EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE

NEW TIME: Wednesday, June 12, 2019 from 10:00 AM – 12:00 NOON

NEW LOCATION: San Francisco Public Library - Main Branch Latino Room

DIRECTIONS TO MEETING LOCATION:
- San Francisco Public Library - Main Branch 100 Larkin St. SF, CA 94102 (Civic Ctr stop on Muni/BART)
- Use the Grove St. entrance
- Latino Room is located on the lower level – same floor as the Poets Café.

Agenda

I. Call to Order Welcome & Introductions Megan Corry, City College 10:00 AM

II. Action Item Approve Minutes from April 8, 2019 Megan Corry 10:05 AM

III. Information EMS Agency Announcements:
- Reminder: Variable Locations for 2019 EMSAC
- Bayshore Ambulance ceased operations
- CPR mannequin demo after meeting

EMSAC Member Announcements
- Open to any committee member

IV. Vote Annual Committee Business:
- Nominations and election 2019 -2020 EMS Advisory Committee Chair and Vice Chair John Brown MD 10:15 AM

V. Vote Public Comment review and Vote:
- 1010 Advisory Committee
- 7010 EMS at Special Events
- 8000 MCI Policy and Plan John Brown MD Mary Magocsy Andrew Holcomb 10:20 AM

VI. Information Centralized Ambulance Destination Determination (CADDiE) Pilot Project John Brown MD 10:50 AM

VII. Information EMS Agency Cardiac Initiatives:
- “2020/60” – STEMI Progam Editha Dorosh Mary Magocsy 11:10 AM
- “2020/50” - CARES 2018 Utstein Results

VIII. Information Items from the Public Megan Corry 11:55 AM

IX. Action Item Adjournment Megan Corry NOON
Contact Mary Magocsy at 487-5019 or mary.magocsy@sfdph.org for questions regarding the meeting.

After the meeting, there will be a short demonstration of new EMS Agency CPR mannequins w/ Bluetooth technology that connect to a cell phone app that incentivizes CPR performance using various novel graphics. All are welcome to participate.

EMS CARDIAC INITIATIVES

“2020/50:” San Francisco will have a cardiac arrest survival rate of 50% or greater with CPC scores of 1 – 2 for witnessed cardiac arrests with bystander intervention and a shockable rhythm by the year 2020.

“2020/60:” San Francisco will have 100% of pre-hospital STEMI patients re-perfused within 60 minutes of first medical contact in 90% of cases for recognized pre-hospital STEMI patients by the year 2020.
## Minutes

<table>
<thead>
<tr>
<th>Item</th>
<th>Discussion</th>
<th>Action</th>
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<tbody>
<tr>
<td>I. Welcome &amp; Introductions</td>
<td>Megan Corry, committee chair called the meeting to order.</td>
<td>Meeting called to order at 13:00</td>
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<tr>
<td>II. Meeting Minutes</td>
<td>February 5, 2019 meeting minutes reviewed.</td>
<td>February 5, 2019 meeting minutes approved.</td>
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<tr>
<td>III. EMS Agency Announcements</td>
<td>Reminder 2019 committee meeting locations will vary since we lost our former meeting space. &lt;br&gt; EMS Week is the 3rd week in May starting May 20th. Awards ceremony is May 21st at SF Library Koret Auditorium (same location as last year). &lt;br&gt; ZSFG is offering ACLS for Experience Provider course on June 5th.</td>
<td>Next meeting June 12 – same location as today. &lt;br&gt; EMS Week calendar of events will be distributed soon. &lt;br&gt; ACLS course info emailed to committee members.</td>
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<tr>
<td>IV. EMSAC Member Announcements</td>
<td>UCSF will be affected by a strike on April 10 from 12 midnight to 23:59 PM. It will include technical employees from all campuses.</td>
<td>SF Public Health will activate their command center to monitor strike activities.</td>
</tr>
<tr>
<td>V. Appointment of Committee Vice-Chair</td>
<td>Eric Silverman, MD from ZSFG &amp; assistant Base Hospital Medical Director appointed to fill vacant vice-chair position. &lt;br&gt; Dr. Brown noted annual chair and vice-chair positions opened every June. Although another vote will take place at the June meeting for those positions, Dr. Brown proposed committee vote today for the vice-chair to confirm the appointment.</td>
<td>Committee unanimously confirmed appointment of Dr. Silverman – congratulations! &lt;br&gt; Annual vote on new committee vice-chair next meeting.</td>
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<td>VI. Results from EMS Pediatric Simulation Training Program</td>
<td>Nicolaus Glomb MD and Kevin Padrez, MD presented a needs assessment for SF EMS provider pediatric simulation training. Data gathered from SFFD 2018 pedi PCRs; survey of EMS providers and focus groups. &lt;br&gt; SFFD monthly pedi encounters range from 195 – 250. Highest encounters in south of market and south east neighborhoods. Ages 16-18 yrs and males. Trauma/MSK/Burns highest primary impressions. &lt;br&gt; Paramedic surveys results included Likert scale rankings of provider opinions on comfort w/ skills in managing pedi pts w/ respiratory, cardiac arrest, shock, newborn, trauma and other clinical issues. Focus group results were provider quotes on level of comfort w/ pedi patients. Overall, providers are uncomfortable w/ peds due to low frequency of encounters and training.</td>
<td>EMS providers want high fidelity pediatric simulation. &lt;br&gt; Results support the additional pedi training.</td>
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</table>
| VII. Proposed revision to Policy 1010 Advisory Committees to Update EMSAC Membership | Sam Schow, alternate ALS representative, and James Lee, primary BLS representatives on EMSAC committee proposed changing the committee membership to include more field representation consisting of 911 and non-911 providers. Proposed motion change to Policy 1010 Advisory Committee Section VII.A - EMSAC Committee membership to replace current structure for ALS and BLS committee representatives by adding:  
- 1 transport paramedic  
- 1 transport EMT  
- 1 first responder paramedic and EMT  
- 1 first responder paramedic and EMT  
- 1 paramedic supervisor  
Committee comments:  
- Backbone of this committee should be a clinical focus despite whatever membership changes are made.  
- Unclear on why changes needed since committee focus is on the EMS system as a whole. | Proposed motion passes with:  
- 10 votes “for”  
- Zero against  
- Zero abstaining  
Proposed change will go out for public comment with next set of proposed revisions. |
| VIII. Centralized Ambulance Destination Determination (CADDIE) Pilot Project: | Dr. Brown presented. Selection of hospital destination is passively governed by Policy 5000 Destination with occasional input from Base Hospital physician. CADDIE proposes that the Base Hospital physician does active re-direction of 911 ambulances based on dynamic data to balance ZSFG and CPMC Emergency Department ambulance arrivals. Goal is to “load balance” arrival of 911 ambulances through the following:  
- Maximize use of current capacity by matching EMS patient need to hospital capacity.  
- Keep patients in medical homes as much as possible.  
- Decrease ambulance surge at individual hospitals during busy periods.  
- Improve ambulance patient turnover times.  
- Improve patient/provider/hospital personnel satisfaction.  
Pilot will exempt stroke and STEMI patients. Anticipate one-week trial (pilot project) end of April/early May. Trial supported by CPMC and ZSFG.  
Committee comments:  
- In-patient hospital capacity has the biggest impact on ED bed capacity since admissions must wait for beds in the ED. This project does not address that issue. | Pilot will go out for public comment next week. Will also be reviewed at EMS Agency Research Subcommittee. After pilot is concluded, data + analysis will be sent to committee. Any recommended policy changes will go through the normal policy review process. |
| IX. EMS Agency Cardiac Initiatives: | EMS Agency is evaluating mechanical compressors for select EMS cardiac arrest cases. Autopulse + Lucas Mechanical CPR compression devices evaluated by a “demonstration day” that was open to any EMS/hospital participant. Results showed a small preference for the Lucas device.  
SF EMS Agency reviewing ~ 300 STEMI cases from 2018. Analysis in progress, but estimating 34.5 minutes from first medical contact to ED for EMS STEMI pts.  
Cardiac Arrest Registry to Enhance Survival (CARES) final 2018 Utstein results not ready for today’s meeting. Jim Duren noted that CPR mechanics were improving across the EMS system. | Evaluation of mechanical compressors for EMS is continuing and will be reported at a future meeting.  
2018 CARES Utstein results for SF EMS deferred to next meeting. |
IX. EMS Agency Cardiac Initiatives:

In-person resuscitation recognition commended the following field personnel:
- **King Medic 12**: Owen Beere and Megan Guidry
- **SFFD Engine 10**: Jose Del Grande, Anthony Reyes, Ronnie Lakin and Gavin Thompson
- **SFFD RC 2**: Hansjuerg Enz

X. Project Friend

Dr. Mary Mercer presented on “Project Friend” that provides increased education and distribution of naloxone to First Responders.
- Project is collaboration between EMS and SF Public Health and incorporates principles of harm reduction with the goal to combat opioid overdose-related deaths throughout CA through the provision of free nasal spray naloxone.
- Supported with local, state and federal funding.

Activities:
- Training certified and non-certified* first responders.
- Training in naloxone administration AND distribution.
- Provide referrals to treatment resources to all patients either administered or distributed naloxone by certified first responders.

Contact Dr. Mary Mercer, Dr. Eric Silverman, + Ms. Virginia Chan for additional information: mary.mercer@ucsf.edu; eric.silverman@ucsf.edu, virginia.chan@ucsf.edu

Anticipate Naloxone distribution protocol for committee review during the summer.

XI. Operations Subcommittee Report

Working on updates to policies (1010 EMS Committees; 7010 Special Events and 8000 MCI.

Any updated policy or protocol will follow the standard process for comment and EMSAC approval.

XII. Items from the Public

The new Chase Center Arena in Mission Bay is opening Sept. 6th. Requesting information about any plans to manage the traffic surge especially when there are concurrent events in SF.

Will add to future agenda.

XIII. Adjournment

Megan Corry ended meeting at 1530 hours.

Next meeting June 12 from 10 am – 12 noon

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**EMS CARDIAC INITIATIVES**

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**“2020/50”** San Francisco will have a cardiac arrest survival rate of 50% with CPC scores of 1 – 2 for witnessed cardiac arrests with bystander CPR and a shockable rhythm by the year 2020.
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<thead>
<tr>
<th>Organization</th>
<th>Primary Representative</th>
<th>Alternate Representative</th>
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<tbody>
<tr>
<td>SFGH - Base Hospital</td>
<td>Mary Mercer</td>
<td>Theresa Sandholdt</td>
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<tr>
<td>SFGH - Trauma</td>
<td>Sue Peterson</td>
<td>David Staconis</td>
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<tr>
<td>SFFD Medical Director</td>
<td>Clement Yeh</td>
<td>Open</td>
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<tr>
<td>SFFD EMS</td>
<td>Andy Zanoff</td>
<td>Tony Molloy</td>
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<tr>
<td>Dept Emergency Communications</td>
<td>Clement Yeh</td>
<td>Maria Luna</td>
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<tr>
<td>CPMC: Van Ness, Davies, Bernal</td>
<td>Shannon Thomas</td>
<td>Colleen Broderius</td>
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<tr>
<td>Chinese Hospital</td>
<td>Joseph Lotsko</td>
<td>Susan Spoelma</td>
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<tr>
<td>Kaiser San Francisco</td>
<td>Scott Campbell</td>
<td>Timothy Tugade</td>
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<tr>
<td>Kaiser South San Francisco</td>
<td>Raymond Han</td>
<td>Jay Frankera</td>
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<tr>
<td>St. Mary’s Medical Center</td>
<td>Amy Fein</td>
<td>Terri Johnson</td>
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<tr>
<td>St. Francis Memorial Hospital</td>
<td>Karl Frank</td>
<td>Maggie Murillo</td>
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<tr>
<td>Seton Medical Center</td>
<td>Michael Thomas</td>
<td>Open</td>
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<tr>
<td>UCSF</td>
<td>Laura Jacobson</td>
<td>Arnold Shepherd</td>
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<tr>
<td>UCSF-Mission Bay</td>
<td>Barbi Feldhauser</td>
<td>Rajesh Daftary</td>
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<tr>
<td>VA Medical Center</td>
<td>Michael Gutierrez</td>
<td>Jonathan Garber</td>
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<tr>
<td>American Medical Response</td>
<td>Brad White</td>
<td>Rod Brouhard</td>
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<tr>
<td>Bayshore Ambulance</td>
<td>David Bockholt</td>
<td>Jeff Delmar</td>
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<tr>
<td>Falck Ambulance</td>
<td>Chris Lebadour</td>
<td>Jennifer LaRault</td>
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<tr>
<td>King-American Ambulance</td>
<td>Josh Nultemeier</td>
<td>Melyssa Farmer</td>
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<tr>
<td>NorCal Ambulance</td>
<td>Danielle Johnstone</td>
<td>Dan Bobier</td>
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<tr>
<td>Pro Transport-1 Ambulance</td>
<td>Alex Baker</td>
<td>Danny Bermingham</td>
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<tr>
<td>SF Emergency Physicians Assoc.</td>
<td>Mickey Rokeach</td>
<td>Hallam Gugelmann</td>
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<tr>
<td>City College Paramedic Program</td>
<td>Megan Corry</td>
<td>Jim Choi</td>
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<tr>
<td>Dept. Public Health</td>
<td>Jan Gurley</td>
<td>Tiffany Rivera</td>
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<tr>
<td>SF ALS Field Provider</td>
<td>Ray Ryan</td>
<td>Sam Schow</td>
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<tr>
<td>SF BLS Field Provider</td>
<td>James Lee</td>
<td>Sina Riahi</td>
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<tr>
<td>Public Representative</td>
<td>Theresa Farina</td>
<td>Richard Pekelney</td>
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**Pediatric Advisor:** Rajesh Daftary, MD  
**Research Coordinator:** Juan Carlos Montoy, MD  
**Education & Training Advisor:** Chris Colwell, MD  
**EMS Fellow:** Sammy Hodroge, MD

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<thead>
<tr>
<th>Guest Name</th>
<th>Organization</th>
<th>EMSA Staff</th>
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<tbody>
<tr>
<td>Nick Glomb</td>
<td>UCSF</td>
<td>Jim Duren</td>
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<tr>
<td>David Malmud</td>
<td>AMR</td>
<td>Mary Magocsy</td>
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<tr>
<td>Joshua Smith</td>
<td>SFFD</td>
<td>Andrew Holcomb</td>
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<td>Aram Bronston</td>
<td>Region 2 RDMHS</td>
<td>John Brown</td>
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<tr>
<td>Nick Payne</td>
<td>SFFD</td>
<td>Crystal Wright</td>
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<tr>
<td>Eric Silverman</td>
<td>ZSFG Hospital</td>
<td>Patricia Zialcita</td>
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<td>Kibrom Tewolde</td>
<td>St Francis Hospital</td>
<td>Editha Dorosh</td>
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<td>Kathy Vo</td>
<td>ZSFG Hospital</td>
<td>Dave Ebarle</td>
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**Revision Summary: Policy 1010 Advisory Committees**

REVISIONS: Minor grammatical updates and format revisions were done throughout the document to improve clarity. Only significant revisions are noted below.

**Section I – Purpose**
- Added EMS Agency Guiding Principles: patient advocacy, evidence-based decision-making, and systems approach to improvement.

**Section II – Policy**
- Added statement about obtaining consensus.

**Section III – Open Public Meetings**
- Added language about conduct during EMS Agency meetings.

**Section IV – Parliamentary Authority/Quorum**
- Added language in which committee can continue without quorum for informational agenda items only.

**Section VI – Committee Officers**
- Added that the EMS Agency Research Advisor is the standing chair for the EMS Agency Research Committee.

**Section VII – Standing Advisory Committee and Subcommittee**

- **Emergency Medical Services Committee (EMSAC)**
  - Added representative from Research Committee
  - Added first response field representative
  - Added IFT field representative

- **Medical Directors Committee**
  - Added new subcommittee to formalize group which has been meeting regularly for 1 year.
  - Included scope, meetings, quorum, and membership.

- **Operations Committee**
  - Added new subcommittee to formalize group which has been meeting regularly for several years.
  - Included scope, meetings, quorum, and membership.

- **Trauma System Audit Subcommittee (TSAC)**
  - Removed representative from burn center for quorum.

- **Stroke Subcommittee**
  - Added new subcommittee for stroke care which will need to be developed for stroke center designation and performance improvement.
  - Included scope, meetings, quorum, and membership.
### Research Committee
- Added new committee for research and pilot projects to formalize group which has been meeting regularly for 1 year. Included scope, meetings, quorum, and membership.

### Appendices
- Updated list of ambulance providers and hospitals to reflect current organizations.

<table>
<thead>
<tr>
<th>Comments: 1010 Advisory Committees Policy</th>
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</table>
| Regarding rescue captains and private supervisors, we think that the language of the policy will be more succinct if that field provider role is simply referred to as "Paramedic Field Supervisor." It is unnecessary to include provider-specific titles (Rescue Captain; On-duty Supervisor) because the position is well-defined and named in Policy 2052. I really like the language you used "transport paramedic vs. non-transport paramedic," as it very simply and clearly distinguishes between the two prehospital field clinician roles without diving into other, more murky aspects. The small clarification that I would make to these descriptions would be to replace "permitted ambulance company" with "permitted ALS provider agency." This edit is simply to preempt the question: "Why are we saying that non-transport paramedics and emts must be working for a permitted ambulance company? They don’t all work for an ambulance company." With these small edits in mind, the revised policy would read as follows: **EMSAC Membership:** Consists of the EMS Agency Medical Director (ex-officio) and one primary representative and one alternate representative from:
1. Ambulance Provider Companies listed in Appendix A
2. San Francisco Receiving Hospitals listed in Appendix B
3. San Francisco Emergency Physicians’ Association
4. City College of San Francisco - Paramedic Training Program
5. San Francisco Department of Public Health
6. San Francisco General Hospital Base Hospital Medical Director
7. San Francisco Fire Department EMS Medical Director
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13. Paramedic Field Supervisor field representative currently accredited in San Francisco and working for a permitted ALS provider agency, appointed by the EMS Agency Medical Director
Members of the public, not affiliated with a regulated provider organization, and appointed by the EMS Agency Medical Director. |
| Reviewed. In light of adding additional representatives on the EMSAC Committee, the EMSA has decided to keep the EMSAC the same and instead hold quarterly town halls with field providers. The town halls would be coordinated through the EMSAC field provider representatives and location space sponsored by the EMSA. |

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- Sam Schow, ALS Field Representative
I’m concerned that the motion and proposal for field representatives from the EMSAC didn’t get translated into the proposed changes shown here. As I recall, the motion was to revise the Advisory Committee policy to replace the current 1 BLS field representative and 1 ALS field representative with the following:
1 non-transport Paramedic
1 non-transport EMT
1 transport Paramedic
1 transport EMT
1 Paramedic field supervisor

If we leave the language as is, then we have public comment on something very different than the approved motion from the EMSAC meeting in April.

- Megan Corry, CCSF Paramedic Program Director

This language [below] reflects the motion that was approved by the committee on 4/8/19.

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The current wording in the May 2019 Public comment (policy 1010) is not correct. And does not reflect the motion which people voted on.

- James Lee, BLS Field Provider Representative

See above response.
I’m sure that others have noted the discrepancies from the minutes regarding section VII and the proposal made by James Lee and Sam Schow. I feel that the purpose and merit of including more field providers to better reflect the changing dynamics during prehospital care may have been lost in the discussion from last meeting and the subsequent proposed changes to the policy. I hope we can continue the discussion with the language that was proposed by my colleagues.

As a field representative I have spent time discussing and listening to the other field workers on the state of EMS in this county. I have come across a disturbing recurring theme concerning the relationship between the EMSA and the Paramedics and EMTs working under the agencies guidance. The sentiment from the field towards the agency is that it is a predatory force to be avoided. “Awards season is over; investigations and disciplinary actions are not far behind”. Having a lawyer in mind before you talk with an agency is not a healthy relationship. Quality control is important but it appears to be the only facet acknowledged by the field. If this sentiment continues we will continue to have low participation. Lack of ownership in this professional community will promote this continued mind set of minimal compliance. If we are still fighting “Normalization of deviance” we can combat it as a community that wants to improve or continue as is where we race to the minimum to avoid a target on our backs.

In keeping with the guiding principles of this committee: You’ll find in this world class EMS system plenty of EMT’s and Paramedics that want to be better patient advocates. There is valuable and un tapped data and evidence concerning the distinct needs of this city that is not being considered. And when it comes to systems approach to improvement, you’ll never see the elephant if those engaging the problems daily are discouraged from telling us what they see.

- Ray Ryan, ALS Field Provider Representative

VII A: The current make-up of the EMSAC leans much more toward the hospitals and has a limited number of field spots shared equally by SFFD, which provides all first response, the large majority of transport and on-scene clinical supervision with other ambulance providers. Would like to see a change to field representatives:

- 1 Field Supervisor from private ambulances
- 1 RC from SFFD - The field rescue captains respond to every critical medical response, working fire and technical rescue in San Francisco. This small group of providers could provide vital field level information and input for the most critical events handled by EMS. They should have their own distinct representative.
- 1 Non-transport EMT (engine or QRV)
- 1 Non-transport paramedic (engine or QRV)
- 1 EMT SFFD ambulance
- 1 Paramedic SFFD ambulance
- 1 EMT private ambulance
- 1 Paramedic private ambulance

VII C: It is unclear why unresolved operational issues would be the purview of the Medical Directors’ subcommittee. Unresolved issues from the Operations subcommittee should go to the full EMSAC for wider discussion and resolution.

- Sandy Tong, SFFD - EMS Division

VII A: See above response.

VII C: Reviewed. Medical directors weigh in on patient care decisions and standards including operations impacting patient care. Not all unresolved operational issues would be reviewed by the medical directors group; some would be referred directly to the EMS Agency Medical Director.
Revision Summary: Policy 7010 Emergency Medical Services at Special Events

REVISIONS: Minor grammatical updates and format revisions were done throughout the document to improve clarity. Only significant revisions are noted below.

Section III
- Modified MCI kit for special events. MCI kit to include same items on ambulance without position vests or worksheets/boards.

Section VI
- DEC shall be notified of ambulance transport from event and will not regularly backfill.

Section IX
- Post-event medical transport reports need to be submitted within 72 hours instead of 2 weeks.

Section XI
- Revises policy to allow for BLS to transport from a special event footprint without an ALS assessment.
- Added reference to Appendix C to determine if patient requires ALS assessment.
- Describes scope of BLS transport from medical plans footprints. Plan needs to be approved by EMS Agency.
- Requirement to communicate with DEC if transport from Special Event.
- Describes training requirements for EMTs in order to utilize BLS transport.
- Requirement to submit PCR to EMS Agency within 24 hours if BLS ambulance transport occurs at an event.
- Clarification for EMSA Policy 4041 and mutual aid escalation versus special event footprint.
- Documentation requirements unchanged from previous 7010 Policy. Moved to new section.

Section XII:
- Updated citations.

Appendix A
- Removed previous Appendix A chart.
- Included list of definitions for event level designations and flow chart for recommended medical resources with minimum medical resources/requirements and provides description. **Level 1** is most resource heavy while **Level 5** has least resources.
- All Levels must have CPR trained resources, AEDs, and 911 access.
- Modified swim/water event requirements to include experienced EMTs or Paramedics on boat, consider use of mechanical compressor, and clarified language around Personal Water Crafts.
- Includes flow chart to assess event Level type based on previous risk assessment.
- Known Risk Factors (in Blue) lead to more utilization of EMS resources.
• Mitigating Risk Factors (in Yellow) lead to less utilization of EMS resources.
• Mitigation Risk Factors allow for a one-time reduction in Level if requirements are met (reassessed after every event).

Appendix B
• Appendix B: Clarified BLS Ambulance use and added definitions based on flow chart in Appendix A to reflect overall changes in Policy 7010.
• Clarified language of water-based resources to reflect overall changes in Policy 7010.
• Added Sobering Services, SEAR, and free speech definitions.

Appendix C
• Added guidance for BLS assets on when to call for ALS assessment and/or transport.
• ALS Criteria added for guidance on when an ALS assessment, transport, or interventions are likely to be necessary.
• Included language that refers to Policy 5000 for sobering services criteria and Policy 5001 trauma triage criteria to minimize difference in policy.

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<tbody>
<tr>
<td>The ability to swim in the SF Bay, especially for events such as our Alcatraz swims, is an important public benefit to those living in the Bay Area and tourists who are visiting. Our swims provide important training opportunities for seasoned athletes, and milestones in the lives of many people. As a group that promotes individual open water achievement and prizes safety, Odyssey supports the proposed rule. We believe that the current rule places requirements on open water swimming groups that are impossible to meet given lack of resources -- in particular, a lack of ALS ambulances and certified paramedics. The rules currently in place make it a practical impossibility for groups like ours to conduct swimming events because there simply are no available ambulances that are approved by the SF DPH. The ability to use BLS ambulances as provided in these draft rules would allow Odyssey to operate its swimming events while still putting swimmer safety first. They strike an accurate balance given real-world constraints. We therefore support the adoption and implementation of the proposed rules.</td>
<td></td>
</tr>
<tr>
<td>Warren Wallace and Jeff Collins, Odyssey Open Water Swimming</td>
<td>Reviewed. Thank you for the feedback.</td>
</tr>
</tbody>
</table>

II.A. Currently, there are fixed venues across SF which more than 2,500 patrons that regularly hold events (Bill Graham, Moscone, etc) and have not been required to submit EMS plans because they have stayed within their building footprint and not hit any permitting requirements. Is the intent of this to require all of those to begin submitting EMS plans? If so, I suspect this will receive a lot of pushback.

II.B. Who ultimately is responsible for submitting the plan, the EMS provider providing services or the Event Promoter? This seems to vary event to event and sometimes promoters will not submit a plan--who gets held responsible? I think that is something to consider adding.

Reviewed. The intent of the policy is to have standard guidelines for Special Event Medical Plan review should a permit issuing agency require a medical plan. The EMS Agency does work closely with fixed venues to ensure medical assets are available to minimize impact to the 911 system.

Reviewed. The responsibility party is the person or organization applying for the event permit.
Another issue we've had (and this is partly a portal issue) is we have been listed on EMS plans for events that we have no part in—sometimes by accident, other times on purpose to make it look like the event has coverage. I think there should be a requirement to list all EMS contacts listed on the plan in the email section of the portal—requiring some acknowledgment from them would be nice as we have had situations where event promoters have improperly listed resources and the plan was approved before we were notified. Not a huge issue since providers could email DPH, but just a thought.

III.C. The MCI kit does not seem to have contents to care for 50 people (aside from 50 tags). More on this later.

IV.A. 7010 seems to only be affective in events that truly need and EMS plan, but I noticed that you no longer have 911 Access/CPR (or AED) as a plan level. I don't know the rest of the city policies as well as you do, but from my reading, unless there is another Mass Gathering Policy in effect, if the event doesn't require a permit and is under 2500, no 911 Access/CPR/AED is required. Along the same lines, if I have an event with 500 people but get an entrainment permit or 50 people for a block party that results in a street closure, am I required to have EMTs onsite? To me, that's what the policy seems to require, but I am not sure if that is correct or the intent.

IV.B. If a Paramedic is providing BLS services (not accredited in CA), I assume they are not permitted to perform an ALS assessment—if so, I think that should be noted. If you are allowing them to perform and assessment (but not ALS procedures), I actually think that could be beneficial to your BLS transport policy, but I am assuming that is not the intent.

IX. I would consider putting in a clause giving an extension if there is a holiday. I would also look into creating a digital form for this—I think this date could be extremely valuable if it was organized in a reportable way for research.

Appendix A
Level: Who is setting the levels when the matrix gives a range? Is the promoter choosing or is DPH specifying?

Mitigating Factors: I would consider more than a 1 time reduction, subject to EMSA’s discretion. For example, after reviewing our treatment numbers this week, if they are similar to last year, we may be asking for a large reduction in resources for B2B next year—since our patient numbers have declined steadily since alcohol was banned but our resources have not decreased significantly. Obviously, B2B will still fall as a Level 1 event, but there are similar situations where we have thousands of people but low ambulance usage where we may initially start out as a Level 1 or 2 but could

Reviewed. If there is a question as to whether resources in the plan are accurate, the EMSA will contact the medical provider. Ambulance providers have requested to be notified if they are listed on a plan.

Reviewed. MCI kit are orientied toward the intial care of MCI patients. Not all patients from an MCI are critical however all of them need to be accounted for and tracked. Additional resources may be requested as needed through the ICS structure. This list is minimum stock. You may opt to upstock your supplies.

Agree. All events should be able to provide 911 Access and CPR. EMSA will revise policy to reflect

Agree. SF paramedics must be be accredited in SF AND be on-duty with a provider at a special event. ALS assessment would be part of their scope of practice.

Agree. EMSA will update the policy to reflect “3 business days.”

Reviewed. The level is set by the EMS Medical Director and are reviewed on a case-by-case basis.

Reviewed. A level reduction will evaluated by EMS data/post-treatment report and is a one-time reduction from the original level. The reduction is re-evaluated every year. The reduction is not solely based on number of ambulance usage. For example, the number of patients in a first aid or sobering station would be taken into account amongst other considerations.
conceivably get down to a Level 3 or 4.

Along the same lines (on the matrix), I would add compliance with EMSA policies as a requirement for reduction eligibility. If you have somebody not submitting plans on time, not sending treatment reports, or not properly allocating resources, they are not someone that should be eligible for a reduction, and that gives you more discretion.

"If an event is reduced by 1 Level and impacts the 911 system or event-type changes, the reduction can be reinstated" --should this be "the event level can be increased." Are you saying that EMSA can keep the reduction in place if the 911 system is impacted or the promoter will need to provide more resources?

What is the acceptable impact on the 911 system? If an event has no ALS units and 1 transport over the course of the event, or 2 ALS units but 1 city unit is pulled once, is that acceptable? In my mind, I would say so--I would say multiple transports would be putting a strain on the EMS system, but I think any utilization is a low threshold--especially when the events are open to the public and the transport is unrelated to the event (ie a transient) but happens within the event boundary.

**Level 1:** We have had some events with 4 ambulances (Pride, Saturday) with no DEC dispatcher, but instead, a EMS service dispatcher. I think that 4 ambulances is a bit too low of a threshold to require DEC onsite. I think suggesting them is reasonable, but the biggest benefit to DEC onsite is actually just relaying 911 calls--which is really independent over the number of ambulances onsite and more correlated with event footprint.

Similarly, we have events that we use 4 ALS ambulances at (Outside Lands) but that we do not use ALS teams--all patients are transported either to our clinic or ALS intercept points at the event perimeter. Tying ALS foot/bike/gator teams to number of onsite ambulances is going to change the way many events are run and actually end up requiring additional paramedics for events.

**Level 3:** My once concern with this policy is it does not address what happens if no company is able to provide an ALS unit. Are there additional options if no units are available?

I also don't see the requirement to have an RN or a Paramedic at an aid station anymore (if this is in another policy, please point me to it). It was hard to find a company to do a single medic but a nurse could provide the ALS assessment and then transfer with BLS. What are your thoughts on allowing BLS with an RN or medic onsite in place of an ALS unit if an ALS unit is not available? I don't know what DPH's thoughts/jurisdiction is to either compel accredited units to take standbys or potentially Agree. EMSA will update the policy to reflect this comment.

Agree. EMSA will clarify language in policy.

Reviewed. EMSA would have to review the event, medical plan, and calls on a case by case basis based upon event and previous event history.

Agree. EMSA will update the policy to include “should” instead of “shall” for Level 1 events.

Agree. Foot teams can be ALS or BLS. EMSA will update policy to clarify ALS “resources.”

Reviewed. Through the risk assessment, if an event meets Level 3, the event must have ALS resources. EMSA works closely with event promoters to ensure assets are sought after early in the planning phase. This policy also allows a mix of ALS/BLS resources that could not be as easily utilized in previous policies.

Reviewed. EMSA cannot compel units to contract for standbys. The EMSA does not permit special events. EMSA approves or denies a medical plan, which may or may not have an indirect effect to the issuance of a permit.
allow for a special permit for providers to be permitted on a temporary (event only) basis within the city. Is DPH willing to cancel major events that can’t get units? What type of accountability is there going to be?

Appendix B

First Aid Station with EMT: I think the MCI requirement is appropriate for an event, but I think there could be a little more flexibility in how many are required. If each aid station is required to have an MCI kit, I am required to have 11 for B2B, and additional 11 on ambulances, and the DEMSU is onsite which is not credited in this policy. For outside lands, all of our kits are on our supervisor cart units so they can quickly be moved to the scene, we don’t keep any at fixed locations (the ambulances have their own). I think it would be more appropriate (and realistic equipment wise) to link the number of kits required to the event size/footprint as many organizations (including us) will likely try to reduce resource if requirements start becoming too cumbersome (i.e. combine aid stations). Interested in your thoughts on this one.

First Aid Station with Paramedic, Nurse, or Physician: In regards to your Physician requirements, I would consider sticking with the competencies you have--and consider defining additional experience related to the expected patients at the event--rather than listing specialties. A Sports Med physician may be fine for athletic events, they will likely not be comfortable dealing with drug/alcohol intoxication. Same with Family Med--they may be great for street fairs, but I have yet to meet one comfortable with critical patients. One of our best doctors for concerts is actually an anesthesiologist.

I also don’t see ALS/Sobering requirements listed in the levels---unless this is in a separate policy, do you plan to put these in (ie what kinds of fixed medical stations are required)? I would be happy to talk about these or look at them if they are listed elsewhere.

Mobile Resources: This looks good, except the AED requirement. I support having as many AEDs onsite as possible, but as you know, this is the most cost prohibitive item. Many other standby companies historically have provided 1 AED for the event at the aid station and had multiple foot units. I think it is important to have AEDs spread out, but for large events, I think there should be some consideration when an event is saturated with them.

For example, we have 20 field teams at Outside Lands plus carts, all of which carry AEDs. Since we usually post teams at first aid tents (first aid, not ALS tents), we do not always have AEDs designated in the tent, simply because we do not own that many and we believe it is more important to keep them with the responding team. For Pride, all our EMS plan teams have AEDs, but we add additional teams into the celebration area. Due to a limit on equipment, these teams do not carry AEDs. We mark them on our

Agree. MCI kits shall be on every ambulance per policy 4001. While policy 4001 reflects many different types of events, most events do not have carts as part of the medical plan unless the event reaches Level 1 or 2. In a case-by-case situation, based on the submission of the plan, EMSA could assist in the best placement of MCI kits for operational purposes. To some degree, the number and location of kits is dependent on the required MCI plan that should be developed by the EMS Provider, which has to be tailored to the event itself. Our intent is to make the event medical resources as prepared as possible for an MCI.

Reviewed. Specialties listed are intended as a range of possibilities; if a specialist with specific experience is engaged for the event, that can be included (with their qualifications) in the medical plan. Not every physician is comfortable/competent operating in a special events environment.

Reviewed. Sobering services are part of the risk assessment under Appendix A matrix.

Reviewed. See above for MCI kit location.
dispatch system so our dispatcher knows not to send them to a cardiac call and carry AEDs on our carts/bikes so we can get them into the crowd if we need to.

As of now, we would likely just leave the additional teams off the EMS plan--our goal is always to exceed what we submit, so for us that's not an issue. However, if DPH wants an accurate count of resources onsite, this is something to consider.

**Appendix C:**

**B.1.** Anxiety attacks are something we often see in the 14-26 year old range and we regularly have elevated respiratory rates. I don't know how specific you want to get with this criteria, but if you really want to cut down on ALS transports, I would probably allow BLS to take a patient under 30 with no hx of airway disease and a known history of anxiety with a normal O2 sat.

3. Need for inhaler--I would probably clarify that this is need for inhaler and none available--if somebody uses their inhaler and improves, but still requires transport, are you making this an ALS transport if they otherwise meet BLS criteria because they used the inhaler?

G. I think you need to add hyperthermia. Yes, this could true heat illness at an athletic event or outdoor event--I am not sure if you want BLS transporting this or not. However, my main concern is hyperthermia due to drug use (specifically serotonin syndrome) that we see a lot of.

We see this a lot--and patients decompensate extremely quickly--so I would personally be inclined to consider this as a critical patient that BLS can transport if faster that waiting for ALS--but I would definitely add this in somewhere.

Clinical Considerations:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3865832/

**H.I.1.** I would consider adding "with symptoms of hypotension"--if you have a pediatric patient (or a very thin female), we often get them with pressures in the 90s but that's baseline or near baseline. I would consider dropping the threshold to <90 or <100 but symptomatic hypotensive.

2. I would consider defining what you consider unstable--specifically adding in hyperthermic

3. My concern here is with the word overdose--how is this defined? There is no "safe" dose for many of the drugs people take, so I think it would be more appropriate to just

<table>
<thead>
<tr>
<th>Partially Agree. Patient could be transported by BLS after an ALS assessment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree. EMSA will update policy to reflect no improvement with self-administered inhaler.</td>
</tr>
<tr>
<td>Agree. EMSA will update policy to reflect drug-induced hyperthermia or hyperthermia of unknown cause.</td>
</tr>
<tr>
<td>Agree. EMSA will update policy to reflect change. Check with current tx protocol</td>
</tr>
<tr>
<td>Agree. EMSA will update policy to reflect change.</td>
</tr>
<tr>
<td>Agree. EMSA will change language to “intoxication”</td>
</tr>
</tbody>
</table>
say intoxication. My next question is, if you have a patient with known alcohol or drug use and they are behaving abnormal, but normal for their clinical history, are you comfortable with BLS taking that if they have stable vitals?

We used to do that quite often—either ETOH or Drug intox patients that appeared stable, had vitals that were expected for their substance, and we had information or suspected drug use—these often went BLS. But clearly their behavior would still be abnormal from baseline. I think this is potentially going to be your most influential ALS saver depending on how this is written. Additionally, if you have an agitated or combative (restrained) patient, does this require ALS or can BLS transport?

In regards to the MCI kit, I think it is a good idea to remove the vests and worksheets from the event medicine kits since those should be on the ambulances. The bullhorn is going to make the kits (for smaller events) large and we meet the requirement with a cheap bullhorn off amazon that probably wouldn’t work that well (because we would not actually use it in an emergency, PD would clear the scene for us), so I would strongly consider removing this along with the vests for event requirements. For most large events, the ambulance will have a PA as well.

What kind of MCI are these kits supposed to provide for? If we are talking the shooting/bombingstage collapse/vehicle attack, I think the CATs and blood stoppers are good, but it would also be beneficially to add some loose (not hemostatic) packing and roller gauze, occlusive dressings, and tape. I would also make a more detailed note about the CATs—if you go on Amazon or Ebay, you can buy knock offs that won’t work for $7 instead of $30—so I would consider listing acceptable brands/models.

For airways, I would strongly consider switching to NPAs. Not only will you most likely not be using an OPA with START, as most patients that need them will end up black, but NPAs are much more useful in more conditions, especially in a situation of a mass opiate overdose, such as at 420.

I also do not see the benefit for the 50 cone masks, as aside from a few for the medical staff, patrons should be evacuating the area. Same with work gloves (not such a big deal), but EMTs are not going to be performing heavy rescue so I am not sure the benefit.

Another thought—do you want the event medicine staff to be doing triage tags or tape? If not a EMS provider, these EMTs are likely to be less experiences than ones from the 911 system, and I know in discussions with BFD, they said they would want to retag all our patients, so we are opting for triage tape only and letting the system do the tags themselves. Just a thought.

Reviewed. Agitated patients need ALS transport in our current system, due to issues around airway monitoring and intervention and the potential need for medication.

Reviewed. EMSA is open to revising the MCI kit. However, the Policy 4001 is not planned on being updated at this time.

Reviewed. The MCI kit is a minimum equipment list. Medical providers can add equipment based on operational needs based on the event.

Reviewed. The cone masks and gloves are for debris, collapse, and PPE after an earthquake.

Reviewed. Event medical staff would be responsible to start the triage process in an MCI. The EMSA would be open to moving to a tape-based system on initial triage but is not planning on updating policy at this time.
It may be beneficial to add special requirements for some specific events—such as adjusting kits to allow for weather issues, mass overdose, etc.

Lastly, I think it is important to note whether this equipment needs to be separate or can be double counted with supplies already at the event—I know very few other standby companies (non-EMS providers) historically have had kits, even with the requirements.

As a side note, I noticed some references to PDT. Is this in effect? If so, can you send to me? Is this just for transport or treatment as well?

- Daniel Berger, Rock Medicine

Good to see some grey areas for special events addressed in the extended policy. Could there be review or feedback from the ambulance providers after the implementation of these changes? Also is there a list of approved special event providers in the city that are not necessarily ambulance providers?

- Ray Ryan, ALS Field Provider Representative

Appendix A: Any changes that result in a reduction of medical coverage at special and big events will result in event staff becoming more reliant on the 911 system. Nationally, the tragic events of Las Vegas (mass shooting) and Boston (marathon bombing) underscore how strong event coverage can dramatically reduce morbidity and mortality when an event becomes a manmade disaster.

Appendix C: If more events can downgrade coverage (less ALS) there will be more calls for ALS assessments, thus pulling more units from the system.

H1: Should be GCS less than or equal to 13 (is written 13 or greater).

J: If a pregnant patient presents with a small abrasion at a BLS staffed event, calling for an ALS assessment seems inappropriate. Should read: All OB/Gyn related emergencies in a pregnant patient needs an ALS assessment.

- Sandy Tong, SFFD - EMS Division

Agreed. The EMSA is working with promoters on a case-by-case basis to ensure public safety based on the scope and type of event.

Reviewed. The EMSA reviews this as an operational need based on medical plan review.

Reviewed. The PDT language is clarified so EMTs can complete a PDT but not an AMA.

Reviewed. Thank you for the feedback in regards to the grey areas. EMSA had a workgroup to rewrite the policy. EMSA will assess the implementation of this policy and review it at a later date. In terms of approved special event providers, there is not currently an approved list. However, EMSA is interested in exploring the possibility.

Appendix A: Reviewed. EMSA’s number one priority is patient care and advocacy. The intent of the risk assessment model is to improve allocation of limited resources to improve the responder. Event resources will initial the response. Significant MCI’s will require support from 911 resources.

Appendix C: Reviewed. While less ALS resources will be required at some events, this decision is driven based on known risks at events, prior treatment/patients, and impact to the 911 system. Furthermore, BLS has an expanded role. Previously, ALS would have to be called whereas BLS can now transport depending on the patient.

H1: Agree. EMSA will update policy.

J: Agree. EMSA will update policy to reflect OB/GYN complaint.
Revision Summary: 8000 Multi-Casualty Policy

REVISIONS:
- Section II: Various minor updates to the cited authorities.
- Section IV. Deleted several listed training requirements due to being redundant (listed in other policies).
- Sections V. and VI. Minor updates to make the language more concise.

8000 Multi-Casualty Plan

REVISIONS: Minor grammatical updates and format revisions were done throughout the document to improve clarity. Only significant revisions are listed below.

Part 1 Standard Operating Procedures: Dispatch, Field Supervisors, Hospitals and DEM Duty Officer
- Ambulance diversion is automatically suspended for all patients during an MCI. Previous version had diversion suspended only for MCI patients.
- Added for Level 4 MCIs (catastrophic incident) additional descriptive language about SFFD battalion stations function as the designated Emergency District Coordination Center (EDCC).

Part 1 Standard Operating Procedures: Hospitals
- Ambulance diversion is automatically suspended for all patients during a MCI.
- Deleted section on MCI Yellow vs. MCI Red vs. HavBed since this is included in other training materials.

Part 2 Background and Training
- Renamed this section “Background and Training” to clarify the intent of this section of the plan.
- 2.1.3 and Authorities and 2.1.4 Training – deleted redundant language on cited authorities and training standards since they are covered in the 8000 MCI Policy.
- 2.2.5 Documentation – Added citation for new Appendix C MCI Field Documentation algorithm.
- 2.2.6 Deceased Care – Added additional details for the handling of the deceased in the field.
- 2.4 Alert Levels – Deleted portions of the Alert table because it was redundant. The same table is found in Part 1 Standard Operating Procedures Alert Levels.

Part 3 Operations
- 3.9 Overview Patient Distribution - Revised when Managed Patient Distribution may be invoked to when Emergency Department capacity is available on Reddinet and/or the total number of patients from an incident exceeds the total number of pre-assigned slots.
- 3.10 Assigned Patient Distributions – Updated the hospitals listed in the tables due the opening of new hospitals and updated the MCI patient totals.
- 3.11 Managed Patient Distribution - Revised when Managed Patient Distribution may be invoked to when Emergency Department capacity is available on Reddinet and/or the total number of patients from an incident exceeds the total number of pre-assigned slots.
- 3.12 Patient Distribution in Level 4 MCI (catastrophic event) – Added reference to see Appendix C Battalion Control.

Appendices
- Deleted Appendix A Health & Medical Contact and Appendix C MCI Field Board since they were placeholder references.
- Appendix A Job Sheets – Multiple minor edits to field tasks for each position. Added MCI organizational charts for first minutes of the MCI Group and for a full Medical Branch Response.
- **Appendix B Battalion Control** — New appendix that describes Battalion Control as a decentralized command structure which makes use of existing San Francisco Fire Department (SFFD) geographical battalions to preserve a functional span of control and ensure effective operations during a catastrophic incident that has caused a complete disruption of the city response and communications infrastructure.

- **Appendix C MCI Field Documentation Algorithm** — New decision tree identifying the type of documentation required given various MCI scenarios and adult vs. pediatric patients.

### Comments: 8000 MCI Plan

| Appendix C: Mentions a multi patient report form, but does not offer an example, describe one or even define the term PRF. | Sample multi-patient form added to Appendix C as a placeholder. Current versions of the form will be provided through the EMS Operations Subcommittee. |
| Sandy Tong, SFFD - EMS Division |

1. On page 34 of 118, under Part 1 of the SOP for DEM Duty Officer, for Level 1 Red MCI Alert, it states: Contact DPH for requests for mental health services for patients in the field. Contact American Red Cross to assist with family reunification or housing services for displaced (refer to DEM Duty Officer handbook for details). This should state "Contact PHEPR" instead of "Contact DPH."

2. "Consultation as appropriate with: DEM AOC, DPH Communicable Disease Control or Environmental Health Duty Officer, DEM command staff, and other city, regional, state or federal agencies as warranted." Instead, PHEPR should be the first contact added both here, since PHEPR would be coordinating both CD and EH.

3. Our role should be listed as "coordinating hospital disaster preparedness and coordinating hospital resource response."

4. Potential area of concern is around this plan's roles and responsibilities for Catastrophic Events. There is an absence of PHEPR and issues regarding lines of authority and communication, as well as an absence of resilient planning. The lines of authority issue is that of the role of Battalion Chiefs vis a vis DPH, our DOC, and hospitals in a Catastrophic Event. This specific issue is one that Josh Smith from Fire pointed out to us at BTB, where he has concerns about whether or not DPH is aware of this plan.

   - Jan Gurley, DPH Public Health Preparedness (PHPR)

1. Reviewed. No revision done due to unable to locate identified section.

2. Reviewed. No revision. Section reads, “Consultation as appropriate with: DEM AOC, DPH Communicable Disease Control or Environmental Health Duty Officer.” Duty Officers or other on-duty staff are initial contacts at the start of an event.

3. Agree. Added language to 2.6.1 under DPH - PHPR.

4. Reviewed. The MCI Plan is oriented toward the initial set up and start of an MCI. It is NOT a complete disaster response manual. It is an EMS operational plan. Agree with the points made but those are addressed in either other plans or an Incident Action Plan that will be developed in response to the specific incident.
I. PURPOSE

To define the roles, structure, membership and procedural standards for advisory committees to the EMS Agency Medical Director, and to achieve, in order of importance, EMS Agency Guiding Principles: (1) patient advocacy, (2) evidence-based decision-making, and (3) a systems approach to improvement.

II. POLICY

A. Advisory committees, composed of EMS system constituents, shall convene to review EMS system issues relevant to their scope of responsibility and recommend actions to the EMS Agency Medical Director concerning matters of policy, procedure, and protocol. The goal is to obtain consensus and mutual agreement on EMS system issues.

B. The EMS Agency Medical Director, as mandated by state statute, provides medical control and assures medical accountability throughout the planning, implementation and evaluation of the EMS System. The EMS Agency Medical Director retains the final decision through his/her medical authority for the EMS system.

III. OPEN PUBLIC MEETINGS

A. All committee and sub-committee meetings are open to members of the public. Meeting agendas, minutes, and other documents pertaining to these committees, except quality improvement documents, are public records and subject to public review. The EMS Agency shall distribute and post on its website an annual meeting schedule.

B. The quality improvement portions of the EMS Advisory Committee and its sub-committees are closed meetings because of confidential patient information reviewed during case discussions.

C. Conduct during EMS Agency-sponsored meetings:
   • Provide everyone an opportunity to speak.
   • Practice mindfulness, openness, and listen respectfully.
   • If differences in opinion occur, agree to disagree professionally.
IV. PARLIAMENTARY AUTHORITY / QUORUM

A. Proceedings of the advisory committee and subcommittees are conducted under the “Robert’s Rules of Order” when they do not conflict with this policy. This policy shall take precedence if any procedures are in conflict with “Robert’s Rules of Order.”

B. A quorum is required to vote on policies, protocols, or approval of committee minutes, call the meeting to order and to transact committee business. A meeting can continue with informational agenda items only if a quorum is not obtained. A committee must maintain a quorum to vote and continue a meeting. Specific quorum requirements are listed in Section VII.

V. COMMITTEE MEMBERSHIP

A. Representative organizations are listed the appendices to this policy. Committee members are nominated by their representative organization and appointed by the EMS Agency Medical Director to a two year term. Members may be re-appointed to their position with concurrence of the EMS Agency Medical Director and their organization.

B. Members who do not attend three meetings within a year may be replaced in their position by the EMS Agency Medical Director.

VI. COMMITTEE OFFICERS

A. Each committee shall elect a Chair and Vice-Chair. The Chair of each committee shall call and preside over all meetings of that committee. The Chair shall develop the committee agenda in consultation with the EMS Agency Medical Director. The Vice-Chair shall assume the duties of the Chair in their absence.

B. Chairs and Vice-Chairs serve a one year term from July 1 – June 30. At the last meeting of each committee before July 1st, the members shall elect a Chair and Vice-Chair. Chair and Vice Chair terms are effective at the first meeting of that committee after July 1st. The committee may vote to extend their term once (for a total of two years of consecutive service) if the current officers who wish to continue. Past officers are eligible for service again after three years from the end of their last term.

This provision does not apply to the Trauma System Audit Sub-Committee or Research Committee, which has the Trauma Medical Director at San Francisco General Hospital and EMS Agency Research Advisor as the standing Chairs, respectively.

C. The EMS Agency will provide professional and clerical support to the advisory committees created by this policy.
VII. STANDING ADVISORY COMMITTEE AND SUBCOMMITTEES

A. Emergency Medical Services Committee (EMSAC): This standing advisory committee is a multi-disciplinary forum for reviewing and making recommendations related to the following:

- Prehospital clinical policies and treatment protocol issues involving First Responder, Basic Life Support, Advanced Life Support, interfacility transport, and/or critical care transport personnel in the San Francisco EMS system;
- General system management and operational policies including communications, system performance, destination, ambulance diversion, and development of strategies to optimize the EMS System;
- Disaster medical emergency management, including mitigation, preparedness, response and recovery, and
- Review Approval of prehospital pilot and research projects.

Meetings: Held five times per year in even numbered months or more frequently by request of the Committee Chair, vote of the committee, or the request of the EMS Agency Medical Director or his/her designee.

Location: As set by agenda

EMS Agency Staff: Medical Director, EMS Administrator, EMS Agency Specialists

Quorum: Consists of:

- 33% + one of the representatives from the prehospital EMS organizations listed under Appendix A.
- 33% + one of the hospital organizations listed under Appendix B.

Membership: Consists of the EMS Agency Medical Director (ex-officio) and one primary representative and one alternate representative from:

1. Ambulance Provider Companies listed in Appendix A
2. San Francisco Receiving Hospitals listed in Appendix B
3. San Francisco Emergency Physicians’ Association
4. City College of San Francisco - Paramedic Training Program
5. San Francisco Department of Public Health
6. San Francisco General Hospital Base Hospital Medical Director
7. Representative from Medical Directors Committee
8. San Francisco Emergency Communications Department Medical Director
9. Paramedic field representatives currently accredited in San Francisco and working for a permitted ambulance company appointed by the EMS Agency Medical Director
10. EMT field representatives currently certified in San Francisco and working on a permitted ambulance company appointed by the EMS Agency Medical Director
11. Members of the public, not affiliated with a regulated provider organization, and appointed by the EMS Agency Medical Director.

B. **Medical Directors Subcommittee:** The standing committee that reviews and makes recommendations related to the following:
   - Overall EMS system medical direction decision-making and clinical oversight
   - Develop and set systemwide EMS initiatives
   - Recommend policy and protocol improvements
   - Review current medical literature and apply latest findings to policy development and patient care
   - Discuss unresolved operational issues referred by the Operations Committee and provide follow-up with policy direction
   - Report bi-monthly to EMSAC Committee on Medical Directors Committee progress

**Meetings:** Held four times per year or more frequently by request of the Committee Chair, vote of the committee, or the request of the EMS Agency Medical Director or his/her designee. At least two meetings, per calendar year, shall be with the Operations Committee.

**Location:** As set by agenda

**EMS Agency Staff:** Medical Director, EMS Administrator, EMS Managers

**Quorum:** Consists of:
   - 33% + one of the Medical Directors from the prehospital EMS organizations listed under Appendix A.
   - At least two Medical Directors from San Francisco General Hospital Base Hospital Medical Director, Emergency Communications Department Medical Director, City College Paramedic Training Program Medical Director, San Francisco Police Department Medical Director, and or EMS Agency Fellow.

**Membership:** Consists of the EMS Agency Medical Director (ex-officio) and one primary representative and one alternate representative from:
   - Medical Director from Ambulance Provider Companies listed in Appendix A
   - City College of San Francisco - Paramedic Training Program
   - San Francisco General Hospital Base Hospital Medical Director
   - San Francisco Emergency Communications Department Medical Director
   - San Francisco Police Department Medical Director
   - EMS Agency Fellow
C. **Operations Subcommittee**: The standing committee that reviews and makes recommendations related to the following:

- EMS system operations, interoperability, and integration of Ambulance Providers, Primary Response, and Department of Emergency Communications (DEC)
- In collaboration and coordination with Medical Directors Committee and EMS Agency, operationalize and implement policies, protocols, and initiatives set forth by EMS Agency and Medical Directors Committee
- Discuss and troubleshoot Ambulance Provider and EMS system issues
- Refer unresolved operational issues to Medical Director Committee for policy decisions and directions
- Report bi-monthly to EMSAC Committee on Operations Committee progress

**Meetings**: Held monthly or more frequently by request of the Committee Chair, vote of the committee, or the request of the EMS Agency Medical Director or his/her designee. At least two meetings, per calendar year, shall be with the Medical Directors Committee.

**Location**: As set by agenda.

**EMS Agency Staff**: Medical Director, EMS Administrator, EMS Agency Specialists

**Quorum**: Consists of:
- Three representatives from the permitted ALS or BLS prehospital EMS organizations listed under Appendix A.
- At least one representative must be from Department of Emergency Management (DEM or DEC).

**Membership**: Consists of the EMS Agency Operations Section Manager and one primary representative and one alternate representative from:
- Ambulance Provider Companies listed in Appendix A
- San Francisco Emergency Communications Department
- Department of Emergency Management

D. **Trauma System Audit Subcommittee (TSAC)**: A standing subcommittee of the EMS Advisory Committee that advises on trauma system policy. Its goals are the evaluation and administration of the trauma system with oversight responsibility for system vulnerabilities, the development of policy and/or approaches to related issues such as major trauma and burn-related prehospital care, injury surveillance, trauma transfers, repatriation, and long-term outcomes.
Meetings: Meets four times per year, coincident with dates of the EMS Advisory Committee, or by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda

EMS Agency Staff: EMS Medical Director, EMS Administrator and Trauma Coordinator

Quorum: Consists of:
- 33% + one of the hospital organizations listed under TSAC Membership
- 33% + one of the prehospital EMS organizations listed under Membership
- One representative from SFGH Trauma Center
- One representative from St. Francis Bothin Burn Center

Membership: Hereby consists of:
- EMS Agency Medical Director (ex-officio)
- Zuckerberg San Francisco General Hospital Trauma Medical Director (ex-officio)
- Zuckerberg San Francisco General Hospital Trauma Program Manager (ex-officio)
- St. Francis Bothin Burn Center Medical Director (ex-officio)
- St. Francis Bothin Burn Center Manager (ex-officio)
- One representative from a minimum of five of the San Francisco Receiving Hospitals listed in Appendix B (including San Francisco General Hospital and St. Francis Memorial Hospital)
- One representative from each approved ALS ambulance provider
- One member of the public not affiliated with a regulated stakeholder organization, appointed by the EMS Agency Medical Director

E. STAR Subcommittee: A standing subcommittee of the EMS Advisory Committee that advises on STEMI and post-cardiac arrest prehospital care. The subcommittee’s goals are the evaluation of STEMI and cardiac arrest policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital STEMI and cardiac arrest care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Meetings: Four times per year by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda.

EMS Agency Staff: EMS Medical Director, EMS Administrator and STAR program coordinator.
Quorum: Consists of:
- Representatives from 3/5 of the STAR designated hospitals listed in Appendix C.
- At least one representative from a permitted ALS ambulance provider

Membership: Hereby consists of:
- EMS Agency Medical Director (ex-officio)
- Two representatives from each approved of the STAR designated hospitals as listed in Policy 5000 Destination; one from hospital administration, and one clinical expert (preferably an interventional cardiologist) who are knowledgeable about the cases reviewed at each institution’s STEMI committee
- One representative from a non-STAR designated hospital
- At least one One representative from each a permitted ALS ambulance provider

F. **Stroke Subcommittee**: A standing subcommittee of the EMS Advisory Committee that advises on stroke prehospital care. The subcommittee’s goals are the evaluation of stroke policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital stroke care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Meetings: Four times per year by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda.

EMS Agency Staff: EMS Medical Director, EMS Administrator, and EMS Quality Manager

Quorum: Consists of:
- Representatives from at least 3 of the Stroke designated hospitals listed in Appendix C.

Membership: Hereby consists of:
- EMS Agency Medical Director (ex-officio)
- Two representatives from each approved of the stroke designated hospitals Policy 5000 Destination; one from hospital administration, and one clinical expert (preferably an interventional neurologist) who are knowledgeable about the cases reviewed at each institution’s stroke committee
- One representative from a non-stroke designated hospital
- One representative from each permitted ALS ambulance provider

G. **Quality Improvement (QI) Subcommittee**: A standing subcommittee of the EMS Advisory Committee that advises on system quality improvement issues. The
The committee’s goal is to report and evaluate the EMS system, and recommend any necessary changes. It assists the EMS Medical Director by evaluating topics and data about issues such as response capabilities, system structure, clinical performance, clinical outcomes, and professional training.

Meetings: Six times per year by request of the subcommittee Chair or the EMS Agency Medical Director

Location: As set by agenda

EMS Agency Staff: EMS Medical Director, EMS Quality Manager

Quorum: Consists of at least one representative from each of the following:
- Department of Emergency Communication
- Prehospital providers, and
- Emergency department supervisors.

Membership: Consists of:
- EMS Agency Medical Director (ex-officio)
- DEC Medical Director
- DEC Quality Management staff
- One representative from a designated EMS receiving hospital
- One representative from each approved ALS ambulance

H. Research Subcommittee: A standing subcommittee of the EMS Advisory Committee that advises on EMS and prehospital research projects. The subcommittee’s goal is to develop research projects to further EMS interests and prehospital care. The subcommittee also assists in the approval of local pilot programs. The research subcommittee is an open committee in which researchers, providers, hospitals, dispatchers, and members of the public are encouraged to attend.

Meetings: Four times per year by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda

EMS Agency Staff: EMS Medical Director

Quorum: Consists of at least four representatives plus the committee chair

Membership: Consists of:
- All EMSAC Committee Members
- Researchers
• Ambulance Providers (Appendix A)
• Receiving Hospitals (Appendix B)
• Members of the Public
• EMS Fellow(s)

VIII. AUTHORITY

California Health and Safety Code, Section 1797 et seq. and 1798 et seq;
California Government Code, Section 54950 et seq.;
California Code of Regulations, Title 22, Division 9;
City and County of San Francisco Administrative Code, Section 67.1 et seq.

APPENDIX A: SAN FRANCISCO AMBULANCE PROVIDERS
1. San Francisco Fire Department
2. American Medical Response
3. King American Ambulance
4. Pro-Transport 1
5. Bayshore Ambulance
6. St. Joseph’s Ambulance
7. Falck Northern California
8. NorCal Ambulance

APPENDIX B: SAN FRANCISCO RECEIVING HOSPITALS
1. Zuckerberg San Francisco General Hospital Trauma Center & Base Hospital
3. Kaiser Permanente Medical Center
4. St. Mary’s Medical Center
5. St. Francis Memorial Hospital
6. University of California, San Francisco Medical Center, Parnassus Campus
7. University of California, San Francisco, Mission Bay Campus
8. Veterans Administration Medical Center
9. Chinese Hospital
10. Seton Medical Center (San Mateo)
11. South Kaiser (San Mateo)

APPENDIX C: STAR DESIGNATED RECEIVING HOSPITALS
1. Zuckerberg San Francisco General Hospital
2. California Pacific Medical Center – Pacific Campus
3. Kaiser Permanente Medical Center
4. St. Mary’s Medical Center
5. University of California, San Francisco Medical Center, Parnassus Campus
EMERGENCY MEDICAL SERVICES
AT SPECIAL EVENTS – EMSAC 6/12/2019

I. PURPOSE
Establish minimum standards for emergency medical services at mass gatherings and special events, and reduce impact to the 911 system.

II. POLICY
For brevity, the term “Special Event” is used to refer to either a Mass Gathering or Special Events in this policy.

A. The term “Special Event” is used in this policy to refer to: any gathering with an expected attendance of more than 2,500 people or more than 100 swimmers; any parade as defined in Article 4 of the San Francisco Police Code; Major Events or Athletic Events as defined in Article 6 of the San Francisco Transportation Code; and events permitted under Chapter 90 of the San Francisco Administrative Code.

B. Special Event Medical Plans requiring review by the EMS Agency Medical Director, or designee, as mandated by applicable Traffic Code(s), shall meet the EMSA assigned Level designation or greater based on the Risk Assessment Matrix in Appendix A, minimum standards for the size and type of event, as defined in this policy. These standards are summarized in the Appendices.

C. The EMS Agency Medical Director has the final authority in determining the applicability of any standard, Level designation, and what shall be considered an adequate Event Medical Plan.

III. SPECIAL EVENT MEDICAL PLANS
A. Special Event Medical Plans shall include, but not be limited to, the following considerations:
   1. Event description, including event name, location and expected attendance.
   2. Participant safety (the safety plan for event participants and spectators)
   3. Non-participant safety (the safety plan for individuals not participating in, but affected by the event such as neighboring local residents and on-lookers)
   4. Descriptions of the following medical resources:
      a) Personnel certified in cardio-pulmonary resuscitation, rapid access to automatic external defibrillator(s), and 911 access;
b) First aid station(s) (if indicated; see Appendix A);  
c) Ambulance(s) (if indicated; see Appendix A);  
d) Mobile medical resource(s) (if indicated; see Appendix A); and  
e) In addition to first aid supplies, a Multi Casualty Incident Medical Kit with medical equipment for 50 victims (Policy 4001). MCI Kit must be the comprehensive MCI kit as required on Ambulances, however Boards/Worksheets and Position Vests are optional. Supervisor/QRV vehicles.

B. Special Event Communications Plans, including name(s) and contact information for the event leader and a point of contact on the day of the event, a description of direct routine communications, and a description of disaster communications if cell phones are not available (e.g. two-way radios). A description of communications between the following shall be included:
   1. Venue staff and/or security personnel, event coordinator, and medical personnel;  
   2. Medical personnel located at a first aid station and mobile resources and/or satellite stations;  
   3. Medical personnel and the City and County 911 Dispatch Center;  
   4. Medical personnel and ambulances as applicable, and  
   5. Medical staff at Receiving Hospitals as applicable.

C. Disaster Plan describing the ability to care for a minimum of 50 event attendees and staff as casualties. The plan must include training of all event medical personnel in the disaster plan, the START disaster triage system, and all appropriate necessary equipment. This may be done at any time prior to the start of the event.

IV. EMT SERVICES AT SPECIAL EVENTS  
A. On-site medical personnel shall be minimally certified as an EMT-1 in California and equipped to provide the complete EMT-1 Scope of Practice as defined in California Code of Regulations, Title 22, Section 100163. 100063. They shall follow San Francisco EMS Agency Policies and Protocols.

B. Paramedics equipped and used to provide Basic Life Support need only be licensed by the State of California.

V. PARAMEDIC SERVICES AT SPECIAL EVENTS  
A. Paramedics, utilizing the Advanced Life Support Scope of Practice, deployed as part of a Special Events Medical Plan shall be:  
   1. Licensed in the state of California;  
   2. Accredited in the City and County of San Francisco;  
   3. On-duty with an approved Paramedic Service Provider for the duration of the event for which they are deployed; and
4. Equipped to provide Advanced Life Support care.
B. Paramedics shall follow San Francisco EMS Agency Policies and Protocols. An on-scene physician may provide medical direction only as allowed in EMS Agency Policy #4041 Physician on Scene.

VI. AMBULANCE SERVICES AT SPECIAL EVENTS
A. Ambulances deployed as part of the approved Event Medical Plan shall be permitted for operation in San Francisco by the EMS Agency.
B. Should an ambulance transport from the event, Department of Emergency Communications (DEC) shall be notified. DEC and/or Ambulance Providers will not regularly backfill an additional unit to a special event.

VII. AUTOMATIC EXTERNAL DEFIBRILLATORS
Automatic External Defibrillators (AEDs) should be made accessible to medical personnel and non-medical personnel trained in its use and located throughout the venue in location(s) that will enable the first shock to a person in cardiac arrest within 5 minutes of notification of qualified personnel. The current San Francisco EMS Response Interval Standard for time to defibrillation must be met by the responding agencies.

VIII. PROCEDURES FOR SUBMITTING SPECIAL EVENT MEDICAL PLANS
A. Special Event Medical Plans shall be submitted following guidelines posted on the San Francisco EMS Agency website. Plans shall be submitted 30 days in advance.
B. The EMS Agency Medical Director or designee shall review the Special Event Medical Plan within 15 days and respond to both the event sponsor and the City permitting agency as follows:
   1. Approved without modification.
   2. Approval pending submission of additional information specified by the reviewer.
   3. Not approved with an explanation of the decision.
C. Plans not approved will be returned to the event sponsor with an explanation of the decision.
The event sponsor may appeal the decision by resubmitting the plan to the EMS Agency Medical Director. A review will occur within 5 days of receipt. The EMS Agency Medical Director’s decision shall be delivered to the event sponsor within 5 business days of the review.

IX. PROCEDURES FOR SUBMITTING POST-EVENT MEDICAL TREATMENT REPORTS
The event sponsor will submit an Event Medical Treatment Report, within 3 business days two weeks of the conclusion of the event, to the EMS Agency Medical Director or designee. The report will provide a summary of the medical incidents during the event that involved the EMS plan medical resources. This summary will include at a
minimum the number of patients seen at the first aid station(s) or other facilities, their age, gender, chief complaint, and disposition.

X. EMS AGENCY STAFF CONTACT
The EMS Agency staff point of contact for questions on this policy or Special Event Medical Plans may be reached via contact information published at the EMS Agency website.

XI. BLS USE, TRANSPORTATION, AND DOCUMENTATION FROM SPECIAL EVENTS
A. If Advanced Life Support (ALS) is available at the special event, an ALS Assessment should occur prior to transport by a Basic Life Support (BLS) ambulance, in accordance with the ALS Criteria in Appendix C.
   1. If an ALS resource is providing triage or determination of BLS patients, the individual or unit shall be designated in the EMS medical plan.
B. A BLS ambulance can transport without an ALS Assessment under the following criteria:
   1. The patient does not meet any ALS Criteria (Appendix C) guidelines
   2. The patient is being transported from inside a designated special event or event box.
   3. The event has an approved medical plan on file with the EMS Agency.
C. If a BLS ambulance transport from a Special Event, the following conditions shall apply:
   1. On departure from special event, BLS ambulance shall notify DEC of transport. DEC will not regularly backfill an additional unit to a special event.
   2. EMTs transporting from the special event shall have, at a minimum, 4 hours of an EMS Agency approved and provider documented annual training in:
      a) Field to Hospital Communications including Early Notification
      b) Communications to DEC
      c) Patient assessment skills
      d) ALS Criteria
      e) Hospital Destinations and Designations
      f) Hospital Diversion
      g) Documentation including Patient Declines Transport (PDT)
   3. The preceding paragraph XI.C.2. is waived if EMT already meets requirements in EMSA Policy 2000, Section VI “Required Training for Independent Work Assignment on an ALS Ambulance”
   4. All patient transported via BLS Ambulance with or without an ALS Assessment shall submit a PCR and exception report to the EMS Agency within 24 hours of transport.
D. A BLS ambulance can transport without an ALS assessment from a special event when authorized under separate EMSA policies.
1. This policy shall not supersede EMSA Policy 4041 “On-Viewed Incidents.” For critical, life-threatening conditions, the BLS ambulance may transport if the ETA to the closest receiving hospital is less than the ETA of responding ALS resources.

2. BLS transportation from a special event is intended for MCI/surge plans pursuant to EMSA Policy 7010 or by EMSA medical director approval via memo. BLS transportation is not be utilized in regular, daily 911 operations and responses.

3. Documentation
   a) EMTs that are an approved resource within an approved EMS medical plan may respond, evaluate, and create PDT documentation (NOT Against Medical Advice).
   b) All AMA patients require an ALS Assessment and shall follow Policy 4040 procedures.

XII. AUTHORITY
California Health and Safety Code, Sections 1797.202, 1797.204, 1797.220, 1798 California Code of Regulation, Title 22, Sections 100063, 100144 100146, 100166, 100168, City & County of San Francisco Traffic Transportation Code sections 800, 801, 802, 804 San Francisco Transportation Code, Division I, Article 6 section 9.2 and 9.3, San Francisco Police Code section 366 Article 4, and Administrative Code section 90.4
APPENDIX A

GUIDELINES FOR MINIMUM MEDICAL RESOURCES AT SPECIAL EVENTS

**Level:** The Level, ranked from 1 (most resources) to 5 (least amount of resources), determines the minimum resources required at a special event. An event must have the available resources based on the highest ranked level based upon known risk factors (ie Event promoter shall follow Level 1 guidelines if ranked to both Level 1 and Level 3).

**Mitigating Factors:** If an event has factors that are less likely to impact the 911 system, the Level can be reduced by 1 Level for a one-time reduction. To be considered for a reduction by the EMSA, the event shall be reoccurring and meet mitigating factors in flow chart listed below. If an event is reduced by 1 Level and impacts the 911 system or event-type changes, the reduction can be revoked by the EMSA Medical Director for future events. The reduction is assessed each year.

**All Levels:** All Levels shall have CPR trained responders with AEDs and CPR plus 911 access.

**Level 1:** Highest Level for minimum medical resources. A Level 1 ranking usually results in city-wide response and coordination. Multiple ALS and BLS units (greater than 4) need to be obtained. ALS resources are required. Foot teams, bikes, gators, and event EMTs are likely to be used heavily. Department of Emergency Communications (DEC) should have an on-site dispatcher. EMSA should have an EMSA Liaison designated for the event. A BLS memo may be pre-approved by the EMSA Medical Director or ready for implementation if necessary for the 911 system.

**Level 2:** Second-highest Level for minimum medical resources. A Level 2 ranking usually results in some public safety department response and coordination. Multiple ALS and BLS units (3 or greater) need to be obtained. ALS resources are required. Foot teams, bikes, gators, and event EMTs are likely to be used heavily. Depending on the event, a Department of Emergency Communications (DEC) may have an on-site dispatcher, and EMSA may have an EMSA Liaison designated for the event. Usually, a BLS memo is unnecessary for a Level 2 event.

**Level 3:** A Level 3 ranking requires 1-2 ALS ambulances. ALS is required for a Level 3 ranking. Foot teams, bikes, gators, and event EMTs shall augment ambulance resources, if appropriate, depending on event footprint.

**Level 4:** A Level 4 ranking requires at a minimum 1 BLS ambulance. Foot teams, bikes, gators, and event EMTs shall augment ambulance resources, if appropriate, depending on event footprint.
**Level 5:** A Level 5 ranking requires event EMTs that have the ability to readily access the entire event footprint.

**Swim or Water Events:** If an event has a swim or water component, it shall have the additional resources in addition to the ranked level. A Paramedic or EMT shall be stationed on a boat with deck access to perform high quality CPR. If an EMT is utilized, the EMT shall have 2+ years of 911 experience and have direct access to 911 Center. Use of a mechanical compressor on the boat shall be considered. Predesignated areas for transport rendezvous must be submitted on map upon plan submission to EMS Agency. Personal Water Crafts (PWCs) or Jet Skis do not carry medical equipment and do not replace Paramedics or EMTs on boats.

**Reoccurring Event:** An event is eligible for a one-step reduction in initial Level designation if the event has minimal patients treated on-site, transports from event, or impact to the 911 system. The one-time reduction from the initial Level is re-evaluated each year or subsequent event based on post-event treatment report and impact to 911 system. This usually applies to family-type events, community-based organizations, and established, re-occurring events. The event promoter must request this reduction as part of the planning process. This approval or denial of the request is determined by the EMSA Medical Director or designee.
SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 7010
Effective Date: June 12, 2019

Suggested Resources
Level 1 = Multiple ALS/BLS (4+) Ambulances, DEC dispatcher, EMS Liaison, BLS memo, Event EMTs
Level 2 = Multiple ALS/BLS (3+) Ambulances, Event EMTs
Level 3 = 1-2 ALS Ambulances, Event EMTs
Level 4 = 1 BLS Ambulance, Event EMTs
Level 5 = Event EMTs
Swim or water events = Paramedic or EMT on boat, EMTs must have 2+ yrs experience working in 911 and have direct communications to DEC, consider use of mechanical compressor, Personal Water Crafts (PWCs) do not carry medical equipment and do not replace Paramedics or EMTs on boats

All EVENTS, including events that do not require a Level determination, must have 911 and CPR/AED access.
APPENDIX B

DEFINITIONS SPECIAL EVENT MEDICAL RESOURCES

CPR & 911 Access: Event staff and/or safety personnel have the capability to notify 911 of any medical emergency and to provide CPR/AED access per San Francisco EMS Agency System Standards [within five (5) minutes in 90% of occurrences]. All events should meet this requirement regardless of crowd size.

First Aid Station with Emergency Medical Technician (EMT): A fixed or mobile facility with the ability to provide first aid level care staffed by at least one EMT or higher skill level personnel. First Aid level care is defined as treatment of minor medical conditions and injuries by care providers that have received training in First Aid, at the EMT level. Examples of First Aid care are cleaning, bandaging and treating simple wounds such as scrapes and shallow cuts, providing cold packs for musculo-skeletal strains and bruises, and giving drinking water and a place to rest for patients who are mildly dehydrated. Each Fixed First Aid Station shall have an AED and MCI Kit present at all times. Examples of a First Aid Station are a tent, a clinic, an ambulance or vehicle of some type. The first aid station must have 911 communications capability. EMTs who are employees of locally permitted ambulance provider agencies are recommended due to their familiarity with local policy, procedure and protocol. It is also recommended that any event employing multiple First Aid Stations also have a designated Event Physician Medical Director and establish a liaison with the Emergency Communications Department and the Fire Department to improve coordination with 911.

First Aid Station with Paramedic, Nurse, or Physician: A similar facility to a First Aid Station with an EMT, but staffed by at least one Accredited Paramedic, Registered Nurse or Physician, holding a current California license. It is preferred that the Nurse and Physician be experienced in emergency medical care and triage of seriously ill or injured patients to higher levels of care. Examples would be RN’s with Emergency Medicine, Critical care, or Urgent Care backgrounds, or Nurse Practitioners or other mid-level provider licensees with similar experience. Examples of appropriate Physicians would be those with Emergency Medicine, Family Practice, Sports Medicine, Internal Medicine or Trauma Care specialization. Physicians and/or Nurses are recommended for large crowd sizes or events needing sobering services; Paramedics may be substituted for smaller size crowds as outlines in the Guidelines for Medical Resource in Special Events Matrix in Appendix A.

BLS (Basic Life Support) Ambulance: An ambulance staffed by two EMTs or Paramedics working at a BLS level. BLS units may be utilized for first response (as a Mobile Team) or to substitute for a fixed First Aid Station with an EMT, not may NOT transport unless the following criteria are met in Section X above. BLS units, in accordance with City of San Francisco Ambulance Ordinance, may not transport the ill or injured from a venue to a receiving hospital unless directed to do so by a designated Event Physician in...
accordance with EMS Agency Policy 4042. In cases where a patient has a life-threatening condition, a dedicated BLS Ambulance may transport only if the ETA to the closest receiving hospital is less than the ETA of responding ALS resources.

**ALS (Advanced Life Support) Ambulance:** An ambulance staffed by at least one Paramedic and one EMT (ALS) or two Paramedics. An ALS Ambulance is a dedicated transport unit, and must be available for any patient within the event footprint. ALS Ambulances may NOT be utilized as both transport unit and fixed First Aid Station.

**Mobile Resource(s):** Mobile or “Roving Medical Resource(s)” are non-ambulance based EMTs and/or paramedics, or higher-level interventionists, that are deployed throughout the footprint of a special event and may be on foot, bicycles, or motorized transport car/vehicle (Gator, Moped, Motorcycle, etc.). Mobile Resource(s) must be able to provide, AT MINIMUM, First Aid Care at a BLS level, and must have communication capability, by radio, cell phone, or other medium (See Appendix D). Each Mobile Resource must carry at least one AED at all times. EMTs, that are dedicated resources within an approved medical plan, may respond, evaluate, and create Patient Declines Transport (PDT) documentation (NOT AMA), for patients that do not qualify under the guidelines in EMSA Policy 4040, Section E.3.a)(1-11).

**Water-Based Resource(s):** A medical response resource (BLS or ALS), that is based on a boat, Personal Water Craft (PWC), or other water-based vessel (Kayak, Surf-Ski, etc.), that is capable of providing medical interventions and rendezvous with another vessel of higher level care, or a ground-based transport unit. If the resources is an EMT, the EMT must have 2+ years of experience working in a 911 system and have direct communication to DEC or land-based assets. Any ALS Resources must be located on a vessel that has an accessible deck, and room/equipment to perform CPR ALS/ACLS interventions (See Appendix D). Each Water-Based Resource(s) must have communication capability, by radio, cell phone, or other medium.

**Sobering Services:** Medically supervised treatment for patients with a primary medical issue of alcohol intoxication as defined by the criteria in Policy 5000, Destination Policy. Sobering Services provided during special events must follow current Department of Public Health Sobering Center guidelines for staffing and patient care.

**Department of Homeland Security SEAR (Special Event Assessment Rating) Designated Events:** Special events that potentially require federal government resources and support. These designated events potentially require Level 1 or Level 2 EMS resources.

**Free Speech Event:** Events protected by the First Amendment of the U.S. Constitution.
APPENDIX C

ALS CRITERIA GUIDELINES FOR SPECIAL EVENTS

An ALS Assessment shall occur for the following clinical indications at a special event. The following list is a guide and is not comprehensive. If in doubt or unsure whether patient needs an ALS assessment, care and/or transport, call for assistance.

A. Abdominal Pain
   1. Discomfort, pain, unusual sensations if patient is > 40 years old and has cardiac history
   2. Severe generalized abdominal pain

B. Breathing
   1. Respirations > 30 min, abnormal respiratory patterns, patient in tripod position
   2. Audible wheezing
   3. Need for inhaler or no improvement after self-administration
   4. Asthma attack or medical history with need for intubation

C. Burns
   1. All thermal burns except minor heat-related, superficial burns
   2. Chemical and/or electrical burns

D. Cardiac
   1. Suspected acute coronary symptoms
   2. Irregular heart rate
   3. Chest pain

E. CVA/Stroke
   1. Suspected stroke with associated symptoms

F. Diabetic
   1. Patient with history of diabetes with decreased mental status, is unable to swallow, has rapid respirations, fails to respond to oral glucose, suspected ketoacidosis

G. Environmental
   1. Hypothermia or Hyperthermia with co-morbidities (i.e. elderly, illness, trauma, alcohol and/or drug-use)
   2. Suspected drug-induced hyperthermia
   3. Temperature greater than 100.5° F or less than 96.5° F

H. Mental Status
   1. Glasgow Coma Score less than or equal to 13
   2. Abnormal behavior with unstable vital signs
   3. Abnormal behavior with suspected drug or alcohol intoxication
   4. Sobering patients that do not meet Policy 5000 “Sobering Services” criteria

I. Vital Signs
   1. Hypotension (Systolic < 90)
   2. Signs of shock (Systolic < 90, Pulse > 120)
3. Sustained tachycardia
4. Hypertension (Systolic >160 or Diastolic > 110)
5. Hypotension and severe bradycardia

J. OB/GYN
   1. All patients with known or suspected pregnancy with an OB/GYN complaint

K. Seizure
   1. Any seizure or seizure-like activity reported prior to arrival

L. Trauma
   1. All patients meeting Policy 5001 Trauma Triage Criteria and/or patients meeting base hospital contact criteria within Policy 5001
   2. Patients with moderate to severe pain requiring pain control
MULTI-CASUALTY INCIDENT POLICY

I. PURPOSE

This policy supports the San Francisco Emergency Medical Services Multi-Casualty Incident (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 and 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
   - California Standardized Emergency Management System (SEMS)
   - California Public Health and Medical Emergency Operations Manual, July 2011 2019

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 in carrying out the assigned roles in a MCI response. This includes:

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

2. All Field First Responders and On-Scene Command Staff as delineated in EMS Agency Policy 2000 Personnel Standards and Scope of Practice.
   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, EMSyste, 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 MCI Medical Group Supervisor for a MCI will submit a 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 and/or Plan of Correction.
CONTENTS

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PART 2: BACKGROUND AND TRAINING

PART 3: OPERATIONS

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B. BATTALION CONTROL

C. MCI DOCUMENTATION ALGORITHM

D. ABBREVIATIONS, ACRONYMS AND GLOSSARY
### Part 1: Standard Operating Procedures: Alert Levels

<table>
<thead>
<tr>
<th>Level</th>
<th>Definition</th>
<th>Purpose</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCI YELLOW ALERT</td>
<td>Incident with a potential for multiple casualties</td>
<td>“Heads Up” about a situation that may become a MCI.</td>
<td>Large residential building is on fire, but no victims have yet been identified.</td>
</tr>
<tr>
<td>LEVEL 1 MCI (RED) ALERT</td>
<td>MCI with 6 - 50 victims of any triage level.</td>
<td>Notifies local EMS system about MCI with 6 – 50 victims.</td>
<td>Bus accident with 15 patients all triaged as YELLOW.</td>
</tr>
<tr>
<td>LEVEL 2 MCI (RED) ALERT</td>
<td>MCI with 51 - 100 victims of any triage level. Requires resources from or distribution of casualties to neighboring counties.</td>
<td>Notifies local EMS and disaster system and Regional Mutual Aid System about MCI with 51 – 100 victims.</td>
<td>Mass transit accident with 95 victims. Need to send trauma patients to ZSFG and Trauma Centers in nearby counties.</td>
</tr>
<tr>
<td>LEVEL 3 MCI (RED) ALERT</td>
<td>MCI with 101 or more victims of any triage level. Requires resources from or distribution of casualties throughout the State or federal response system.</td>
<td>Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about MCI with &gt; 101 victims. Assumes infrastructure is essentially intact but has numerous disruptions.</td>
<td>High magnitude earthquake with hundreds of casualties. Example: 1989 Loma Prieta Earthquake</td>
</tr>
<tr>
<td>LEVEL 4 MCI (RED) ALERT</td>
<td>Catastrophic disaster with significant infrastructure damage, and unknown number of injuries and deaths. Requires significant, long-term support from State and Federal government.</td>
<td>Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about a catastrophic disaster. Recovery outlook is long-term.</td>
<td>Significant earthquake with massive infrastructure disruption necessitating large scale evacuations and external support.</td>
</tr>
<tr>
<td>LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION</td>
<td>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.</td>
<td>Disruption to the medical 911 system. EMS and hospital providers may be requested to report about their resources (number of ambulances / hospital beds / etc.).</td>
<td>Extreme heat generates hundreds of medical 911 calls resulting in ambulance shortages and saturation of hospital emergency departments.</td>
</tr>
</tbody>
</table>
## MCI Plan Part 1: Standard Operating Procedures

### 911 DISPATCH (DEC)

#### MCI YELLOW ALERT

**“Heads Up” about Incident with a potential for multiple casualties**

- Dispatch available resources to meet the initial needs of the scene per normal procedures and as requested by Incident Commander or designee.
- Confirm Field Supervisor assignment.
- Notify other ambulance providers and to determine available ambulances as necessary.
- Enter alert on the Reddinet website to notify ambulance providers and poll hospital Emergency Departments for available Emergency Department beds for Red/Yellow/Green patients.
- Upgrade to Level 1, 2 or 3 MCI (Red) Alert as appropriate or announce Yellow Alert termination. Change alert status on Reddinet.
- **Alert Termination:** Field Incident Command or Medical Group Supervisor.

#### LEVEL 1 MCI (RED) ALERT

**6 - 50 victims of any triage level**

- Dispatch available resources to meet the initial needs of the scene per normal procedures and as requested by Incident Commander or designee. Communicate to all responding ambulances designated routes for ingress / egress and staging.
- In communication with the Incident Commander, designate a dedicated incident radio channels (command + tactical), if necessary. Inform all responding apparatus/agencies.
- Notify other ambulance providers and to determine available ambulances as necessary.
- Enter the incident on the Reddinet website to poll hospital Emergency Departments for available Emergency Department beds for Red/Yellow/Green patients.
- Monitor Reddinet website and contact hospitals as necessary to determine number of Red/Yellow/Green patients they can accept. Relay information to Transportation Unit Leader.
- Make hospital destination recommendations to the Transportation Unit Leader based upon information from the “MCI Transport Form” and hospital capability reports on the Reddinet website.
- In-County Mutual aid ambulances may be used per DEC policy.
- Maintain “MCI Transport Form” to record number and type of patients, transport units, and hospital destinations.
- Notify hospitals about in-coming patients when assigned by the Transportation Unit Leader, if resources allow:
  - Name of ambulance company + unit number
  - Number of in-coming patients and their triage category designation (R/Y/G)
  - ETA
- **Ambulance diversion is automatically suspended for all patients.**
- Consider notification of DEM Duty Officer of potential need of additional resources.

---

**Note:**

- Actions are prioritized based on the potential for multiple casualties and the initial needs of the scene.
- DEC stands for District Emergency Coordinator.
- Red/Yellow/Green refer to the triage categories for patients.
<table>
<thead>
<tr>
<th>LEVEL 2</th>
<th>MCI (RED) ALERT</th>
<th>51 - 100 victims of any triage level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alert Termination: Field Incident Command or Medical Group Supervisor.</td>
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<tr>
<td></td>
<td>Follow same steps for Level 1 Red Alert listed above.</td>
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<tr>
<td></td>
<td>If 911 ambulances shortage, go to “911 Ambulance Surge: Level Zero Actions for DEC and DEM Duty Officer.”</td>
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<tr>
<td></td>
<td>If additional resources beyond current in-county supply, contact the neighboring county’s Public Safety Answering Point (PSAP) to initiate an “Immediate Need” of agreed upon resources up to a single Ambulance Strike Team and contact the DEM Duty Officer. The DEM Duty Officer will contact the MHOAC for approval of additional teams.</td>
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<tr>
<td></td>
<td>For requests of other types of Medical Mutual Aid, contact the DEM Duty Officer. The DEM Duty Officer will contact the MHOAC.</td>
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<tr>
<td></td>
<td>Requests originating through the Fire Mutual Aid System for SFFD ambulances will be approved through SFFD in consultation with the MHOAC.</td>
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<tr>
<td></td>
<td>Out-of-County Mutual aid ambulances may be used if approved by the MHOAC.</td>
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<tr>
<td></td>
<td>Direct all Out-of-County Mutual aid ambulances to designated staging.</td>
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<td></td>
<td>Requests to modify the EMS response patterns must be approved by the EMS Medical Director or designee.</td>
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<tr>
<td></td>
<td>Consider activating your internal emergency response plan for large incidents.</td>
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<tr>
<td></td>
<td>Notify DEM Duty Officer of potential need of additional resources.</td>
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</tr>
<tr>
<td></td>
<td>Alert Termination: Incident Command</td>
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<table>
<thead>
<tr>
<th>LEVEL 3</th>
<th>MCI (RED) ALERT</th>
<th>101 or greater number of victims of any triage level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Follow same steps for Levels 1 and 2 Red Alerts listed above.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Activate your internal emergency response plan for large incidents.</td>
<td></td>
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<tr>
<td></td>
<td>Notify DEM Duty Officer of potential need of additional resources.</td>
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<tr>
<td></td>
<td>Alert Termination: Incident Command.</td>
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</table>

<table>
<thead>
<tr>
<th>LEVEL 4</th>
<th>MCI (RED) ALERT</th>
<th>Catastrophic disaster</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ensure safety of all dispatch staff. Evacuate if building is unsafe.</td>
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<tr>
<td></td>
<td>Activate your internal emergency response plan.</td>
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<tr>
<td></td>
<td>Restore communication services if disrupted.</td>
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<tr>
<td></td>
<td>Notify DEM Duty Officer of potential need of additional resources.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Each battalion station is the designated Emergency District Coordination Center (EDCC) where a Battalion Chief controls the assets in his/her emergency district. When Fire Battalion Stations are used to house the EDCC, primary coordination and communication will be with the Fire DOC utilizing all available communication systems.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ambulance response units will be organized through the EDCC until the dispatch communications infrastructure and central command are restored. This includes mutual aid ambulances.</td>
<td></td>
</tr>
<tr>
<td>LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION</td>
<td>Other city department representatives at the EDCC will communicate and coordinate their departmental resources with the relevant DOC when it becomes operational. Unified Command is used at the EDCC when there are other city department representatives present. EDCC will determine resource allocation priorities within its district. Resource requests will be communicated to the EOC through the Community Branch when it is activated. Alert Termination: SFFD has the authority to activate/deactivate an Emergency District Coordination Centers (EDCCs) decentralized command structure. (See Appendix “X” Battalion Control)</td>
<td></td>
</tr>
<tr>
<td>If 911 ambulance shortage, follow actions described in “911 Ambulance Surge: Level Zero Actions for DEC and DEM Duty Officer.” If San Francisco General Hospital cannot receive Trauma Patients: a) Notify San Mateo Public Safety Communications, and, b) Notify DEM Duty Officer. For any other hospital issue affecting their ability to receive patients, notify DEM Duty Officer. Alert Termination: 911 Dispatch or DEM Agency Duty Officer.</td>
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</tr>
</tbody>
</table>
## PRIVATE AMBULANCE DISPATCH

### MCI YELLOW ALERT

“Heads Up” about Incident with a potential for multiple casualties

- Inform ambulance crews about Yellow Alert incident. Dispatch available ambulances if requested by DEC per normal procedures.
- Determine availability of additional ambulances as necessary.
- Input into Reddinet website, the number of available ALS and BLS ambulances **within 5 or less minutes**.
- Monitor for upgrade to Red Alert or termination of Yellow Alert.

### LEVEL 1 MCI (RED) ALERT

6 - 50 victims of any triage level

- Dispatch available ambulances as requested by DEC per normal procedures.
- Inform responding ambulance crews about:
  - Designated incident radio channels (command + tactical)
  - Designated routes for ingress / egress and staging.
- Input into Reddinet website, the number of available ALS and BLS ambulances **within 5 or less minutes**. DEC may request additional ambulance units when short 911 ambulances during a MCI response.
- During a MCI, all Private Ambulance Dispatch Centers are required to:
  - Monitor Reddinet and the incident radio channels for the duration of the MCI;
  - Update the number of available ALS and BLS ambulances as appropriate for the duration of the MCI.
- In-County Mutual aid ambulances may be used per DEC policy.
- **Ambulance diversion is automatically suspended for all patients.**
- Inform responding ambulance crews when Red Alert is terminated.

### LEVEL 2 MCI (RED) ALERT

51 - 100 victims of any triage level

- Follow same steps for Level 1 Red Alert listed above.
- DEM Duty Officer may provide instructions about modifications to the standard medical 911 Response.
- Consider activating your internal emergency response plan for large incidents.

### LEVEL 3 MCI (RED) ALERT

101 or greater number of victims of any triage level

- Follow same steps for Levels 1 and 2 Red Alerts listed above.
- Activate your internal emergency response plan for large incidents.
- DEM Duty Officer may provide instructions about modifications to the standard medical 911 Response.
- Out-of-County Mutual aid ambulances from other counties may be used if approved by MHOAC.
<table>
<thead>
<tr>
<th>LEVEL 4</th>
<th>MCI (RED) ALERT</th>
<th>Catastrophic disaster with significant infrastructure damage + unknown number of injuries casualties and deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>❑ Ensure safety of all dispatch staff (evacuate if building is unsafe).</td>
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</tr>
<tr>
<td></td>
<td>❑ Activate all emergency response plans.</td>
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<td></td>
<td>❑ Restore communication services if disrupted.</td>
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</tr>
<tr>
<td></td>
<td>❑ <strong>Alert Termination:</strong> SFFD has the authority to activate/deactivate an Emergency District Coordination Centers (EDCCs) decentralized command structure. See Appendix B Battalion Control</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LEVEL ZERO</th>
<th>MEDICAL 911 SYSTEM DISRUPTION</th>
<th>Significant 911 ambulance shortage OR Hospital(s) issue closes it to 911 Ambulances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>❑ Input into Reddinet the number of available ALS and BLS ambulances <strong>within 5 or less minutes.</strong></td>
<td></td>
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<tr>
<td></td>
<td>❑ DEC may request additional ambulance units when short 911 ambulances during a MCI response.</td>
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<td></td>
<td>❑ BLS ambulances may be requested in specific situations and when authorized by the EMS Agency Medical Director.</td>
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</table>
# Part 1: Standard Operating Procedures: Field Supervisors (or Medical Group)

## MCI Yellow Alert

“Heads Up” about Incident with a potential for multiple casualties

- Call MCI Yellow Alert on the initial Control Channel if there are potential patients.
- Upgrade to appropriate MCI Red Alert Level if there are actual patients OR cancel alert if it is not a MCI.
- Follow your agency’s standard response procedures.

## Level 1 MCI (Red) Alert

6 - 50 victims of any triage level

- (If not done by Incident Commander) - Radio a Situation Report on the initial Control Channel to DEC (911 Dispatch) within the first 15 minutes that includes:
  - 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 and Egress, and
  - Additional and / or Specialized Resources if needed.
- Follow your agency’s standard response procedures for Medical Group activation and operations.
- Consider requesting the Base Hospital to deploy an EMS Medical Director Approved Physician to the scene.
- Radio back to DEC which hospitals will receive patients, how many, what type, and any special needs (pediatrics, hazmat). Update DEC every 30 minutes or anytime there is a significant change in the MCI incident. This action may be delegated to Patient Transport Officer.
- In-County Mutual aid ambulances may be used per DEC policy.
- Consider alternate transport resources.
- Use MCI documentation algorithm 2.2.5.
- Responsible for patient tracking information until function assigned to Patient Loading Coordinator.
- EMS Response Time Standards are still in effect.
- **Diversion is automatically suspended for all ambulance patients.**
| LEVEL 2 | MCI (RED) ALERT  
51 - 100 victims of any triage level |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Follow same steps for Level 1 Red Alert listed above.</td>
<td></td>
</tr>
<tr>
<td>Request field supplements as needed:</td>
<td></td>
</tr>
<tr>
<td>o Mobile Multi-Casualty Unit (request through SFFD)</td>
<td></td>
</tr>
<tr>
<td>o Mutual Aid Ambulance Strike Team(s)</td>
<td></td>
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<tr>
<td>o MCI Trailers (through DEM Duty Officer)</td>
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<tr>
<td>o Disaster Medical Supply Units</td>
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<tr>
<td>o Alternate transport vehicles (e.g. Mass Casualty Transport Bus, Muni buses, etc.) may be used to transport patients.</td>
<td></td>
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<tr>
<td>o EMS Physician</td>
<td></td>
</tr>
<tr>
<td>Consider activating your internal emergency response plan to surge available resources.</td>
<td></td>
</tr>
<tr>
<td>Consider setting up Alternate Treatment Site to hold patients awaiting transport.</td>
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</tr>
<tr>
<td>DEC may provide instructions about modifying EMS Response patterns. EMS Response Time Standards are suspended during Modified EMS Responses.</td>
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</tbody>
</table>

| LEVEL 3 | MCI (RED) ALERT  
101 or greater number of victims of any triage level |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Follow same steps for Levels 1 and 2 Red Alert listed above.</td>
<td></td>
</tr>
<tr>
<td>Activate city emergency response plan to surge available resources.</td>
<td></td>
</tr>
<tr>
<td>Set up designated staging areas for Mutual Aid Ambulances.</td>
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<tr>
<td>Set up Alternate Treatment Sites for holding patients awaiting transport.</td>
<td></td>
</tr>
</tbody>
</table>

| LEVEL 4 | MCI (RED) ALERT  
Catastrophic disaster |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>SFFD may invoke a decentralized command structure based on their division or battalion districts if central dispatch is interrupted.</td>
<td></td>
</tr>
<tr>
<td>Follow same steps for Levels 1, 2 and 3 Red Alert listed above.</td>
<td></td>
</tr>
<tr>
<td>Each battalion station is the designated Emergency District Coordination Center (EDCC) where a Battalion Chief controls the assets in his/her emergency district. When Fire Battalion Stations are used to house the EDCC, primary coordination and communication will be with the Fire DOC utilizing all available communication systems. See Appendix B Battalion Control.</td>
<td></td>
</tr>
<tr>
<td>Ambulance response units will be organized through the EDCC until the dispatch communications infrastructure and central command are restored. This includes mutual aid ambulances.</td>
<td></td>
</tr>
<tr>
<td>Other city department representatives at the EDCC will communicate and coordinate their departmental resources with the relevant DOC when it becomes operational. Unified Command is used at the EDCC when there are other city department representatives present.</td>
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</tbody>
</table>
EDCC will determine resource allocation priorities within its district. Resource requests will be communicated to the EOC through the Community Branch when it is activated.

| LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION | If there is a 911 ambulance shortage, facilitate expedited turn-around times at impacted hospitals.  
If San Francisco General Hospital cannot receive Trauma Patients, follow Trauma Bypass policy #5021  
If other hospitals are closed to ambulances, contact DEC for instructions from EMS Medical Director or designee about modifications to hospital destination and ambulance diversion policies. |
## PART 1: STANDARD OPERATING PROCEDURES: HOSPITALS

<table>
<thead>
<tr>
<th>Level</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MCI YELLOW ALERT</strong></td>
<td>• Be aware of a situation in progress that may result in a MCI. Be ready to receive patients from the MCI.</td>
</tr>
<tr>
<td>“Heads Up” about Incident with a potential for multiple casualties</td>
<td>• Respond to Reddinet poll for available ED beds if initiated. <strong>Required response must be done within 15 minutes.</strong></td>
</tr>
<tr>
<td><strong>LEVEL 1</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MCI (RED) ALERT</strong></td>
<td>• Notify ED staff / house supervisors and other hospital responders per normal procedures.</td>
</tr>
<tr>
<td>6 - 50 victims of any triage level</td>
<td>• Assess need for initiation of internal response plans and Hospital Incident Command per normal procedures.</td>
</tr>
<tr>
<td></td>
<td>• ED Charge Nurse inputs into Reddinet the number of available ED beds for Immediate (Red), Delayed (Yellow) and Minor (Green) patients <strong>within 15 minutes.</strong> Patient distribution will follow Reddinet availability if possible.</td>
</tr>
<tr>
<td></td>
<td>• If Reddinet availability is not completed, each hospital will receive a preassigned number of patients according to the distribution chart in Section 3.10 of this policy.</td>
</tr>
<tr>
<td></td>
<td>• Casualties may self-present to ED (patients not transported by EMS).</td>
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<tr>
<td></td>
<td>• <strong>Ambulance diversion is automatically suspended for all patients.</strong></td>
</tr>
<tr>
<td></td>
<td>• During a MCI, all Emergency Department Charge Nurses are required to:</td>
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<tr>
<td></td>
<td>• Monitor Reddinet and the radios for the duration of the MCI;</td>
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<tr>
<td></td>
<td>• Input the number of available ED beds for Immediate (Red), Delayed (Yellow) and Minor (Green) patients <strong>within the first 15 minutes;</strong> and</td>
</tr>
<tr>
<td></td>
<td>• Update the number of available ED beds as appropriate for the duration of the MCI.</td>
</tr>
<tr>
<td></td>
<td>• Complete patient tracking per EMS policy direction.</td>
</tr>
<tr>
<td><strong>LEVEL 2</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MCI (RED) ALERT</strong></td>
<td>• Follow same steps for Level 1 Red Alert listed above.</td>
</tr>
<tr>
<td>51 - 100 victims of any triage level</td>
<td>• Consider activating your internal emergency response plan for large incidents.</td>
</tr>
<tr>
<td></td>
<td>• Update Reddinet per EOC instructions.</td>
</tr>
</tbody>
</table>
| LEVEL 3 | MCI (RED) ALERT  
101 or greater number of victims of any triage level |
|---------|--------------------------------------------------|
|         | Follow same steps for Levels 1 and 2 Red Alerts listed above.  
|         | Activate internal your emergency response plan for large incidents and establish Hospital Incident Command Center.  
|         | Prepare to receive large number of MCI patients beyond the pre-assigned numbers. |

| LEVEL 4 | MCI (RED) ALERT  
Catastrophic disaster |
|---------|--------------------------------------------------|
|         | Follow same steps for Levels 1, 2 and 3 Red Alert listed above.  
|         | Ensure safety of all staff. Evacuate if building is unsafe.  
|         | Activate all emergency response plans. Restore services.  
|         | Support to and from all hospitals will be organized through the Emergency District Coordination Centers until the communications infrastructure and central command are restored.  
|         | Each battalion station is the designated Emergency District Coordination Center (EDCC) where a Battalion Chief controls the assets in his/her emergency district. When Fire Battalion Stations are used to house the EDCC, primary coordination and communication will be with the Fire DOC utilizing all available communication systems. See Appendix B Battalion Control.  
|         | Ambulance response units will be organized through the Emergency District Coordination Centers until the dispatch communications infrastructure and central command are restored. This includes mutual aid ambulances.  
|         | Other city department representatives at the EDCC will communicate and coordinate their departmental resources with the relevant DOC when it becomes operational. Unified Command is used at the EDCC when there are other city department representatives present.  
|         | EDCC will determine resource allocation priorities within its district. Resource requests will be communicated to the EOC through the Community Branch when it is activated.  
|         | Crisis standards of care MAY be invoked by the San Francisco Chief Health Officer. |

| LEVEL ZERO | MEDICAL 911 SYSTEM DISRUPTION  
Significant 911 ambulance shortage OR Hospital(s) issue closes it to 911 Ambulances |
|------------|---------------------------------------------------------------------------------|
|            | Notify DEC dispatch **(415-558-3291 and / or designated EOC number)** if your hospital is experiencing a disruption that prevents it from accepting 911 ambulances at the Emergency Department.  
|            | Respond to requests from DEC dispatch or DEM Duty Officer about your hospital status.  
|            | Notify DEC **(415-558-3291 and / or designated EOC number)** when your hospital is open and ready to receive 911 ambulances at the Emergency Department. |
# PART 1: STANDARD OPERATING PROCEDURES: DEM DUTY OFFICER / EOC MEDICAL-PUBLIC HEALTH GROUP

<table>
<thead>
<tr>
<th>Level</th>
<th>Actions</th>
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</table>
| MCI YELLOW ALERT       | “Heads Up” about Incident with a potential for multiple casualties  
|                        | - Monitor for upgrade to Red Alert for termination of Yellow Alert.  
|                        | - Notify MHOAC to determine need for additional notifications or alerts to region or state.  
|                        | - Mutual aid is generally not activated except for unusual circumstances.  
|                        | - **Ambulance diversion is automatically suspended for all patients.**  
|                        | - Monitor for overload of the EMS System (significant ambulance shortages and / or hospitals overloaded).  
|                        |   - Reddinet polling of hospitals and ambulance providers.  
|                        |   - First Watch and Computer Automated Dispatch (CAD) at 911 Dispatch - monitor call volume / type and number of standard deviations above norm.  
|                        |   - Consultation as appropriate with: DEM AOC, DPH Communicable Disease Control or Environmental Health Duty Officer, DEM command staff, and other city, regional, state or federal agencies as warranted.  
| LEVEL 1 MCI (RED) ALERT| 6 - 50 victims of any triage level  
|                        | - Follow same steps for Level 1 Red Alert listed above.  
|                        | - Contact EMS Medical Director to determine whether modifications to the EMS response standards are necessary. Modifications of the standard responses must be authorized by the EMS Agency Medical Director.  
|                        | - For significant MCIs, an EOC activation will support the field response in coordination with the Fire Branch EMS Group:  
|                        |   - The EOC Operations Section - Fire Branch, EMS Group manages the immediate operations for the MCI patient response.  
|                        |   - The EOC Operations Section – Health & Human Services Branch, Public Health & Medical Services Group assumes the both the DEM Duty Officer EMS activities and the MHOAC function as the primary coordination body for medical-health services and resources within the Operational Area (county) for the duration of the EOC activation.  
|                        |   - Medical Mutual Aid will be invoked.  
| LEVEL 2 MCI (RED) ALERT| 51 - 100 victims of any triage level  
|                        |
| LEVEL 3 | MCI (RED) ALERT
| 101 or greater number of victims of any triage level |
| --- | --- |
| • Follow same steps for Red Alerts Levels 1 and 2 listed above. |
| • The Department of Public Health DOC may be activated to support the EOC’s Operations Section – Health & Human Services Branch, Public Health & Medical Services Group. |

| LEVEL 4 | MCI (RED) ALERT
| Catastrophic disaster |
| --- | --- |
| • City EOC and all departmental DOCs are activated if building sites are safe and staff available to operate. |
| • All emergency declarations are invoked. Mutual aid will be requested from the Regional Mutual Aid System, State and Federal responders about a catastrophic disaster. Recovery outlook is long-term. |
| • Follow same steps for Levels 1, 2 and 3 Red Alert listed above. |
| • Each battalion station is the designated Emergency District Coordination Center (EDCC) where a Battalion Chief controls the assets in his/her emergency district. When Fire Battalion Stations are used to house the EDCC, primary coordination and communication will be with the Fire DOC utilizing all available communication systems. See Appendix B Battalion Control. |
| • Ambulance response units will be organized through the District Coordination Centers until the dispatch communications infrastructure and central command are restored. This includes mutual aid ambulances. |
| • Other city department representatives at the EDCC will communicate and coordinate their departmental resources with the relevant DOC when it becomes operational. Unified Command is used at the EDCC when there are other city department representatives present. |
| • EDCC will determine resource allocation priorities within its district. |

| LEVEL ZERO | MEDICAL 911 SYSTEM DISRUPTION
<p>| Significant 911 ambulance shortage OR Hospital(s) issue closes it to 911 Ambulances |
| --- | --- |
| • DEM Duty Officer will consult with DEM Manager On Call who will determine need for additional notifications or activations. |
| • Assess cause and impact on medical 911 system capability through: |
| • Reddinet polling |
| • First Watch - Quantify call volume / type and number of standard deviations above norm. |
| • CAD |
| • Consultation with: |
| o DEC |
| o Ambulance company and / or hospital supervisory staff. |
| o Consultation as appropriate with: |
| o DEM Administrator on Call |
| o DPH Communicable Disease Control Duty Officer or Environmental Health Duty Officer |</p>
<table>
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<tr>
<td>o DEM command staff</td>
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<tr>
<td>o Other city, regional, state or federal agency as warranted.</td>
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<tr>
<td>• MHOAC to notify RDHMC and state EMS Authority, if warranted.</td>
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- Develop an Action Plan in consultation with EMS Medical Director, DPH Director of Health, SFFD Chief and the leadership of affected EMS Providers that will include a determination of the need to escalate the system alert level to a same response actions used during a Level 1, 2, or 3 MCI Alert.
PART 2: BACKGROUND AND TRAINING

Section 2.1 Introduction

2.1.1 Objectives

The Department of Public Health - Emergency Medical Services (EMS) Agency Multiple 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 divided into four parts:

1. **Part 1 Standard Operating Procedures:** A script for easy reference to the initial actions for responders.
2. **Part 2 Background and Training:** Provides relevant background information about the structure and response operations. It is intended for training for responders who are new to MCI responses or need a refresher.
3. **Part 3 Operations:** Describes in detail the activities that all EMS participants must follow during a general response to a MCI.
4. **Appendices:** Provide reference information relevant to supporting a successful response operation. It includes guides to Medical Branch/Group job sheets, Battalion Control, documentation and glossary, etc.

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 an incident response.
2.1.3 Authorities, Standards and Guidelines

Authorities, standards and guidelines are listed in 8000 MCI Policy section II.

2.1.4 Training and Competency Levels

First Receivers (hospitals), First Responders, Ambulance Strike Team Leaders, and Command staff training standards are listed in 8000 MCI Policy section IV.

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” (Respirations, Perfusion, Mentation). START is an acronym for Simple Triage and Rapid Treatment. 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.
Jump START is based on the START physiologic triage system used for adults. However, Jump START 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 Jump START 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.
**START:** Simple Triage and Rapid Treatment

**TRIAGE FLOW CHART**

- **Respirations**
  - **NO**
    - Position airway
    - Breathing?
      - **NO**
        - Deceased (Black)
      - **YES**
        - Immediate (red)
  - **YES**
    - more than 30 /min
    - Immediate (red)
    - less than 30 /min
      - Assess Perfusion

- **Perfusion**
  - Capillary refill greater than 2 seconds or no radial pulse
    - Control bleeding
      - Immediate (red)
  - Capillary refill less than 2 seconds or radial pulse
    - Assess mental status
      - Fails to follow simple commands
      - Follows simple commands
        - Immediate (red)
        - Delayed (yellow)

*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” (Respirations, Perfusion, Mental Status) to remember the assessment sequence.*

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

2. **RESPIRATIONS**
   - If respiratory rate is 30/minute or less go to PERFUSSION 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. **PERFUSION**
   - 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. **MENTAL 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

JumpSTART Pediatric MCI Triage

- Able to walk?
  - YES: MINOR → Secondary Triage
  - NO: Breathing?
    - NO: Position upper airway → BREATHING → IMMEDIATE
    - YES: Palpable pulse?
      - NO: APNEIC → DECEASED
      - YES: 5 seconds breaths → BREATHING
        → IMMEDIATE

- Respiratory Rate
  - <15 or >45: IMMEDIATE
  - 15-45
    - Palpable Pulse?
      - YES: T° (inappropriate), posturing or "U" → IMMEDIATE
      - NO: IMMEDIATE

- AVPU
  - "A", "V" or "P" (appropriate) → DELAYED
  - "A", "V" or "P" (inappropriate) → IMMEDIATE

(©Loe Ranzi MD, 2002)
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 LEMSA approved 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 Area(s). At minimum, patient identifying information (e.g. patient description or identification if available) and destination shall be written on the triage tags. Vital signs and treatment shall be added to the triage tags when the time and situation permit it.

2.2.5 Documentation

A Patient Care Report is to be completed on each patient transported if it can be accomplished taking into consideration the situation and the resources. The EMS Medical Director, MHOAC, or designee, may suspend standard PCR protocol and direct that triage tags be used as the minimal level documentation of field assessment and treatment.

Patients refusing transport can be divided into three groups:

- Patients allowing assessment
- Patients refusing assessment
- Pediatric patients with legal capacity to refuse transport (ref. SF EMSA Policy # 4040)

All assessed adult patients encountered on scene of an MCI who refuse transport should have assessment findings and treatments documented on a triage tag and sign Multiple Patient
Release Form (MPRF). When the patient leaves the scene, their triage tag should be retained as a patient care record.

All adult patients encountered on scene of an MCI refusing assessment should sign the MCI Multiple Patient Release Form (MPRF).

Pediatric patients with legal capacity to refuse transport, who are not transported from the scene of an MCI, should have assessment findings and treatments documented on a triage tag and sign Multiple Patient Release Form (MPRF). See Appendix C Field Documentation Algorithm.

2.2.6 Deceased Care

Patients triaged as Deceased or Expectant per triage guidelines should be labeled as Deceased / Expectant with the triage tape. 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 potential crime scene, Responders should not move the Deceased / Expectant patients. 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 identifying information on the triage tag and attach directly to the body. Include:
   - Date, time and location body found,
   - Name/address of decedent, if known (do not disturb decedent for identification),
   - If identified, how and when,
   - Name/phone of person making identity or filling out tag, and
   - Note any contamination
   - Medical Examiner’s morgue tag number

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. In coordination with the Medical Examiner or law enforcement, 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. In coordination with the Medical Examiner or law enforcement, 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. It is the responsibility of each individual position to accurately monitor and report patient tracking information. 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). 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 Area Unit Leader - Coordinates the triage of all patients. Reports to MGS. Supervises Triage Personnel / Litter Bearers and Morgue Manager. Responsible for documentation of all triaged patients.

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

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

9. Minor (Green) Treatment Manager - Responsible for treatment and re-triage of patients assigned to the Minor Treatment Area.
10. **Patient Loading Coordinator** – Coordinates movement of patients from Treatment Area to Transport Area. Reports to Treatment Unit Leader.

11. **Patient Transportation Area 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. **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.

13. **Ground Ambulance (Staging) Coordinator** - Coordinates ground ambulances or other ground-based patient transportation vehicles. Manages the Ambulance Staging Area(s). Dispatches ambulances as requested. Reports to Transportation Unit Leader.

14. **Air Ambulance Coordinator** - Establishes and coordinates helispots and air medical operations with the Air Operations Group. 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. The Medical Group Supervisor should ensure every consideration is made that the areas selected will enhance the safety and management of the incident. 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).
- Appropriate security of the location(s)
- Ability to maintain patient privacy

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 of the initial triage of patients.
**Treatment Area** – Location for the treatment of patients. In a small incident, 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.

**Morgue Area** – Location for holding the deceased.

**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.

**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.).

### Section 2.4 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. Alert levels are listed below, and a complete chart is found in Part 1 Standard Operating Procedures Alerts. Section 3.4 of this Plan describes the operational use of the MCI alert levels.

The progressive MCI Levels for San Francisco are important because they correspond to a specific set of actions when responding to a MCI incident. **It should be noted that the cut offs for the number of victims needed to call either a Level 1, 2 or 3 MCI alert are flexible.**

<table>
<thead>
<tr>
<th>MCI YELLOW ALERT</th>
<th>Incident with a potential for multiple casualties</th>
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<tbody>
<tr>
<td>LEVEL 1 MCI (RED) ALERT</td>
<td>MCI with 6 - 50 victims of any triage level.</td>
</tr>
<tr>
<td>LEVEL 2 MCI (RED) ALERT</td>
<td>MCI with 51 - 100 victims of any triage level. Requires resources from or distribution of casualties to neighboring counties.</td>
</tr>
<tr>
<td>LEVEL 3 MCI (RED) ALERT</td>
<td>MCI with 101 or more victims of any triage level. Requires resources from or distribution of casualties throughout the State or federal response system.</td>
</tr>
<tr>
<td>LEVEL 4 MCI (RED) ALERT</td>
<td>Catastrophic disaster with significant infrastructure damage, and unknown number of injuries and deaths. Requires significant, long-term support from State and Federal government.</td>
</tr>
<tr>
<td>LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION</td>
<td>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.</td>
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*Ver. 6/19*
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 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 distribute 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, ALS ambulances, Multi-Casualty Transport vehicles and EMS First Response 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, Pro-Transport 1 and Bayshore 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, 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 ambulance providers listed above may be authorized by the MHOAC or designee based on incident resource requirements.

Air Medical Service Providers: Offer on scene emergency medical care and air evacuation of patients. California Highway Patrol (CHP), 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.

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

- EMS Agency: Responsible for planning, coordinating, and evaluating emergency medical services for San Francisco. During a MCI or medical disaster, the EMS
Agency fulfills 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.

- **Public Health Emergency Preparedness and Response**: Responsible for planning and coordinating the public health response and hospital disaster preparedness and response.
- **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 Special Weapons and Tactics (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. 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.

Department of Parking and Traffic (DPT): May assist with perimeter control during a MCI.

Other agencies may provide support as identified during the incident.

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.

Examples of Single Command Incidents

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.

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 function (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
  - Mass casualty transport Ambu Bus
  - 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 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 Office of Emergency Services (CalOES). 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 DPH EMS Agency Medical Director. Several staff from the Department of Public Health 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 (2019). Operational details about the Medical Mutual Aid process are further described in Sections 3.14 of this Plan.
PART 3: OPERATIONS

Section 3.1 Introduction

The Department of Public Health - 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. 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),
- Nature of the Incident (e.g. Structure Fire; Gas Attack),
- Hazards (e.g. Unstable Debris; HazMat; Fire; Active Shooter),
- Number of Victims
- ICS structure,
- Radio call signs for Incident Command and Medical Group Supervisor,
- Location of command post,
- Ingress and egress information,
- 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(ies) 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

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 or more experienced personnel arrives to assume the Medical Group Supervisor role. Paramedic #2 (or EMT #2) will be the Triage Unit Leader until relieved or reassigned. 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 through the Incident Commander back to DEC who relays it to all responding agencies.

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. 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 On-Scene EMS Field Staff 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.

Third On-Scene 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 the 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 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:
   - Alert level for the incident,
   - Incident name (e.g. Shotwell Street Fire),
   - Nature of the Incident (e.g. Structure Fire; Gas Attack),
   - Hazards (e.g. Unstable Debris; HazMat; Fire; Active Shooter),
   - Number of Victims
   - ICS position assignments,
   - Radio call signs for Incident Command and Medical Group Supervisor,
   - Location of command post,
   - Ingress and egress information,
   - 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.

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

3. During a MCI, all Receiving Emergency Department Charge Nurses are required to:
   - Monitor Reddinet and the radio communication 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. DEC communicates the Reddinet report on the number and types of MCI patients that each hospital can take to the Medical Group Supervisor or Patient Transport Officer on designated Transport Channel.

5. Medical Group Supervisor or Patient Transport Officer will radio back to DEC which hospitals will receive patients, how many, what type, and any special needs (pediatrics,
6. DEC communicates with hospitals to report patient numbers, types, and any special needs.

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

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

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 or 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 to 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 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 left where they lie or moved to a separate Morgue Area if resources adequate. **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 set up a physical “triage funnel” with tape or natural barrier 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 injury / illness 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 chief complaint, assessment findings, treatments, and vital signs on the triage tag.
- First aid, BLS and ALS level care depending on provider training, availability of personnel and resources, and only if the situation safely allows.
- Prioritizing 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 prioritize patients and report to the Patient Transport Officer. The Patient Transport Officer will choose an appropriate mode of transportation for the patient. Possible patient transportation options may include:

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

The Patient Transport Officer will request medical transport vehicles through the chain of command / Incident Commander to the 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 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) is 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 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 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. 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.

### 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
  - Rescue Equipment
  - Specialized Equipment

- **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)

### 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 are 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.
- Consider activating alternate transport vehicles.

**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.
- Consider activating alternate transport vehicles.

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 Reddinet. If Reddinet is not functioning, DEC will directly contact hospitals via the radio for bed availability. Landline telephones may provide backup communications in the event the 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. Managed Distribution is when the Patient Transport Officer actively determines the hospital distribution for MCI patients when Emergency Department capacity is available on Reddinet and/or the total number of patients from an incident exceeds the total number of pre-assigned slots.

Section 3.10 Assigned Patient Distributions

Below is the initial distribution plan for MCI patients to hospitals 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 adjust based on the MCI situation or reported hospital availability.

<table>
<thead>
<tr>
<th>Assigned Distribution ¹</th>
<th>Hospital</th>
<th>Immediate (Red)</th>
<th>Delayed (Yellow)</th>
<th>Minor (Green)</th>
<th>ONLY Green</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ZSFG Trauma Center</td>
<td>1st 10 major traumas</td>
<td>4</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>UCSF Parnassus</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Van Ness – CPMC</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Kaiser</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>St. Francis Memorial</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Bernal - CPMC</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>St. Mary’s Medical Center</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Davies - CPMC</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(pediatric preferred) UCSF- Mission Bay</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Seton – Daly City</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>South Kaiser – So. SF</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(only delayed + minor) Chinese Hospital</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(only delayed + minor) VA Medical Ctr</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Subtotals:</td>
<td></td>
<td>30</td>
<td>52</td>
<td>78</td>
<td>160</td>
</tr>
<tr>
<td>Total:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>160</td>
</tr>
</tbody>
</table>

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 bus. In this situation, a hospital will receive “Only Green” patients due to the large number arriving at the same time.
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 Disaster Medical Health Coordinator (RDMHC) 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

<table>
<thead>
<tr>
<th>Patient Type</th>
<th>Triage</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Immediate (Red)</td>
<td>Start with hospitals with those farthest away from the incident.</td>
</tr>
<tr>
<td></td>
<td>Delayed (Yellow)</td>
<td>Start with hospitals with those farthest away from the incident after all Red medical patients have been transported.</td>
</tr>
<tr>
<td></td>
<td>Minor (Green)</td>
<td>Start with hospitals with those farthest away from the incident after all Yellow medical patients have been transported.</td>
</tr>
</tbody>
</table>
| Trauma¹ Meeting Physiologic or Anatomic Criteria | Immediate (Red) or Delayed (Yellow) | • 1st Ten trauma patients to ZSFG. ZSFG will indicate their ability to take additional patients.  
• When ZSFG is at capacity, remaining trauma patients may go to 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. |
| Trauma¹ 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

Managed Distribution is when the Patient Transport Officer actively determines the hospital distribution for MCI patients when Emergency Department capacity is available on Reddinet and / or the total number of patients from an incident exceeds the total number of pre-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 (MHOAC) located at the Emergency Operations Center (EOC).
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 DPH - 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 team 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 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. See Appendix B Battalion Control for additional details.

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 Joint
Emergency Operations Center (JEOC) to secure transportation and out-of-county destinations. Possible transportation options include but are not limited to:

**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

**Water-based Craft**
- Ferries
- Cruise Ships

**Larger 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 California Office of Emergency Services (Cal OES) 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 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. 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 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.

1.16.2 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 3.14 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 determined 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 (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 supply lists may be 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 an 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 determined 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. CalOES 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.

Ver. 6/19
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 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 Need” of a single Strike Team prior to contacting the MHOAC.
   - The San Francisco MHOAC is responsible for the approval of the request(s) for additional 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. CalOES 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 Protocol 11.01 Austere Care is the approved guideline for austere care in the pre-hospital environment. Refer to that protocol for further details. EMS Agency Protocol 11.01 Austere Care 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 operations for an incident response cease. 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.
APPENDIX A: MEDICAL GROUP/BRANCH JOB SHEETS, ORGANIZATION CHARTS, AND FIELD LAYOUT

1. First Tasks When Arriving On-Scene
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. Patient Loading Coordinator
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
8. MCI Organizational Chart - First Minutes Medical Group Response
9. MCI Organizational Chart - Full Medical Branch Activation
10. MCI Scene
**First Tasks When Arriving On-Scene**

**FIRST ARRIVING UNIT:**
The First arriving unit is responsible for implementing MCI procedures, which includes the following:

- Bring MCI bag, MCI management boards, PPE, gurney, back board, jump kit, monitor, oxygen. Don vests.
- Initiate Incident Command system. Follow incident management priorities:
  - Prioritize life safety
  - Incident stabilization
  - Prevent further property damage
- Complete scene size-up and communicate to DEC:
  - Report initial alert level (Yellow / Red / 1-4),
  - Location of Incident,
  - Type of Incident/Nature of Incident;
  - Hazards (if present),
  - Number of victims (estimated or actual number),
  - Initial route of Ingress (best route to enter) and Egress, and
  - Additional and / or Specialized Resources if needed.
- Establish Command Post
- Upon arrival of a more qualified officer, transfer command and relay status report and await further assignment and instructions:
  - First assignments are Triage and Treatment Leader roles

**ADDITIONAL AMBULANCE ASSIGNMENTS:**

- All ambulances on arrival should check in first with the IC. Generally, Triage and Treatment Unit Leader roles will be designated to paramedics. Depending on whether responding ambulances are single or dual medic, the MGS may reassign one of the first Unit Leader roles to the subsequent ambulance personnel.
# 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 (if a branch response is used), including the direction and execution of branch planning for the assignment of resources.

**Immediate Actions:**
- Don vest & PPE.
- 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.
- Report out casualty information to the Operations Chief.

**On-Going Actions:**
- Maintain a written record of activities using the Standardized ICS / MCI Forms.
- Monitor conditions within the medical incident for safe practices.
- Coordinate re-supply efforts with Logistics.
- Coordinate special staffing procedures with Logistics Branch sufficient to maintain response.
- 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:

- Don vest & PPE. Initiate MCI management boards
- Designate areas for decontamination, triage, treatment, transport, and ambulance staging. Determine need for multiple casualty collection points.
- Designate temporary morgue, helicopter landing zones and medical equipment resources staging area if appropriate.
- Request medical tactical channel through communication center.
- Oversee patient treatment and disposition
- Communicate situation report to IC:
  - Patients in each treatment area (from treatment leader)
  - Patients transported (from transport leader)
  - Patients released from the scene (from treatment leader)
  - Fatalities at the scene
- Consider assigning a scribe/assistant(s).
- Responsible for patient tracking information until function assigned to Patient Loading Coordinator.

On-Going Actions:

- Maintain an ICS 214 record for the incident. Assist the IC with preparation of standardized ICS / MCI form.
- Conduct reconnaissance of all possible patient areas. Oversee Medical Group personnel and operations. Monitor conditions for hazards. Notify Safety Officer of unsafe or hazardous conditions.
- Request additional supplies / resources through the Incident Commander such as Multi-Casualty Transport Unit, Chempack, SFFD Multi-Casualty Unit, AMR Disaster Medical Support Unit, or alternate forms of mass transport and / or temporary shelter if inclement weather.
- Maintain a written record of activities using the Standardized MCI Forms.
  - Monitor conditions within the medical incident for safe practices
  - Coordinate re-supply efforts
  - Ensures that there are enough personnel to assist in Medical Group / Branch activities.
- Communicate updated situation report to IC at regular time intervals (at a minimum every 30 minutes) or for significant changes.
**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:**
- Don vest & PPE. Initiate MCI management boards, triage tags and tape.
- Designate triage teams. Complete sweep through scene to locate, collect, and triage casualties. Perform initial triage with triage tape. Coordinate litter teams with IC.
- If designated as a crime scene, do not move deceased/expectant patients without clearance from law enforcement.
- Establish triage funnel. Mark patient flow with scene tape, if required.
- Coordinate patient triage using the START (adults) and Jump START (pediatric) triage systems.

**On-Going Actions:**
- Maintain written records for patients using triage tags. PCRs will be completed on all transported patients. See Appendix C MCI Documentation Algorithm.
- Collect and report numbers of patients and their acuity to the MGS at regular time intervals (at least every 30 minutes). Record patient tracking on MCI management board.
- Ensure safe practices within the Triage Area including monitoring of adequate decontamination in the event a hazardous materials incident.
  - Monitor patient flow.
  - Provide Medical Supply Manager with list of supplies to be replenished.
  - Periodically scan the scene for new or overlooked patients.
  - Monitor personnel for signs of stress or fatigue.
  - Participate in incident planning meetings as directed.
- Notify Medical Group Supervisor and Treatment Unit Leader when all patients have received initial triage and moved to designated treatment areas. Report the final count of patients.
- After all victims have been evaluated, reassign triage teams, per MGS.
**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 or tape affixed to upper extremities.

**On-Going Actions:**
- Move patients to appropriate Treatment Areas.
- Provide appropriate medical treatment to patients prior to movement as incident conditions allow.
- Assist with secondary triage of patients in treatment areas, if assigned.
- Report to Triage Unit Leader for reassignment when initial triage tasks have been completed.
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 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 secondary triage, medical treatment of victims and preparation / coordination for their transport.

**Immediate Actions:**
- Don vest and PPE. Initiate MCI management board.
- Supervise personnel in the Treatment Area
- Establish triage funnel with Triage Unit Leader

**On-Going Actions:**
- Coordinate all patient care in the Treatment Area
- Oversee preparations for patient transport
- Provide supplies for Red, Yellow, and Green Treatment Areas and if necessary Morgue Area.
- Coordinate the rapid movement of patients from Triage Areas to Treatment Areas.
- Ensure ongoing triage and recategorisation of all patients in Treatment Areas.
- Redirect Treatment Area Managers to perform ongoing triage of patients.
- Ensure patients have triage tags and are “packaged” for transport.
- Ensure direct handoff of all transported patients to Transport Unit Leader prior to leaving scene to include transport priority.
- Maintain written records of patients using triage tags and Treatment Areas MCI management boards.
- Requests additional staffing and resources through the Medical Group Supervisor to assure that each treatment area remains adequately staffed until the event is demobilized or otherwise directed by the Medical Group Supervisor.
Immediate (Red) 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:
- Don vest and PPE.
- 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.

On-Going Actions:
- Initiate or update triage tags on all patients in Treatment Area.
- 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.
- Advise transport crews to check in/out with Transport Unit Leader prior to transport of patient from scene.
- Request additional resources and personnel as needed.
## Delayed (Yellow) 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:**
- Don vest and PPE.
- 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.

**On-Going Actions:**
- Initiate or update triage tags on all patients in Treatment Area.
- 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 documentation of treatment and patient information on triage tags and patient status boards.
- Advise transport crews to check in/out with Transport Unit Leader prior to transport of patient from scene.
- Request additional resources and personnel as needed.
Minor (Green) 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:
- Don vest and PPE.
- 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.
- Initiate or update triage tags on all patients in Treatment Area.

On-Going Actions:
- Ensure that patients are prioritized for transportation.
- Ensures patients are “packaged” for transport.
- Coordinate transportation of patients with the Transport Unit Leader. Consider alternate transportation resources.
- 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.
- Advise transport crews to check in/out with Transport Unit Leader prior to transport of patient from scene.
- Any patient refusing transport must sign Multiple Patient Refusal Form (MPRF). Collect triage tags prior to patient departure.
- Request additional resources and personnel as needed.
Patient Loading Coordinator

Reports to: Treatment Unit Leader

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

Talk Group: __________ Radio call sign: Patient Loading Coordinator

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:**
- Don vest and PPE.
- Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
- Establish communications with the Patient Transportation Unit Leader.

**On-Going Actions:**
- 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.
- Report patient tracking information to Medical Group Supervisor.
- Coordinate ambulance loading with the Treatment Managers and ambulance personnel.
- Maintain Unit/Activity Log (ICS Form 214).
**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:** 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:**
- Don vest and PPE.
- Identify ambulance staging location if not already designated.
- Determine and maintain access and egress routes for patients and transporting units.
- Assign an assistant for patient tracking and communications.
- Prioritize transport of critical patients. Patients of different acuities (e.g. one red and one yellow) can be mixed only after the most critically injured patients in highest categories have been transported from scene.

**On-Going Actions:**
- Coordinate movement of patients to transportation area with Treatment Unit Leader or Patient Loading Coordinator.
- Coordinate ambulance flow through Transport Area.
- Oversee assignment of adequate numbers of 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.
- Consider trauma triage criteria when determining patient movement to trauma center(s).
- Determine transportation resource requirements for all patients (e.g. bariatric ambulance, isolette, alternate transport, etc).
- Coordinate the movement of patients with Medical Communications Coordinator, Ground Ambulance Coordinator, and Air Ambulance Coordinator, if activated.
- Confirm patient destination with DEC to determine which hospitals will receive patients, how many, what type, and any special needs (pediatrics, hazmat). Updates will be provided regularly or anytime there is a significant change in the MCI incident.
- Document patient destination, transporting unit, triage tag, and patient demographics.
- Notify the Medical Group Supervisor when the last patients has been transported from the scene and the transportation function is terminated.
- Maintain Unit/Activity Log (ICS Form 214)
- Request additional resources through Medical Group Supervisor or Medical Supply Coordinator if used.
Medical Communications Coordinator

Reports to: Transportation Unit Leader

Assignment Location: Transport Area

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: Maintain medical communications between the Transportation Unit Leader and DEC for assignment of patient destination and patient tracking. This may be the scribe/assistant to the Transportation Unit Leader.

Immediate Actions:
- Obtain basic patient information and acuity category from Treatment Area Unit Leader or Treatment Dispatch Manager, if activated.
- Confirm and record patient destinations, ("This is Medical Comms at Transport Area – I copy to take 2 Green patients with Triage Tag numbers 6293 and 6456 to St Mary’s Hospital. Is the correct?").

On-Going Actions:
- Coordinate patient movement via ground assets with Ground Ambulance Coordinator.
- Coordinate patient movement via helicopter with Air Ambulance Coordinator.
Ground Ambulance (Staging) Coordinator

Reports to: Transportation Unit Leader

Assignment Location: Transport Area

Talk Group: __________  Radio call sign: Ground Ambulance Coordinator

Skills needed: Knowledge of destination criteria.

Mission: Coordinate ground ambulances or other ground-based patient transportation vehicles. Manage the Ambulance Staging Area(s). Dispatch ambulances as requested.

Immediate Actions:
- Don vest and PPE.
- Confirm access and egress routes for ground ambulances.
- Establish and maintain communications with the Medical Communications Coordinator, Transportation Unit Leader, and Air Ambulance Coordinator, if activated.
- Confirm and maintain appropriate staging area(s) for ambulances.
- Coordinate security for Staging Area.

On-Going Actions:
- Track ambulance status. Control and document all resources entering and leaving the Staging Area.
- Maintain check-in procedures for new arrivals.
  - Confirm radio channels with incoming crews.
  - Confirm incoming crews have MCI kit.
  - Confirm adequate PPE for all personnel.
  - Brief incoming crews of supply requests from Treatment Unit Leader.
  - Brief crews on patient loading zones and ingress/egress routes.
  - Ensure all personnel remain with their units until assigned.
- Fulfill ambulance requests from Transportation Unit Leader and Medical Communications Coordinator, if activated.
- Request additional resources through Transportation Area Unit Leader or Medical Supply Coordinator if activated.
- Advise transport crews to check in/out with Transport Unit Leader prior to transport of patient from scene.
## Air Ambulance Coordinator

**Reports to:** Transportation Unit Leader  
**Assignment Location:** Air Transport Area  
**Talk Group:** __________  
**Radio call sign:** Air Ambulance Coordinator  
**Skills needed:** Knowledge of air operations, landing zones, and destination criteria.

**Mission:** Establish and coordinate helispots and air medical operations with the Air Operations Group.

**Immediate Actions:**
- Per EMS Policy 4020, identify appropriate LZs for air ambulances with Helispot Manager that are of adequate size for civilian helicopters:
  - 75’ x 75’ for day (per helicopter).
  - 125’ x 125’ for night (per helicopter).
  - If military aircraft is used, confirm LZ size with military air operations.
- Establish LZ security (remove bystanders, stop traffic flow, etc.).
- Identify back-up site (in case alternate LZ is needed).
- Walk LZ for possible flying object debris.
- Have charged line ready to wet down landing zone if dusty.
- Nighttime operations:
  - Mark LZ with strobes in a square pattern.
  - Keep rotating beacons on unless instructed to turn off by pilot.
- Establish communication with incoming crews.
- Communicate hazards (HOTSAW: Hazards, Obstruction, Terrain, Surface, Animals, Wind/Weather) via common channel (CALCORD).
- Coordinate air transport requests with the Medical Communications Coordinator.
- Coordinate ground ambulance transport of patients to helispots.
- Coordinate patient loading with Patient Loading Coordinator.

**On-Going Actions:**
- Ensure 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.
- Advise transport crews to check in/out with Transport Unit Leader prior to transport of patient from scene.

**Landing Procedures:**
- Clear LZ prior to aircraft arrival.

*Ver. 6/19*
- Do not approach the aircraft until advised by the air crew.
- Follow all directions given by air crew.
- Give medical report to air crew.
- If you drop something near the aircraft, **do not retrieve, reach for, or chase it.** Notify air crew member and they will retrieve it for you.
- After aircraft has cleared LZ and is airborne, remain on LZ frequency for an additional 2-3 minutes or until pilot secures communications with LZ manager.

- **Safety:**
  - Remain on radio; be vigilant during final approach.
  - If hazard exists, relay "STOP or "GO AROUND."
  - Approach down slope side of helicopter only.
  - Secure blankets, clothing, helmets.
  - Raise nothing above head height.
  - Wear eye protection and helmet.
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. Knowledge of local resources, including DMSU and MCU-1/2.

Mission: Coordinate requests, receive, distribute, track and maintain stock for medical supplies and equipment assigned to the Medical Group.

Immediate and On-Going Actions:

- Don vest and PPE.
- 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.
MCI Organization Chart

Full Medical Branch Activation
APPENDIX B: BATTALION CONTROL DURING CATASTROPHIC INCIDENTS

Battalion Control is a decentralized command structure which makes use of existing San Francisco Fire Department (SFFD) geographical battalions to preserve a functional span of control and ensure effective operations during a catastrophic incident that has caused a complete disruption of the city response and communications infrastructure.

In the San Francisco Emergency Response Plan (ERP), SFFD Battalion Houses are referred to as Emergency District Coordination Centers (EDCC). Ambulance response units will be organized through the EDCCs until the dispatch communications infrastructure and central command are restored. All in-service ambulance units (SFFD and private companies) must report to the nearest Battalion station for direction whenever the EDCCs command structure is invoked.

Triggers
In the event of a large-scale emergency or during multiple, simultaneous incidents, a modified response may be triggered. Types of triggering events may include:
- Major earthquake and or tsunami
- Multiple large-scale events
- Any event that over tasks SFFD resources
- Loss of communications

SFFD RESPONSE LEVELS:
- Normal
- 10-1 response- modified response
- Division Control (10-2)
  - At the discretion of Chiefs of Department (CD1, CD2, or CD3), or
  - At the discretion of Division 2 and/or Division 3 after conferring with the Department of Emergency Communications (“DEC”) Supervisor, or
  - Single engines will be dispatched to any reported fires, or
  - After approval from LEMSA, ambulances only will be dispatched to any medical calls.
- Battalion Control (10-3)
  - At the discretion of CD1, CD2, or CD3, or
  - At the discretion of Division 2 and/or Division 3 after conferring with the DEC Supervisor, or
  - In the case of total communication systems failure, Battalion Control activation will be automatically triggered.
Division and Battalion Stations:

**DIVISION 2: Station 5:**

<table>
<thead>
<tr>
<th>Battalion 1</th>
<th>Battalion 4</th>
<th>Battalion 5</th>
<th>Battalion 7</th>
<th>Battalion 8</th>
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<tr>
<td>Station 2</td>
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<td><strong>Station 38</strong></td>
<td>Station 12</td>
<td><strong>Station 31</strong></td>
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<td>Station 41</td>
<td>Station 51</td>
<td>Station 21</td>
<td>Station 34</td>
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**DIVISION 3: Station 7:**

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<thead>
<tr>
<th>Battalion 2</th>
<th>Battalion 3</th>
<th>Battalion 6</th>
<th>Battalion 9</th>
<th>Battalion 10</th>
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<tbody>
<tr>
<td>Station 1</td>
<td>Station 4</td>
<td><strong>Station 7</strong></td>
<td>Station 15</td>
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*Division Houses Highlighted BLUE*
*Battalion Houses Highlighted YELLOW*

**Locations:**

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<tr>
<th>Station 1</th>
<th>935 Folsom at 5th Street</th>
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<td>Station 5** +</td>
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<tr>
<td>Station 6</td>
<td>135 Sanchez Street at Henry Street</td>
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<td>Station 7** +</td>
<td>2300 Folsom Street at 19th Street</td>
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<td>Station 8*</td>
<td>36 Bluxome Street at 4th Street</td>
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<td>499 41st Avenue at Geary Boulevard</td>
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<td>Pier 22½, The Embarcadero at Harrison Street</td>
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<td>218 Lincoln Blvd at Keyes Avenue</td>
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* Battalion House  
**Division House  
***EMS Division  
+ Medical cache house
On Scene

No Contact
- Estimate # for After Action Report

Contact
- Pediatrics
  - With Guardian
    - No Transport: PRF
    - Transport: PCR
  - No Guardian
    - Transport: PCR

- Adults
  - Allows Assessment
    - Transport: PCR
    - No Transport: PRF
  - Refuses Assessment
    - Transport: PRF
    - No Transport: PRF
City and County of San Francisco
MCI Plan: Multiple Patient Release Form

Agency: ________________________________ Date: ___/___/___   Incident Name or Location: _________________________

I/we hereby refuse the emergency medical services, assessment, treatment and/or transportation to a medical facility offered and advised by the above-named service provider. I/we hereby release the San Francisco EMS System, the provider service, their personnel and employees of any further responsibility and acknowledge that I have been advised by the medical personnel that I may need emergency first-aid treatment, which I am refusing, and acknowledged by my signature below. I understand my refusal may jeopardize my health, and I/we should consult a private physician regarding medical treatment. I hereby release the above-named parties from any and all claims of liability in connection with this incident and my signed refusal.

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Signature: ______________________ Time: _________ Date: ___/___/___ Relationship (if minor): ________

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EMS Crew Member Name: __________________________ EMT / Paramedic (circle) License #: __________
EMS Unit #: __________ ICS Position: __________ Location of Release: ______________________________
# APPENDIX D: ABBREVIATIONS, ACRONYMS & GLOSSARY

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
<td>ICS</td>
<td>Incident Command System</td>
</tr>
<tr>
<td>BLS</td>
<td>Basic Life Support</td>
<td>JEOC</td>
<td>Joint Emergency Operations Center</td>
</tr>
<tr>
<td>CAL-MAT</td>
<td>California Medical Assistance Team</td>
<td>MCI</td>
<td>Multi-Casualty Incident</td>
</tr>
<tr>
<td>CDMN</td>
<td>California Disaster Medical Network</td>
<td>MGS</td>
<td>Medical Group Supervisor</td>
</tr>
<tr>
<td>CDPH</td>
<td>California Department of Public Health</td>
<td>MHOAC</td>
<td>Medical/Health Operational Area Coordinator</td>
</tr>
<tr>
<td>DEM</td>
<td>Department of Emergency Management</td>
<td>NDMS</td>
<td>National Disaster Medical System</td>
</tr>
<tr>
<td>DMAT</td>
<td>Disaster Medical Assistance Team</td>
<td>NIMS</td>
<td>National Incident Management System</td>
</tr>
<tr>
<td>DMORT</td>
<td>Disaster Mortuary Team</td>
<td>OA</td>
<td>Operational Area</td>
</tr>
<tr>
<td>DOC</td>
<td>Department Operations Center</td>
<td>OES</td>
<td>Office of Emergency Services</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
<td>PDC</td>
<td>Patient Distribution Center</td>
</tr>
<tr>
<td>EOC</td>
<td>Emergency Operations Center</td>
<td>RDMHC</td>
<td>Regional Disaster Medical/Health Coordinator</td>
</tr>
<tr>
<td>EOP</td>
<td>Emergency Operations Plan</td>
<td>RDMHS</td>
<td>Regional Disaster Medical/Health Specialist</td>
</tr>
<tr>
<td>ESF</td>
<td>Emergency Support Function</td>
<td>SEMS</td>
<td>Standardized Emergency Management System</td>
</tr>
<tr>
<td>FEMA</td>
<td>Federal Emergency Management Agency</td>
<td>SFFD</td>
<td>San Francisco Fire Department</td>
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<tr>
<td>DMAT</td>
<td>Disaster Medical Assistance Team</td>
<td>SFPD</td>
<td>San Francisco Police Department</td>
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<td>DPH</td>
<td>Department of Public Health</td>
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*Ver. 5/19*
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.