Multiple Casualty Incident Plan

A comprehensive operational plan for the management of
Multi-casualty events occurring in the
County of Santa Clara, California.

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Replaces Multiple Patient Management Plan

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Scope
This Multiple Casualty Incident (MCI) Plan, a component of the Santa Clara County Emergency Medical Services (EMS) System, describes the response to incidents involving multiple patients within the Santa Clara County Operational Area. The impact of such an event is generally not confined to the borders of the community managing the incident nor exclusive to only EMS providers. Effective MCI planning requires multi-agency involvement, understanding, agreement, and cooperation. This plan was developed jointly between the Santa Clara County EMS Agency, county public safety partners, county hospitals, and private transport providers of Santa Clara County.

Definition
An MCI may be defined as any event causing injury and/or death of a number of patients beyond what an EMS system is routinely capable of handling. An MCI differs from an EMS disaster or catastrophic event in that MCI casualties originate from the same scene, casualty numbers are generally known or can be estimated from the onset, and operational management is maintained at the scene of the incident. An MCI may be the result of any number of events including natural disaster, human error, accident, or terrorist activity. Classifications of an MCI event may vary across the state based upon the number of patients, severity of injuries, cause of the event, and available resources. This plan covers small MCI EMS operations with jurisdictional mitigation to large MCI EMS operations controlled by a regional Emergency Operations Center (EOC) and beyond.

In Santa Clara County MCI levels are defined as follows:

1. Level 1 Activation   5-10 patients.
2. Level 2 Activation   11-20 patients.
3. Level 3 Activation   21-100 patients.
4. Level 4 Activation   101-1000 patients.
5. Level 5 Activation   1000+ patients.

Santa Clara County Communications will automatically dispatch an XSC EMS Ambulance Task Force 1 (ATF1) upon notification of an MCI Level 1 activation. Notification of MCI Level 2-5 activations will result in an automatic dispatch of an XSC EMS Ambulance Task Force 2 (ATF2). The IC should coordinate with the EMS Duty Chief for transport resources beyond an ATF 2.

Objectives and Authority
The goal of this MCI plan is to ensure rapid medical assistance is received by victims and to provide this assistance through adequate and coordinated efforts that will minimize loss of life, disabling injuries, and human suffering.

Objectives
1. Establish a common organizational and management structure for the coordination of emergency response by multiple agencies to an MCI in Santa

Clara County using the Incident Command System (ICS), FIRESCOPE, and the California Standardized Emergency Management System (SEMS).
2. Develop a plan to effectively respond to and manage casualties of an MCI while maintaining capability and resources to respond to other emergencies within the county.
3. Identify strategies of care that minimize loss of life, disabling injuries, and human suffering by providing prompt medical triage and treatment while ensuring rapid acuity based transportation of the injured.
4. Develop a patient transportation/destination plan that maximizes the county hospital and trauma system addressing all modes of transportation.
5. Identify a mechanism to ensure timely and accurate patient tracking and demographic identification.
6. Incorporate response from the County Medical Examiner (ME) office to ensure timely effective management of an MCI which includes multiple fatalities.

Authority
The California Health and Safety Code, Division 2.5, provides for the development and implementation of this plan by The Santa Clara County EMS Agency. Statutory authority for the MCI plan includes sections 1797.103, 1797.150-153, 1797.204, 1797.220, 1797.250, and 1797.252.

Competency Levels
In order to effectively utilize this Plan, users should possess the following competencies:

- Working knowledge of the National Incident Management System (NIMS).
- Working knowledge of the California Standardized Emergency Management System (SEMS).
- Working knowledge of the Incident Command System (ICS) (Level 100 minimum).
- Hazardous Materials Awareness.
- Simple Triage and Rapid Treatment (START) and JumpSTART Pediatric Triage.
- Working knowledge of FIRESCOPE ICS 420, Field Operations Guide (FOG).
- Working knowledge of the Santa Clara County Fire Mutual Aid Plan.
- Working knowledge of Santa Clara County Prehospital Care Policy.

In addition, the following competencies are recommended (all users).
- ICS Levels 200, 300, and 400.
- Hazardous Materials First Responder-Operations.

Standards and Guidance
This Plan meets the standards of the following by reference or incorporation:

- National Incident Management System (NIMS).
- Standardized Emergency Management System (SEMS).
- Incident Command System (ICS).

- Simple Triage and Rapid Treatment (START).
- FIRESCOPE FOG 420-1.
- California Master Mutual Aid Agreement.
- Emergency Management Assistant Compact (EMAC).
- Government Code, State of California.
- California Emergency Services Act.
- Santa Clara County Local Fire Service and Rescue Mutual Aid Plan.

Roles and Responsibilities

The response and mitigation of multiple casualty events require the participation of government and non-government resources through coordinated efforts. Successful management of multiple casualty events requires the coordination of government resources, charged with lawful authority, for the mitigation and management of such incidents. No matter the size of an event, all disasters are locally managed with support from external resources. These include, but are not limited to the following:

Fire Service and Law Enforcement Organizations

These organizations are responsible for the response, management, and mitigation of incidents that occur within their jurisdiction. A fire or law enforcement officer shall normally serve as the Incident Commander or participant in a Unified or Area Command when applicable.

The Incident Commander holds the ultimate authority for all decisions made related to the incident. Some exceptions may apply as related to County, State, or Federal authority based upon the nature of the incident. Examples may include events involving terrorism, biological agents, natural disaster, federally regulated facilities and transportation.

Santa Clara County fire based ambulance resources not normally counted on to provide routine medical transport may be requested to supplement the EMS System or directly support the incident during MCI events.

The California Highway Patrol maintains authority for all California highways, varied levels of dignitary protection, and other public protection activities.

The Santa Clara County Sheriff provides wide area, wilderness, and underwater search and rescue operations as well as disaster management in addition to standard law enforcement duties.

Santa Clara County Emergency Medical Services Agency

The EMS Agency is responsible to plan, implement, and evaluate emergency medical services in the County of Santa Clara; as such, its officers may be called upon to fill any number of diverse rolls based upon the nature of the event. These may include, but are not limited to the roles listed below:

- **Agency Liaison** – Provides counsel to Command, at various levels, to ensure all public and private prehospital care services are functioning appropriately and are responsive to the needs of the event. The Agency may make policy amendments, clinical care modifications, or modify civil agreements, within its authority, to ensure the mitigation of the actual or potential danger to the health and welfare of the public.
- **Serve as an Agent of the County Health Officer** –The EMS Agency may serve at the will of the County Health Officer. This includes, but is not limited to, authorization to take any and all actions to prevent or mitigate a potential or actual public health emergency including coordination with other County services.
- **Fill ICS Positions in the Field** – Agency personnel may fill various Incident Command System positions as appropriate. Commonly held field positions may include Medical Group/Division/Branch Supervisor, Transportation Supervisor, Technical Specialist, Agency Representative, etc. Includes serving as the Medical Health Operational Area Coordinator (MHOAC).
- **County Emergency Operations Center** (EOC) – In events of a large or complex nature, the EMS Agency may direct patient destination, ambulance resources, hospital availability, and medical mutual aid through the County EOC or the Agency Department Operations Center (DOC) in coordination with the County Office of Emergency Services, Fire Mutual Aid Coordinator, Law Mutual Aid Coordinator, Region II Regional Disaster Medical Health Coordinator (RDMHC).

County of Santa Clara Resources
In addition to those County Departments/Agencies listed above, the following County departments/organizations may play a key role in the management of multiple casualty events:

- Santa Clara County Communications.
- Santa Clara County Office of Emergency Services.
- Santa Clara County Health and Hospital System.
- Santa Clara County Medical Examiner.

Private Service Providers and Community Based Organizations
A wide variety of public service providers and community based organizations support the EMS System by providing resources critical to the management of MCI events. These include, but are not limited to the following organizations:

- County Contracted Ambulance Service – In addition to providing daily 911 EMS System response, the Contractor is also responsible for responding to MCI events and providing associated patient treatment and transport.
- Non-County Contracted Ambulance Services – Provide emergency assistance to the EMS System when an event is beyond the resources provided by the County Contracted Ambulance Service Provider. Non-Contracted providers are the

primary patient care and transportation system for the medical care facilities within the County (inter-facility transfer).

- General Acute Care Hospitals and Trauma Centers – Responsible for providing emergency medical care to the victims of illness and/or injury.
- Community Clinics and Public Health Department Regions – Responsible for providing clinical care at the community level. May be used by the EMS System when general acute care hospitals are overwhelmed due to large events or extraordinary numbers of patients in need of clinical care exist.
- American Red Cross – Can be called upon to assist by providing shelter, food, health and mental health services to help victims and families. May assist Medical Examiner Office with family assistance and reunification centers.
- Amateur Radio Emergency Service/Radio Amateur Civil Emergency Service (ARES/RACES) – A corps of trained amateur radio operator volunteers organized to assist in public service and communications in times of emergency.
- Medical Volunteers for Disaster Response/Medical Reserve Corps (MVDR/MRC) - Organized in Santa Clara County to support medical and health emergencies. The MVDR cadre consists of over 500 registered members that range in scope from nurses and physicians to social and mental health professionals. The MVDR program is accessed through the County EMS Agency.

Scene Management

The Santa Clara County MCI Plan subscribes to concepts and principles established by NIMS and thereby adopting the Incident Command System as the primary tool for incident management. ICS is a standardized approach to the command, control, and coordination of emergency response providing a common hierarchy within which responders from multiple agencies can be effective. ICS is widely applicable and is utilized by all levels of government and many private sector organizations.

Each agency shall retain full command authority within its jurisdiction at all times. Agencies that are assisting in support of a single jurisdiction will function under the direction of that jurisdiction's designated IC for effective use of resources.

For multi-agency and/or multi-jurisdictional incidents, a unified command structure may be established with incident command responsibilities being jointly provided by those agencies (e.g. law, fire, EMS Agency, public health) sharing legal jurisdiction and/or contributing to the process of the following:

- Determining the overall incident objectives.
- Selection of tactical strategies.
- Management of assigned resources.
- Processing and dissemination of information.
- Conducting integrated tactical operations.

Region and State Integration

California Public Health and Medical Emergency Operations Manual describes three State incident levels based on the need for health and/or medical resources to

effectively manage an incident. When requesting resources from outside the Operational Area, the EMS Duty Chief or MHOAC will need to ensure they translate the current local MCI Level to the more widely known State Levels.

- State Level 1 Public Health and Medical Incidents can be adequately mitigated using available health and/or medical resources from within the affected Operational Area or by accessing resources from other Operational Areas through existing agreements (including day-to-day agreements, memoranda of understanding, or other emergency assistance agreements). The MHOAC should be notified of a State Level 1 Public Health and Medical Incident.
- State Level 2 Public Health and Medical Incidents require resources from Operational Areas within the Mutual Aid Region beyond existing agreements (including day-to-day agreements, memoranda of understanding or other emergency assistance agreements) and may include the need for distribution of patients to other Operational Areas. A State Level 2 Public Health and Medical Incident will typically require assistance from the RDMHC program within the Mutual Aid Region and may require emergency system activation, including activations of DOCs and EOCs within the Operational Area and Mutual Aid Region.
- State Level 3 Public Health and Medical Incidents require health and/or medical resources that exceed the response capabilities of the affected Operational Area and associated Mutual Aid Region. Similar to State Level 2 incidents, requests for health and medical resources are coordinated by the MHOAC within the affected Operational Area, working in conjunction with the RDMHC Program. A State Level 3 incident will lead to activation of DOCs/EOCs within the Operational Area, Mutual Aid Region, and State.

OPERATIONS SECTION

Areas of responsibility

1. Public Safety Jurisdiction.
   a. Overall incident management and mitigation of events occurring within each individual jurisdiction.
   b. Triage of the ill and/or injured.
   c. On-scene treatment of the ill and/or injured.

2. Contracted Ambulance Service Provider.
   a. Supplies ambulances to the public safety jurisdiction for the purpose of providing rapid transportation from the treatment area to the hospital.
   b. The contractor's assigned supervisor coordinates ambulance operations, communicates with hospitals, and serves as a liaison to the EMS Duty Chief.
   c. Ensures adequate ambulance resources are available to the 911 EMS System.

3. Non-Contracted Ambulance Service Providers.
   a. Used in the 911 System, either at the scene of the incident or by responding to 911 medical calls.

4. County EMS Duty Chief.
   a. Takes any appropriate actions to ensure the following objectives are met. This may include suspension of hospital diversion, policy modification or suspension, amended dispatch procedures, etc.
      i. Ensures adequate resources are available to support the incident.
      ii. Ensures adequate resources are available to support the 911 EMS System.
      iii. Provides technical assistance in support of the incident.

5. Operational (Op) Area Medical Health Branch (Health Officer, MHOAC, and EMS Agency).
   a. Coordinates global patient destination.
   b. Coordinates Field Treatment Sites/Casualty Collection Points.
   c. Coordinates in-county medical-health resources.
   d. Manages medical mutual aid requests.
   e. Coordinates medical-health resources.
   f. Coordinates with County EOC and RDMHC.

6. Hospitals.
   a. Prepare to receive patients transported from the scene as well as those who have left the scene on their own (ensure decontamination as appropriate).
   b. Implement an incident command structure for hospital operations.
   c. Initiate internal surge capacity plans.
   d. Implement appropriate contingency actions and plans.
   e. Monitor EMResource for incident information.

Multiple Casualty Incident
Operational and Strategic Focus

EXAMPLES

Activation 1

Multiple vehicle accident; small aircraft collision; multiple shooting victims at a contained scene with no "active" shooter threat; etc. Focus is on scene management, providing resources to support the incident, and the rapid transportation of patients to appropriate facilities. Does not affect normal operations. Generally no measurable impact to County 911-EMS System. Up to 10 patients.

Activation 2

Ongoing "active" shooter event with no containment; fire at multiple family occupancy; mass transportation incident; etc. Generally overwhelms the initial first response requiring additional units. Focus remains on scene management, providing resources to support the incident, and the rapid transportation of patients to appropriate facilities. May require contingency activations to maintain County 911-EMS System i.e., Standard Dispatch Orders. Up to 20 patients.

Activation 3

Aircraft collision; skilled nursing facility evacuation; large motor vehicle collision; etc. The focus is on the management of the scene and resources necessary to mitigate the problem and maintaining the County's 911-EMS System. It is necessary for the County to make modifications to the daily 911-EMS System to support the incident and stability of the System. Up to 100 patients.

Activation 4

Large aircraft collision; hospital facility evacuation, isolated natural event, etc. The focus is on the management of the scene and resources necessary to mitigate the problem and maintaining the County's 911-EMS System. It is necessary for the County to make modifications to the daily 911-EMS System support the incident and stability of the System. This includes the use of mutual aid resources and the aid of external partner management organizations. Up to 1000 patients.

Activation 5

Significant events involving a large number of patients. The focus is on the management of the scene and resources necessary to mitigate the problem and maintaining the County's 911-EMS System. It is necessary for the County to make modifications to the daily 911-EMS System support the incident and stability of the System. This includes the significant use of mutual aid resources from state and federal partners. Over 1000 patients.

Medical Group Functions

Triage Unit

1. Triage is the process for prehospital providers to rapidly classify/identify victims of an MCI event so that immediate live saving treatments can be applied and acuity based transportation expedited. Triage will be performed using the Simple Triage and Rapid Treatment (START) triage system for adult victims while the Jump START triage system will be used for pediatric patients. Triage tags may be used on any event, but are recommended for any Level 2 or above activation (see documentation section below).

2. Triage normally occurs at the immediate site, or impact area, of the incident. However, safety concerns for the patients and medical personnel may force triage to be performed in an area adjacent to this site or at a Casualty Collection Point. Should this be the case, coordination with the Treatment Unit Leader and Medical Group Supervisor is imperative.
   a. Spontaneous triage sites may form at multiple or undesirable locations as victims evacuate a dangerous/active situation through nearest exits.

3. After ensuring scene safety, the first EMS personnel on scene immediately perform a primary survival scan (e.g. ambulatory survivors or non-ambulatory survivors with spontaneous movement), size-up the incident scene, and begin triage providing basic care to patients suffering life threatening conditions (e.g., airway problems or severe bleeding). Victims are triaged where they lie. The Triage Team commences tagging victims by patient priority.
   a. Acuity based triage colors for both triage tape and triage tags are universally accepted as **Black** (morgue/deceased), **Red** (immediate/life threatening), **Yellow** (delayed/serious non-life threatening), and **Green** (minor/walking wounded). Only Black, Red, Yellow, and Green are acceptable triage colors.
   b. Triage personnel should report the number of patients and their triage category to their supervisor as soon as that information is available. Exact numbers or patient triage category are not required at this point. Estimates like: 3-5, 4-8, 10-15, 30-50, 100 plus are adequate in the early stages. A more accurate count can be communicated when available.

4. Patients are triaged and tagged in the triage area before walking or being moved by litter bearers (if non-ambulatory) to the Treatment Area. An effective tactic is for the Triage Unit Leader to set up a physical "triage funnel" with tape, sawhorses, cones, traffic delineators etc. through which all patients are routed. The Treatment Unit Leader may consider placing personnel at the triage funnel to direct litter bearers to the appropriate treatment location.

5. **Red/Immediate patients must be transported as soon as possible. Red/Immediate patients are to be moved to the Treatment Area only if there is a delay in transport due to a lack of transportation units.**

6. After initial triage is used to sort patients, personnel will use criteria specified in the Santa Clara County EMS Prehospital Care Policies regarding trauma and specialty care destinations.

7. The table below (Triage Conversion Matrix) may be helpful:
   a. To apply START Triage transport priorities to those multi-patient trauma situations where first responders elect not to use the START Triage "RPM" method to evaluate patient status (Level 1 MCI).
   b. As a secondary trauma screening where there are a large number of trauma patients that could quickly overwhelm county trauma facilities. The EMS Duty Chief, in these circumstances, may authorize trauma patients that fall into the below Minor or Delayed classification to be transported to a non-trauma hospital.

Triage Conversion Matrix Applying START Triage Patient Classifications to Conventional Patient Classifications		
START/JumpSTART	Conventional Trauma Triage & Routine Medical Assessment (Likely MCI Incident Types)	
	Major Trauma Victim (MTV)	Environmental/Poisoning/Other Emergencies
Immediate	▪ Physiologic, Anatomic & Mechanism ▪ Physiologic & Mechanism ▪ Major Burn Criteria	▪ Altered Mental Status ▪ Anaphylaxis ▪ Respiratory Distress ▪ Shock
Delayed	▪ Anatomic & Mechanism	▪ Could benefit from ALS interventions, if available
Minor	▪ Mechanism only ▪ All other not meeting MTV Criteria	▪ All other not requiring ALS interventions
Morgue	▪ Field Pronouncement of Death Criteria	▪ Field Pronouncement of Death Criteria

8. Victims found "Dead-On-Arrival" should be covered, left where they are found and identified by a Triage Tag, **Black**/Morgue.
   a. Note any personal information available relative to the identity of the deceased victim on the top portion of the tag.
   b. If it is necessary to move the deceased victim, the exact location found must be noted in order to assist in subsequent investigations. A temporary morgue can be established in an area isolated from the patient care areas, if required. NOTE: Scene integrity should never be compromised. All steps necessary to prevent disturbing the MCI scene will be taken.

9. Patients who have been exposed to various HAZMAT or WMD may need to be triaged using guidelines that are specific to the agent to which they have been exposed. Patients who have been exposed, or who believe they have been exposed to chemical, biological or radiological weapons have much different triage needs than trauma patients.

a. The management of contaminated patients potentially requires a notably different scene layout. An orderly flow of patients from initial triage in the Exclusion Zone (hot zone), Refuge Area, or Safe Refuge Area, through decontamination in the Contamination Reduction Corridor (warm zone), to secondary triage in the Support Zone (cold zone), and then on to the transport area must be established to prevent contamination of responders, transport vehicles, and receiving hospitals.

b. Patients may receive antidotes and other lifesaving treatments in the Exclusion Zone. Entry into this area is restricted to HAZMAT team members.

c. The Contamination Reduction Zone is the area where personnel and equipment decontamination and Exclusion Zone support takes place. The Contamination Reduction Corridor is the first place that patients will be decontaminated. Patients may receive antidotes and other lifesaving treatments in the Contamination Reduction Zone. Once patients have been decontaminated, they will be transferred into the care of EMS Providers in the Support Zone.

10. Triage Unit Leader supervises triage personnel who perform the actual triage of patients and the Morgue Area Manager.
a. Triage Unit Leader.
   i. Recommend assigning to Fire Officer.
   ii. Reports to Medical Group Supervisor.
   iii. Responsible for triage management and movement of patients from the triage area to Treatment area.
   iv. Identifies initial morgue area.
b. Triage personnel may work closely with personnel from other Groups or Branches in order to access patients, for example, a Rescue Group or Extrication Group may need to remove a trapped patient in order for Triage personnel to evaluate the patient. Triage Unit personnel may transition into Treatment area upon completion of triage.
c. Morgue Manager establishes morgue operations; this responsibility ultimately rests with law enforcement or the Medical Examiner's Office, but may be staffed by others until their arrival. Movement of deceased victims should be at the direction of the Medical Examiner.

Treatment Unit
1. Patient Treatment is a function established at MCI incidents when patient or casualty load is greater than available transportation resources. If sufficient ambulances are not immediately available or the extent of the MCI exceeds local resources, a Treatment Unit is necessary.

2. **Getting the patient to a hospital takes precedence over treating at the scene.** If transportation is available, patients triaged to **Red**/Immediate category should move straight from Triage into an ambulance for transport to a hospital. Treatment in these situations should take place while enroute to the hospital.

3. Treatment of immediate life threatening injuries (severe bleeding and airway) are initially addressed during START Triage.

4. Victims are moved to a Treatment Unit at a safe location by triage priority and subsequently transported in ambulances or other types of vehicles.

5. Treatment Areas must be large enough to accommodate the anticipated number of patients that could be received.
   a. Treatment Areas are divided into three physically separated areas.
      i. Immediate Treatment Area
      ii. Delayed Treatment Area
      iii. Minor Treatment Area
   b. Areas should be marked by colored flags, tarps, or color markers matching patient acuity of the triage tag, (Red, Yellow, and Green).

6. A location near the Treatment Area should be established for persons involved in the MCI who have sustained no apparent injuries. These people should be continuously monitored. People in this group may have subsequent complaints that require movement to the Treatment Area. Prior to movement, initiate a Triage Tag for accountability.

7. Assign treatment teams consisting of one paramedic and one EMT or two EMTs.
   a. Treatment teams may be split for more efficient use of resources.
   b. One paramedic may be assigned to each immediate patient.
   c. EMTs should be used to monitor minor patients, keep them grouped together and to monitor for patients deteriorating into a higher acuity category.

8. Patients shall be re-triaged upon arrival in Treatment Area. Additional patient treatment will consist of the following:
   a. Continual assessment. Patients should be re-triaged every 15 minutes.
      i. This is especially important for **Yellow**/Delayed patients as their medical condition can quickly deteriorate into **Red**/Immediate status.
   b. Checking and recording vital signs and chief complaint on the triage tag.
   c. Establishing and maintaining an airway and controlling hemorrhage.
   d. If staffing and time allows, a more detailed assessment and ALS treatment should be provided.
      i. Personnel will follow County BLS/ALS Protocols for treatment to expedite patient care and transportation. The requirement to make Base Contact to obtain approval for additional medications is waived during an MCI.
   e. Preparing patients for transport.

9. After initial triage, personnel will use criteria specified in the Santa Clara County EMS Trauma Triage Criteria and Patient Destination Policy to identify trauma patients who will require transport to a designated trauma hospital.

10. Patients should be moved from Treatment Area to Transport Area when

a. Patient is packaged and ready to go.
b. Hospital bed destination has been identified.
c. Transport ambulance is ready to accept loading.

11. Treatment Unit Leader is responsible for treatment, preparation for transport, and the movement of patients to ambulance loading location(s). Supervises Treatment Managers and Patient Loading Coordinator.
   a. A Battalion Chief or Company Officer can easily fill Treatment Unit Leader position, does not require a paramedic.
   b. Reports to Medical Group Supervisor.
   c. Treatment Unit Leader and Treatment Managers need not be the most medically qualified personal at incident; the most medically qualified should be working in treatment teams performing patient care in the Immediate Patient treatment area.
   d. Patient Loading Coordinator.
      i. Verifies patients are prioritized for transportation.
      ii. Matches patients needing transportation with vehicles and assigned destinations.
      iii. Coordinates with Treatment Managers and Transportation Group movement of patients from treatment areas to ambulances loading area.
      iv. Coordinates ambulance loading with Treatment Mangers and ambulance personnel.
      v. Advises Med Comm of patient readiness and priority for transport.
      vi. Ensures appropriate patient tracking information is recorded.

Transportation Unit/Group
1. One of the primary functions to occur at an MCI event is the expeditious transportation of victims from the incident to an appropriate medical facility.

2. Many victims are likely to leave the scene either on their own or via actions of nearby good Samaritans seeking shelter and/or treatment at the closest emergency department or hospital.
   a. This is likely to occur before first responders are able to complete the triage process and establish control of the scene.
   b. Unexpected patient influx may overwhelm the closest emergency department. This is of particular concern when an incident occurs in close proximity to a hospital.
   c. It is essential that notification of regional hospitals/trauma centers closest to the incident scene occur as quickly as possible.

3. The Transportation Group should be established separate from Medical Group/Divisions.
   a. On large incidents multiple Medical Divisions may be necessary. Through experience, it is widely recognized that all patient transportation from an incident must be coordinated through one Transportation Group. To do so otherwise would likely move the disaster to the medical facilities. This lack of

coordination will result in the overloading and disproportionate distribution of patients e.g., a train wreck may require a Medical Division on each side of the train (the train being a physical barrier between groups of patients) while only one Transportation Group should exist to coordinate transportation.

Patient Loading
1. Transport resources are limited. Ambulance personnel should stay with their ambulances and are not recommended to be assigned to treatment or triage areas.

2. Early determination of ambulance ingress and egress routes (ambulance staging area to loading area, and then away from incident to destination hospitals) will be a priority to facilitate rapid patient transportation.
   a. Stage ambulances away from incident until transportation needs occur.
   b. On smaller incidents ambulance staging/loading may occur in same area.
   c. Traffic flows should be unobstructed and require no backing.
   d. At loading area, ambulances should be placed side by side so that patients can be loaded efficiently.
   e. Work with law enforcement to develop traffic plan.

3. Effective utilization of available EMS transportation resources is critical. As such, multiple patients should be assigned to ambulances that are transporting to hospitals.
   a. **Red/**Immediate patients are the transport priority. Once loaded with **Red**/Immediate patient(s), ambulances should not be held to accommodate additional loading of minor or delayed patients.
   b. Vehicle loading should be maximized without jeopardizing patient care including, but not limited to, the examples shown below.
      i. 2 **Red**/Immediate + 1 **Yellow**/Delayed + 1 **Green**/Minor.
      ii. 1 **Red/**Immediate + 1 **Yellow**/Delayed or 2 **Green**/Minor.
      iii. 2 **Yellow**/Delayed + 2 **Green**/Minor.
   c. Alternative methods of transportation, such as mass transit or school bus, may be used for the transportation of **Green**/Minor patients. These minor injury patients should be accompanied by a medically qualified individual capable of maintaining medical treatment and evaluation as needed.

4. Early activation of Air Operations should be considered to allow for transportation of victims to distant trauma, burn, or pediatric centers. Only in extraordinary circumstances should an air ambulance be used for transport to a local hospital.

Destination
1. MCI patient destinations are determined by the Transportation Supervisor or Medical Communications Coordinator (if designated) as per the following:
   a. Level 1 and Level 2 MCI.
      i. Patient choice.
      ii. Most appropriate.

        iii. Trauma/Burn criteria.
        iv. Hospital Bypass apply.
        v. Patient Routing Worksheet (MCI Appendix A).
   b. Level 3 MCI.
        i. Most appropriate.
        ii. Trauma/Burn criteria.
        iii. Hospital Bypass does not apply unless facility on internal disaster.
        iv. May use EMResource for bed availability.
        v. Patient Routing Worksheet (MCI Appendix A).
   c. Level 4 and Level 5 MCI.
        i. County Routing or MHOAC (out of County) may direct patient destinations
        ii. Trauma/Burn criteria as determined by EMS Duty Chief.
        iii. Hospital Bypass does not apply unless facility on internal disaster.
        iv. EMResource for bed availability.

2. Destinations may be determined without prior authorization or an EMResource bed count. Transportation Group personnel shall attempt to equally distribute patients to appropriate hospital to prevent overloading any one facility. Hospitals should prepare to receive up to the following patient counts on initial distribution from arriving ambulances upon receipt of an MCI activation from EMResource:
   a. Trauma patients to each SCC trauma center (total of 8 each).
        i. 2 **Red/**Immediate.
        ii. 2 **Yellow/**Delayed.
        iii. 4 **Green/**Minor.
   b. Non-trauma patients to each SCC receiving hospital (total of 8 each).
        i. 2 **Red/**Immediate.
        ii. 2 **Yellow/**Delayed.
        iii. 4 **Green**/Minor.

3. Once the Medical Communications Coordinator position is filled, ambulances transporting patients shall not communicate with the receiving hospital (ring downs). Communication to the hospitals should be from the Medical Communications Coordinator (Command 92), only to advise a count and severity e.g., Medic 66 in bound with 2 **Red**/Immediate and 1 **Yellow**/Delayed.

4. Destinations for trauma, pediatric, and burns patients will be considered throughout the incident until resources become overloaded. Trauma centers are the preferred destination over burn centers for combined multisystem/penetrating trauma and thermal/chemical burns.

5. The Transportation Supervisor or Medical Communications Coordinator will maintain the Patient Routing Worksheet and the Patient Transportation Tracking Sheet (MCI Appendix A). Ambulance personnel shall also complete a Patient Transportation Tracking Worksheet (MCI Appendix A) in each ambulance to account for patients transported.

Transportation Group Supervisor
1. The Transportation Group Supervisor directing the activities of the Medical Communications Coordinator, the Ground Ambulance Coordinator, and the Air Ambulance Coordinator are collectively responsible for movement of patients from the scene to medical facilities.

2. Transportation Group Supervisor.
   a. Recommend assignment to EMS Field Supervisor.
   b. Reports to the Medical Group Supervisor or Operations Section Chief if established as a group.
   c. Responsible for coordination of patient transportation and maintenance of records relating to patient identification, condition, and destination.
   d. Establish and direct Air and Ground Ambulance Coordinators.
   e. Designate ambulance staging and loading areas.
   f. Ensure establishment of communications with appropriate hospital or other coordinating agency/facility (County Routing).

3. Medical Communications Coordinator.
   a. Recommend assignment to EMS Field Supervisor.
   b. Determines and maintains current status of hospital/medical facility availability and capabilities.
   c. Coordinates patient destination with the appropriate hospital or other coordinating facility/agency (County Routing).
   d. Communicates patient transportation needs to Ground and Air Ambulance Coordinators based on requests from the Treatment Area Managers and/or Patient Loading Coordinator.

4. Ground/Air Ambulance Coordinator.
   a. Select ambulance staging and loading areas.
   b. Select ingress and egress routes.
   c. Coordinate other ground transportation resources as needed e.g., public transportation.
   d. Establish safe helispot(s) and coordinate with Air Operations Branch.

Treatment in Transportation
1. Due to the nature of most MCI incidents, the rapid patient transportation function of an ambulance provider often becomes the priority with individual patient care taking a lesser priority. If time and circumstances permit, patient treatment may take place while enroute to the hospital.

2. Patient treatment during transportation is affected by a number of situations:
   a. Large patient count at incident site.
   b. Overwhelming patient to transport provider ratio.
   c. Travel time to hospital.

3. The chart shown on the next page (MCI Standard of Care) provides a visual example of how patient treatment during transport expectations change as MCI conditions may dictate. The EMS System may operate in one of three modes:
   a. Conventional – EMS System is operating as designed with little to no stress on the system. Normal day to day operations.
      i. Level 1 and Level 2 Activations.
         1. BLS.
         2. ALS applicable to patients' needs.
         3. Personnel will follow County BLS/ALS Protocols for treatment to expedite patient care and transportation. The requirement to make Base Contact to obtain approval for additional medications is waived at a Level 2 MCI.
         4. Routine medical care and patient destinations determined by patient choice, closest, trauma/burn criteria, etc.
         5. EMS Agency may implement specific protocol to ensure operations remain in Conventional mode e.g., Select Standard Dispatch Orders (SD01, SD11…).
   b. Contingency – EMS System operating under stress. Procedures and practices may be temporarily altered. Medical surge capabilities implemented. Action taken designed to maintain system status avoiding Crisis.
      i. Level 3 and Level 4 Activations.
         1. BLS.
         2. ALS (as available).
         3. Personnel will follow County BLS/ALS Protocols for treatment to expedite patient care and transportation. The requirement to make Base Contact to obtain approval for additional medications is waived during an MCI.
         4. Incident personnel determine patient destination, no Hospital Bypass.
         5. Alternate means of transportation may be used.
         6. Secondary trauma screening may be necessary.
   c. Crisis – EMS System stretched to limits. Crisis activation usually results in significant adjustment to standards of care. Regional and State mutual aid required. Provides best possible care to patients given the circumstances and resources available.
      i. Level 4 and Level 5 Activations.
         1. BLS (open airway and external bleeding control) during transport.
         2. County routing implemented.
         3. Field treatment and alternate care site destinations considered.

MCI Standard of Care					
MCI Level	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
Patient Count	Up to 10	11 to 20	21-100	101-1000	1000+
Care Type	Conventional	Conventional/Contingency	Contingency	Contingency/Crisis	Crisis
Patient Load Per Ambulance	1-2	2-3	3-4	4	4
Triage	• Routine medical care • Adult/Pediatric • MTV Trauma Criteria	• START • JumpSTART • MTV Trauma Criteria	• START • JumpSTART • MTV Trauma Criteria	• START • JumpSTART • MTV Trauma Criteria	• START • JumpSTART • MTV Trauma Criteria
Treatment During Transportation	• BLS • ALS (as applicable) • External bleeding control • Decompression • Spinal Motion Restriction • Base hospital contact • Rapid transport	• BLS • ALS (as applicable) • External bleeding control • Decompression • Spinal Motion Restriction • Rapid transport	• BLS • ALS (as available) • External bleeding control • Decompression • Spinal Motion Restriction • Rapid transport	• BLS • External bleeding control • Rapid transport	• BLS • External bleeding control • Rapid transport
Transport Method	• Ground ambulance • Air ambulance	• Ground ambulance • Air ambulance	• Ground ambulance • Air ambulance • Bus	• Ground ambulance • Bus • POV/Other	• Ground ambulance • Bus • POV/Other
Destinations	• Patient choice • Closest/Most appropriate • Trauma/Burn Criteria • Hospital bypass apply	• Patient choice • Closest/Most appropriate • Trauma/Burn Criteria • Hospital bypass apply	• Closest/Most appropriate • Trauma/Burn Criteria • Secondary screening of Green/Minor trauma patients • No hospital bypass • County routing	• County routing • Closest/Most appropriate • Trauma/Burn Criteria • Secondary screening of Green/Minor Trauma Patients • No hospital bypass	• County routing • Closest/most appropriate (if county routing not established) • No hospital bypass

Patient Documentation

Patient accountability must be maintained from a patient's inception into triage/ treatment/transport and terminates at patient's discharge from field care or hospital. Tracking is a function under treatment, transportation, and hospitals.

1. Level 1 MCI - Triage Tags may be used in addition to the required Electronic Patient Care Report (ePCR).

2. Level 2 through Level 5 MCI - Triage Tags are used followed by an approved ePCR for each patient.
   a. An ePCR is to be made out on each casualty transported.
   b. ePCRs on patients who refuse transport shall be included if possible.
   c. The EMS Duty Chief is authorized to suspend standard ePCR protocol. Patient documentation options are as follows:
      i. EMS Field Notes (ICS 214, First Responder Worksheet, etc.) or paper PCR followed up with full ePCR within 24 hrs.
      ii. Triage Tags used as the minimal level documentation of field assessment and treatment.

3. Anytime Triage Tags are used, the following actions must occur:
   a. It will be kept with each patient as part of the official medical record and retained in the medical record of the receiving hospital after patient discharge, or until such time that the EMS Medical Director authorizes the discard of the tag.
   b. Ambulance personnel shall photograph both sides of Triage Tag of patients transported.
   c. The triage tag number shall be included in the documentation on each ePCR.
   d. Minimum patient information documented on each tag should include:
      i. Patient Name (if possible).
      ii. Destination.
   e. Upon treatment area activation, the following additional information shall be documented on the triage tag:
      i. Chief Complaint/Injury(s).
      ii. Field Treatment.
      iii. Vital Signs (if possible).
   f. A Patient Transportation Tracking Worksheet shall be used by both Transportation Group personnel as well as ambulance transport personnel.

Hospitals

1. EMResource shall be used to notify hospitals of MCI activation, cancellations, and bed queries.

2. Accept and plan for un-triaged patients going to all hospitals.

3. Hospitals that are nearest to the scene of the MCI should prepare for walk-in patients who left the scene prior to arrival of Public Safety or EMS personnel.
   a. Unannounced arrival of casualties likely transported by a number of non-ambulance vehicles (e.g., private or police cars, taxis, or on foot).
   b. First arriving patients are likely to have not been triaged, received care on scene, or been decontaminated.
   c. The hospital nearest to the incident will likely receive the bulk of the initial patients as casualties are transported to the closest or most familiar hospital.

4. Transportation Group personnel shall attempt to equally distribute patients to appropriate hospitals to prevent overloading any one facility. Hospitals should prepare to receive up to the following patient counts on initial distribution from arriving ambulances upon receipt of an MCI activation from EMResource.
   a. Trauma patients to each SCC trauma center (total of 8 each).
      i. 2 **Red**/Immediate.
      ii. 2 **Yellow**/Delayed.
      iii. 4 **Green**/Minor.
   b. Non trauma patients to each SCC receiving hospital (total of 8 each).
      i. 2 **Red**/Immediate.
      ii. 2 **Yellow**/Delayed.
      iii. 4 **Green**/Minor.
   c. All hospitals are expected to increase capacity beyond initial round distribution numbers.

5. All hospitals are expected to have contingency plans for MCI surge events.
   a. Consider activation of Medical Surge Plan (as determined by hospital protocol) and establishing an incident command structure to help manage large events.
      i. Conduct internal notifications and institute appropriate ED procedures as per facility protocol.
      ii. Develop plan to recall off duty staff to support extended operations.
      iii. Assess security needs and potential for lockdown.
   b. Assess ability to handle additional patients and respond to EMResource bed queries.

6. Hospital Bypass.
   a. Level 1 and Level 2 MCI – Hospital Bypass still applies.
   b. Level 3 through Level 5 MCI – No Hospital Bypass unless facility is on internal disaster.

7. Rapid turnaround of ambulances from hospitals back to incident is critical. Past experience has shown that off-loading patients at a receiving or triage area outside of the Emergency Department facilitated a quick turnaround.
   a. Consider modification of conventional ambulance off-loading from back in style to drive through. Establishment of an ambulance traffic pattern that provides one-way ingress and egress will ensure an expeditious and smooth flow.
   b. Ambulance patient offload times at hospitals shall not exceed 5 minutes.

8. Hospital Communications.
   a. The hospital shall assure that qualified staff trained in EMResource and EMS 800 MHz radios are available to monitor both.
   b. Until a Medical Communication Coordinator is established on scene, conventional ambulance ring downs shall occur.
   c. Once the Medical Communication Coordinator position is filled, ambulances transporting patients from MCI shall not communicate with the receiving hospital (ring downs). Communication to the hospitals should be from the Medical Communications Coordinator (Command 92), only to advise a count and severity e.g., Medic 66 in bound with 2 **Red**/Immediate and 1 **Yellow**/Delayed.

9. Hospital shall track patients by creating a log of patient names and tag numbers.
   a. Hospitals shall maintain EMS triage tag from scene in patient's medical record throughout incident and until such time that the EMS Medical Director authorizes the discard of the tags.

10. Secondary patient distribution may be required to ensure trauma patients are relocated from a non-trauma hospital to an appropriate trauma hospital and that no one hospital is overloaded.
    a. Plan for secondary triage of trauma patients from non-trauma hospitals to trauma centers, both local and distant (w/in OA, w/in Region, outside Region).
    b. Non-trauma hospitals may activate 911 for immediate need trauma transfers as resources allow.
    c. Secondary triage & transport from heavily impacted hospitals by EMS to less impacted hospitals.

Santa Clara County Medical Examiner (ME)
An MCI that presents multiple or mass fatalities will present unique challenges on personnel, equipment, and cold storage capacity to handle significant numbers of deceased victims and related supplies. Primary responsibility for the investigation, recovery, management of human remains, management of death certification, and notification of next of kin or family member resides within the authority of the Chief Medical Examiner of Santa Clara County Medical Examiner's office. The Chief Medical

Examiner shall be contacted at any MCI event that results in the death of any victim and will be the primary lead for the following:

1. Search and recovery operations.
   a. Recovery of human remains, personal effects, and evidence collection and preservation.
   b. Coordination with law enforcement to ensure site security.

2. Morgue services/victim identification center.
   a. Identification, processing, and disposition of human remains.
   b. Establish temporary morgue if necessary.

3. Family Assistance Center.
   a. Support of surviving family members.
   b. Provide timely and accurate information.
   c. Regularly scheduled briefings.

4. Mutual Aid.
   a. A mass fatality incident involving more fatalities and body parts than can be reasonably managed by available local resources may require assistance from neighboring Operational Areas, Region, State and/or Federal agencies.
   b. NIMS structure and practice protocols will be used as recommended in the National Response Framework (NRF).

EMS Agency
- The EMS Agency will assess hospitals, ambulance providers, and other healthcare providers to establish the degree of functionality.
- The EMS Agency will activate the MHOAC role to request needed resources from outside the Operational Area via the regional medical mutual aid plan of the Regional Disaster Medical Health System and report situation status to medical and health regional and state agencies.
- Overwhelming numbers of victims may require non-traditional medical resources such as field treatment sites (FTS) (see MCI Appendix B), local clinics, and urgent care centers in order to provide initial emergency medical assistance.

LEVEL 1 ACTIVATION
Multi-Casualty Incident

Description

- ### Up to 10 patients

Description	Actions
Public Safety Answering Point (PSAP)	- Local public safety jurisdiction PSAP coordinates all non-ambulance resource requests. - County Communications PSAP coordinates the dispatch of all ambulance and medical health resources. - County Communications advises all ambulance dispatch centers of MCI Activation. - Obtain and relay incident information to assisting PSAPs (e.g., patient count, types of injuries, special considerations)
Communications	- EMS resources will communicate on assigned EMS radio channels. - IC or designee may communicate directly with EMS Field Supervisor enroute to the incident. - After arrival on the scene, the public safety IC provides a report on conditions including the number of patients in each category to the EMS Field Supervisor. The EMS Field Supervisors shall recommend an appropriate number of ambulances to the IC.
EMS Resources	- County Communications will automatically dispatch an XSC EMS Ambulance Task Force 1 upon notification of a Level 1 activation. If an ambulance has already been dispatched to the event, 2 additional ambulances and an EMS Field Supervisor will be added to fill an ATF1. - An ATF will not be automatically dispatched to the Palo Alto Service Area. - The EMS Field Supervisor closest to the incident shall be attached to the event. - Additional EMS resources shall be ordered through the Incident Commander or designee (e.g., Transportation Group Supervisor, EMS Field Supervisor)

LEVEL 1 ACTIVATION CONTINUED…

Description	Actions
Notifications	- Local public safety agency determines internal notifications. - All MCI activations shall be announced on EMResources. - EMS Duty Chief shall be advised of all MCI activations.
EMS Agency	- EMS Duty Chief monitors event and may respond. - EMS Duty Chief ensures adequate resources are provided to the incident.
Recommended Medical Group Positions	Public Safety Agency. - Medical Group Supervisor. - Triage Unit Leader. - Treatment Unit Leader. - Transportation Unit Leader (may be assigned to the EMS Field Supervisor). EMS Field Supervisor. - Transportation Unit Leader (may be assigned to the Public Safety Agency). - Ground Ambulance Staging Manager.
Triage and Treatment Standards	- START Triage may be used, but Prehospital Trauma Triage and criteria apply - Routine medical care (Conventional) at scene and during transportation.
Patient Destination	- Trauma, burn, and pediatric destination criteria remain intact. - Hospital bypass applies. - Consideration shall be made for census advisories, facility size, and location. - Use Patient Routing Worksheet (MCI Appendix A) - First round patient distribution is 2 critical (**Red**/Immediate) and 6 non-critical (**Yellow**/Delayed + **Green**/Minor) to any open facility. - On scene personnel shall ensure that no one hospital is overloaded.
Site Plan	- Ambulances stage at a designated location until the need for transportation occurs. - Formal treatment areas are generally not identified.
Documentation	- Triage Tags may be used, but must be followed up by appropriate Patient Care Report for each person. - Patient Transportation Tracking Worksheet (MCI Appendix A) may be used.

LEVEL 1 ACTIVATION END

LEVEL 2 ACTIVATION
Multi-Casualty Incident

Description

- **Up to 20 patients.**

Description	Actions
PSAP	• Same as Level 1 Activation plus the following. • County Communications notifies all ambulance dispatch centers of MCI activation.
Communications	• Same as Level 1 Activation plus the following. • EMS command and/or tactical channels may be assigned.
EMS Resources	• Level 1 Activation conditions apply with the following changes. • County Communications will automatically dispatch an XSC EMS Ambulance Task Force 2 upon notification of a Level 2 activation. If an ambulance has already been dispatched to the event, 5 additional ambulances and 2 EMS Field Supervisors will be added to fill an ATF2. • The 2 EMS Field Supervisors closest to the incident are attached to the event.
Notifications	• Same as Level 1 Activation plus the following. • Ambulance dispatch centers notified of MCI Level 2 activation. • Hospitals notified through EMResource of MCI Level 2 Activation.
EMS Agency	• Same as Level 1 Activation plus the following. • Additional EMS Agency personnel will respond as necessary.
Recommended Medical Group Positions	• Same as Level 1 Activation plus the following. EMS Supervisor. • Medical Communications Coordinator. EMS Duty Chief. • Agency Representative. • Technical Specialist. • Other ICS position as assigned by IC.

LEVEL 2 ACTIVATION CONTINUED…

Description	Actions
Triage and Treatment Standards	• START Triage implemented
Patient Destinations	• Same as Level 1 Activation
Site Plan	• Same as Level 1 Activation plus the following • Formal treatment areas are identified
Documentation	• Triage Tags are used, but must be followed up by appropriate Patient Care Report for each person. • Transportation Group and ambulance personnel shall maintain a Patient Transportation Tracking Worksheet (MCI Appendix A).

LEVEL 2 ACTIVATION END

LEVEL 3 ACTIVATION
Multi-Casualty Incident

Description

A Level 3 Activation may be indicated when routine Emergency Medical Services System resources are stressed or may become stressed due to an actual or potential event requiring resources in excess of those provided by the jurisdiction or contracted ambulance service provider. The County shall hold the responsibility to authorize Level 3 Activations. However, local jurisdictions shall make a recommendation for activation whenever appropriate.

- Level 3 Activations include incidents with at least 20 patients and up to 100 patients.
- Local public safety agencies (or designee) request medical-health resources through the County. The County will determine what resources are available and notify the appropriate ICS position for each event/jurisdictions of the resources that will be allocated.
- The County will serve as a broker and resource controller for all medical-health resources within the County and shall make any appropriate notifications to the Regional Disaster Medical Health Coordinator and County OES.
- Actions taken during Level 3 Activations shall focus on maintaining the integrity of the 911 System, providing resources to multiple patient events, and ensuring the general health and welfare of the public.
- Specific guidelines for the management of Level 3 activations can be found in associated reference documents (i.e.: Mass Prophylaxis Plan, Pandemic Influenza Plan, etc.)

Description	Actions
PSAP	- Same as Level 1 Activation plus the following. - County Communication notifies all ambulance dispatch centers of MCI Level 3 Activation

LEVEL 3 ACTIVATION CONTINUED…

Description	Actions
Communications	• Same as Level 1 Activation plus the following. • EMS command and/or tactical channels may be assigned.
EMS Resources	• Level 1 Activation conditions apply with the following changes. • County Communications will automatically dispatch an XSC EMS Ambulance Task Force 2 upon notification of a Level 3 activation. If an ambulance has already been dispatched to the event, 5 additional ambulances and 2 EMS Field Supervisors will be added to fill an ATF2. IC may request additional transport resources as needed. • The 2 EMS Field Supervisor closest to the incident are attached to the event • Non-traditional EMS resources may be used. • All ambulance services may provide 911 services. • Response and transport methods may be altered.
Notifications	• Same as Level 1 Activation plus the following. • Ambulance dispatch centers notified of MCI Level 3 activation. • Hospitals notified through EMResource of MCI Level 3 Activation and provide in-house bed availability.
EMS Agency	• Same as Level 1 Activation plus the following. • Additional EMS Agency personnel will respond as necessary.
Recommended NIMS/SEMS Structure	Public Safety Agency. • Manages on-scene operations. EMS Field Supervisor. • Assists with on-scene operations as necessary. EMS Duty Chief. • DOC or County EOC may be activated to coordinate Medical Health resources. In absence of activation, the EMS Duty Chief will have responsibility for completing tasks.

LEVEL 3 ACTIVATION CONTINUED…

Description	Actions
Recommended NIMS/SEMS (cont.)	Op Area Medical Health Branch. • Coordinates global patient destination. • Coordinates Field Treatment Sites/Casualty Collection Points. • Coordinates in-county medical-health resources. • Manages medical mutual aid requests. • Coordinates medical-health resources (outbreak teams, lab, prophylaxis, etc.). • Coordinates with the County EOC and RDMHC/S. County Emergency Operations Center. • Activation may occur based on nature of event.
Triage and Treatment Standards	• START Triage is used. • Routine medical care (Conventional) at scene; medical care during transportation may be modified (Contingency).
Patient Destination	• Trauma, burn, and pediatric destination criteria remain intact. • Hospital bypass does not apply unless facility on internal disaster. • Use Patient Routing Worksheet (Appendix A). • Limited use of casualty collection points may be implemented. • Additional rounds of patient distribution remain at 2 critical (**Red**/Immediate) and 6 non-critical (**Yellow**/Delayed + **Green**/Minor). • County may route patients to facilities through the Op Area Medical Health Branch or County Communications (County Routing).
Site Plan	• Same as Level 1 Activation plus the following. • Formal treatment areas are identified.
Documentation	• Triage Tags are used. • Additional documentation (PCR) requirements determined by EMS Duty Chief. • Transportation Group and ambulance personnel shall maintain a Patient Transportation Tracking Worksheet (MCI Appendix A). • ICS 214 and T-Cards completed as directed by IC.

LEVEL 3 ACTIVATION END

LEVEL 4 ACTIVATION
Multi-Casualty Incident

Description

A Level 4 Activation may be indicated when routine Emergency Medical Services System resources are stressed due to an actual event requiring extraordinary measures that may extend beyond the available resources of the County.

- Level 4 Activations anticipate that the incident will have over 100 patients.
- Local public safety agencies (or designee) request medical-health resources through the County. The County will determine what resources are available and notify the appropriate ICS position for each event/jurisdictions of the resources that will be allocated.
- The County will serve as a broker and resource controller for all medical-health resources within the County and shall make any appropriate Medical Mutual Aid Resource Requests through the Region.
- Actions taken during Level 4 Activations shall focus on maintaining the integrity of the 911 System, providing resources to multiple patient events, and ensuring the health and welfare of the public.
- Level 4 Activations require the use of non-traditional patient care delivery methods as coordinated by the County.

Description	Actions
PSAP	- Same as Level 1 Activation plus the following. - County Communication notifies all ambulance dispatch centers of MCI Level 4 Activation. - County Communications coordinates the dispatch of all ambulance, private, and medical-health resources.
Communications	- Same as Level 1 Activation plus the following. - EMS command and/or tactical channels may be assigned.

LEVEL 4 ACTIVATION CONTINUED…

Description	Actions
EMS Resources	• County Communications will automatically dispatch an XSC EMS Ambulance Task Force 2 upon notification of a Level 4 activation. IC will coordinate with EMS Duty Chief for additional transport resources. • Non-traditional EMS resources are be used. • All ambulance services may provide 911 services. • Response and transport methods may be altered.
Notifications	• Same as Level 1 Activation plus the following. • Ambulance dispatch centers notified of MCI Level 4 activation. • Hospitals notified through EMResource. Provide in-house bed availability.
EMS Agency	• Same as Level 1 Activation plus the following. • Additional EMS Agency personnel will respond as necessary.
Recommended NIMS/SEMS	Public Safety Agency. • Manages on-scene operations. EMS Field Supervisor. • Assists with on-scene operations as necessary. EMS Duty Chief. • Management of the daily operations of the 911-System. Op Area Medical Health Branch. • Coordinates global patient destination. • Coordinates Field Treatment Sites/Casualty Collection Points. • Coordinates in-county medical-health resources. • Manages medical mutual aid requests. • Coordinates medical-health resources (outbreak teams, lab, prophylaxis, etc.). • Coordinates with the County EOC and RDMHC/S. County Emergency Operations Center. • Activation may occur based on nature of event.

LEVEL 4 ACTIVATION CONTINUED…

Description	Actions
Triage and Treatment Standards	• START Triage is used. • Routine medical care (Conventional) at scene; medical care during transportation may be modified (Contingency).
Patient Destination	• County routes patients to facilities through the Op Area Medical Health Branch or County Communications (County Routing). • Use of casualty collection points may be implemented.
Site Plan	• Same as Level 1 Activation plus the following. • Formal treatment areas are identified.
Documentation	• Triage Tags may be used as complete patient documentation as determined by EMS Duty Chief. • Transportation Group and ambulance personnel shall maintain a Patient Transportation Tracking Worksheet (MCI Appendix A). • ICS 214 and T-Cards completed as directed by IC.

LEVEL 4 ACTIVATION END

LEVEL 5 ACTIVATION
Catastrophic Event

Description
A Level 5 Activation may be indicated when routine Emergency Medical Services System resources are stressed due to an actual event requiring extraordinary measures that may extend beyond the available resources of the County. These events exceed the County's ability to manage or mitigate the event without the assistance of state and federal resources.

- Level 4 Activations anticipate that the incident will have over 1000 patients.
- Local public safety agencies (or designee) request medical-health resources through the County. The County will determine what resources are available and notify the appropriate ICS position for each event/jurisdictions of the resources that will be allocated.
- The County will serve as a broker and resource controller for all medical-health resources within the County and shall make any appropriate Medical Mutual Aid Resource Requests through the Region.
- Actions taken during Level 5 Activations shall focus on maintaining the integrity of the 911 System, providing resources to multiple patient events, and ensuring the health and welfare of the public.
- Level 5 Activations require the use of non-traditional patient care delivery methods as coordinated by the County.

LEVEL 5 ACTIVATION CONTINUED…

Description	Actions
Recommended NIMS/SEMS Structure	Op Area Medical Health Branch. • Coordinates global patient destination. • Coordinates Field Treatment Sites/Casualty Collection Points. • Coordinates in-county medical-health resources. • Manages medical mutual aid requests. • Coordinates medical-health resources (outbreak teams, lab, prophylaxis, etc.). • Coordinates with the County EOC and RDMHC/S. County Emergency Operations Center. • Coordination with County emergency response partners. • Authorizes use of mutual aid including ordering of resources. • Coordination with other Operational Areas. Regional Emergency Operations Center. • Coordination of medical-health inter-county/region resources. • Coordination with EMSA, DHS, and OES. State Emergency Operations Center. • Coordination with Operational Area/Regional, State, and Federal Resources.

LEVEL 5 ACTIVATION END