

- 2.4 Upon activation of a MCI Level 2, PSC will page EMS On-Call and the MHOAC with the same information provided to hospitals during an MCI Level 1 activation as well as an on-scene point of contact.
- 2.5 First on scene – The first unit to arrive at the scene will provide a size-up of the incident to PSC, which should include the following:
 - 2.5.1 Type of incident
 - 2.5.2 Location of incident including city/unincorporated area, cross streets or Highway and best ingress and egress route(s).
 - 2.5.3 Approximate number of patients and MCI level being declared.
 - 2.5.4 Location of command post, incident name, Incident Commander and Medical Branch Director or Medical Group Supervisor and staging locations – both Fire and EMS if separate – for incoming units.

3. COMMUNICATIONS

- 3.1 MCIs are assigned a Command and Tactical Talk Group.
 - 3.1.1 Resources will utilize the assigned Talk Groups based on their defined functions and specifications.
 - 3.1.2 The Medical Branch Director or Medical Group Supervisor will communicate relevant EMS information and requests to the appropriate ICS position (e.g., Communications, Operations, IC, etc.) via the assigned Fire Command Channel.
- 3.2 The Patient Transportation Unit Leader, Medical Communications Coordinator, or designee will contact receiving hospitals with patient count and information [e.g., patient(s), acuity level (e.g., red, yellow, green, black), Triage Tag Number(s), Medic Number, and ETA] via the hospital's assigned Talk Group upon departure from the scene as appropriate.
- 3.3 The Medical Branch Director or Medical Group Supervisor or designee shall request PSC secure the medical EMS incident on EMSsystem after the Medical Branch/Medical Group has demobilized.
 - 3.3.1 PSC will perform an all hospital ring down advising hospitals the medical EMS incident has been secured when the EMSsystem incident has been closed.

4. RESOURCE REQUESTS

- 4.1 As MCI levels change, the Medical Branch Director or Medical Group Supervisor will notify the Incident Commander of each level

increase/decrease.

- 4.2 BLS ambulances may be needed to transport ALS level patients during an MCI. Whenever possible, a firefighter/paramedic with ALS equipment should provide patient care during transport.
- 4.3 All resource requests must go through the Incident Commander in coordination with the Medical Branch Director or Medical Group Supervisor and the Patient Transportation Unit Leader at the Incident Command Post.
- 4.4 In-county resource requests must be approved by the Incident Commander in coordination with the Medical Branch Director or Medical Group Supervisor and the Patient Transportation Unit Leader.
 - 4.4.1 Upon activation of a Level 2 MCI, PSC shall poll SacComm and other pre-identified/pre-approved ambulance resources via EMSsystem.
 - 4.4.2 With Incident Commander approval, the Medical Branch Director or Medical Group Supervisor may request from PSC the San Mateo County Special Operations Unit (SOU), Disaster Medical Supply Unit (DMSU), ATVs, STAR cars and/or MCI trailer(s).
- 4.5 Per the State Public Health and Medical Emergency Operations Manual (EOM), out-of-county resource requests shall be considered as long as the following are true:
 - 4.5.1 The resource need is imminent and significant.
 - 4.5.2 The supply of the requested resource has been exhausted, or exhaustion is imminent.
 - 4.5.3 Other acceptable alternatives (e.g., corporate supply chain, approved surge providers) have been exhausted, or exhaustion is imminent.
- 4.6 Out-of-county resource requests to PSC must be approved by the Incident Commander in coordination with the Medical Branch Director or Medical Group Supervisor and Patient Transportation Unit Leader. PSC must notify EMS On-Call and MHOAC immediately after placing a resource request with another County. The notification must include the resource(s) requested and the County receiving the request.
 - 4.6.1 With Incident Commander approval and EMS On Call/MHOAC notification, the Medical Branch Director or Medical Group Supervisor or the contracted 911 ambulance provider's Supervisor may request PSC to poll initial attack single resources from neighboring counties.

4.6.1.1 Ambulance Strike Teams, along with Disaster Medical

Supply Units, should be considered for immediate need and planned need requests – not initial attack.

4.6.2 Out-of-county medical mutual aid can be requested through the following counties:

- North Zone
 1. San Francisco
 2. Alameda

- Central Zone
 1. Alameda County
 2. San Francisco
 3. Santa Clara County

- South Zone
 1. Santa Clara County
 2. Alameda County

- Coast Zone
 1. Santa Cruz County
 2. San Francisco

4.7 In addition to the use of Stanford Life Flight and Calstar for air medical transport, consider the use of other air medical transport providers including REACH, Mercy Air or PHI Air Medical; or air search and rescue providers including CHP, Coast Guard or East Bay Regional Parks. These providers should only be utilized for medical mutual aid when Stanford Life Flight and Calstar are not available.

5. DOCUMENTATION

5.1 During an MCI, triage tags shall be used on each patient. At a minimum, patient information documented on each tag should include:

- Triage Tag number
- Destination

5.1.1 Upon treatment area activation, the following additional information shall be documented on the triage tag:

- Chief Complaint/Injury(s)
- Field Treatment
- Vital Signs (if possible)
- Patient Name (if possible)

5.2 In addition to triage tags, patients that are transported by ambulance must have a patient care report (PCR) completed by the transporting crew at all times and by Fire when patient care is provided.

5.2.1 Request for minimum patient documentation on a PCR listed above and/or the use of a hardcopy (paper) PCR during an MCI must be approved by the EMS On-Call or MHOAC. An electronic PCR shall be completed on all patients after the event closure if paper PCR's were used.

5.3 Upon conclusion of the event, the contracted 911 ambulance provider's Supervisor shall request and receive from the EMS Agency the hospital polling results from EMSsystem within three (3) business days.

5.4 Within seven (7) business days, the contracted 911 ambulance provider's Supervisor will complete the MCI Review Form and submit to EMS. For larger MCIs, the contracted 911 ambulance provider's Supervisor may request more time or a waiver from EMS where EMS may choose to conduct a formal After Action Report.

5.5 Incident reviews may be requested by the field to the EMS Agency for any MCIs.

6. PATIENT DISTRIBUTION

6.1 The Patient Transportation Unit Leader will select patient destinations to the appropriate facility based on standard protocols and real time EMSsystem MCI hospital polling. For larger MCIs, the Patient Transportation Unit Leader shall consult with EMS On-Call and/or the MHOAC for patient destinations including those that may extend beyond the Operational Area.

6.1.1 In the event that prospective hospital destinations have not responded in a timely manner on EMSsystem, or there is a significant amount of patients needing transport, San Mateo County receiving hospitals have committed in advance to receiving up to 2 delayed (yellow) patients and 4 minor (green) patients.

6.1.2 All regional trauma centers have agreed to accept up to four patients meeting major trauma criteria initially and will reassess their capability periodically.

6.2 Patient count and destination information shall be shared with the EMS On-Call and/or MHOAC initially and agreed-upon regular updates.

7. FIELD TREATMENT SITE

7.1 In the event of an extended MCI where on-scene patient triage and treatment may extend any length of time, the Medical Branch Director or Medical Group Supervisor and contracted 911 ambulance provider's Supervisor should consider the establishment of a temporary field treatment site with Incident Commander approval.

7.1.1 Should a temporary field treatment site be necessary, requests for basic needs supplies (e.g., water, food, sanitation, blankets,

clothing, etc.) and on-site amenities (e.g., portable toilets, tents, cots, etc.) should be made via the Incident Commander.

7.1.1.1 Assistance can be requested of impacted City EOC(s), County EOC and/or EMS On-Call/MHOAC

8. SAN FRANCISCO INTERNATIONAL AIRPORT (SFO) AIRPORT EMERGENCY PLAN (AEP)

8.1 The San Francisco International Airport (SFO) is owned and operated by the City and County of San Francisco (CCSF) and physically located within the County of San Mateo. CCSF is responsible for developing and exercising the Airport Emergency Plan. While the San Francisco Police Department and San Francisco Fire Department are respectively responsible for local law enforcement and fire suppression/medical at the airport, the transport and Advanced Life Support (ALS) care of patients fall under the auspices of the San Mateo County EMS Agency medical direction and is included in its Exclusive Operating Area (EOA).

8.1.1 Per the SFO AEP, the San Mateo County MCI Plan is activated at an Alert 3 level with an on-airport crash. For Alert 3 on-airport crashes, the San Mateo County EMS System is responsible for all EMS transports and can choose to work in Unified Command with the San Francisco Fire Department Airport Division. (For a list of San Francisco resources that would respond to an Alert 3 on-airport crash, please see the San Francisco International Airport Airport Emergency Plan table on page 8)

EMS RESPONSE PLAN TO MCIs

Alarm	Ambulance	Supervisor	Cover-In/Notification
Initial Response	ALS Ambulance		
Level 1 MCI * **	ALS Ambulance ALS Ambulance Contracted 911 Ambulance Provider's Supervisor	Contracted 911 Ambulance Provider's Supervisor	Notify JPA Supervisors Poll Hospitals via EMS System Consider notification of CISM Team through the IC
Level 2 MCI	ALS Ambulance ALS Ambulance		Notify EMS On-Call and MHOAC Notify Contracted 911 Ambulance Provider's Management Consider use of SOF Rescues, STAR cars or ATVs for transport purposes Poll Contracted 911 Ambulance Provider's non-911 system ambulance resources from surrounding counties via SacComm Poll other pre-identified/pre-approved in-county and out-of-county BLS providers. Notify OES On-Call
Level 3 MCI***	BLS Ambulance BLS Ambulance		Dispatch IDT Call Back MSU 137
Level 4 MCI	BLS Ambulance BLS Ambulance		Consider establishing Medical Communications Coordinator
Level 5 MCI	BLS Ambulance BLS Ambulance		
Level 6 MCI OR GREATER (add 2 BLS for each level increase)	BLS Ambulance BLS Ambulance		

NOTE: Consider Medical Mutual Aid for all levels.

*** Consider utilization of air ambulance resources at any time based on need**

**** Consider utilization of SamTrans buses at any time based on need**

***** Incident Command may utilize ALS resources at any time based on need**

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**San Francisco International Airport (SFO)
Airport Emergency Plan (AEP)
San Francisco Resources to Alert 3 On-Airport Crash**

Code 101	Staffing (per unit)
Engine Company (5)	1 officer/3 fire fighters (1 minimum is an EMT)
Truck Company (3)	1 officer/4 fire fighters (1 minimum is an EMT)
Battalion Chief (2)	2 chiefs
Division Chief (2)	1 chief/1 incident support specialist
Heavy Rescue Squad (1)	1 officer/ 3 fire fighters (all are EMTs)
Rescue Captain (1)	1 paramedic/EMS Captain
Ambulance (1)	1 paramedic and 1 EMT
Fire Boat (1)	1 officer/3 fire fighters/1 boat operator (1 paramedic and 1 minimum EMT)
Hose Tender (1)	1 fire fighter

Code 101 (Second Alarm)	Staffing (per unit)
Engine Company (4)	1 officer/3 fire fighters (1 minimum as an EMT)
Truck Company (1)	1 officer/4 fire fighters (1 minimum as an EMT)
Battalion Chief (2)	2 chiefs
Rescue Captain (1)	1 paramedic/EMS captain
Ambulance (1)	1 paramedic/1 EMT
Rescue Boat (1)	1 officer/1 paramedic/1 EMT
Hazmat Unit (1)	1 officer/3 fire fighters (1 minimum as an EMT)
Multi-Casualty Unit (1)	1 officer/3 fire fighters (1 minimum as an EMT)
Mobile Command Post (1)	1 fire fighter
Decon Unit (1)	1 officer/3 fire fighters
Bureau of Equipment (apparatus support) (1)	2 fire fighters
Mobile Air (breathing air support) (1)	1 fire fighter

ICS POSITIONS BASED ON FIRESCOPE FIELD OPERATIONS GUIDE (FOG) MEDICAL BRANCH DEFINITION

The Medical Branch structure is designed to provide the Incident Commander with a basic, expandable system to manage a large number of patients during an incident. If incident conditions warrant, Medical Groups may be established under the Medical Branch Director.

The degree of implementation will depend upon the complexity of the incident.

As the complexity of an incident exceeds the capacity of the local medical health resources, additional response capabilities may be provided through provisions of the Public Health and Medical Emergency Operations Manual (EOM) through the Medical Health Operational Area Coordinator (MHOAC).

ICS POSITION CHECKLISTS - COMMON RESPONSIBILITIES

The following is a checklist applicable to all ICS personnel and should be reviewed first:

- a. Receive assignment from your agency, including:
 1. Job assignment, e.g., Strike Team designation, overhead position, etc.
 2. Resource order number and request number
 3. Reporting location
 4. Reporting time
 5. Any special communications instructions, e.g., travel frequency
- b. Upon arrival at the incident, check in at designated Check-in location.
- c. Receive briefing from immediate supervisor.
- d. Don ICS position vest and acquire work materials.
- e. Conduct all tasks in a manner that ensures safety and welfare of you and your co-workers utilizing accepted risk analysis methods.
- f. Organize and brief subordinates.
- g. Know the assigned frequency (ies) for your area of responsibility and ensure that communication equipment is operating properly.
- h. Use clear text and ICS terminology (no codes) in all radio communications. All radio communications to the Incident Communications Center will be addressed: "(Incident Name) Communications," e.g., "Webb Communications".
- i. Complete forms and reports required of the assigned position and send through supervisor to Documentation Unit.
- j. Respond to demobilization orders and brief subordinates regarding demobilization.

UNIT LEADER RESPONSIBILITIES

A number of the Unit Leader responsibilities are common to all units in all parts of the organization. Common responsibilities of Unit Leaders are listed below. These will not be repeated in Unit Leader Position Checklists in subsequent chapters:

- a. Participate in incident planning meetings as required.
- b. Determine current status of unit activities.
- c. Confirm dispatch and estimated time of arrival of staff and supplies.
- d. Assign specific duties to staff and supervise staff.
- e. Develop and implement accountability, safety, security, and risk management measures for personnel and resources.
- f. Supervise demobilization of unit, including storage of supplies.
- g. Provide Supply Unit Leader with a list of supplies to be replenished.

ICS POSITION CHECKLISTS – ICS POSITIONS

MEDICAL BRANCH DIRECTOR - The Medical Branch Director is responsible for the implementation of the Incident Action Plan within the Medical Branch. The Branch Director reports to the Operations Section Chief and supervises the Medical Group(s) and the Patient Transportation function (Unit or Group). Patient Transportation may be upgraded from a Unit to a Group based on the size and complexity of the incident:

- a. Review Common Responsibilities (Page 9).
- b. Review Group Assignments for effectiveness of current operations and modify as needed.
- c. Provide input to Operations Section Chief for the Incident Action Plan.
- d. Supervise Branch activities and confer with Safety Officer to assure safety of all personnel using effective risk analysis and management techniques.
- e. Report to Operations Section Chief on Branch activities.

MEDICAL GROUP SUPERVISOR - The Medical Group Supervisor reports to the Medical Branch Director and supervises the Triage Unit Leader, Treatment Unit Leader, Patient Transportation Unit Leader and Medical Supply Coordinator. The Medical Group Supervisor establishes command and controls the activities within a Medical Group:

- a. Review Common Responsibilities (Page 9).
- b. Participate in Medical Branch/Operations Section planning activities.
- c. Establish Medical Group with assigned personnel, request additional personnel and resources sufficient to handle the magnitude of the incident.
- d. Designate Unit Leaders and Treatment Area locations as appropriate.
- e. Isolate Morgue and Minor Treatment Area from Immediate and Delayed Treatment Areas.
- f. Request law enforcement for security, traffic control and access for the Medical Group areas.
- g. Determine amount and types of additional medical resources and supplies needed to handle the magnitude of the incident (medical caches, backboards, litters, and cots).
- h. Ensure activation or notification of appropriate hospital or other coordinating facility/agency including the EMS Agency.
- i. Coordinate with assisting agencies such as law enforcement, Coroner, Public Health and private ambulance companies. Law enforcement/Coroner shall have responsibility for crime scene and decedent management.
- j. Coordinate with agencies such as Red Cross and utilities.
- k. Ensure adequate patient decontamination and proper notifications are made (if applicable).
- l. Consider responder rehabilitation.

TRIAGE UNIT LEADER - The Triage Unit Leader (MCTL) reports to the Medical Group Supervisor and supervises triage personnel/litter bearers and the Morgue Manager. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the Triage Area. When triage has been completed and all the patients have been moved to the treatment areas, the Triage Unit Leader may be reassigned as needed:

- a. Review Common Responsibilities (Page 9).
- b. Review Unit Leader Responsibilities (Page 9).
- c. Develop organization sufficient to handle assignment.
- d. Inform Medical Group Supervisor of resource needs.
- e. Implement triage process.

- f. Coordinate movement of patients from the Triage Area to the appropriate Treatment Area.
- g. Ensure adequate patient decontamination and proper notifications are made (if applicable).
- h. Assign resources as triage personnel/litter bearers.
- i. Give periodic status reports to Medical Group Supervisor.
- j. Maintain security and control of the Triage Area.
- k. Establish a temporary Morgue Area in coordination with law enforcement/Coroner if necessary.

MORGUE MANAGER - The Morgue Manager (MCMM) reports to the Triage Unit Leader and assumes responsibility for Morgue Area. Coordinates the handling of decedents with law enforcement and Coroner:

- a. Review Common Responsibilities (Page 9).
- b. Assess resource/supply needs and order as needed.
- c. Coordinate all Morgue Area activities with investigative authorities.
- d. Keep area off limits to all but authorized personnel.
- e. Keep identity of deceased persons confidential.
- f. Maintain appropriate records.

TREATMENT UNIT LEADER - The Treatment Unit Leader (MCUL) reports to the Medical Group Supervisor and supervises Treatment Area Managers and the Patient Loading Coordinator. The Treatment Unit Leader assumes responsibility for treatment, preparation for transport, and the movement of patients to loading location(s):

- a. Review Common Responsibilities (Page 9).
- b. Review Unit Leader Responsibilities (Page 9).
- c. Develop organization sufficient to handle assignment.
- d. Direct and supervise Immediate, Delayed, and Minor Treatment Areas and Patient Loading Coordinator.
- e. Ensure adequate patient decontamination and that proper notifications are made (if applicable).
- f. Ensure continued assessment of patients and re-assess/re-locate as necessary throughout Treatment Areas.
- g. Coordinate movement of patients from Triage Area to Treatment Areas with Triage Unit Leader.
- h. Assign incident personnel to be treatment personnel/litter bearers.
- i. Request sufficient medical caches and supplies including DMSU or support trailers.
- j. Establish communications and coordination with Patient Transportation Unit Leader.
- k. Responsible for the movement of patients to ambulance loading areas.
- l. Give periodic status reports to Medical Group Supervisor.

PATIENT LOADING COORDINATOR – The Patient Loading Coordinator reports to the Treatment Unit Leader and is responsible for coordinating with the Patient Transportation Unit Leader (or Group Supervisor if established), the transportation of patients out of the Treatment Areas:

- a. Review Common Responsibilities (Page 9).
- b. Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
- c. Establish communications with the Patient Transportation Unit Leader.

- d. Verify that patients are prioritized for transportation.
- e. Advise Medical Communications Coordinator of patient readiness and priority for transport.
- f. Coordinate transportation of patients with Medical Communications Coordinator.
- g. Ensure that appropriate patient tracking information is recorded.
- h. Coordinate ambulance loading with the Treatment Managers and ambulance personnel.

IMMEDIATE TREATMENT AREA MANAGER - The Immediate Treatment Area Manager (MCIM) reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to Immediate Treatment Area:

- a. Review Common Responsibilities (Page 9).
- b. Assign treatment personnel to patients.
- c. Provide assessment of patients and re-assess/re-locate as necessary.
- d. Ensure appropriate level of treatment is provided to patients.
- e. Ensure that patients are prioritized for transportation.
- f. Coordinate transportation of patients with Patient Loading Coordinator.
- g. Notify Patient Loading Coordinator of patient readiness and priority for transportation.
- h. Ensure that appropriate patient information is recorded.

DELAYED TREATMENT AREA MANAGER - The Delayed Treatment Area Manager (MCDM) reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to Delayed Treatment Area:

- a. Review Common Responsibilities (Page 9).
- b. Assign treatment personnel to patients.
- c. Provide assessment of patients and re-assess/relocate as necessary.
- d. Ensure appropriate level of treatment is provided to patients.
- e. Ensure that patients are prioritized for transportation.
- f. Coordinate transportation of patients with Patient Loading Coordinator.
- g. Notify Patient Loading Coordinator of patient readiness and priority for transportation.
- h. Ensure that appropriate patient information is recorded.

MINOR TREATMENT AREA MANAGER - The Minor Treatment Area Manager (MCMT) reports to the Treatment Unit Leader and is responsible for treatment and re-triage of patients assigned to Minor Treatment Area:

- a. Review Common Responsibilities (Page 9).
- b. Assign treatment personnel to patients.
- c. Provide assessment of patients and re-assess/relocate as necessary.
- d. Ensure appropriate level of treatment is provided to patients.
- e. Ensure that patients are prioritized for transportation.
- f. Coordinate transportation of patients with Patient Loading Coordinator.
- g. Notify Patient Loading Coordinator of patient readiness and priority for transportation.
- h. Ensure that appropriate patient information is recorded.

PATIENT TRANSPORTATION UNIT LEADER - The Patient Transportation Unit Leader reports to the Medical Group Supervisor and supervises the Medical Communications Coordinator and the

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

- a. Review Common Responsibilities (Page 9).
- b. Review Unit Leader Responsibilities (Page 9).
- c. Ensure the establishment of communications with the appropriate hospital or other coordinating facility/agency.
- d. Designate Ambulance Staging Area(s).
- e. Direct the off-incident transportation of patients as determined by The Medical Communications Coordinator.
- f. Ensure that patient information and destinations are recorded.
- g. Establish communications with the Ambulance Coordinator and the Helispot Manager.
- h. Request additional medical transportation resources (air/ground) as required.
- i. Notify the Ambulance Coordinator of ambulance requests.
- j. Coordinate the establishment of the Helispot(s) with the Medical Group Supervisor and the Helispot Manager.

MEDICAL COMMUNICATIONS COORDINATOR - The Medical Communications Coordinator (MCCC) reports to the Patient Transportation Unit Leader, and establishes communications with the appropriate hospital or other coordinating facility/agency to maintain status of available hospital beds to ensure proper patient destination.

- a. Review Common Responsibilities (Page 9).
- b. Establish communications with the appropriate hospital or other coordinating facility/agency. Provide pertinent incident information and periodic updates.
- c. Determine and maintain current status of hospital/medical facility availability and capability.
- d. Receive basic patient information and condition from Treatment Area Managers and/or Patient Loading Coordinator.
- e. Coordinate patient destination with the appropriate hospital or other coordinating facility/agency.
- f. Communicate patient transportation needs to Ambulance Coordinator based on requests from the Treatment Area Managers and/or Patient Loading Coordinator.
- g. Communicate air transportation needs to the Ambulance Coordinator based on requests from the Treatment Area Managers and/or Patient Loading Coordinator.

AMBULANCE COORDINATOR - The Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the Ambulance Staging Area(s), and dispatches ambulances as requested:

- a. Review Common Responsibilities (Page 9).
- b. Establish appropriate Staging Area for ambulances.
- c. Establish routes of travel for ambulances for incident operations.
- d. Establish and maintain communications with the Helispot Manager regarding air transportation assignments.
- e. Establish and maintain communications with the Medical Communications Coordinator and Patient Loading Coordinator.
- f. Provide ambulances upon request from the Medical Communications Coordinator.
- g. Ensure that necessary equipment is available in the ambulance for patient

- needs during transportation.
- h. Establish contact with ambulance providers at the scene.
 - i. Request additional ground transportation resources as appropriate.
 - j. Consider the use of alternate transportation resources such as buses or vans based on local policy.
 - k. Provide an inventory of medical supplies available at Ambulance Staging Area for use at the scene.

MEDICAL SUPPLY COORDINATOR -The Medical Supply Coordinator reports to the Medical Group Supervisor and acquires and maintains control of appropriate medical equipment and supplies from units assigned to the Medical Group:

- a. Review Common Responsibilities (Page 9).
- b. Acquire, distribute and maintain status of medical equipment and supplies within the Medical Group.*
- c. Request additional medical supplies.*
- d. Distribute medical supplies to Treatment and Triage Units.
- e. Consider the utilization of a Disaster Medical Support Unit (DMSU) or incident support trailers.

* If the Logistics Section were established, this position would coordinate with the Logistics Section Chief or Supply Unit Leader.

GLOSSARY

Alternate Transport Vehicle (ATV) – ATVs are rescue/transport vehicles that may be used for patient transportation during disasters and emergencies.

Ambulance Strike Team (AST) – A team of five properly staffed and equipped ambulances of the same capabilities, one Disaster Medical Supply Unit (DMSU), and one team leader with a vehicle, all with like communications equipment.

Command Talk Group Usage – When assigned, utilization of a Command Talk Group (e.g., MCI 1) includes, but is not limited to, communications between PSC and responding units, resource assignment while en route, initial size-up, establishing ICS positions, communications between PSC and the incident, communications between Staging and the Transportation Unit Leader and on-scene communications when no Tactical Talk Group has been assigned.

Critical Incident Stress Management Team (CISM) – The CISM is the peer-based county response team that is available to assist responders (police, fire, ambulance, dispatchers, etc.) with the emotional aspects following a significant event.

Disaster Medical Supply Unit (MSU 137) – A supply truck loaded with medical equipment and supplies, comprehensive communications capabilities and provisions to support an Ambulance Strike Team for up to 72 hours.

Dispatch Talk Group Usage – Utilization of the EMS Dispatch Talk Group (e.g., Red) includes, but is not limited to, resource deployment, incident assignment, communications to and from a single resource incident and communications with multiple resources to an incident with no Command Talk Group assigned.

Emergency Medical Services Authority (EMSA) – The EMS Authority is charged with providing leadership in developing and implementing EMS systems throughout California and setting standards for the training and scope of practice of various levels of EMS personnel. The EMS Authority also has responsibility for promoting disaster medical preparedness throughout the state, and, when required, coordinating and supporting the state's medical response to major disasters.

Emergency Operations Manual (EOM) – The EOM is the California Public Health and Medical disaster manual developed to strengthen coordination within the Public Health and Medical System during unusual events and emergencies that have public health or medical impact. The EOM describes basic roles and activities within the Public Health and Medical System and coordination with the emergency management structure at all levels of California's Standardized Emergency Management System (SEMS).

EMSystem – EMSystem is a web based system used by San Mateo County to monitor real-time hospital emergency department status, and real-time bed availability during emergencies and disasters including the Hospital Available Beds for Emergencies and Disasters (HAVBED).

Hospital Talk Group – The Hospital Talk Group is a dedicated channel on the County’s 700 MHz digital trunked radio system for all hospitals to communicate with one another, EMS, dispatch and/or other EMS first responders.

Incident Command System (ICS) – ICS is defined as the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure with responsibility for the management of assigned resources to effectively accomplish stated objectives pertaining to the incident. See glossary of terms for detailed definitions of all ICS positions.

Incident Dispatch Team (IDT) – The Incident Dispatch Team is a unit of San Mateo County Public Safety Communications. It consists of an IDT Director and qualified dispatchers who have received specialized training to perform communications and resource status support at the scene of a fire or fire related incident. The IDT responds automatically as a pre-designated resource within San Mateo County, or outside the county as requested by the state Office of Emergency Services Fire and Rescue Mutual Aid System.

JumpSTART Triage – A system that allows field care personnel to triage pediatric patients aged 1-8 years into one of four categories: Immediate, Delayed, Minor and Deceased (see attached JUMPSTART flowchart).

Medical Mutual Aid - the need for additional medical resources outside the county – the latter needing approval from the EMS On Call and/or MHOAC per policy

MCI Alarm Plan/MCI Ambulance Plan – San Mateo County EMS plan establishing levels of response based on required resources to a MCI through the proper implementation of the Incident Command System. The plan allocates pre-determined medical resources to the scene of a confirmed MCI.

Multi-Casualty Incident (MCI) – An incident in which the combination of numbers of injured personnel and type of injuries go beyond the capability of an emergency service’s normal first response.

National Disaster Management System – NDMS is a system of Federal and non-Federal medical resources combined into a unified response to meet natural and man-made disaster needs, as well as support patient treatment requirements from military contingencies. The NDMS is an interagency partnership between the Department of Health and Human Services, the Department of Homeland Security, the Department of Defense and the Department of Veteran’s Affairs and is based on the 2005 Memorandum of Agreement (MOA) between these agencies.

National Incident Management System (NIMS) – The National Incident Management System (NIMS) is a system used in the United States to coordinate emergency preparedness and incident management among various federal, state, and local agencies.

Public Safety Communications (PSC) – San Mateo County Public Safety Communications (PSC) is a central dispatch center providing dispatching services for 9-1-1 or emergency lines for fire, police or emergency medical assistance and supports emergency service providers who respond to the public’s calls for help.

SacComm – AMR’s regional dispatch center for non-emergency BLS and CCT Services.

Single Point Resource Ordering – Ordering of all resources for an event goes through one entity where every order must first be approved by the Incident Commander.

Special Operations Unit (SOU) – The SOU is a tactical team of EMT-Ps and EMTs specially trained in large scale MCIs as well as other large scale disasters and/or significant events including, but not limited to, greater alarm fire requirements for evacuations; hazardous material incidents; water rescue support operations; active shooter incidents; etc.

Standardized Emergency Management System (SEMS) – The system required by Government Code section 8607(a) for managing response to multi-agency and multi-jurisdictional emergencies in California. It is designed to provide standard terminology, operational concepts, mutual aid procedures and common communications at the state and local level.

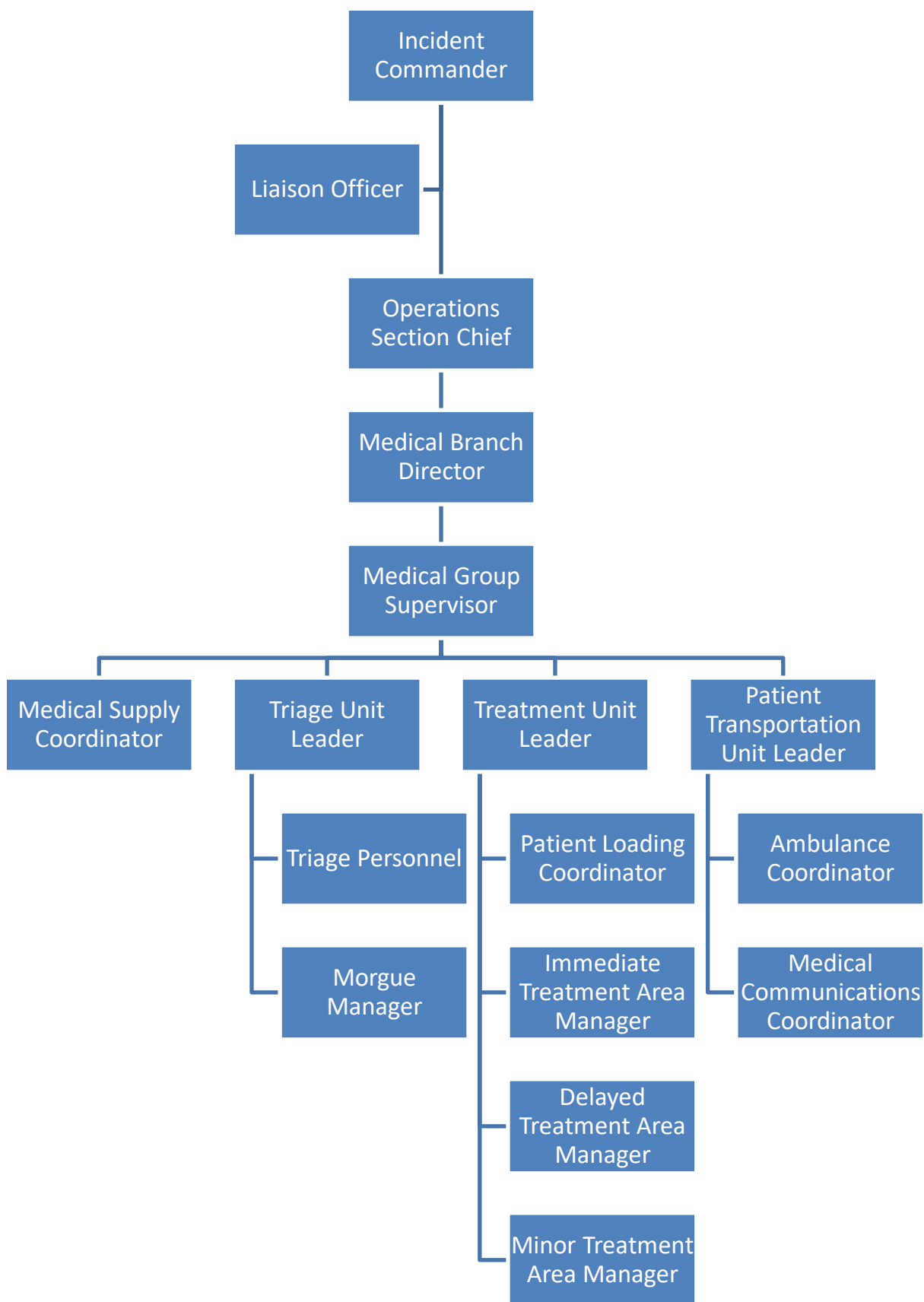
START Triage – Acronym for Simple Triage and Rapid Treatment that is a system that allows field care personnel to triage adult patients into one of four categories: Immediate, Delayed, Minor and Deceased (see attached START flowchart).

Supplemental Transport Resources (STAR) Car – A fully stocked ambulance staged at pre-determined location(s) throughout the County that can be utilized when needed per policy.

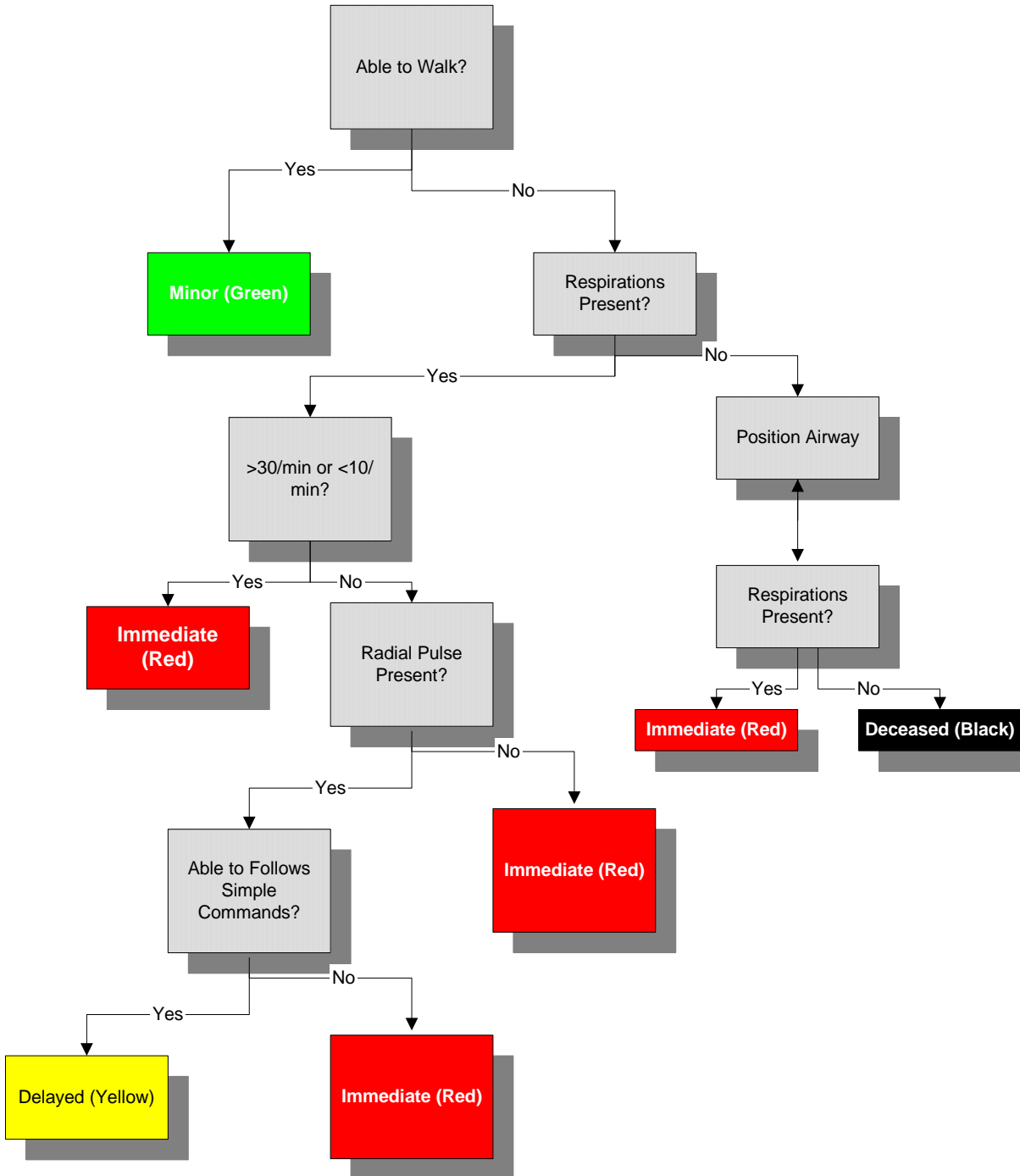
Tactical Talk Group Usage – When assigned, utilization of a Tactical Talk Group (e.g., MCI 2, Yellow), includes, but is not limited to, incident communications not defined in Command Talk Group usage. Units assigned to the incident shall switch to the Tactical Talk Group as they approach the scene (i.e., one block away).

Triage Tags – Printed tags first responders and medical personnel use during an MCI to classify the severity of patients’ conditions.

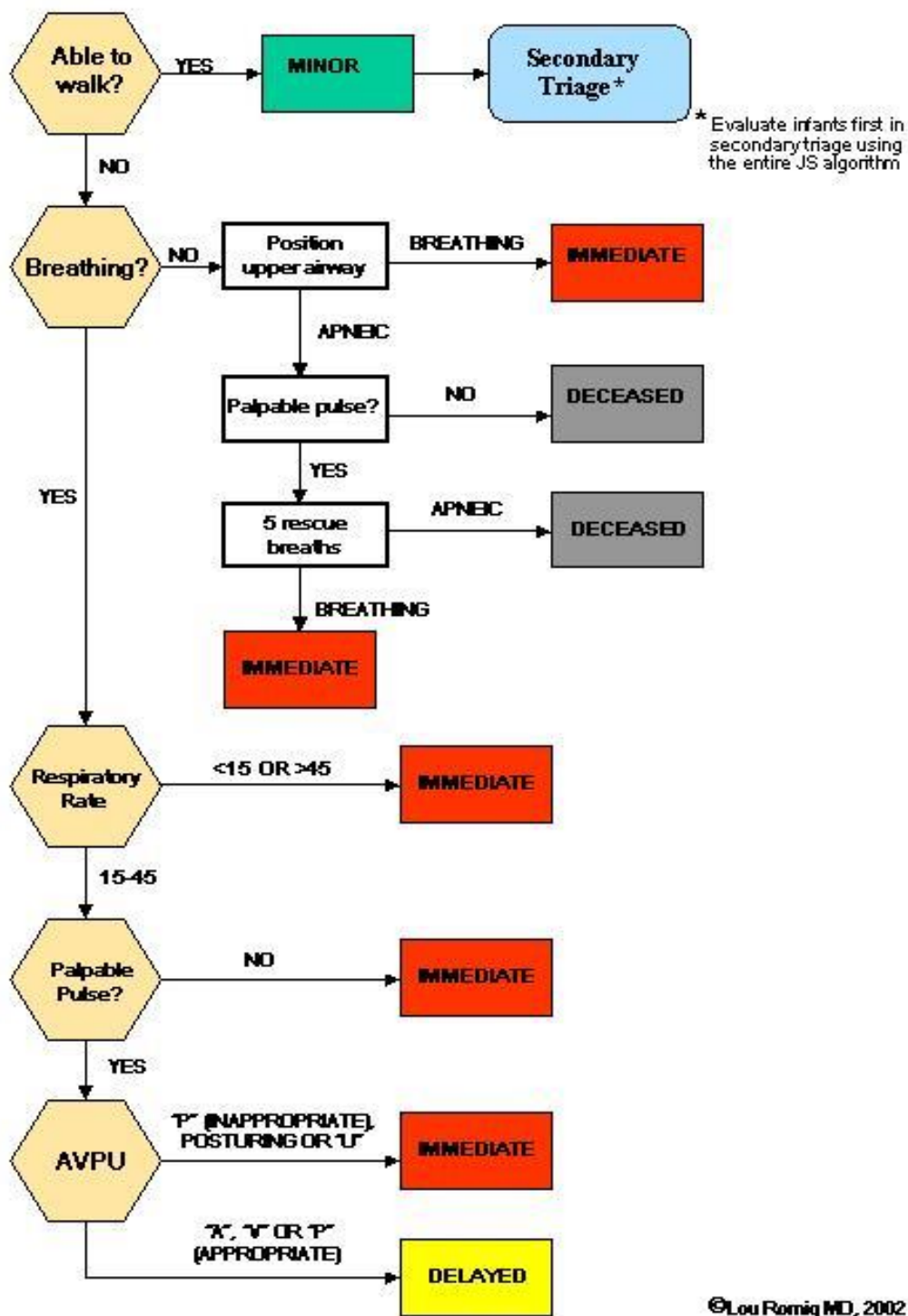
MEDICAL GROUP DIAGRAM



SAN MATEO COUNTY START TRIAGE



JumpSTART Pediatric MCI Triage[®]



©Lou Romig MD, 2002

TRANSPORTATION RECEIPT Tag Number **E10004869 4869**

Destination _____ Via _____ Time _____

Chief Complaint _____

All Risk TRIAGE TAG E10004869

Age _____ M F

First _____ M

Last _____

Address _____

City _____ St _____ Zip _____

Phone _____ Religious Pref _____

If Contaminated DMS-05420 • Rev 3-12

Blast Injury

Deformities
 Contusions
 Abrasions
 Punctures/Penetrations
 Burns
 Tenderness
 Lacerations
 Swelling
 Other _____

AFN Chief Complaint _____

Mechanism of Injury _____

VITALS	Time	B/P	Pulse	Respiration

TRANSPORTATION RECEIPT For Use by Transportation Recorder Only DMS-05420

Age _____ M F

First _____ M

Last _____

Tourniquet Applied Airway Management

Time _____ OPA NPA

GCS Tx In: E: _____ M: _____ V: _____ Time: _____

GCS Tx Out: E: _____ M: _____ V: _____ Time: _____

Known Allergies: _____

Treatment Administered/Comments

D	Time	Drug Solution	Dose

OSOLUODGEM
Salivation Laceration Urination Defecation G.I. Distress Emesis Moles

INJECTOR TYPE _____ 01 02 03

INJECTOR TYPE _____ 01 02 03

Primary Decon 2ndary Decon SOLUTION _____

START triage system Initial Ribbon Triage

MINOR Move the Walking Wounded

RESPIRATIONS Yes - 2 Sec. Can Do
 No + 2 Sec. Can't Do

PERFUSION - 2 Sec. + 2 Sec.

MENTAL STATUS Can Do Can't Do

IMMEDIATE Respirations - Over 30

IMMEDIATE Perfusion - Cap. Refill Over 2 sec. or Radial Pulse Absent

IMMEDIATE Mental Status - Unable to Follow Simple Commands

DELAYED All Others

MORGUE No Respirations After Head Tilt

RE-TRIAGED **RE-TRIAGED**

MORGUE E10004869 **MORGUE** E10004869

IMMEDIATE E10004869 **IMMEDIATE** E10004869

DELAYED E10004869 **DELAYED** E10004869

MINOR E10004869 **MINOR** E10004869

CONTAMINATED E10004869

MORGUE E10004869 **MORGUE** E10004869

IMMEDIATE E10004869 **IMMEDIATE** E10004869

DELAYED E10004869 **DELAYED** E10004869

MINOR E10004869 **MINOR** E10004869

CONTAMINATED E10004869

AMBULANCE RECEIPT

Destination _____

WRISTBAND

EMT

Personal Property Receipt

Name _____

Comments _____

AMBULANCE RECEIPT

Name _____ M _____ Last _____

First _____ M _____ Last _____

WRISTBAND

Personal Property Receipt

Name _____ M _____ Last _____

First _____ M _____ Last _____

ADHESIVE AREA