinator about any situation requiring out-of-county transport of critical trauma patients. Either ground or air medical transport may be used to move patients. *EMS Policy 4020 EMS Aircraft Utilization* lists regional trauma centers with helipads and describes the use of air medical resources.

Triage and Disposition of Medical and Trauma Patients

Patient Type	Triage	Disposition
Medical	Immediate (Red)	Start with hospitals with those furthest away from the incident.
	Delayed (Yellow)	Start with hospitals with those furthest away from the incident after all Red medical patients have been transported.
	Minor (Green)	Start with hospitals with those furthest away from the incident after all Yellow medical patients have been transported.
Trauma[1] Meeting Physiologic or Anatomic Criteria	Immediate (Red) or Delayed (Yellow)	• 1st Ten trauma patients to ZSFG. ZSFGH will indicate their ability to take additional patients. • When ZSFG is at capacity, remaining trauma patients may go regional trauma centers via ground or air medical services – which ever has the shortest travel time. • Trauma patients may be transported to SF community hospitals if it is determined that a patient is unlikely to survive travel time to an out-of-county trauma center.
Trauma[1] Meeting Mechanism Criteria	Minor (Green)	May be transported to community hospitals.
Deceased	Deceased (Black)	Medical Examiner

[1] Trauma patients will be re-triaged in the Treatment or Transport Area using the Trauma Triage Criteria when possible to identify critical patients requiring trauma center care.

Section 3.11 Managed Patient Distribution

A **managed distribution** process will start when the total number of patients from an incident **exceeds** the total number assigned slots. Patients will be distributed to San Francisco hospitals until they reach capacity. Managed distribution will also be used to move patients to other Bay Area hospitals or beyond through the Medical Mutual Aid process facilitated by the Medical Health Operational Area Coordinator located at the Emergency Operations Center (EOC).

Hospitals are expected to communicate with the EMS Agency / Department of Emergency Management Duty Officer the number of patients received from the MCI and the patients'

dispositions, utilizing the form found in Appendix E, Patient Tracking Form. This form should be completed within 24 hours of the conclusion of the Red Alert/notification of ending of the MCI level 0 through 4.

3.11.1 Role of EOC Operations Section – Health & Human Services Branch, Public Health & Medical Services Group

In San Francisco, the Medical Health Operational Area Coordinator (MHOAC) is the DEM - EMS Agency Medical Director. The MHOAC (or designated backup) reports to the Emergency Operations Center (EOC) when it is activated. In the ICS structure, the MHOAC is in the EOC's Operations Section – Health & Human Services Branch, **Public Health & Medical Services Group**. The EOC's - Public Health & Medical Services Group assumes the MHOAC function as the primary coordination body for medical-health services and resources within the Operational Area (County) when the EOC is activated.

During a MCI, the EOC's - Public Health & Medical Services Group will notify the Region 2 Regional Disaster Medical Health Coordinator (RDMHC) through the Mutual Aid process as described in Section 3.17. The RDMHC will identify available hospital beds in the Bay Area and other sites within Region 2.

1. The RDMHC will provide direction on patient distributions to hospitals within the Bay Area.

2. The RDMHC will provide direction on patient distributions to hospitals beyond the Bay Area if the incident is large or there are incidents simultaneously occurring in other counties that require sending patients to more distant areas within Region 2.

3. The EOC's - Public Health & Medical Services Group will work with the other ICS sections or branches within the city EOC to support patient operations in the field such as facilitating ambulance strike teams requests to either do the patient transports to Bay Area hospitals or backfill San Francisco 911 ambulances.

The Department of Public Health – Departmental Operations Center (DPH DOC) may be activated to assist with or assume any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

3.11.2 Role of the State and Federal Governments

The Region 2 RDMHC identifies out-of-county hospital beds. If there are no available beds within our region, the RDMHC will work with the California Dept of Public Health/State EMS Authority Medical-Health Coordination Center (MHCC) to identify the next appropriate

region(s) within California to identify available beds. If there are no beds within California, the California Dept of Public Health/State EMS Authority at the State Operations Center will contact the federal National Disaster Medical System to identify beds in other states.

The MHOAC, RDMHC, and California Dept of Public Health/State EMS Authority MHCC do all initial contacts, briefings and coordination between the local, region, state and federal levels of government responsible for the movement of patients in a disaster. The MHOAC, San Francisco EOC, RDMHC, and State EMS Authority will jointly work together to secure and coordinate as needed medical transportation arrangements and / or other logistical needs for moving patients to out-of-county hospitals.

Section 3.12 Patient Distributions in a Level 4 MCI (Red) Alert

A Level 4 MCI is a citywide catastrophic event. For planning purposes, it is assumed that there is a complete disruption of the City response and communications infrastructure. The ability for a formal emergency response and patient distribution system to be organized will be determined at the time of the incident based upon the presenting circumstances. A decentralized command structure using Emergency District Coordination Centers may be invoked by SFFD when central dispatch is interrupted. Ambulance response units may be organized through the Emergency District Coordination Centers until the dispatch communications infrastructure and central command are restored. Patient distributions may be directed through the Emergency District Coordination Center with the overall goal of executing mass medical evacuations.

Section 3.13 Alternate Care Sites

The Department of Public Health may set up free-standing alternative care sites with their disaster tents. The MHOAC and Department of Public Health - Health Officer will determine the role of free-standing alternative care sites in supporting the medical system and / or field operations and what outside support is needed (e.g. state or federal Disaster Medical Assistance Teams).

Section 3.14 Mass Medical Evacuations

3.14.1 Procedures

Mass medical evacuations may be undertaken when all in-county medical and health facilities are at capacity, or compromised due to damage to their infrastructure. Due to the resource intensive nature of medical care, mass medical evacuations may also be done when there is

significant damage to non-medical infrastructures or utilities (e.g. water, etc.) that interferes with the ability to provide critical support services to medical facilities to keep them open.

The MHOAC, in consultation with the Health Officer, city leadership, and the medical facilities will determine whether to undertake mass medical evacuations after weighing its benefits versus risks. The MHOAC with support from the EOC's Public Health & Medical Services Group will work through the RDMHC and California Dept of Public Health/State EMS Authority JEOC to secure transportation and out-of-county destinations. Possible transportation options include:

Mobile Ground Vehicles
- Private vehicles
- Buses
- Wheel Chair Vans / Gurney Vans
- Ambulances - BLS, ALS, Critical Care Transport Units, Specialty Units (Neonatal transports, Bariatric Ambulances)

Air Medical Services
- Rotary
- Fixed Wing

Large Military Transport or Federalized Medical Aircraft

For mobile ground medical vehicles, field operations will follow the same mutual aid procedures used for the Ambulance Strike Teams. EMS Policy #4020 EMS Aircraft Utilization will be followed for air medical transport categorized as:
- Air Ambulance
- ALS or BLS Rescue Aircraft
- Auxiliary Rescue Aircraft

San Francisco International Airport (SFO) will be used as a landing and coordinating facility if large numbers of air ambulances are used to move patients. The San Francisco EOC's Public Health & Medical Services Group will coordinate patient evacuation operations with SFO.

3.14.2 Mass Medical Evacuations Requiring Large Military Transport or Federalized Aircraft

The EOC's - Public Health & Medical Services Group will work through the Region 2 RDMHC to contact state or federal agencies to secure large capacity military transport or federalized aircraft if thousands of patients must be moved. Federal transportation resources will likely be coordinated through the U.S. Dept of Defense Aero-Medical Evacuation System.

Potential landing sites for large medical aircraft are SFO, Moffett Airfield or Travis Air Force Base. The 129th Rescue Wing of the Air National Guard, based at Moffett Airfield, has large transport helicopters that may land in San Francisco. The EOC's EMS and Public Health Group

will work through the other EOC Sections to coordinate with SFO, Moffett Airfield or Travis Air Force Base to secure landing sites and patient transport areas.

The Department of Public Health (DPH) DOC (if activated) may assist with or assume any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

3.14.3 Patient Destination and Distribution When Large Military Transport or Federalized Aircraft Are Used

The National Disaster Medical System (NDMS) will identify and distribute patients to out-of-state destinations through the Federal Coordination Centers if they are not done through the CalEMA Region 2 RDMHC to in-state locations. The RDMHC contacts NDMS through the State Operations Centers.

All large military transport or federalized aircraft landing sites must have an established an on-site temporary medical facility that includes a sheltering structure, medical personnel and supplies. These temporary facilities are used to stage and provide care to patients while they await long-range evacuation by air. These temporary sites are called **Casualty Distribution Points.** The EOC's Public Health & Medical Services Group will determine whether San Francisco can assemble the resources or whether it will be staffed by California Medical Assistance Teams (CAL-MATs) or federal Disaster Medical Assistance Teams (DMATs).

The EOC's Public Health & Medical Services Group will confer with the ICS Operations Chief and Incident Commander to determine if a separate Air Operations Branch will be established in the ICS structure to manage and support the Casualty Distribution Point at the landing site for the aircraft. The Firescope ICS 420-1 Manual Air Operations Branch organizational chart and position descriptions may be adapted for organizing air medical evacuations.

Section 3.15 Mass Medical Evacuation Patient Tracking

Patient information will be tracked on both the sending and receiving side of MCI operations. The Patient Transportation Coordinator in the field Transport Area and the Patient Unit Leader in the Patient Distribution Group both maintain Patient Logs that include:

- Incident Name / Incident Type
- Patient name (if known)
- Patient Age and Gender
- Triage tag number
- Triage Level
- Chief complaint
- Name of transport provider with unit number
- Destination
- Date/Time of departure
- City/State of Origin (for out-of-county destinations)

Section 3.16 Receipt of Out-of-County Patients

3.16.1 Procedures for Accepting Out-of-County Patients

The Medical-Health Operations Coordinator (MHOAC) and the San Francisco Health Officer are the only authorized individuals to make the final determination of whether or not to accept patients that are evacuated through the California Medical Mutual Aid System. Staff in other City departments must refer to the MHOAC any requests from another California county or the State involving receiving evacuated patients.

The Region 2 RDMHC will first contact the San Francisco MHOAC to brief him/her on the number and types of out-of-county patients needing care. The MHOAC will work with the DEC or, if activated, EOC's Public Health & Medical Services Group, to determine the number of available medical facility beds. Every effort will be made to accommodate the request. However, the MHOAC and Health Officer will weigh the supply of available beds against the current local demands for those resources and only accept out-of-county patients if San Francisco medical facilities can reasonably accommodate additional patients while continuing to meet local demands for medical resources.

3.16.2 Organization for Receipt of Out-of-County Patients

The number and types of incoming patients will determine the local organizational structure for accepting and managing their distribution:

1. For a small number of patients, the MHOAC may request that the sending facility directly contact the local receiving facility to initiate a transfer process.
2. For larger numbers of patients, the MHOAC may request a limited activation of the EOC's Public Health & Medical Services Group to serve as the single-point-of-contact for the RDMHC. The MHOAC may also request a limited citywide EOC activation of other sections or branches to support the receipt of out-of-county patients.
3. For significant events in other counties that necessitate sending large numbers of patients to San Francisco, the MHOAC in consultation with the Dept of Emergency Management will fully activate:
    - Emergency Operations Center
    - DPH DOC and other relevant departmental DOCs
    - Hospital Command centers

If large numbers of patients are being airlifted into San Francisco, the MHOAC will follow the same procedures for mass medical evacuations to out-of-county destinations identified in Section 3.13 to receive the patients. When *receiving* patients evacuated by air, the medical

facility at the landing site is called the **Casualty Receiving Point**. The MHOAC will also work with local ambulance providers to secure transportation to in-county hospital destinations from the landing site.

Section 3.17 Medical Mutual Aid Resources

Many medical assets are available within San Francisco and should be accessed first before activating California's Medical Mutual Aid System, unless it has been determine by direct patient care providers (field or hospital) that an out-of-county asset may provide a better patient outcome or if it is determined that local resources are exhausted/overwhelmed. Options for medical mutual aid resources or responses within include:

Patient Transportation
- Ground – Ambulances; alternative transport (Muni buses for green patients able to tolerate sitting upright)
- Air Ambulances
- Strike Teams or Task Forces

Supplies and Equipment
- Medical Supplies Caches and Equipment Trailers
- Specialized Equipment

Treatment Areas
- Portable or Mobile Facilities
- Medical Equipment and Supplies
- Pharmaceuticals

Personnel
- ALS or BLS Personnel
- Californian Medical Assistance Teams (Cal-MAT – state)
- Disaster Medical Assistance Teams (DMAT - federal)
- Medical and Nursing Personnel affiliated with Medical Volunteer Registries
- Mission Support Teams provide administrative, logistical, and liaison support.

Non-medical supplies lists maybe found through the citywide EOC's Logistics Section.

The MHOAC maintains a Medical & Health Special Resources guide. The San Francisco Department of Public Health Emergency Operations Manual also contains a list of other available medical and health resources. The DPH list does not include equipment and supplies that may be available from individual medical providers within San Francisco such as private hospitals.

Other available options for in-county resources include the caches that each medical-health provider maintains. This may be the best available option if your resource need is very limited or if there are medical specialty items that may only be immediately available through another medical provider (e.g. special surgical instruments, etc.). Requests to access provider caches must go through an individual provider's leadership or, if activated, their disaster command center.

Section 3.18 Initiating Medical Mutual Aid

3.18.1 The Use of Medical Mutual Aid

Medical mutual aid is driven by patient medical needs. Therefore, medical mutual aid may be used in more situations that non-medical mutual aid. These situations may include:

- When the surging of medical resources within San Francisco has been exhausted due to overwhelming patient demand.
- For medical resources that have a limited supply in San Francisco. For example, limited supplies of trauma center beds for critical trauma patients or burn care beds for severely burned patients may necessitate sending patients to out of county facilities even though the total number of patients resulting from a particular incident is low.
- When it is determined that patients may receive treatment faster if they are sent to out-of-county facilities using the Mutual Aid process rather than "surging" in-county assets. For example, San Francisco has disaster medical field care clinics that may take several hours to set up, supply and staff whereas sending patients to out-of-county facilities may take less than one hour.

Many medical assets are available within San Francisco and should be accessed first before requesting Mutual Aid, unless it has been determine by direct patient care providers (field or hospital) that out-of-county assets may provide a better patient outcome.

3.18.2 Initiating a Medical Mutual Aid Request for Resources into San Francisco

The Incident Commander (IC), the DEC, any hospital or medical facility, DPH or other city agency may initiate a medical mutual aid resource request by notifying the following:

- DEM Duty Officer if the EOC is not activated. The DEM Duty Officer may be contacted 24/7 through the DEC. The DEM Duty Officer will contact the MHOAC.
- EOC's Public Health & Medical Services Group, if activated, will contact the MHOAC.

All requests for Health and Medical mutual aid resources into the San Francisco Operational Area shall be authorized and coordinated through the MHOAC or his/her designee. The MHOAC or EOC's Public Health & Medical Services Group (if activated) shall complete the mutual aid resource request using the California Disaster Health Operations Manual process and templates. The California Emergency Management Agency (CalEMA) will assign a Mission Number once the request is entered into the Regional Information Management System (RIMS).

The MHOAC or designee may also request EOC or DOC activations to assist in supporting the receipt of out-of-county mutual aid assets. The MHOAC and / or EOC's Public Health & Medical Services Group will advise city leadership about any medical mutual requests.

3.18.3 Providing Medical Mutual Aid Resource to Other Counties

1. Requests originating through the **Fire Mutual Aid System** for SFFD ambulances will be approved through SFFD in consultation with the MHOAC.
2. Requests originating through the **Medical Mutual Aid System** are authorized and coordinated through the MHOAC or his/her designee. The Region 2 RDMHC will contact the MHOAC to make a request. The MHOAC or designee will take the mutual aid request information and contact the appropriate city agency or medical-health facility to fulfill the request. The MHOAC may elect to coordinate the sending of mutual aid assets to the out-of-county destinations, or delegate that task to the agency fulfilling the request or request EOC and/or DOC activations to supporting the sending of San Francisco mutual aid assets to out-of-county destinations.

3.18.4 Resource Request Tracking and Fulfillment

The RDMHC and the MHOAC will advise each other when a resource request(s) has been fulfilled, whether any changes in quantity or substitutions were necessary, its projected delivery time, or if the request was cancelled. The MHOAC may task the EOC Logistic Section with tracking the status of the resource request.

Section 3.19 Ambulance Strike Teams

Ambulance Strike Teams from other counties may be requested through mutual aid. In California, the standard Ambulance Strike Team consist of five ambulances (ambulance with two personnel) with common communications and a leader and are typed according to FEMA typing for medical and health resources. Each may include a Disaster Medical Support Unit or comparable local support unit to serve as an operational command, control, and communications center.

3.19.1 Ambulance Strike Teams Standard Configurations

1. ***ALS Ambulance Strike Team****:* 5 ambulances with 2 ALS personnel, or 1 ALS and 1 BLS personnel, both trained in ICS 100 plus 1 Strike Team Leader trained in ICS 100, 200 & 300, and Strike Team Leader Training. (**NOTE:** The Strike Team Leader may be omitted if for short deployments lasting only several hours).

2. ***BLS Ambulance Strike Team****:* 5 ambulances with BLS personnel trained in ICS 100 plus 1 Strike Team Leader trained in ICS 100, 200 & 300, and Strike Team Leader Training. (**NOTE:** The Strike Team Leader may be omitted if for short deployments lasting only several hours).

3.19.2 Sending San Francisco Ambulance Strike Teams to Other Counties

Requests originating through the **Fire Mutual Aid System** for SFFD ambulances will be approved through SFFD in consultation with the MHOAC. Requests originating through the **Medical Mutual Aid System** are authorized and coordinated through the MHOAC or his/her designee.

The MHOAC (or EOC's Public Health & Medical Services Group if activated) will contact local ambulance providers, including SFFD, to ascertain their availability of ambulances and staff for a Strike Team. The RDMHC and the MHOAC will advise each other of the following when an ambulance Strike Team request(s) has been fulfilled:

- Provider company or agency name, unit number, unit type (ALS or BLS), and estimated time of arrival (ETA) for each ambulance dispatched.
- Contact number in the event of for cancellation while the Strike Team is en route.
- Location of ambulance staging area(s).

3.19.3 Receiving Ambulance Strike Teams from Other Counties

1. **MCI Alert (actual incident in progress):** The Incident Commander (IC) or Medical Group Supervisor may initiate an Ambulance Strike Team request by contacting DEC who may contact the Public Safety Answering Point (PSAP) in a neighboring county to initiate an "Immediate Send" of a single Strike Team prior to contacting the MHOAC.
   - The San Francisco MHOAC is responsible for the approval of the request(s) for Ambulance Strike Teams into San Francisco.
   - The MHOAC or EOC's Public Health & Medical Services Group (if activated) shall complete the mutual aid resource request using the California Disaster Health

Operations Manual process and templates. The California Emergency Management Agency (CalEMA) will assign a Mission Number once the request is entered into the Regional Information Management System (RIMS).

- The San Francisco MHOAC is also responsible for coordinating the receipt of out-of-county ambulance strike teams with the OES Region 2 RDMHC, but may delegate that responsibility to the field Incident Commander.

2. **Level Zero Alert (with a shortage of ambulances):** DEC will contact the DEM Duty Officer who will contact the MHOAC. DEC will also follow the Level Zero procedures to initiate "in-county mutual aid" from the non-911 ambulance providers before initiating a request for out-of-county Ambulance Strike Teams.

3.19.4 Patient Treatment Protocols during a Mutual Aid Response

EMS Personnel operating in another county during a mutual aid response will follow all applicable San Francisco EMS Agency Policies and Medical Protocols with the exception of EMS Agency #5000 Destination Policy. The Incident Commander, Medical Group Supervisor or Transport Unit Leader for the incident will assign local receiving facility destinations for the mutual aid response.

Section 3.20 Emergency Declarations – Invoking Austere Medical Care Standards

3.20.1 Definition and Intent

Austere Medical Care is a modified standard of care provided during disaster situations when medical resources, supplies and / or medical personnel are extremely limited or unavailable.

The goal of a modified standard of care is to provide a basic (austere) level of medical care that is less time and resource intensive. By modifying the standard of care to a more basic (austere) level, fewer medical resources are provided to an individual person, but, instead are distributed to a greater number of individuals in a given population. The intent of austere medical care standards is to attempt to do the most good for the greatest number of people during a disaster situation.

3.20.2 Authorization and Limitations

In San Francisco, austere care only applies to EMS field care. It does not affect in-patient hospital services. Austere medical care is only used in situations of extreme resource shortage resulting from a catastrophic event. Field personnel should consider requests for authorization

of Austere Medical Care Standards when the situation is completely overwhelming local resources and the possibility of receiving mutual aid resources are remote.

Requests for authorization of Austere Medical Care Standards must be routed through the chain of command. Austere medical care in the pre-hospital environment is authorized only by the **County Health Officer or, in his/her absence, the Deputy Health Officer.** Authorization of the use of austere medical care will be communicated through the Incident Command System.

3.20.3 How to Perform Austere Care

The San Francisco EMS Agency P-100 Austere Care Protocol is the approved guideline for austere care in the pre-hospital environment. Refer to that protocol for further details. EMS Agency P-100 Austere Care Protocol does NOT apply to in-hospital care.

Section 3.21 Demobilization

Demobilization will not be covered in this MCI Plan. For incidents in San Francisco, demobilization plans will be developed and disseminated through the EOC or delegated to the relevant DOC when an incident response winds down. San Francisco EMS responders deployed in mutual aid response will be released from their assignment according to the incident demobilization plan developed by the original responder agency that requested mutual aid.

Annexes

(TO BE DEVELOPED)

Appendices

APPENDIX A: MEDICAL & HEALTH CONTACTS

The contact list is provided directly to local EMS providers and is **not** posted on-line.

APPENDIX B: MEDICAL BRANCH / GROUP POSITIONS

1. Common Tasks: All Field Personnel

2. Medical Branch Director

3. Medical Group Supervisor (MGS)

4. Triage Area:
    a. Triage Area Unit Leader
    b. Triage Personnel
    c. Morgue Manager

5. Treatment Area:
    a. Treatment Area Unit Leader
    b. Immediate Treatment Area Manager
    c. Delayed Treatment Area Manager
    d. Minor Treatment Area Manager
    e. Treatment Dispatch Manager

6. Patient Transportation Area:
    a. Patient Transport Area Unit Leader
    b. Medical Communications Coordinator
    c. Air Ambulance Coordinator
    d. Ground Ambulance Coordinator

7. Medical Supply Coordinator

First On-Scene Tasks

Field Personnel – Immediate Actions

- Report for duty and receive assignment position from Incident Commander (IC), Medical Branch Director or Medical Group Supervisor if used.
- Don color-coded MCI Position Vests. Use flashcards, command boards and triage tags to manage incident work and treat patients.
- Acquire any necessary work materials.
- Know your assigned radio frequency and ensure that radios are available and functioning.
- Use clear text and ICS terminology in all communications.
- Maintain activity log (ICS form 214).
- Respond to orders to escalate response and response actions.
- Response to order to demobilize or scale back efforts.

Field Supervisory Personnel – Immediate Actions

- Complete all immediate actions listed for field personnel above.
- Assign, organize and brief subordinates.
- Maintain accountability of assigned personnel as to Assignment Location, personal safety and welfare.
- Assure rotation of personnel from high stress or high risk areas.
- Monitor personnel for signs of stress or fatigue.
- Request additional resources as needed.

Medical Branch Director

Reports to: Operations Section Chief or Incident Commander

Supervises: Medical Group Supervisor(s) and Transportation function (Unit or Group).

Assignment Location: Command Post

Talk Group: _____ **Radio call sign:** Medical Branch Director

Skills needed: ALS level EMS professional with management and command experience and knowledge of SEMS, ICS and MCI management policies.

Mission: To implement the Incident Action Plan within the Medical Branch, including the direction and execution of branch planning for the assignment of resources.

Immediate Actions:

- Assist the IC in setting strategic goals, establish objectives, setting priorities and assigning specific objective to units or groups.
- Act as liaison between the Medical Groups and the Operations Chief and/or Incident Commander
- Supervise personnel in the Medical Groups
- Coordinate activities and response efforts between Medical Groups
- Reports out casualty information to the Operations Chief.

Ongoing Actions:

- Maintain a written record of activities using the Standardized MCI Forms.
- Monitor conditions within the medical incident for safe practices
- Coordinate re-supply efforts with Logistics
- Coordinate special staffing procedures including call backs and hold over of employees
- Updates casualty information for the Operations Chief.

Medical Group Supervisor

Reports to: Incident Commander or Operations Section Chief (may report to Medical Branch Director in larger events)

Supervises: Triage, Treatment and Transport Unit Leaders and Medical Supply Coordinator

Assignment Location: Command Post

Talk Group: _____ **Radio call sign:** MGS

Skills needed: ALS level EMS professional with management and command experience and knowledge of SEMS, ICS and MCI management policies.

Mission: To supervise the Unit Leaders and establish command and control of the activities within the Medical Group for effective delivery of emergency medical care during the MCI.

Immediate Actions:

- Designate areas for triage, treatment areas, transport, and ambulance staging.
- Designate temporary morgue, helicopter landing zones and medical equipment resources staging area if appropriate.
- Medical Group Supervisor communicates with SFFD Officer located at DEC which hospitals will receive patients, how many, what type, and any special needs (peds, hazmat). Provides updates every 30 minutes or if a significant change in the MCI (this action may be delegated to the Patient Transport Officer).
- Maintain an ICS 214 record for the incident. Assist the IC with preparation of IC 201.
- Oversees Medical Group personnel and operations. Monitors conditions for hazards. Notifies Safety Officer of unsafe or hazardous conditions.
- Requests additional resources through the Incident Commander
- Acts as the liaison between MCI Branch and the Operations Section Chief or IC and gives updates as needed.
- Reports out casualty information to the Medical Branch Director.

Ongoing Actions:

- Maintain a written record of activities using the Standardized MCI Forms.
- Monitor conditions within the medical incident for safe practices
- Coordinate re-supply efforts with Logistics
- Coordinate special staffing procedures including call backs and hold over of employees
- Updates casualty information to the Medical Branch Director.
- Ensures that there are enough personnel to assist in Medical Group / Branch activities.

Triage Area Unit Leader

Reports to: Medical Group Supervisor

Supervises: Triage Personnel, Litter Bearers and Morgue Manager

Assignment Location: Triage Area or base of Triage route

Talk Group: _____ **Radio call sign:** Triage Area Leader

Skills needed: EMS professional with experience and training in principles of *START* and *JUMP START* triage.

Mission: Supervise and coordinate triage personnel to rapidly identify and triage all MCI patients and assign them to appropriate Treatment Areas.

Immediate Actions:

- Designate triage teams. Complete sweep through scene to locate and triage casualties.
  Organize Litter Teams – Comprised or four persons on flat terrain and 6 persons on broken terrain or uneven terrain. Used to evacuate patient or move them between the Medical Group Areas.
- Establish route with barrier tape through which casualties are moved.
- Coordinate patient triage using the *START* (adults) and *JUMP START (*pediatric) triage systems.
- Maintain written records for patients using triage tags. In a Level 1 MCI, PCRs will be completed on all patients.
- Ensure safe practices within the Triage Area including monitoring of adequate decontamination in the event a hazardous materials incident.
- Periodically scan the scene for new or overlooked patients.
- Reassign triage teams to treatment Areas after al victims have been evaluated.
- Notify Medical Group Supervisor, Treatment Unit Leader when all patients have received initial and secondary triage.

Ongoing Actions:

- Monitor patient flow.
- Provide medical Supply Manger with list of supplies to be replenished
- Participate in incident planning meetings as directed.

Triage Personnel

Reports to: Triage Unit Leader

Assignment Location: Triage Area

Talk Group: _____ **Radio call sign:** Triage

Skills needed: First responders, EMT-1s, and paramedics with experience in *START* triage, *JUMP START* triage and trauma triage criteria.

Mission: Triage patients and assign them to appropriate Treatment Areas.

Immediate Actions:

- Report to designated on scene triage assignment location(s).
- Using the principles of START and JUMP START, triage and tag injured patients with triage tags affixed to upper extremities.
- Classify patients while noting injuries and vital signs taken.
- Direct movement of patients to appropriate Treatment Areas.
- Carry non-ambulatory patients to Treatment Areas.
- Assist with secondary triage of patients in treatment Areas using Trauma Center triage criteria.
- Provide appropriate medical treatment to patients prior to movement as incident conditions allow.

Morgue Manager

Reports to: Triage Unit Leader

Assignment Location: Morgue Area

Talk Group: _____ **Radio call sign**: Morgue Manager

Skills needed: First responders or Medical Examiner's Office Staff.

Mission: Responsible for all Morgue Area operations.

Immediate and On-Going Actions:

- Tracks, records and reports out the number of deceased and their names (if known) to Triage Unit Leader.
- Assess resource/supply needs and order as needed.
- Keep area off limits to all but authorized personnel.
- Coordinate with law enforcement and assist the Coroner or Medical Examiner representative.
- Evidence preservation for crime scenes.

Treatment Area Unit Leader

Reports to: Medical Group Supervisor

Supervises: Immediate Treatment Manager, Delayed Treatment Manager, Minor Treatment Manager and Treatment Dispatch Manager

Assignment Location: Treatment Area or between Red and Yellow Treatment Areas

Talk Group: _____ **Radio call sign:** Treatment Area Leader

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Supervise and coordinate Treatment Area Managers to rapidly perform on-scene medical treatment of victims and preparation / coordination for their transport.

Immediate Actions:

- Supervise personnel in the Treatment Area
- Coordinate all patient care in the Treatment Area
- Oversee preparations for patient transport
- Provides supplies for Red, Yellow and Green Treatment Areas.
- Coordinate the rapid movement of patients from Triage Areas to Treatment Areas.
- Ensures ongoing triage and reclassification of all patients in Treatment Areas.
- Redirects Treatment Area Managers to perform secondary triage of patients using the Trauma Triage categories.
- Ensures patients are "packaged" for transport.
- Coordinates the movement of patients to Transportation Area.
- Maintain written records of patients using triage tags and Treatment Areas Status Boards.

Ongoing Actions:

- Requests additional staffing and resources through the Medical Group Supervisor.

Immediate Treatment Manager

Reports to: Treatment Unit Leader

Assignment Location: Immediate Treatment Area

Talk Group: _____ **Radio call sign:** as assigned

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

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

Immediate Actions:

- Establish medical teams as necessary; request personnel from Treatment Unit Leader
- Assign treatment personnel to patients received in the Immediate Treatment Area
- Perform secondary triage of patients.
- Ensure that patients are prioritized for transportation.
- Ensures patients are "packaged" for transport.
- Coordinate transportation of patients with the Transport Unit Leader
- Notify Treatment Unit Leader of patient readiness and priority for transport.
- Assure that treatment is documented and patient information is recorded on triage tags and patient status boards.

Ongoing Actions:

- Request additional resources and personnel as needed.

Delayed Treatment Manager

Reports to: Treatment Unit Leader

Assignment Location: Delayed Treatment Area

Talk Group: _____ **Radio call sign:** as assigned

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Supervises treatment and re-triage of patients assigned to Delayed Treatment Area.

Immediate Actions:

- Establish medical teams as necessary; request personnel from Treatment Unit Leader.
- Assign treatment personnel to patients received in the Delayed Treatment Area
- Perform secondary triage of patients.
- Ensure that patients are prioritized for transportation.
- Ensures patients are "packaged" for transport.
- Coordinate transportation of patients with the Transport Unit Leader.
- Notify Treatment Unit Leader of patient readiness and priority for transport.
- Assure that treatment is documented and patient information is recorded on triage tags and patient status boards.

Ongoing Actions:

- Request additional resources and personnel as needed.

Minor Treatment Manager

Reports to: Treatment Unit Leader

Assignment Location: Treatment Area

Talk Group: _____ **Radio call sign:** as assigned

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Supervises treatment and re-triage of patients assigned to Minor Treatment Area.

Immediate Actions:

- Establish medical teams as necessary; request personnel from Treatment Unit Leader
- Assign treatment personnel to patients received in the Minor Treatment Area
- Perform secondary triage of patients.
- Ensure that patients are prioritized for transportation
- Coordinate transportation of patients with the Transport Unit Leader
- Ensures patients are "packaged" for transport.
- Notify Treatment Unit Leader of patient readiness and priority for transport.
- Assure that treatment is documented and patient information is recorded on triage tags and patient status boards.

Ongoing Actions:

- Request additional resources and personnel as needed

Treatment Dispatch Manager

Reports to: Treatment Unit Leader

Assignment Location: Treatment Area or between Immediate, Delayed and Minor Treatment Areas

Talk Group: _____ **Radio call sign:** Treatment Dispatch Manger

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Coordinates movement of patients between Treatment Area to Transport Area with Patient Transportation Unit Leader (or Group Supervisor if established).

Immediate Actions:

- ❑ Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
- ❑ Establish communications with the Patient Transportation Unit Leader.
- ❑ Verify that patients are prioritized for transportation.
- ❑ Verify that patients are "packaged" and ready for transport.
- ❑ Advise Medical Communications Coordinator of patient readiness and priority for transport.
- ❑ Coordinate transportation of patients with Medical Communications Coordinator.
- ❑ Assure that appropriate patient tracking information is recorded.
- ❑ Coordinate ambulance loading with the Treatment Managers and ambulance personnel.
- ❑ Maintain Unit/Activity Log (ICS Form 214).

Patient Transportation Area Unit Leader

Reports to: Medical Group Supervisor

Supervises: Ground Ambulance Coordinator, Air Ambulance Coordinator and Medical Communications Coordinator

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Patient Transport Area Leader

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate. Knowledge of hospital destination criteria.

Mission: Responsible for communications with Patient Distribution Group and coordinating patient loading into ambulances or other patient transport vehicles. Maintains patient records.

Immediate Actions:

- Determine and maintain access and egress routes for patients and transporting units
- Coordinate movement of patients to transportation Area with Treatment Unit Leader
- Coordinate ambulance flow through Transport Area.
- Oversee assignment of sufficient personnel to bear litters.
- Utilize destination schematics for patient movement.
- Review available trauma center and hospital resources. Determine need for transport to regional trauma centers; notify MGS if indicated.
- Ensure that trauma triage criteria are utilized in determining patient movement to trauma center(s).
- *If delegated by* Medical Group Supervisor*,* will radio back to the SFFD Officer located at DEC which hospitals will receive patients, how many, what type, and any special needs (pediatrics, hazmat). Updates will be provided every 30 minutes or anytime there is a significant change in the MCI incident*.*
- *Ensure that patients in different triage categories are not mixed together in transport vehicles (ex: do not mix red and green patients in same ambulance).*

On-Going Actions:

- Maintain Unit/Activity Log (ICS Form 214)
- Request additional resources through Patient Transport Area Unit Leader or Medical Supply Coordinator if used.

Medical Communications Coordinator

Reports to: Patient Transportation Unit Leader

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Medical Communications Coordinator

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate. Knowledge of hospital destination criteria.

Mission: Maintains medical communications with the Patient Distribution Group for assignment of hospital facilities for MCI patients. Selects the mode of medical transport based upon patient need using patient condition information provided by the Treatment Dispatch Manager.

Immediate Actions:

- Receives basic patient information and condition from Treatment Dispatch Manager.
- Contacts the Patient Distribution Group to obtain the name and contact information for the Patient Distribution Unit Leader.
- Reports to the Patient Distribution Unit Leader, the number of MCI patients, their triage levels and triage tag numbers.
- Obtains from the Patient Distribution Unit Leader, the assigned receiving facility for each patient.
- Confirms assigned facilities, ("This is Medical Comms at Transport Area – I copy to take 2 Green patients with Triage Tag numbers 6293 and 6456 to St Lukes Hospital. Is the correct?").
- Advises the Patient Distribution Unit Leader of any remaining field MCI patients awaiting disposition.
- Communicates ground transportation requests to Ground Ambulance Coordinators.
- Communicates air ambulance requests to the Air Operations Branch Director or Air Ambulance Coordinator.

Ground Ambulance Coordinator

Reports to: Patient Transportation Unit Leader

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Ground Ambulance Coordinator

Skills needed: Knowledge of hospital Assignment Locations and destination criteria.

Mission: Coordinates ground ambulances or other ground-based patient transportation vehicles. Manages the Ambulance Staging Area(s). Dispatches ambulances as requested.

Immediate Actions:

- Establishes access and egress routes for ground ambulances.
- Establish appropriate staging area(s) for ambulances.
- Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
- Establish and maintain check-in procedures for new arrivals.
- Provide ambulances upon request from the Medical Communications Coordinator.
- Request additional transportation resources as appropriate.

On-Going Actions:

- Maintain Transport Worksheet of patient transports that includes:
  1. Triage tag number
  2. Triage Level
  3. Patient name (if known)
  4. Patient Age and Gender
  5. Type of transport unit
  6. Name of transport unit provider
  7. Transport unit provider unit number
  8. Destination
  9. Time of departure
  10. ETA
- Assure that necessary equipment is available for patient needs during transportation.
- Request additional resources through Patient Transport Area Unit Leader or Medical Supply Coordinator if used.

Air Ambulance Coordinator

Reports to: Patient Transportation Unit Leader

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Ambulance Coordinator

Skills needed: Knowledge of hospital Assignment Locations and destination criteria.

Mission: Establishes and coordinates helispots and air medical operations with the Air Operations Group.

Immediate Actions:

- Establish appropriate helispots for air ambulances.
- Establish routes of travel for air ambulances for incident operations.
- Establish and maintain communications with the Air Operations Branch Director regarding Air Ambulance Transportation Assignments.
- Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
- Establish and maintain check-in procedures for new arrivals.
- Provide air ambulances upon request from the Medical Communications Coordinator.
- Coordinate ground ambulance transport of patients to helispots.

On-Going Actions:

- Maintain Transport Worksheet of patient transports that includes:
  1. Triage tag number
  2. Triage Level
  3. Patient name (if known)
  4. Patient Age and Gender
  5. Type of transport unit
  6. Name of transport unit provider
  7. Transport unit provider unit number
  8. Destination
  9. Time of departure
  10. ETA
- Assure that necessary equipment is available for patient needs during transportation.
- Request additional resources through Patient Transport Area Unit Leader or Medical Supply Coordinator if used.

Medical Supply Coordinator

Reports to: Medical Group Supervisor

Assignment Location: Supply cache on scene, Treatment area or Bureau of Equipment

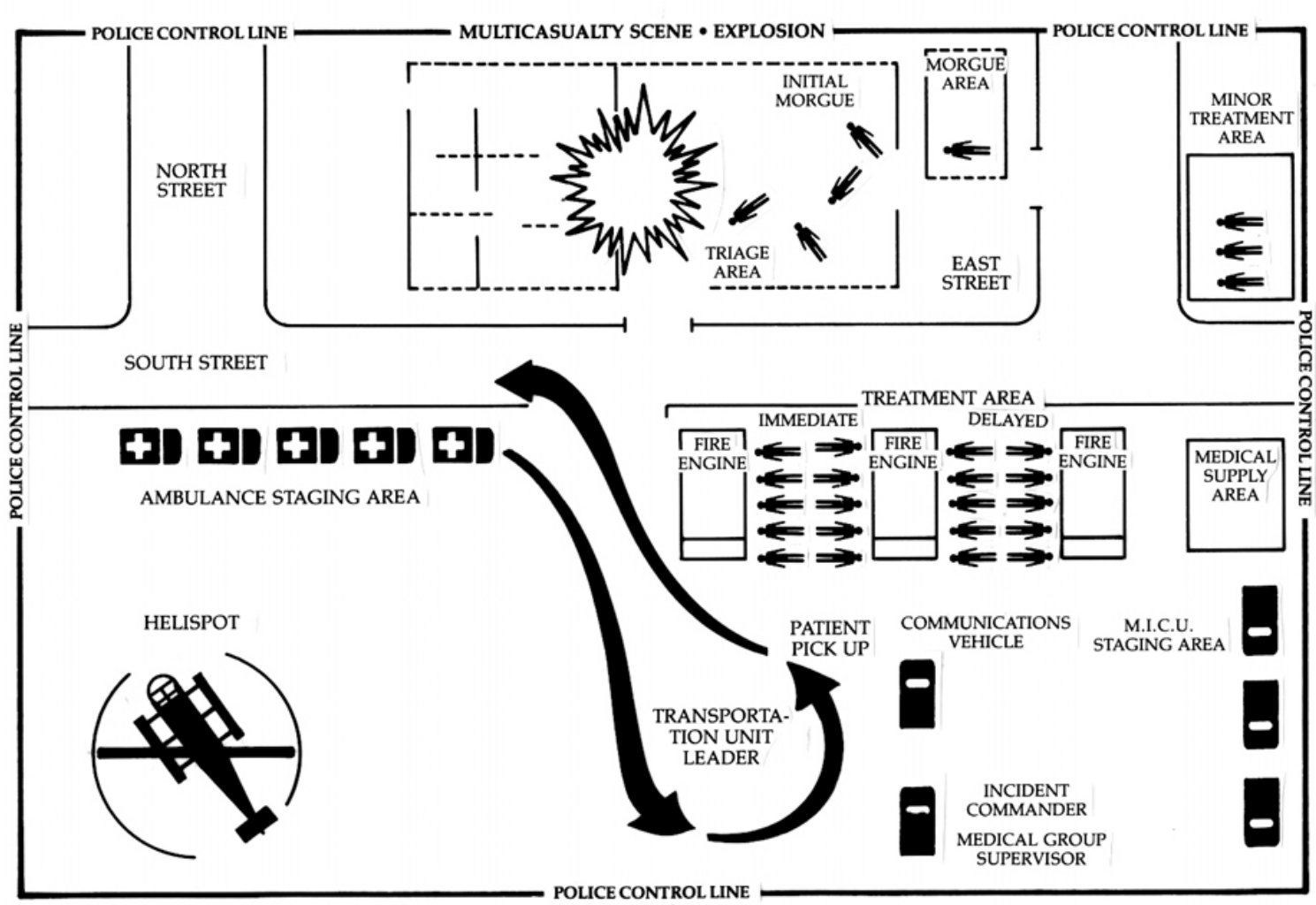
Talk Group: _____ **Radio call sign:** Medical Supply Coordinator

Skills needed: Knowledge of medical supplies and equipment, but may be a non-medical person. Knowledgeable about managing and maintaining inventory.

Mission: Coordinates requests, receives, distributes, tracks and maintains stock for medical supplies and equipment assigned to the Medical Group.

Immediate Actions:

- If the Logistics Section is established, the Medical Supply Coordinator will coordinate requests through the Logistics Section Chief or Supply Unit Leader. Otherwise, requests are funneled through the Medical Group Supervisor to the Incident Commander.
- Maintain and distribute inventory
- Coordinate personnel performing medical re-supply
- Establish secure medical supply cache near incident
- Oversee retrieval and management of cached supplies


POLICE CONTROL LINE
MULTICASUALTY SCENE • EXPLOSION
POLICE CONTROL LINE
INITIAL MORGUE
MORGUE AREA
MINOR TREATMENT AREA
NORTH STREET
TRIAGE AREA
EAST STREET
POLICE CONTROL LINE
SOUTH STREET
TREATMENT AREA
IMMEDIATE
DELAYED
FIRE ENGINE
FIRE ENGINE
FIRE ENGINE
MEDICAL SUPPLY AREA
AMBULANCE STAGING AREA
HELISPOT
PATIENT PICK UP
COMMUNICATIONS VEHICLE
M.I.C.U. STAGING AREA
TRANSPORTA-TION UNIT LEADER
INCIDENT COMMANDER
MEDICAL GROUP SUPERVISOR
POLICE CONTROL LINE

APPENDIX C: MCI FIELD BOARDS

Distributed separately due the large file size.

APPENDIX D: ABBREVIATIONS, ACRONYMS & GLOSSARY

Abbreviations and Acronyms

ALS	Advanced Life Support
BLS	Basic Life Support
CAL-MAT	California Medical Assistance Team
CDMN	California Disaster Medical Network
CDPH	California Department of Public Health
DEM	Department of Emergency Management
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Team
DOC	Department Operations Center
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
DMAT	Disaster Medical Assistance Team
DPH	Department of Public Health
ICS	Incident Command System
JEOC	Joint Emergency Operations Center
MCI	Multi-Casualty Incident
MGS	Medical Group Supervisor
MHOAC	Medical/Health Operational Area Coordinator
NDMS	National Disaster Medical System
NIMS	National Incident Management System
OA	Operational Area
OES	Office of Emergency Services
PDC	Patient Distribution Center
RDMHC	Regional Disaster Medical/Health Coordinator
RDMHS	Regional Disaster Medical/Health Specialist
SEMS	Standardized Emergency Management System
SFFD	San Francisco Fire Department
SFPD	San Francisco Police Department

Glossary

Ambulance Strike Team	A team of five staffed and equipped medical transport vehicles of the same capabilities with like communications equipment and one team leader with vehicle and like communications equipment. In California's, Ambulance Strike Teams consist of five ambulances with two personnel) and a Strike Team leader.
Alternate Care Sites	Used by public health departments or hospitals for as a temporary patient overflow area when healthcare facilities are overwhelmed. ACS are appropriate only for low acuity or end-of-life patients. May be used to cohort infectious disease patients.
Area Command (Unified Area Command)	An ICS organization established (1) to oversee the management of multiple incidents that are each being handled by an ICS command or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned.
Austere Medical Care	A modified standard of care provided during disaster situations when medical resources, supplies and / or medical personnel are extremely limited or unavailable.
Casualty Distribution Points	Sites established at airports near impacted Operational Areas to gather and stage victims for long-range evacuation by air to unaffected areas. These sites may be staffed by CAL-MATs or DMATs.
Casualty Receiving Points	Sites established at airports in unaffected areas to receive victims evacuated by air and distribute them to local hospitals.
Delayed Treatment	Patients with injuries are not immediately life threatening who can wait up to several hours for definitive medical care or surgical intervention.
Emergency Operations Center (EOC)	The physical location at which civil jurisdictions coordinate information and resources to support incident management (on-scene operations). An EOC may be a temporary facility or permanently established in a fixed facility.
Field Treatment Site	Used by EMS for the congregation, triage temporary care, holding and evacuation of injured patients in a multiple or mass casualty situation. A Field Treatment site operates for brief periods of time (e.g. 48 hours) or until new patients no longer arrives at the site.
Immediate Treatment	Patients with life threatening injuries that require immediate definitive medical or surgical intervention.
Incident Command System (ICS)	Standardized, on-scene, all-hazard incident management concept designed to allow diverse emergency management agencies to work together by providing a flexible and scalable response organization framework.

Medical Health Operational Area Coordinator (MHOAC)	An individual appointed by a county Department of Health Director / local Health Officer who is responsible for coordinating medical-health services and resources within the Operational Area (County) in the event of a disaster or major incident where medical mutual aid is required.
Minor Treatment	Ambulatory patients with injuries that only require first-aid treatment.
Mutual Aid Region	One of the six geographical areas defined by the California Governor's Office of Emergency Services for the coordination of resources in the event of a disaster or major incident where mutual aid is requested.
National Disaster Medical System (NDMS)	A section of the United States Department of Health and Human Services (HHS) responsible for managing Federal government's medical response to major emergencies and disasters. It is under the Emergency Support Function #8 – Public Health and Medical Services.
National Incident Management System (NIMS)	A system mandated by Homeland Security Presidential Directory 5 (HSPD-5) that provides a consistent nationwide approach for Federal, State, local, and tribal governments; the private-sector; and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. California has incorporated NIMS into the State's SEMS process.
Operational Area (OA)	An intermediate level of the State emergency medical services organization, consisting of a county and all political subdivisions within the county.
Regional Disaster Medical and Health Coordinator (RDMHC)	At the regional level, EMS Authority and CDPH jointly appoint the Regional Disaster Medical Health Coordinator (RDMHC) whose responsibilities include supporting the mutual aid requests of MHOACs for disaster response within the region and providing mutual aid support to other areas of the state in support of the state medical response system.
Regional Disaster Medical Health Specialist (RDMHS)	The RDMHS provides the day-to-day planning and coordination of medical and health disaster response in the six mutual aid regions. During disaster response, the RDMHS may be designated by the RDMHC as the key contact for OAs to request and/or to provide medical and health resources.
Regional Emergency Operations Center (REOC)	The first level facility of the Governor's Office of Emergency Services to manage a disaster. The REOC provides an emergency support staff operating from a fixed facility, which are responsive to the needs of the Operational Areas and coordinates with the State Operational Center.
Simple Triage And Rapid Treatment	Usually called START. Initial triage system that has been adopted for use by the California Fire Chiefs' Association.

Standardized Emergency Management System (SEMS) The emergency management system identified in the California Government Code 8607, for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the ICS and is intended to standardize response to emergencies in the State.

Triage The screening and classification of sick, wounded, or injured persons to determine priority needs in order to ensure the efficient use of medical manpower, equipment, and facilities.

Policy 8000 Appendix E: Report of Hospital Patients Received from Incident

INCIDENT NAME:

INCIDENT DATE:

PERSON COMPLETING FORM:

YOUR CONTACT PHONE:

HOSPITAL NAME:

Arrival Date	Time Of Arrival	Hosp MR #	Patient Name	Age	Gender	Nationality	Mode Of Arrival	Current Status / Disposition (CHOOSE ONE)	Receiving Transfer Facility	Comments
MM/DD/YY	24-Hour		Last, First	# / units	Male, Female, Other, Unknown	USA or List Country Name	Ambulance Self-Transport, Transfer, Other	1) Still in ED; 2)Discharged from ED; 3) Expired in ED; 4) Left ED without Being Seen; 5) Admitted and still in-patient; 6) Admitted and discharged home; 7) Expired during in-patient stay; 8) Transferred to another facility.	List name and address of tranfer facility that received patient.	List any comments