

CALIFORNIA DISASTER MEDICAL OPERATIONS MANUAL

CALIFORNIA EMERGENCY MEDICAL SERVICES AUTHORITY



December 3, 2008

DMS #219

Acknowledgements

Emergency Medical Services Administrators Association of California California Emergency Medical Services Authority Regional Disaster Medical Health Coordinator/Specialist Disaster Committee Members

Michael Petrie, EMT-P, MBA, MA
Administrator
San Francisco EMS Agency
EMSAAC Disaster Committee Chair
CDMOM Development Co-Chair

Jeffrey L. Rubin
Chief
Disaster Medical Services Division
California EMS Authority
CDMOM Development Co-Chair

Steve Andriese
Director
Mountain Valley EMS Agency

Ed Hill
Region V RDMHS
Kern County EMS Department

Larry Masterman, MICP, CEM
Northern California EMS Agency

Russ Blind
Senior EMS Coordinator Kern
County EMS Department

Nancy Lapolla, MPH
Director, EMS Agency
Emergency Preparedness Manager,
Public Health Department
Santa Barbara County

Jim Morrissey
Terrorism Preparedness
Coordinator
Alameda County EMS Agency

Doug Buchanan
Disaster Coordinator
Mountain Valley EMS Agency

Art Lathrop
EMS Director
Contra Costa Health Services

Michael Osur
Deputy Director
Riverside County Department of
Public Health

Barbara Center, RN
Region II RDMHS
Contra Costa EMS Agency

Bruce Lee
EMSAAC President
EMS Director
Santa Clara County EMS Agency

Juan P. Perez
Disaster Medical/Health Specialist
Disaster Medical Services
California EMS Authority

Ross Elliott
Director
Kern County EMS Department

Randy Linthicum
Manager
Hospital Preparedness Program
California EMS Authority

Eric Rudnick, MD
Northern California EMS Agency

Michael Frenn
Administrator
Solano County EMS Agency

Stuart Long
Region VI RDMHS
Inland Counties EMS Agency

Lisa Schoenthal
Deputy Chief
Disaster Medical Services
California EMS Authority

Kay Fruhwirth, MSN, RN
Assistant Director
Los Angeles County
EMS Agency

Patrick Lynch, RN
Regions III & IV RDMHS
San Joaquin County EMS Agency

Bryan Hanley
Region I RDMHS
Los Angeles County EMS Agency

Consulting Support
Global Vision Consortium

Steve Andriese

Calvin Freeman

Bruce Binder

Doug Buchanan

TABLE OF CONTENTS

I.	INTRODUCTION	1
A.	California Disaster Medical Operations Manual Purpose and Development Process.....	1
B.	Terms Used in the California Disaster Medical Operations Manual	4
C.	Acronyms	14
II.	INCIDENT LEVEL / CLASSIFICATION / SITE / DURATION.....	16
A.	Levels of Medical Incidents	16
1.	<i>Level I Medical Incident</i>	16
2.	<i>Level II Medical Incident</i>	16
3.	<i>Level III Medical Incident</i>	17
B.	Medical Incident Classifications	17
1.	Traumatic Incident.....	17
2.	Chemical (Hazmat) Incident	17
3.	Radiological (Hazmat) Incident.....	18
4.	Non-Specific Site Incidents – Biological / Clandestine Radiological Incidents	18
5.	Non-Specific Site Incidents – Extreme Weather/Environmental Incidents	19
6.	Medical Resource Depletion Incident.....	19
7.	Medical Evacuation Incident.....	19
C.	Incident Sites.....	20
1.	Single Site Incidents.....	20
2.	Multi-Site Incidents	20
D.	Incident Duration	20
1.	Short Term Incidents	20
2.	Extended Term Incidents.....	21
3.	Long Term Incidents.....	21
E.	Incident Evolution	21
III.	DISASTER MEDICAL SYSTEM	22
A.	Field Site(s)	22
B.	Local.....	22
C.	Operational Area	22
D.	Region	25
E.	State	26
F.	Federal	27

- IV. FIELD MEDICAL OPERATIONS29
 - A. Standardized Protocols and Training 29
 - 1. Standardized Field Protocols.....29
 - 2. Standardized Training for Mass Casualty Incident Field Operations.....29
 - B. Multi-Site Incidents 29
 - 1. Communications.....29
 - 2. Resource Allocation.....29
 - 3. Complexity of Multi-Site Patient Distribution.....29
 - C. Non-Specific Site Incidents 30
 - 1. Impact on Response Capability 30
 - 2. Protective Actions..... 30
 - 3. Continuity of Operations Planning 30
- V. MEDICAL MUTUAL AID32
 - A. Medical Resources..... 32
 - 1. Operational Area 32
 - 2. Region 32
 - 3. State 32
 - 4. Federal 32
 - B. Level I Medical Incident – Local Operations..... 33
 - 1. Notification/Activation 34
 - 2. LEMSA Responsibilities 34
 - C. Level II and Level III Medical Incidents– Mutual Aid Operations..... 34
 - 1. Incident Assessment 34
 - 2. Status Reporting..... 35
 - 3. Initial Response and Immediate and Planned Need EMS Ambulances..... 35
 - 4. Notification/Activation Procedure..... 36
 - 5. Medical Transportation and Hospital Resource Availability Assessment 42
 - 6. Resource Request..... 42
 - 7. Mobilizing Resources 43
 - 8. Resource Tracking 43
 - 9. Demobilization 44
 - Summary of Medical Response Actions, Roles, and Responsibilities For Level I, II, and III Medical Incidents..... 44
- VI. PATIENT DISTRIBUTION45
 - A. Overview 45

B. Medical Surge 45

 1. Surge within the OA..... 45

 2. Use of External Resources..... 45

C. Patient Distribution Roles and Responsibilities 46

 1. Medical/Health Operational Area Coordinator (MHOAC) 46

 2. Regional Disaster Medical Health Coordinator/Specialist (RDMHC/S) 46

 3. Operational Area - Patient Distribution Center (OAPDC) 47

 4. Regional Patient Distribution Center (RPDC)..... 49

 5. State Patient Distribution Center (SPDC)..... 50

D. Patient Distribution Process 51

 1. Notification / Activation 51

 2. Communications and CDMN Information Management Procedures..... 51

E. Level II or III Medical Incident - Distribution of Patients outside the County..... 53

 1. Overview..... 53

 2. *Level II Medical Incident* - Procedures 53

 3. *Level III Medical Incident* - Procedures 54

F. Receiving Patients from Outside the County..... 55

VII. ADMINISTRATIVE SUPPORT 56

ATTACHMENT 1..... 57

 Responsibility / Duty Sheets 57

 Local EMS Agency (LEMSA) 58

 Medical/Health Operational Area Coordinator (MHOAC) 61

 Regional Disaster Medical/Health Coordinator/Specialist (RDMHC/S) 63

 Medical Health Coordination Center (MHCC) 66

 California Emergency Medical Services Authority (EMS Authority) 68

 Operational Area (Local) EMS Dispatch Center..... 70

 Regional Medical Dispatch Center (RMDC)..... 72

 Operational Area Patient Distribution Center (OAPDC) 74

 Regional Patient Distribution Center (RPDC)..... 77

 State Patient Distribution Center (SPDC)..... 80

ATTACHMENT 2..... 83

 Local, Regional, State and Federal Resource List 83

I. INTRODUCTION

A. California Disaster Medical Operations Manual Purpose and Development Process

California's disaster medical system is undergoing significant change as it faces new challenges, gains new tools, and places additional demands on state and local disaster responders. In light of the recent increased threat of terrorist attacks, and the ongoing risk of natural disasters, emergency medical services systems in California have a responsibility to ensure all medical responders and healthcare facilities at all levels are prepared to respond quickly and efficiently to these events in a coordinated effort to reduce the loss of life associated with these events.

To meet these challenges, the system as a whole must standardize and enhance its level of performance to ensure that critical medical resources respond as rapidly as possible, are applied where they do the most good, and are provided at levels sufficient to meet the needs of disaster patients.

To promote this goal, the California Emergency Medical Services (EMS) Authority and the Emergency Medical Services Administrators Association of California (EMSAAC) established a Disaster Medical Task Force in November 2006. This Task Force was charged to develop the California Disaster Medical Operations Manual (CDMOM) to define and standardize disaster medical response operational procedures and set performance guidelines to ensure that Californians are effectively served by the system's new capabilities.

The CDMOM provides operational guidance for implementation of the California Disaster Medical Response Plan (EMS Authority, 2007) and Disaster Medical Systems Guidelines (EMS Authority, 2003) for incidents that require response coordination among multiple jurisdictions at all levels of government and the private sector. The CDMOM addresses disaster medical response at field, local area, operational area, region, and state levels. CDMOM users include local EMS Agencies, Local Health Departments, Medical/Health Operational Area Coordinators, Regional Disaster Medical/Health Coordinators and Specialists, field responders, hospitals, and state agencies with disaster medical response roles.

The CDMOM conforms to the Standardized Emergency Management System (SEMS) and National Incident Management System (NIMS), the California State Emergency Plan, and the California Master Mutual Aid Agreement.

The development of the complete CDMOM will occur in phases. This initial edition provides standardized medical response terminology, definitions of response roles, operational procedures, and performance guidelines for:

- Initial response actions, including defining and assessing incidents, assessing resource needs, and procedures for alerting and notifying response agencies
- Medical field operations in mass casualty incidents involving multiple jurisdictions
- Medical mutual aid, including procedures for ordering and receiving resources from outside the affected operational area
- Distribution of patients across jurisdictional boundaries

The CDMOM takes into account the variability in organization, governance, operational policies and protocols, and disaster response capabilities among California's local EMS systems by focusing only on the essential elements for multi-jurisdictional responses.

The CDMOM, however, assumes a certain level of development and some standardization of local disaster medical services system capabilities, structures, and policies. These assumptions include expectations that local EMS systems have:

- Plans, policies, and protocols for managing the response to mass casualty incidents that are consistent with FIRESCOPE
- Capability and protocols for determining hospital bed availability
- Protocols for assigning patient destination in multi-casualty incidents
- EMS responders with disaster response training, including training in the Incident Command System
- A designated Medical/Health Operational Area Coordinator (MHOAC)
- Single points of contact at the operational area (OA) and regional levels for assessment of hospital capacity, ambulance dispatch, and patient distribution
- Local protocols for generating and approving requests for medical mutual aid

The CDMOM also assumes that local EMS agencies, health departments, fire agencies and offices of emergency services work collaboratively at the operational area level during responses to major disasters. The CDMOM recognizes that public safety EMS resources (first response and transportation) found through the Fire Mutual Aid System frequently have dual roles during disaster response and on a day-to-day basis. During a disaster, these resources remain under the control of the Fire Mutual Aid System and their availability is solely at the discretion of the Operational Area Fire and Rescue Coordinator as authorized by the Local Fire Chief.

The CDMOM introduces several new terms to describe key response functions performed at the levels of operational areas and regions and statewide. These functions – hospital alert and assessment, ambulance dispatch, and patient distribution – are performed by local EMS systems throughout California. The CDMOM adopted a common vocabulary for these functions and the respective single points of contact for coordination:

- Hospital alert and assessment – Hospital Alert and Assessment System (HAAS)
- Ambulance dispatch (at the operational area and regional levels) – Medical Dispatch Center
- Patient distribution (at the operational area, regional and state levels) – Patient Distribution Center
- Medical/Health Coordination Center (MHCC) (at the state level) that provides a 24 hour, seven days per week point of contact for Operational Areas and Regional Disaster Medical/Health Coordinators to alert the California EMS Authority of an emergency with the potential to require medical mutual aid from beyond the impacted region. Currently this function is implemented through the EMS Authority's Duty Officer.

Attachment 1 provides duty sheets for these and other key components of California's disaster medical response system that provide operational direction for performance of these functions.

California's disaster medical response system uses the *California Disaster Medical Network* (CDMN) to manage disaster information. The EMS Authority is committed to furthering the development and promoting use of CDMN throughout California. When fully implemented, CDMN will be used to complete and update situation status reports;

manage medical resource request, mobilization and tracking information, and manage patient distribution information.

The CDMOM is an evolving document for an evolving system. Future versions will address other disaster medical operations and incorporate new information and feedback provided by users of this initial edition, including guidance related to approval of resource requests at each SEMS level and procedures for resolving reimbursement issues. The Task Force also plans to work with California's Department of Public Health and local health officials to integrate disaster public health and disaster medical response operations at the various SEMS response levels.

Finally, the CDMOM lays the groundwork for future development of functions and systems required for establishing a statewide system for managing major medical disasters including implementing a state-level Medical Health Coordinating Center (MHCC), implementing the CDMN statewide, establishing regional medical response capabilities in all mutual aid regions, and developing training curricula and courses for disaster medical system personnel.

Comments on the CDMOM and suggestions for future development are encouraged and may be submitted to either of the following:

JEFFREY L. RUBIN
Chief, Disaster Medical Services Division

California EMS Authority
1930 9th Street, Sacramento, CA 95814
Main (916) 322-4336 FAX (916) 323-4898

MICHAEL PETRIE
Administrator

San Francisco EMS Agency
Chair, EMSAAC Disaster Subcommittee
68 12th Street, Suite 220
San Francisco, CA 94103
Main (415) 355-2600 FAX (415) 552-0194

B. Terms Used in the California Disaster Medical Operations Manual

TERM	DEFINITION
Alternate Care Sites (ACS)	A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support, at a minimum, inpatient and/or outpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility (i.e., extensions of general acute care hospitals, clinics, or long term care facilities), but rather are designated under the authority of the local government.
Alternate Care Site Cache (ACS cache)	Medical equipment and supplies that will provide medical support for an Alternate Care Site (ACS). Each cache will provide support for 50 patients for up to 14 days. ACS caches have been established under the California Department of Public Health's (CDPH) Emergency Preparedness Office (EPO) and are located in several areas of the state for immediate deployment. A limited number of ventilators can be provided with each cache upon request.
Ambulance Strike Team (AST)	A team of five properly staffed and equipped medical transport vehicles of the same capabilities and one team leader with vehicle, all with like communications equipment.
Area Command (Unified Area Command)	An organization established (1) to oversee the management of multiple incidents that are each being handled by an ICS organization or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Area Command has the responsibility to set overall strategy and priorities, allocate critical resources according to priorities, ensure that incidents are properly managed, and ensure that objectives are met and strategies followed. Area Command becomes Unified Area Command when incidents are multi-jurisdictional. Area Command may be established at an emergency operations center facility or at some location other than an incident command post.
Assistance by Hire	Assistance by hire resources are those elements of personnel and equipment which are provided by cooperating agencies through specific arrangements not associated with a mutual aid plan.

TERM	DEFINITION
<p>Assistant Secretary for Preparedness and Response (ASPR), Office of Preparedness and Emergency Operations (OPEO)</p>	<p>The Office of Preparedness and Emergency Operations (OPEO) is responsible for developing operational plans, analytical products, and training exercises to ensure the preparedness of the Office, the Department, the Federal Government and the public to respond to domestic and international public health and medical threats and emergencies. OPEO is also responsible for ensuring that ASPR has the systems, logistical support, and procedures necessary to coordinate the Department's operational response to acts of terrorism and other public health and medical threats and emergencies.</p> <p>OPEO is the lead for interagency planning and response activities required to fulfill HHS responsibilities under ESF #8 of the NRP and HSPD #10. These include the following:</p> <ul style="list-style-type: none"> • Management of the Secretary's Operations Center (SOC) • Management of the Incident Response Coordination Teams (IRCT) • Planning and evaluation of Departmental and interagency response exercises • Coordination of the HHS Continuity of Operations (COOP) and Continuity of Government (COG) programs. <p>OPEO maintains a regional planning and response coordination capability, and has operational responsibility for HHS functions related to the National Disaster Medical Systems (NDMS). OPEO acts as the primary operational liaison to emergency response entities within HHS (e.g., FDA, HRSA, SAMHSA, CDC), within the interagency community (e.g., HDS, VA, DoD), and the public.</p>
<p>Automatic Aid Agreement</p>	<p>A mechanism to expedite the provision of emergency assistance between jurisdictions or organizations by defining the circumstances and procedures that allow the communications center of a responding agency to dispatch resources automatically in response to a request from a party to the agreement.</p>
<p>Auxiliary Communications System</p>	<p>A program created by government's disaster or emergency management office to supplement its emergency communications with unpaid staff. Skilled and dedicated people, licensed and unlicensed, are recruited to serve in one or more of four categories: administrative, management, technical, and operations. Also, the Amateur (HAM) Radio System used in the event that local EMS radio system and telephone systems are unavailable.</p>

TERM	DEFINITION
California Disaster Medical Network (CDMN)	A web-based network for creating, updating, and distributing situation status reports; managing information for requesting, mobilizing, and tracking the status of medical resources; and assisting with the distribution of patients during mass casualty incidents.
California Medical Assistance Team (CAL-MAT)	<p>CAL-MATs are planned as scalable teams of up to 40 persons that operate under state direction for response to catastrophic disasters. CAL-MATs are assets of California's disaster medical mutual aid system and will augment medical care in disaster areas where hospitals and medical care systems have been damaged or overwhelmed. CAL-MATs:</p> <ul style="list-style-type: none"> • Maintain caches that contain medical supplies and equipment, tents, pharmaceuticals, and interoperable communications. • Are supported in the field by the EMS Authority Mission Support Teams (MST). • Have members who register pre-event through California Medical Volunteers (CAL-MED).
Casualty Distribution Points (CDP)	CDPs are established at airports near impacted OAs to gather and stage patients for long-range evacuation by air to unaffected areas. CDPs may be staffed by CAL-MATs or Disaster Medical Assistance Teams (DMATs).
CHEMPACK	The program operated by the Centers for Disease Control (CDC) and provides state and local governments a sustainable nerve agent antidote cache that increases their capability to respond quickly to a nerve agent event such as a terrorist attack. The CHEMPACK Program places caches of nerve agent antidotes throughout the state to assist local medical personnel in their response to a nerve agent terrorist attack or large pesticide exposure.
Cooperative Agreement	A formal agreement among governmental entities that describes the circumstances, conditions, limitations, and other defining factors, including provisions for reimbursement of costs incurred, related to the provision of assistance in an emergency.

TERM	DEFINITION
Disaster Healthcare Volunteers (formerly known as ESAR-VHP)	<p>Disaster Healthcare Volunteers is an emergency personnel management system developed to enroll California health care personnel with active unrestricted licenses as volunteers (paid or unpaid) for disaster service. The system validates enrollee licenses and credentials prior to an emergency and provides a mechanism for contacting and mobilizing needed personnel. The system may be accessed by authorized Medical and Health Branch personnel at the State Operations Center (SOC), Joint Emergency Operations Center (JEOC), and EMS Authority Department Operations Center (DOC). The system may also be accessed locally by the Medical Health Operational Area Coordinators and Medical Reserve Corps Coordinators.</p>
Disaster Medical Assistance Team (DMAT)	<p>Federal medical response teams composed of professional and paraprofessional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. Specialized DMATs deal with specific medical conditions such as crushing injuries, burn, and mental health emergencies.</p> <p>DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site.</p>
Disaster Medical Management Team (DMMT)	<p>A state or federal team of trained professional disaster medical response management personnel.</p>
Disaster Medical Support Units (DMSU)	<p>The California EMS Authority and local EMS systems have placed a fleet of vehicles throughout the state equipped to support Ambulance Strike Teams and other disaster medical operations. These vehicles contain medical equipment and supplies, comprehensive communications capabilities and provisions to support response personnel for several days.</p>
Emergency Medical Services Authority (EMS Authority)	<p>The EMS Authority, as the lead agency responsible for coordinating California's medical response to disasters, provides medical resources to local governments in support of their disaster response. This may include the identification, acquisition and deployment of medical supplies and personnel from unaffected regions of the state to meet the needs of disaster patients. Response activities may also include arranging for evacuation of injured patients to hospitals in areas/regions not impacted by a disaster.</p>

TERM	DEFINITION
Emergency Medical Services System (EMS System)	The EMS System consists of EMS service providers and responders, the local EMS agencies (LEMSA), base hospitals/alternate base stations, dispatchers, and the EMS Authority (EMSA), along with their respective personnel, supplies, and equipment and disaster medical personnel at the local, regional and state levels.
Emergency Operations Center (EOC)	The physical location at which civil jurisdictions coordinate information and resources to support incident management (on-scene operations). An EOC may be a temporary facility or permanently established in a fixed facility.
Evacuation	Organized, phased, and supervised withdrawal, dispersal, or removal of civilians from dangerous or potentially dangerous areas, and their reception and care in safe areas.
Field Treatment Site (FTS)	Temporary sites utilized for emergencies when permanent medical facilities are not available or adequate to meet emergency medical care needs. The FTS is designed to provide triage and medical care for up to 48 hours or until new patients are no longer arriving at the site. The Medical/Health Branch has the authority to activate an FTS and determine the number and location of FTSSs.
Fire and Rescue Coordinator, Operational Area	The position, filled by the fire service in each operational area, responsible for coordinating the requesting, mobilizing and tracking of fire resources, including EMS resources, available within the fire service.
Fire and Rescue Coordinator, Regional	The position, filled by the fire service in each of the OES mutual aid regions, responsible for coordinating the requesting, mobilizing and tracking of fire resources including EMS resources available within the fire service.
Hospital Available Beds for Emergencies and Disasters Plus (HAvBED Plus)	California's enhanced system for capturing bed availability data to create bed availability information based on standardized definitions.
Hospital Alert / Assessment System (HAAS)	Electronic web-based system for alerting and assessing hospital capabilities (e.g., EMSsystems, Reddinet, EMResource, StatusNet 911, QNet).

TERM	DEFINITION
Incident Command System (ICS)	A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.
Incident Management Team (IMT)	The IC and appropriate Command and General Staff personnel assigned to an incident
Local Emergency Medical Services Agency (LEMSA)	The agency, department, or office having primary responsibility for administration of emergency medical services in a county.
Long Term Care Facilities	A collective term for healthcare facilities designated for the care and treatment of patients or residents requiring rehabilitation or extended care for chronic conditions. Long term care facilities are licensed by the CDPH Licensing and Certification Division.
Mass Casualty Incident	A disaster that results in a large number of casualties that overwhelm available emergency medical services, facilities, and resources.
Medical Communications Coordinator (Med.Comm)	The Medical Communications Coordinator maintains communications with the patient distribution center or other medical facilities to assure proper patient transportation and destination and coordinates information through the Patient Transportation Group Supervisor and the Transportation Recorder.
Medical Dispatch Center, Operational Area (OAMDC)	A center, designated by the LEMSA in each operational area, to serve as the single point of contact within the OA for the acquisition and coordination of EMS medical transport resources during response to disasters.
Medical Dispatch Center, Regional (RMDC)	Designated by the RDMHC in each OES mutual aid region, the RMDC serves as the single point of contact within the region for the acquisition and coordination of EMS resources during response to disasters.

TERM	DEFINITION
Medical Health Coordination Center (MHCC)	The MHCC is the 24 hour, seven days per week disaster medical response point of contact that assists RDMHC/Ss with the immediate response to medical disasters by disseminating situation status information, identifying resource needs, and locating immediately needed resources from area near the impacted OA. The MHCC function is activated by contacting the EMS Authority Duty Officer and may be performed by the CDPH/EMSA Joint Emergency Operations Center (JEOC).
Medical Health Operational Area Coordinator (MHOAC)	The position, filled by designation by the Local Health Officer and EMS Agency Administrator, responsible to facilitate development of OA medical/health disaster response plans. In most OAs, the MHOAC implements the OA's disaster medical/health response plan, coordinates the Medical/Health Branch of the OA EOC, coordinates developing OA mutual aid requests for external resources and the OA's response to external requests, and facilitates the establishment of priorities through the Multi-Agency Coordination Group for Medical/Health requests and response.
Medical Shelters	A temporary facility equipped to treat patients with palliative care requirements or existing chronic medical conditions with maintenance care requirements (e.g., renal failure, diabetes, etc.).
Medical Task Force (MTF)	Any combination of resources assembled to support a specific medical mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.
Metropolitan Medical Response System (MMRS)	MMRS prepares jurisdictions for response to a range of mass casualty incidents, including CBRNE, and agriculture to epidemic outbreaks, natural disasters and large-scale hazardous materials incidents. MMRS: <ul style="list-style-type: none"> • Provide medical management or medical assistance in support of an emergency response • Provide technical assistance with the identification of CBRNE agents and coordinating the continuity of medical care • Support coordination with designated regional, state, and Federal incident response assets.
Mission Support Team (MST)	A team that provides support and specific logistical functions for field disaster medical resources such as CAL-MATs, ASTs, Mobile Field Hospitals, and individuals deployed by the State in response to local requests from an OA for support.

TERM	DEFINITION
Mobile Field Hospital (MFH)	A large mobile medical unit deployed to replace or augment acute hospital care capacity during response to a major disaster. California's MFHs can be staffed and equipped to provide basic emergency, surgical and recovery services. Each MFH may be deployed as a 50 to 200--bed facility or in combination with other MFHs to provide up to 600 beds at a single site.
Mutual Aid	Mutual aid is the voluntary provision of services and facilities by agencies or organizations to assist each other when existing resources prove to be inadequate.
Mutual Aid Region	One of the six geographical areas defined by the California Governor's Office of Emergency Services for the coordination of resources in the event of a disaster or major incident where mutual aid is requested.
National Disaster Medical System (NDMS)	See Assistant Secretary for Preparedness and Response, DHHS (ASPR), above.
National Incident Management System (NIMS)	A system mandated by Homeland Security Presidential Directory 5 (HSPD-5) that provides a consistent nationwide approach for Federal, State, local, and tribal governments; the private-sector; and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. To provide for interoperability and compatibility among Federal, State, local, and tribal capabilities, the NIMS includes a core set of concepts, principles, and terminology. HSPD-5 identifies these as the ICS; multiagency coordination systems; training; identification and management of resources (including systems for classifying types of resources); qualification and certification; and the collection, tracking, and reporting of incident information and incident resources. California has incorporated NIMS into the State's SEMS process.
Operational Area (OA)	An intermediate level of the State emergency management organization, consisting of a county and all political subdivisions within the county.
OA EMS Dispatch Center (or Local EMS Dispatch Center)	An EMS dispatch center, assigned by the LEMSA to serve as the single point of contact within the OA for the acquisition and coordination of EMS resources.
Patient Distribution Center, Operational Area (OAPDC)	A function, assigned by the LEMSA, to coordinate the distribution of casualties at the operational area level.
Patient Distribution Center, Regional (RPDC)	A function, assigned by each RDMHC, to coordinate the distribution of patients at the regional level during disasters.

TERM	DEFINITION
Patient Distribution Center, State (SPDC)	The state level function for coordinating the distribution of patients at the state and federal level during disasters. The SPDC function is performed by the CDPH/EMSA JEOC.
Patient Reception Areas (PRA)	A geographic locale containing one or more airfields; adequate patient staging facilities; and adequate local patient transport assets that support patient reception and transport to a group of voluntary, pre-identified, non-Federal, acute care hospitals capable of providing definitive care for patients in a domestic disaster, emergency, or military contingency.
Regional Disaster Medical and Health Coordinator (RDMHC)	The EMS Authority and CDPH jointly appoint a Regional Disaster Medical Health Coordinator (RDMHC) in each of the six mutual aid regions. RDMHC responsibilities include supporting the mutual aid requests of MHOACs for disaster response within the region and coordinating mutual aid support to other areas of the state in support of the state medical response system. The RDMHC also serves as a source of information to the state medical and health response system.
Regional Disaster Medical Health Specialist (RDMHS)	The RDMHS provides the day-to-day planning and coordination of medical and health disaster response in the State's six mutual aid regions. During disaster response, the RDMHS may be designated by the RDMHC as the key contact for OAs to request and/or to provide medical and health resources.
Regional Emergency Operations Center (REOC)	The first level facility of the Governor's Office of Emergency Services to manage a disaster. The REOC provides an emergency support staff operating from a fixed facility in each of the three OES Administrative Regions to respond to the needs of OAs and coordinate with the SOC.
Response Information Management System (RIMS)	An Internet based information management system for collecting information on the disaster situation, communicating action plans, and receiving mission requests. Use of RIMS is limited to OAs, regional and State governmental agencies.
Strategic National Stockpile Push Packages (SNS)	Push packages are an asset of the CDC's Strategic National Stockpile program. While their locations are not publicized, the system is designed to deliver part or all of a package to any location in the U.S. within 12 hours of an approved request. Push packages include large quantities of pharmaceuticals, IV solutions, medical supplies, equipment and other assets to treat mass casualties from a wide variety of incidents.
Spontaneous Gathering Locations	Field personnel may be assigned to locations or find themselves in circumstances, where casualties have congregated spontaneously. Sites for spontaneous gathering include parks and schools. Facilities may be austere or non-existent.

TERM	DEFINITION
Standardized Emergency Management System (SEMS)	The emergency management system identified in the California Government Code 8607, for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the ICS and is intended to standardize response to emergencies in the State.
State Operations Center (SOC)	Established by OES to oversee, as necessary, the REOC, and is activated when more than one REOC is opened. The SOC establishes overall response priorities and coordinates with federal responders.
Surge, Healthcare	A healthcare surge is proclaimed in a local jurisdiction when an authorized local official, such as a local health officer or other appropriate designee, using professional judgment determines, subsequent to a significant emergency or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity in hospitals, long-term care facilities, community care clinics, public health departments, other primary and secondary care providers, resources and/or emergency medical services.

C. Acronyms

ACS	Alternate Care Site
ASPR	Office of the Assistant Secretary for Preparedness and Response
AST	Ambulance Strike Team
CAL-MAT	California Medical Assistance Team
CDMN	California Disaster Medical Network
CDMOM	California Disaster Medical Operations Manual
CDP	Casualty Distribution Points
CDPH	California Department of Public Health
DMAT	Disaster Medical Assistance Team
DMMT	Disaster Medical Management Team
DMORT	Disaster Mortuary Operational Response Team
DMS	(California) Disaster Medical System
DMSU	Disaster Medical Support Units
DOC	Department Operations Center
EMS Authority	Emergency Medical Services Authority
EOC	Emergency Operations Center
FTS	Field Treatment Site
HAAS	Hospital Alert / Assessment System
HAvBED Plus	Hospital Available Beds for Emergencies and Disasters Plus
ICS	Incident Command System
IMT	Incident Management Team
IRCT	Incident Response Coordination Team
JEOC	Joint Emergency Operations Center
LEMSA	Local Emergency Medical Services Agency
MBD	Medical Branch Director
MCC	Medical Communication Coordinator
MCI	Mass Casualty Incident
MFH	Mobile Field Hospital
MGS	Medical Group Supervisor
MHCC	Medical Health Coordination Center
MHOAC	Medical Health Operational Area Coordinator

MMRS	Metropolitan Medical Response System
MST	Mission Support Team
MTF	Medical Task Force
NDMS	National Disaster Medical System (See ASPR)
NIMS	National Incident Management System
OA	Operational Area
OAMDC	Operational Area Medical Dispatch Center
OAPDC	Operational Area Patient Distribution Center
OARFC	Operational Area Fire and Rescue Coordinator
OES	Office of Emergency Services
PPE	Personal Protective Equipment
PRA	Patient Reception Area
RDMHC	Regional Disaster Medical Health Coordinator
RDMHS	Regional Disaster Medical Health Specialist
REOC	Regional Emergency Operations Center
RFC	Regional Fire and Rescue Coordinator
RIMS	Response Information Management System
RMDC	Regional Medical Dispatch Center
RPDC	Regional Patient Distribution Center
SEMS	Standardized Emergency Management System
SNS	Strategic National Stockpile
SOC	State Operations Center
SPDC	State Patient Distribution Center

II. INCIDENT LEVEL / CLASSIFICATION / SITE / DURATION

The purpose of this section is to provide a common taxonomy for categorizing medical emergency incidents in California by level, classification, site, and duration to ensure clear and consistent incident descriptions. Each characteristic presents particular implications for response and mitigation actions.

A. Levels of Medical Incidents

California's Disaster Medical System (DMS) uses the following classifications to define levels of medical incidents:

- **Level I Medical Incident** – Requires response resources from the only affected from operational area (OA) (or as available from outside the OA through day to day agreements)
- **Level II Medical Incident** – Requires response resources from or distribution of casualties to other OAs within the mutual aid region of the impacted OA
- **Level III Medical Incident** – Requires State or federal response resources or distribution of patients beyond the mutual aid region using state or federal systems and resources

These definitions are based solely on the level of unmet need for medical resources and patient destinations to effectively mitigate the incident, rather than the number of patients, severity of injuries, or degree of damage.

1. Level I Medical Incident

Level I Medical Incidents are multiple or mass casualty incidents, as defined by local policy, that can be adequately mitigated utilizing available medical resources and facilities within the impacted operational area (OA), or resources from outside the impacted OA that are routinely used on day-to-day incidents (e.g., automatic and routine mutual aid agreements, nearby receiving facilities, etc.).

In large urban areas, the size, patient acuity, and number of patients of a *Level I Medical Incident* may be substantial and require the activation of local Emergency Operations Centers (EOC(s)). The incident, however, is designated as a *Level I Medical Incident* as long as it is handled using only resources internal to the OA.

2. Level II Medical Incident

A *Level II Medical Incidents* requires application of medical resources beyond those available within (or routinely used from outside) the OA, but does not require extensive state or federal medical resources to mitigate the emergency.

During a *Level II Medical Incident*, requested medical resources may be supplied by *adjacent* OAs within the same mutual aid region (or resources available through pre-established agreements with a neighboring state when the OA lies on a state border). During a *Level II Medical Incident*, an OA may also use specialized state or federal resources for a limited single use function such as a mobile field hospital (MFH) to replace and augment OA hospital capacity.

During a *Level II Medical Incident*, all out-of-area medical resource requests are coordinated by the Medical/Health Operational Area Coordinator (MHOAC) of the

impacted OA or his/her designee, through the Regional Disaster Medical Health Coordinator or Specialist (RDMHC/S).

3. Level III Medical Incident

In a *Level III Medical Incident*, the medical resource needs exceed the response capabilities of the impacted OA and its region. This determination is made from an assessment of the current and expected demand for and status of medical resources in affected OAs and regions. If there is a clear need for out-of-region resources or if communication with the impacted area is not available, State and federal government response agencies may automatically begin forward deployment of resources. As in *Level II Medical Incidents*, requests for medical resources will come from the MHOACs of affected OAs through the RDMHC/S.

B. Medical Incident Classifications

Incident classification refers to the characteristics of an incident, which affect response strategy and lead agency assignment, including requirements for protective action and equipment. A single incident can exhibit multiple classifications simultaneously or change from one incident classification to another over time.

1. Traumatic Incident

CLASSIFICATION: Mass Casualty Incident Trauma

Traumatic Incidents produce physical injuries and/or burns. Examples of traumatic incidents include traffic collisions, earthquakes, plane crashes, building collapses, explosions, mass shootings, etc.

RESPONSIBILITY: During traumatic incidents, on-scene EMS personnel have primary responsibility for on-scene triage, treatment, patient distribution, and destination determination as established by policies of the LEMSA. EMS is also usually responsible for managing and staffing the on-scene Incident Command System (ICS) Operations Section Medical Branch or Medical Group, coordinating with the OA Patient Distribution Center (OAPDC), and coordinating medical policy associated with the incident. The MHOAC is responsible for ensuring a mechanism is in place for acquiring medical resources from outside the OA, if needed.

2. Chemical (Hazmat) Incident

CLASSIFICATION: Mass Casualty Incident Hazmat*

Chemical Incidents are caused by the release of toxic materials. Releases may be accidental or intentional, overt or covert.

RESPONSIBILITY: The local EMS system is responsible for on-scene victim triage, treatment, patient distribution, and destination determination, as in traumatic incidents. Victim decontamination and site hazards may delay medical care of patients.

* Considerations adapted from: Emergency Response Plan, Addendum 4: Radiological Operations, New York City Fire Department Guidelines, February 2, 2006

Local EMS policies or the incident action plan for a chemical or radiological incident should address the following special considerations:

- The level of personal protective equipment (PPE) needed by transporting personnel during transport of decontaminated patients
- The potential for long-term contamination of the transport vehicles and the advisability of using non-ambulance modes of transport
- Whether a second decontamination should take place at the hospital prior to admission

Local protocols may provide for some level of treatment of patients in the contamination reduction zone through direct communication with the Medical Group in the support zone, or by utilizing EMS personnel as members of the Hazmat team.

3. Radiological (Hazmat) Incident

CLASSIFICATION: Mass Casualty Incident Hazmat

Radiological Incidents are caused by the release of radioactive matter, or radioactive energy from a radiation emission device. Releases may be accidental or intentional, overt or covert.

RESPONSIBILITY: The local EMS system is responsible for on-scene victim triage, treatment, patient distribution, and destination determination, as in traumatic incidents.

Local EMS policies or the incident action plan for a radiological incident should address the following special considerations:

- Medical problems take priority over radiological concerns. Necessary lifesaving medical treatment and transport should precede decontamination or other radiation management procedures
- The level of personal protective equipment (PPE) and respiratory protection needed by transporting personnel during transport of radiologically contaminated victim
- Methods to determine radiation levels and limits to transporting personnel
- Techniques for wrapping and monitoring a radiologically contaminated victim during transport
- The potential for long-term contamination of the transport vehicles and the advisability of using non-ambulance modes of transport
- Capability of a receiving hospital to perform radiological decontamination

Local protocols may provide for some level of treatment of less serious patients in the contamination reduction zone through direct communication with the Medical Group in the support zone, or by utilizing EMS personnel as members of the Hazmat team.

4. Non-Specific Site Incidents – Biological / Clandestine Radiological Incidents

CLASSIFICATION: Mass Casualty Incident Medical

Non-Specific Site Incidents are biological or clandestine radiological incidents for which an exposure is not observed until the affected population develops symptoms

that may occur well after the initial exposure. Exposure from a single source may generate a non-specific site incident as victims disperse before symptoms appear. As symptoms become apparent, victims will likely present to the EMS system via 911 calls or directly to local medical facilities through self-transport. Medical systems and facilities over a large geographical area may be rapidly overwhelmed. Health care workers and their families may also be affected, thereby reducing the supply of responders and other health care workers at a time of peak demand.

RESPONSIBILITY: *Non-Specific Site Incidents* are usually not confined to a discrete location where a localized incident command structure can be established. Incident command is usually established for the entire OA within the OA's EOC or Area Command. Medical operations are usually managed through a Medical, Health or Medical/Health Branch of the OA EOC; or through a Department Operations Center (DOC) of a Local Health Department (LHD) or Local EMS Agency, depending on the organization of the OA.

The LHD is usually the lead agency for non-specific site incidents, although the EMS system and local medical facilities may be significantly impacted. The EMS system assists local health authorities in the planning, response, and mitigation of the incident. Medical response and recovery operations remain the responsibility of the LEMSA.

5. Non-Specific Site Incidents – Extreme Weather/Environmental Incidents

CLASSIFICATION: Mass Casualty Incident Medical

An extreme weather or environmental *Non-Specific Site Incident* is usually the result of extremely hot or cold weather. Health affects may not become apparent until well after the event.

RESPONSIBILITY: Refer to *Non-Specific Site Incidents – Biological / Clandestine Radiological Incidents* above for response management implications.

6. Medical Resource Depletion Incident

CLASSIFICATION: Mass Casualty Incident Medical

A *Medical Resource Depletion Incident* occurs when day-to-day medical resources are inadequate to meet the demand for those services due to a reduction in the supply of medical resources (staff, equipment, space, etc.). below normal levels.

RESPONSIBILITY: The responsibility for addressing a *Medical Resource Depletion Incident* is shared and potentially complex. The impacted facilities or services have primary responsibility for addressing the shortage. However, government intervention may be required when the shortage affects the greater community. If the cause of the incident is a shortage of EMS or local hospital resources, the LEMSA is responsible for coordinating the EMS response to the event.

7. Medical Evacuation Incident

CLASSIFICATION: Mass Casualty Incident Medical

A *Medical Evacuation Incident* is the mandatory evacuation of non-ambulatory or semi-ambulatory persons from a hospital or skilled nursing facility. Evacuees may require only non-emergency transport services. In the case of a mandatory

evacuation of an entire hospital, medical care will be required prior to and during transport.

RESPONSIBILITY: A medical evacuation incident requires performance of seven distinct tasks by the EMS system and hospitals after removal of patients from the immediate threat:

- Categorization of patients needing medical evacuation by HAvBED Plus bed types
- Care and preparation of patients prior to transport
- Identifying and arranging patient destinations
- Identifying and arranging transport, including non-ambulance vehicles
- Providing patient care during transport
- Identifying and acquiring necessary medical equipment, records, staff, and supplies for transport
- Re-evaluating/assessing patients at destination

In a planned evacuation, impacted facilities are responsible for ensuring that all of the above tasks are accomplished and the EMS system is typically limited to providing transportation.

In an emergency evacuation, or if the facility is otherwise unable to manage the evacuation, the EMS system may need to assume a higher level of responsibility for on-scene care, arranging patient distribution through the emergency patient distribution system, and coordinating field and facility-based activities.

C. Incident Sites

1. Single Site Incidents

In Single Site Incidents, all field operations are located at one location under a single ICS command structure. There may be more than one Medical Group established if geographical divisions are used, but usually only one Patient Transportation Group is established for all patient transport and distribution.

2. Multi-Site Incidents

Multi-Site Incidents are two or more related or unrelated mass casualty incidents regardless of type, occurring simultaneously within a single operational area (OA). Each incident may compete for scarce resources, requiring a centrally coordinated response.

Multi-site Incidents require setting priorities for use of limited resources and managing the complexity of distributing patients simultaneously from multiple incidents.

D. Incident Duration

1. Short Term Incidents

Short Term Incidents are resolved in less than 12 hours. Field, support staff, and administrative staff may be required to work some overtime hours; however, long term staffing of the incident site and other locations is usually not required.

2. Extended Term Incidents

Extended Term Incidents last 12-72 hours and may tax staffing in field, hospital, EOC, and DOC settings. Managing extended term incidents may require:

- Early release of staff during the first operational period to ensure their future availability
- Establishment of a staff schedule to ensure adequate coverage throughout the incident
- Assessment of need for additional field and administrative staff assistance from neighboring LEMSAs or other county departments
- Provision of advice to field and hospital providers to prepare for extended scheduling early in the first operational period

3. Long Term Incidents

Long Term Incidents require staffing EOC and DOC positions for more than 72 hours. In addition to the personnel strategies described above for Extended Term Incidents, response agencies may consider:

- Mutual aid assistance
- Acquisition and just-in-time training of staff from other agencies
- Assistance from other state and federal response agencies

E. Incident Evolution

Incidents may begin as one type of incident and evolve into another type or present multiple types simultaneously. These shifts may dramatically change the role, responsibility, involvement, and authority of the LEMSA and the OA's medical response.

III. DISASTER MEDICAL SYSTEM

This section provides a description of the disaster medical system organizational structure and roles and responsibilities for each of the SEMS/NIMS levels.

A. Field Site(s)

In the field setting, the Medical Branch Director (MBD), or Medical Group Supervisor (MGS), manages medical field operations under the supervision of the Operations Section Chief according to local protocol.

B. Local

Cities and Districts with legal jurisdiction over an incident may establish emergency operation centers (EOCs) or departmental operations centers (DOCs) specific to the event. Emergency medical response is usually managed at the OA level with medical planning and operations implemented in coordination with field ICs and operational area EOCs or DOCs.

C. Operational Area

California's OAs vary in the manner in which they organize their disaster medical services systems and distribute responsibilities among LEMSAs, LHDs, and Medical/Health Operational Area Coordinator (MHOACs) for disaster medical preparedness and response. MHOAC operational responsibilities may be delegated to or shared with the LEMSA and LHD. (See **Attachment 1- Responsibility/Duty Sheets**, for a description of the disaster medical functions of LEMSAs, MHOACs, RDMHC/Ss, and EMS Authority, as well as the Medical/Health Coordination Center (MHCC), and OA, regional and state Medical Dispatch Centers and Patient Distribution Centers).

1. Operational Area Emergency Operations Center (OA EOC) Medical/Health Branch and Medical Departmental Operations Center (DOC):

- Provide overall system planning and support
- Set medical objectives for each incident during multi-site incident responses
- Approve medical and health response public information releases
- Prepare and distribute medical system status reports
- Approve local and mutual aid medical resource expenditures
- Provide policy level direction
- Perform interagency coordination

2. Medical/Health Operational Area Coordinator (MHOAC):

- Assists the Operational Area Emergency Coordinator with the coordination of medical and health resources within the operational area
- Evaluates the availability of resources within the operational area and identifies medical health resource requirements
- Coordinates the dispatch of requested resources available within the operational area
- Reports to the RDMHC/S on the situation and resource status of the operational area

- Serves as the point of contact in the OA for coordination with the RDMHC, REOC, and EMSA and CDPH at the Medical/Health Coordination Center (MHCC)
 - Assesses hospital and patient transportation status, resource requests, and resource availability information
 - Coordinates medical and health mutual aid requests from within the operational area
 - Sets priorities for application of resources within the operational area in accordance with the Incident Action Plan, assists with the prioritization and assignment of incoming resources, and identifies shortfalls
 - Requests mutual aid resources from the RDMHC to fill requests from and reinforce depleted resources within the operational area
 - Mobilizes and tracks local medical and health mutual aid resources sent outside the OA
 - Coordinates the establishment of Casualty Distribution Points (CDP) and Patient Reception Areas (PRAs)
 - Coordinates requests for EMS resources with the OA Fire and Rescue Coordinator
3. Local EMS System Response Resources:
- Implement the Operational Area Disaster Medical/Health Plan and Incident Action Plans
 - Coordinate with hospitals and emergency care providers
 - Assess immediate and ongoing medical resource requirements
 - Provide scene triage, treatment, and stabilization
 - Transport and track patients transported through EMS
 - Assign patients to available hospital services
 - Implement surge plans
 - Provide EMS staff to support the OA EOC or DOC Medical/Health Branch
4. Local EMS Agency (LEMSA):
- Performs disaster preparedness, planning and training for EMS system
 - Develops disaster policies and protocols for the EMS system
 - Coordinates overall OA EMS and hospital response to an incident
 - Supports MHOAC operations
 - Conducts medical system status surveillance and reporting
 - Coordinates establishment of temporary Field Treatment Sites
 - Authorizes modified levels of EMS system response and standards of care
 - Coordinates OA medical operations with the LHD, OA Fire and Rescue Coordinator, and OA EOC
5. Operational Area EMS Dispatch Center:
- Assures availability of EMS system transportation and personnel resources during an incident
 - Coordinates system operations with the LEMSA
 - Assesses the OA's EMS transport capabilities

- Coordinates EMS ambulance mutual aid requests with the Regional Medical Dispatch Center (RMDC)
 - Coordinates with the MHOAC
6. Operational Area Patient Distribution Center (OAPDC):
- Assesses and reports local emergency department and hospital capabilities
 - Coordinates distribution of patients from mass casualty incidents within the OA
 - Coordinates distribution of patients from mass casualty incidents to out-of-OA receiving facilities through the Regional Patient Distribution Center (RPDC)
 - Coordinates reception and distribution of patients transported to the OA from external incidents
 - Coordinates with the MHOAC
7. Hospital Providers:
- Develop disaster plans that include provisions for the transfer or evacuation of patients to similar facilities, arrival of spontaneous volunteers, and staff credentialing
 - Assess and report resources and capabilities to the OAPDC, EMS Dispatch Center, or MHOAC, according to local protocol
 - Coordinate response planning and operations during mass casualty incidents with the LEMSA, LHD, and OA EOC or DOC
 - Implement surge plans during mass casualty incidents
 - Coordinate patient distribution and tracking with the OAPDC and EMS Dispatch Center
 - Establish alternate care sites in coordination with LHD
8. Ambulance Service Providers:
- Coordinate planning and operations during mass casualty incidents with the LEMSA and OA EOC or DOC
 - Assess resources and capabilities and report to the OAPDC and EMS Dispatch Center
 - Implement internal surge plans for mass casualty incidents
 - Coordinate EMS mutual aid and patient distribution activities with the OAPDC and EMS Dispatch Center
 - Ensure proper level of personal protective equipment (PPE)
9. Operational Area Fire and Rescue Coordinator:
- Coordinates application and tracking of fire EMS assets with the MHOAC
 - Coordinates requests from the Regional Fire and Rescue Coordinator for OA fire EMS assets
 - Coordinates requests for out-of-area fire EMS resources with the Regional Fire and Rescue Coordinator
 - Identifies and resolves competing priorities for ambulance resources with MHOAC and LEMSA

D. Region

1. Regional Disaster Medical Health Coordinator and Specialist (RDMHC/S):

The RDMHC is responsible for the coordination of medical and health mutual aid among the operational areas within the mutual aid region. The RDMHS is staff to the RDMHC. Collectively, their responsibilities include:

- Develop plans for the provision of medical or public health mutual aid among the counties within the region
- Coordinate with the MHOACs within the region to manage supplying, receiving, and allocating mutual aid resources
- Assist MHOACs to develop and implement OA disaster medical and health response plans
- Coordinate medical mutual aid operations with the REOC
- Designate and provide oversight of the RMDCs and RPDCs
- Process medical mutual aid requests received from OAs within the region, other RDMHC/Ss, and the State Patient Distribution Center (SPDC)
- Support situation status communication between the local OAs and the State EMS Authority during an incident
- Coordinate patient distribution within, into, and out of the region
- Coordinate medical and health resource mobilization for response within, into, and out of the region
- Coordinate with the Regional Fire and Rescue Coordinator and REOC to assess availability of and request fire service medical resources
- Establish and maintain communication and coordination with MHOACs within the region during an incident

2. Regional Medical Dispatch Center (RMDC):

At the request of the RDMHC/S, the RMDC:

- Maintains a current list of ambulances, pre-approved by each LEMSA in the region, for dispatch to immediate need requests (medical transportation resources prepared to respond within three hours of a request)
- Initiates dispatch of initial immediate need ambulances when requested by an impacted OA
- Initiates assessment of EMS system ambulance availability by OA EMS dispatch centers when requested by the MHCC or RDMHC/S
- Updates *Transport Assessment Capability Assessment* in CDMN (or equivalent automated resource)

3. Regional Patient Distribution Center (RPDC):

At the request of the RDMHC/S:

- Initiates hospital capability assessment in unaffected OAs during a mass casualty incident
- Coordinates patient distribution within the region
- Coordinates with adjacent regions and the State Patient Distribution Center (SPDC) for patient distribution outside the region

- Ensures situation status updates are provided to hospitals as requested by the RDMHC/S via the Hospital Alert / Assessment System (HAAS) or via the OA
4. Regional Fire and Rescue Coordinator:
 - Coordinates response to resource requests from OA Fire and Rescue Coordinators
 - Coordinates planning and mobilization of fire-based EMS resources with the RDMHC/S, when appropriate
 5. Regional Emergency Operations Center (REOC):

OES coordinates the regional level response to disasters through the REOC. The REOC Medical/Health Branch:

 - Is staffed by the EMS Authority
 - Acquires, prioritizes, and allocates medical and health resources
 - Coordinates non-medical and health resources with other branches in the REOC
 - Provides the coordination necessary for consistency in medical care
 - Monitors and updates response information in CDMN

E. State

1. Governors Office of Emergency Services (OES):

OES is the lead State agency for all aspects of emergency management, including planning, response coordination, recovery coordination, mitigation efforts, and training. The OES Director coordinates the State's disaster preparedness and response activities, assisted by representatives of state agencies, under the authority of the Emergency Services Act and Executive Order W-9-91.

OES is responsible for:

 - Development of the State Emergency Plan
 - Activation and operation of the State Operations Center (SOC) and Regional Emergency Operations Centers (REOC)
 - Participation in Disaster Field Office activities
 - Coordination of emergency response and recovery activities with the Federal Regional Operation Center and the Joint Information Center
2. Emergency Medical Services Authority (EMS Authority):
 - Provides statewide leadership, planning, and coordination for large-scale incidents
 - Establishes resource priorities and coordination during *Level III Medical Incidents*
 - Mobilizes state medical and management resources when requested by local jurisdictions or indicated by system triggers
 - Requests and coordinates the mobilization of federal medical resources through OES
 - Serves as *State Patient Distribution Center (SPDC)* in *Level III Medical Incidents* requiring statewide or national distribution of patients
 - Provides assistance to regions and OAs as requested
 - Serves as liaison between all state agencies, and regional / OA medical systems

3. Medical Health Coordination Center (MHCC):

- Activated by contacting the EMS Authority Duty Officer when an impacted OA or Region anticipates potential need for medical mutual aid
- Serves as the initial 24/7 state disaster medical contact point for RDMHC/S(s) and OAs
- Initiates and manages initial and scheduled statewide conference calls during a mass casualty incident in support of the impacted OA and Region
- Initiates the assessment of ambulance availability during an incident
- Initiates the assessment of hospital capacity immediately following an incident
- Disseminates situation status updates

F. Federal

1. Department of Homeland Security:

Coordinates federal operations to respond to disasters caused by terrorist attack, major disasters and other emergencies

2. Federal Emergency Management Agency (FEMA):

Facilitates the partnerships between state, tribal, and local governments and emergency responders with federal, private, and non-governmental entities to utilize all the nation's medical and health resources to respond and mitigate medical and health related disasters caused by terrorist attack, major disasters and other emergencies

3. Department of Health and Human Services (DHHS):

Coordinates federal medical and health operations to respond to medical and health related disasters caused by terrorist attack, major disasters and other emergencies

4. DHHS Office of the Assistant Secretary for Preparedness and Response (ASPR):

- Oversees the National Disaster Medical System (NDMS) and other disaster medical and health programs
- Provides medical response teams, supplies, equipment, and other resources to the disaster area
- Coordinates patient movement from disaster sites to unaffected areas of the nation
- Assures availability of definitive medical care at participating receiving hospitals in unaffected areas

DISASTER MEDICAL RESPONSE SYSTEM ORGANIZATIONAL STRUCTURE

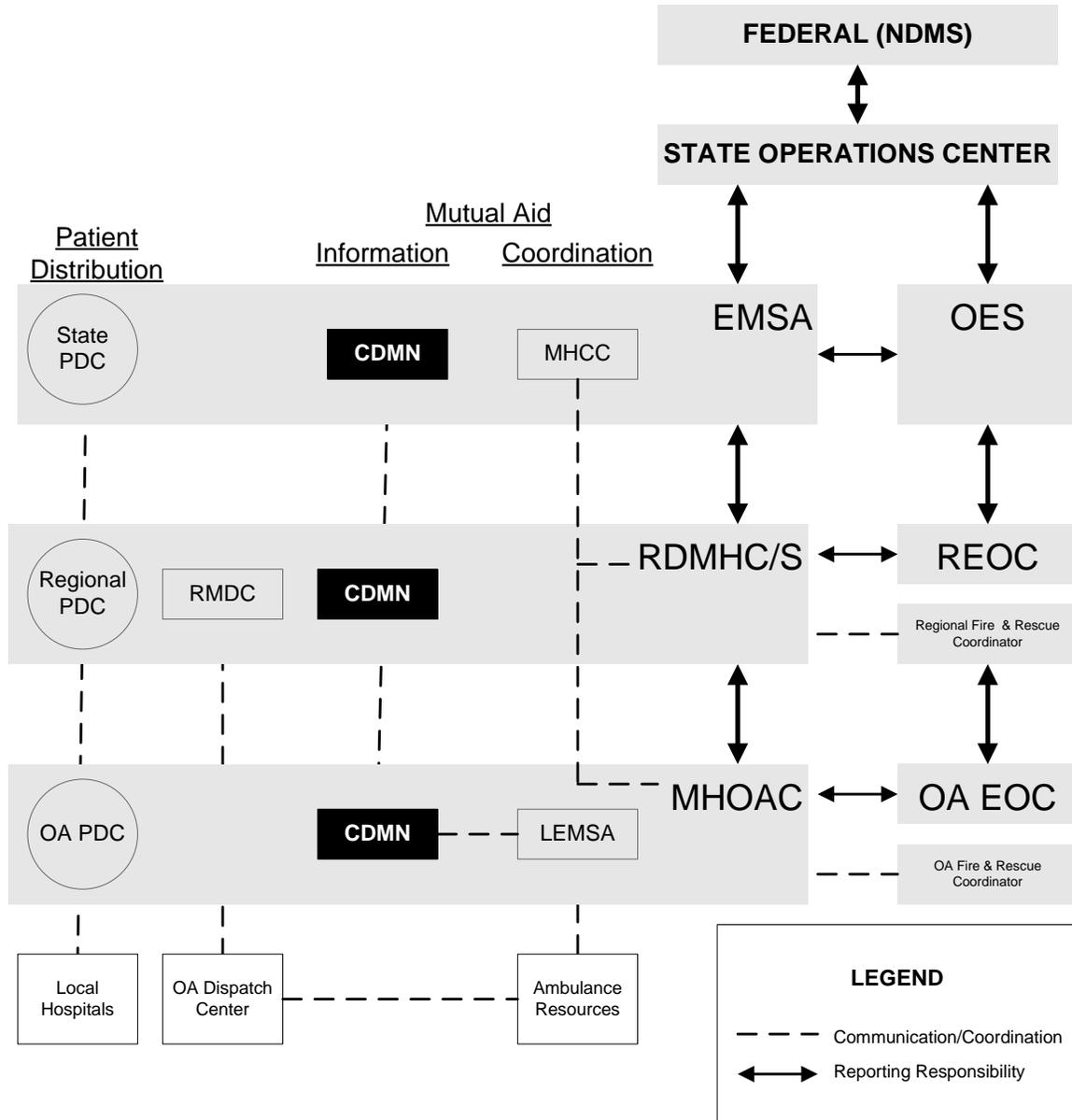


Figure 1

IV. FIELD MEDICAL OPERATIONS

A. Standardized Protocols and Training

1. Standardized Field Protocols

The California FIREScope Multi-Casualty Incident response system is the operational standard for response to mass casualty incidents in California. LEMSAs should ensure that local mass casualty incident field operations policies are consistent with FIREScope protocols.

2. Standardized Training for Mass Casualty Incident Field Operations

Local EMS systems should follow FIREScope training requirements, standards established by the U.S. Department of Homeland Security and the California Office of Emergency Services (OES), and the guidance in this document when establishing local training standards and programs.

B. Multi-Site Incidents

TYPE:	Multi-Site
LEVEL:	Level I / Level II

A multi-site incident is the simultaneous occurrence of two or more mass casualty incidents in a single operational area. ICS structure is implemented at each incident site according to local protocols and response considerations, including:

1. Communications

- Each site is clearly and uniquely identified during all communications
- Different medical tactical communication frequency is used at each site, if possible
- During a mass casualty incident, the site name and ICS position is included during all communications

2. Resource Allocation

- Resource requests should include the name of the requesting incident site and the location where the resource is to report
- Priorities for allocation of scarce resources are determined at a central site separate from the incidents (e.g., the LEMSA or OA EOC)

3. Complexity of Multi-Site Patient Distribution

Patient movement may be delayed and require destinations that are more distant than in normal operations.

C. Non-Specific Site Incidents

TYPE: Non-Specific Site: (Environmental, Biological, Clandestine Radiological)
LEVEL: Level I / Level II or / Level III

1. Impact on Response Capability

Non-specific site incidents may affect the delivery of EMS and medical services by reducing the availability of staff or creating other resource and logistic shortages. The OA may implement the following measures to mitigate the reduced capacity of the EMS system:

- Establish public advice lines for the public to seek medical advice as an alternative to using the 911 system or presenting at local medical facilities
- Triage of 911 medical calls and the initiation of modified response standards
- Require strict adherence to PPE standards for ambulance / first response
- Require post-transport disinfection of transport units
- Establish Field Treatment Sites

OA EOC capability may be limited by staff shortages and the need for social distancing measures.

2. Protective Actions

LHDs may promote use of protective actions, identify sources of healthcare, and provide other critical information. LHDs may also take the following actions:

- Instruct general public in use of PPE and precautions
- Order closure of schools and non-essential businesses
- Isolation and social distancing measures
- Implement local surge plans
- Request community clinics, urgent care centers, etc., to extend hours of operation
- Establish Alternate Care Sites (ACS)

3. Continuity of Operations Planning

LEMSAs should request response agencies, hospitals and ambulance companies to update their Continuity of Operations (COOP) plans to address pandemic influenza and other hazards to mitigate the effect of non-specific site incidents on response capabilities.

V. MEDICAL MUTUAL AID

The foundation of California's disaster medical response system is the capacity for jurisdictions to make medical resources available through California's Medical Mutual Aid System and other inter-OA resource sharing procedures. The processes for requesting, mobilizing, tracking, and demobilizing those resources are described below and with the capabilities and procedures that ensure that medical transport resource needs are rapidly identified, communicated and responded to. **Attachment 2 – Local, Regional, State and Federal Resource List** provides additional information on disaster medical resources available from local, state, and federal sources. Additional public health response and mutual aid resources are available through Local Health Departments, the California Department of Public Health, and the federal Department of Health and Human Services.

A. Medical Resources

1. Operational Area

EMS resources are usually classified as single resources and include:

- Skilled pre-hospital response and hospital personnel
- Patient transport services
- Disaster Healthcare Volunteers
- Medical Reserve Corps (MRC)
- Metropolitan Medical Response System Assets
- Other medical equipment / supplies

2. Region

Resources available on a regional basis:

- Ambulance Strike Teams formed within the region
- Task Forces formed within the region
- Region-based supplies and equipment

3. State

The EMS Authority manages or may mobilize a variety of medical resources for response to a major disaster:

- California Disaster Medical Assistance Teams (CAL-MATs)
- Mobile Field Hospitals (MFHs)
- Mission Support Teams (MSTs)
- Disaster Medical Management Teams (DMMTs)

4. Federal

The federal government also has medical resources that can be mobilized for catastrophic incidents:

- Strategic National Stockpile
- Federal Medical Stations
- Disaster Medical Assistance Teams (DMATs) and specialty response teams

- Incident Response Coordination Team (IRCT)
- National Medical Response Teams (NMRTs)
- International Medical/Surgical Response Team (IMSuRT)
- Disaster Mortuary Operational Response Team (DMORT)
- Management Support Teams (MST)

State and federal agency disaster medical resources may not be available for several days. Additionally, during pandemics or other national emergencies, national assets are likely to have limited availability.

B. Level I Medical Incident – Local Operations

During incidents of all levels and classifications, local EMS responders should routinely use ICS and FIREScope mass casualty incident guidance and procedures for field response as defined in local protocols, including establishing an ICS medical branch or medical group. OAs request mutual aid only when OA resources are, or will soon be reasonably exhausted. Although most incidents do not require mutual aid, EMS responders should routinely assess the likelihood of requiring external resources to manage the incident.

During large or complex *Level I Medical Incidents* in which a local EOC or Medical DOC is activated; some medical response management functions may be transferred to the MHOAC or LEMSA in accordance with local policies and protocols. Figure 3, diagrams the procedures described below.

**Recommended Level I Medical Incident
Medical Mutual Aid Notification/
Activation**

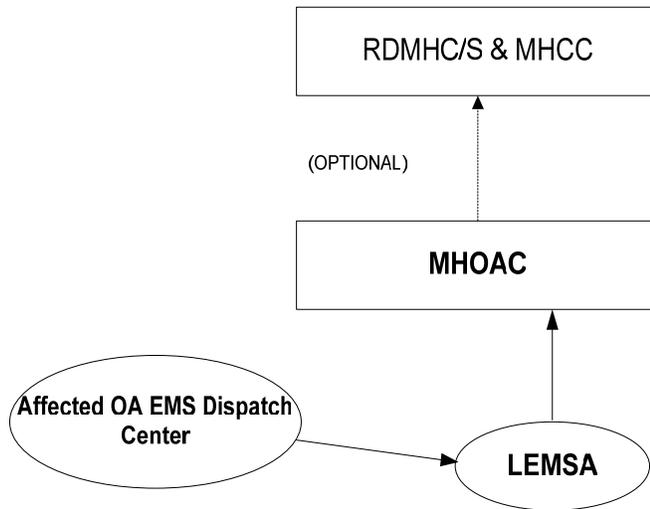


Figure 3

1. Notification/Activation

Level I Medical Incidents are managed in accordance with local policy by local EMS dispatch center(s). OAs should establish policies that automatically trigger a **notification** of the LEMSA and/or MHOAC if a resource commitment, incident characteristics or incident impact reach a pre-determined threshold. Absent such policies, EMS Dispatch Center(s) should notify the LEMSA if there is a possible need for mutual aid resources.

When notified, the LEMSA issues a **Mutual Aid Notification** by alerting the MHOAC and other key medical mutual aid system elements (if not already alerted) of the potential of an incident to reach Level II status to ensure their preparedness to execute their mutual aid response roles, if activated. The notification is made via a pre-established 24-hour contact point.

A **Mutual Aid Activation** is the formal request from the LEMSA of the impacted OA to the MHOAC to initiate resource acquisition or other response activities.

2. LEMSA Responsibilities

Each LEMSA should also establish:

- Ambulance automatic aid agreements with adjacent LEMSAs that define the number and type of Advanced and Basic Life Support (ALS or BLS) ambulances that are available for routine automatic aid responses across county lines and for initial response to mass casualty incidents.
- Protocols that define how and when the local EMS dispatch center can use those resources.
- Policies that identify a single EMS Dispatch Center for each operational area to serve as a single point of contact and medical resource coordination during a mass casualty incident.
- When notified of a *Level I Medical Incident*, the LEMSA notifies the MHOAC who, based on local policy thresholds, may notify the Medical Health Coordination Center (MHCC), which will in-turn notify the RDMHC/S. Local policy should ensure notification of the MHCC when the OA anticipates the need for medical mutual aid resources.

C. Level II and Level III Medical Incidents– Mutual Aid Operations

During larger *Level II* and *Level III Medical Incidents*, the OA will establish an EOC and/or a Medical DOC. Significant medical response management functions are likely to be performed by the MHOAC or LEMSA in accordance with local policies and protocols.

1. Incident Assessment

OAs may not have sufficient information in the immediate aftermath of an incident to determine if mutual aid is required. If the LEMSA cannot rule out the need for external resources, it should alert the MHOAC and MHCC. If the incident is assessed as a *Level II* or *Level III Medical Incident*, the LEMSA activates the MHOAC, establishes the incident in CDMN, and initiates ongoing incident assessments from the field, local hospitals, EMS system providers, and other involved medical facilities. These assessments should be conducted at regular

intervals and address damage assessment, resource status, patient volume, number of casualties by triage category, and resource needs.

2. Status Reporting

CDMN is the primary means for ensuring response agencies are informed of response system progress and situation changes between regularly scheduled conference calls. The impacted OA LEMSA creates the initial “incident” record in CDMN and provides an initial incident status report immediately following notification. As new information is received and confirmed, the impacted LEMSA updates situation status reports, maps, etc., in CDMN. All RDMHC/Ss, MHOACs, LEMSAs, RMDCs, EMS Authority, and the MHCC will be able to monitor these updates in CDMN.

3. Initial Response and Immediate and Planned Need EMS Ambulances

When an affected OA recognizes the need for external resources, the local EMS Dispatch Center activates the mutual aid system by directly contacting the Regional Medical Dispatch Center (RMDC) for **initial response** ambulance requests and the LEMSA for **immediate need** and **planned need** medical resource requests.

a. Initial Response Ambulances

Initial response ambulances are resources that each LEMSA has pre-approved for auto-aid or initial response release. Every RMDC maintains a list of the number of ambulances that each LEMSA in its region has pre-approved for initial response release. These ambulances may be requested at any time unless a LEMSA has notified the RMDC that they are unavailable. They are used for first wave, short duration responses.

The RMDC in the impacted region may request additional ambulances directly from the RMDC in an adjacent region. Out-of-region ambulances may be requested prior to in-region ambulances if they are closer than ambulances located in the affected region. (Requests for initial response ambulances from more than one region requires notification of the RDMHC and MHCC). The OA EMS Dispatch center receiving a request notifies the LEMSA (or designee) in the impacted OA of the request according to local policy, even if it does not anticipate additional medical resource requests. The LEMSA (or designee) then determines if additional notifications or activations are necessary, based on its assessment of the incident and local policy.

Initial response ambulances respond as they would to any other Code 3 emergency call. The requesting OA should prepare to relieve and demobilize initial response units within 8-12 hours of deployment.

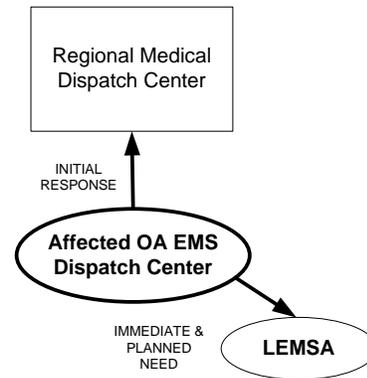


Figure 4

When initial response resources are dispatched:

1. The sending RMDC notifies the impacted OA EMS dispatch center of the provider name, unit number, unit type (ALS or BLS), and estimated time of arrival (ETA) of each ambulance dispatched.
2. The OA EMS Dispatch Center forwards the ambulance information to the requesting MHOAC. The MHOAC enters the information into CDMN.
3. The OA EMS Dispatch Center updates the MHOAC of status changes of ambulance resources (on-scene, released, etc.). The MHOAC or LEMSA then updates the status of the ambulances in CDMN.

b. Immediate and Planned Need Ambulances

Immediate need ambulances are resources prepared to respond within three (3) hours of a request. These ambulances are requested in sufficient quantity to mitigate the emergency. Personnel associated with these resources should be prepared for an extended deployment.

Planned need resources have an estimated time of arrival greater than three hours. These ambulances are requested to relieve initial and immediate need ambulances or for planned events in the next operational period. These resources are usually requested to relieve first wave resources during the next operational period (12-24 hours).

Medical mutual aid resources (medical personnel, equipment / supplies, and transportation), other than initial response ambulance mutual aid, are ordered by the MHOAC (or designee) of the impacted OA through the Medical Mutual Aid System as described below.

4. Notification/Activation Procedure

a. LEMSA

When an OA determines that an incident is potentially a Level II or III Medical Incident, the LEMSA notifies/activates the MHOAC. (Alternatively, local policy may specify notification of the MHOAC prior to, or simultaneously with the LEMSA).

b. MHOAC

When notified, the MHOAC contacts the MHCC (or alternatively the RDMHC, which in turn will contact the MHCC [EMS Duty Officer]) and provides the following information:

- Level of incident (if known)
- Classification of incident
- Status of the incident (continuing or contained)
- Brief description of the incident

c. MHCC Notification and Initial Sit-Stat Conference Call

When notified by a MHOAC or RDMHC:

1. The MHCC and MHOAC set a time for a conference call involving pre-designated OA, regional, and state personnel. The purpose of the initial call

is to ensure that all relevant system elements are notified of the incident and are preparing to activate as needed. The initial conference call should take no more than 15-20 minutes.

2. The MHCC provides invited participants with the time and call-in information of the conference call through an alert transmitted via the communication method designated by agencies for their 24-hour answering point (pager, cell phone, etc.). The alert message briefly describes the incident, its location, and the time and contact information for the conference call (e.g., **6.2 Earthquake in Santa Cruz. Call 1-800-XXX-XXXX, PIN 1234 at 0710 hours**).
3. Conference call participants for a *Level III Medical Incident* should include:
 - Impacted OA MHOACs
 - Impacted OA LEMSAs
 - Impacted region RDMHC/Ss
 - Impacted region Regional Fire and Rescue Coordinators
 - MHCC (EMSA Duty Officer)
 - RDMHC/Ss from regions that may provide mutual aid
 - Regional Fire and Rescue Coordinators from regions that may provide mutual aid
 - California EMS Authority
 - California OES
 - CDPH
4. The MHCC may notify/alert RMDCs and RPDCs in potentially affected Regions to assess and report ambulance availability and hospital capacity, respectively. The MHCC may also notify other response system stakeholders identified by the MHOAC or RDMHC(s).
5. The MHCC acts as the Call Leader and is responsible for:
 - Ensuring necessary participants are on the call.
 - Announcing when the conference call officially begins
 - Taking roll call
 - Taking notes
 - Facilitating the call
 - Identifying information shortfalls that should be addressed during next call
 - Reviewing agreed upon assignments and action steps at the end of the call
 - Scheduling additional conference call times and assessing if other response organizations should be involved
 - Contacting and updating essential personnel who did not participate in the conference call
 - Disseminating a meeting summary within an hour of the end of the call via e-mail and CDMN

d. Entering Incident Information into CDMN

The impacted LEMSA, MHOAC or OAPDC creates an incident, reports initial status, and develops incident related maps in CDMN. Subsequent hospital and ambulance availability assessment information is linked to this initial status report. The EMS Dispatch Center, OAPDC, and local OES may provide information required to complete data entry into CDMN. Additional maps of staging areas, rendezvous sites, etc., can be updated as information becomes available.

Initial MHCC Sit-Stat Conference Call Format

- 1. Role Call** (*Call Leader*)
- 2. Situation Status Report** (*Impacted LEMSA*)
 - Incident name
 - Incident location(s)
 - Order numbering system
 - Level and type of incident
 - Description of incident
 - Estimated number of casualties - (*Immediate (Red), Delayed (Yellow), Minor (Green), Deceased (Black) - if available*)
 - General infrastructure involvement (roads / buildings / utilities/ etc.)
 - Medical infrastructure status (hospitals, LTC facilities, EMS services, dispatch, etc.)
 - Incident trend predictions (worsening, stabilizing)
 - Contact information (telephone, pager, cellular, radio, satellite phone)
 - Special circumstances (fires, hazardous materials, violence, presence of VIPs, etc.)
- 3. Resources Available within the OA** (*Impacted LEMSA*)
 - Personnel
 - Equipment
 - Transportation
 - Hospital / Receiving Facilities
- 4. Anticipate Medical Resource Needs** (*Impacted LEMSA*)
 - Define immediate need for resources and begin arrangements for their mobilization. Formal resource requests must be submitted through the formal mutual aid request process
 - Consider need for initiating movement of State and federal push resources
 - Communicate location of Staging Areas and Mobilization Points, if known
- 5. Summarize Information on CDMN** (*MHCC*)
 - The MHCC summarizes of information posted on CDMN
 - Reinforce the importance of up-to-date information on event and response status, incident site maps, and staging area maps
- 6. Review Assignments and Action Steps**
- 7. Scheduled Time for Subsequent Conference Call(s)** (*Call Leader*)

e. Initial Regional Sit-Stat Conference Call

1. Following the initial MHCC conference call, RDMHC/Ss from affected regions and from regions that may provide mutual aid conduct conference calls with LEMSAs, MHOACs and other response agencies in their respective regions to ensure their notification, brief them on the initial situation and status and ensure they are preparing to activate if needed. Conference call participants and alerting methods are predetermined through protocols established by the RDMHC/S.
2. Potential participants in a *Level III Medical Incident* Regional Conference Call include:
 - MHOACs and on-call LEMSA staff from the impacted OAs in the mutual aid region
 - The RDMHC and RDMHS
 - The Regional Fire and Rescue Coordinator
 - MHOACs from OAs that may provide resource assistance
3. The alert is transmitted via the communication method designated by agencies for their 24-hour answering point (pager, cell phone, etc.). The alert will provide a message that briefly describes the incident, its location, and the time and contact information for the conference call (e.g., **6.2 Earthquake in Santa Cruz. Call 1-800-XXX-XXXX, PIN 1234 at 0710 hours**). The time of the conference call is determined by the reporting MHOAC and the RDMHC/S based on the urgency of the event.

The RDMHC/S will act as the Call Leader and is responsible for:

- Ensuring necessary participants are on the call.
 - Announcing when the conference call officially begins.
 - Taking roll call.
 - Taking notes.
 - Facilitating the call.
 - Identifying information shortfalls that should be addressed during next call.
 - Reviewing agreed upon assignments and action steps at the end of the call.
 - Scheduling additional conference call times and assessing if other response organizations should be involved.
 - Contacting and updating essential personnel who did not participate in the conference call.
 - Disseminating a meeting summary within an hour of the end of the call via email and CDMN.
4. The initial conference call should take no more than 15-20 minutes. (5) Following the Regional Sit-Stat Conference Call, MHOACs / LEMSAs update OA hospitals, ambulance service providers, dispatch centers, PDCs, LHD, and OES of the results on conference call results.

Initial Regional Sit-Stat Conference Call Format

(Note: This conference call format may also be used for *Level II Medical Incidents*)

1. **Role Call** (Call Leader)
2. **Situation Status Report** (*Impacted LEMSA or RDMHC/S*)
 - Incident name
 - Incident location(s)
 - Order numbering system
 - Level and type of incident
 - Description of incident
 - Estimated number of casualties - (*Immediate (Red), Delayed (Yellow), Minor (Green), Deceased (Black) - if available*)
 - General infrastructure involvement (roads / buildings / utilities / etc.)
 - Medical infrastructure status (hospitals, LTC facilities, EMS services, dispatch, etc.)
 - Incident trend predictions (worsening, stabilizing)
 - Contact information (telephone, pager, cellular, radio, satellite phone)
 - Special circumstances (fires, hazardous materials, violence, presence of VIPs, etc.)
3. **Resources Available within the Impacted OA** (*Impacted LEMSA or RDMHC/S*)
 - Personnel
 - Equipment
 - Transportation
 - Hospital / Receiving Facilities
4. **Anticipated Medical Resource Needs** (*RDMHC/S*)
 - Define immediate need for resources and begin arrangements for their mobilization. Formal resource requests must be submitted through the formal mutual aid request process
 - Consider need for initiating movement of State and federal push resources
 - Communicate location of Staging Areas and Mobilization Points, if known
5. **Summarize information on CDMN** (*RDMHC/S*)
 - The MHCC summarizes information posted on CDMN
 - The MHCC reminds conference call participants to update incident and response status, incident site maps, and staging area maps
6. **Review Agreed on Assignments and Action Steps**
7. **Scheduled Time for Subsequent Conference Call(s)** (*Call Leader*)

NOTE: The situation status updates made in CDMN can be cut-and-pasted into RIMS or any local reporting system simply by blocking the text and using the cut and paste browser feature.

5. Medical Transportation and Hospital Resource Availability Assessment

When notified by the impacted MHOAC that a potential *Level II or III Medical Incident* has occurred, the MHCC assesses ambulance and hospital capabilities based on information made available by the RMDCs and local hospital alert systems.

a. Medical Transportation

The *EMS Transport* screen of CDMN lists the ambulances, gurney cars, wheelchair cars, etc., available in 3 and 24 hours in the OAs and regions surrounding the event.

- NOTE:** To avoid double counting ambulances that operate in multiple jurisdictions, each OA will count only:
- Private and fire based emergency ambulance service providers with contracts to respond to 911 medical emergencies within the OA, and
 - Non-emergency (inter-facility transfer) providers which have their primary base of operations within the OA

b. Hospital Assessment

The MHCC, via the RPDCs, will issue an alert and status request to hospitals in the affected area through administrative access to local HAAS (e.g., Reddinet and EMSystems). Updated HAAS information will auto-populate the EMS Hospital screen in CDMN. During the initial alert, based on the circumstances of the incident and pre-established MHCC protocol, the hospitals may be asked to complete only the Emergency Department capacity for numbers of Immediate, Delayed, and Minor patients they are able to receive, the in-house (California HAvBED Plus) capacity section, or both.

The MHCC or RDMHC/S will request updates to the Resource Availability Assessment as needed throughout the event as determined during the regular Regional / State Sit-Stat Conference Calls.

6. Resource Request

Resource needs may be identified by field sites, local facilities, or LEMSAs during or between ongoing incident assessments. LEMSAs should immediately forward requests for resources to the MHOAC and initiate a resource request in CDMN. All requests for medical mutual aid resources must be approved by the OA EOC according to OA protocol prior to forwarding an official request to the REOC or SOC.

The MHOAC coordinates the process for acquiring medical mutual aid resources requested by the OA. The MHOAC initiates the resource tracking process in CDMN by entering the following information:

- Priority
- Status
- Request number
- Requestor
- Description of requested resource
- Preferred communications method and contact information

- Delivery location and map
- Special instructions

The MHOAC then transmits the request to the RDMHC/S. The RDMHC/S assumes responsibility for filling the request and reports the status of the process to the requesting MHOAC. The sending MHOAC updates the status of the resource in CDMN from “Requested” to “En route.”

If EMS transport units are requested, the RDMHC/S uses the CDMN EMS Transport Screen to identify in-region resources and forwards requests to the appropriate MHOACs. Alternatively, following notification of the MHCC, the MHOAC may request resources from the RDMHC/S of a single adjacent region. If resources are required from more than one adjacent region, the MHCC is notified and will coordinate resource acquisition among multiple regions. A request for multiple resources of the same type may be split by the sending RDMHC/S into smaller requests to multiple resource owners if those resource requests cannot be filled by a single vendor or at the same time.

If response information cannot be transmitted within CDMN, the CDMN Mission/Request Tasking Form can be printed and sent to the RDMHC/S by fax or email, or information can be transmitted by voice via telephone or radio.

7. Mobilizing Resources

The requesting RDMHC/S provides responding ambulances and other resources with the following information:

- Special instructions as noted in the initial request
- Instructions to contact the RMDC in the impacted area and the sending MHOAC on arrival and at the time of release
- Recommended equipment and personal gear they should carry, based on the anticipated length of the assignment and the situation and resource availability in the affected area

The requesting RDMHC/S also asks for a contact telephone number for cancellation of a resource while en route, or for information updates. If the resource is canceled en route, the requesting RDMHC/S will advise the sending MHOAC who will revise the status of the resource in CDMN to “Canceled.”

8. Resource Tracking

Resource tracking and status reporting is performed by the sending jurisdiction at the lowest SEMS level, i.e., resources sent from an OA are tracked and recorded by the sending OA’s MHOAC and ambulance strike teams and task forces assembled from multiple OAs within a region are tracked by the sending region’s RDMHC/S.

The notification process is as follows:

- When responding resources arrive at the impacted area, they notify the RMDC and provide their Resource Request Number
- The RMDC and sending entity provide the responding resource updates on directions and ask for an ETA to the scene

- At the requesting OA staging area, the responding resource re-contacts the impacted RMDC and sending entity with their Resource Request Number and report that they have arrived on-scene

9. Demobilization

Responders should be demobilized according to scene procedures prior to being released from their assignment. When released from the scene and prior to returning to their point of origin, responders should contact the impacted area RMDC, provide their Resource Request Number, and advise that they have been released.

The RMDC, acting on instructions from the OA EOC and with approval of the sending agency, may reassign or release the resource. If the resource is reassigned, the status log is updated and the resource remains under the control of the local jurisdiction. If released, the RMDC changes the status of the resource to “Released.” The units / individuals are advised to contact the sending MHOAC/RDMHC/S when they return to their point of origin. The sending MHOAC/RDMHC/S logs the return time and schedule a debriefing if appropriate.

Summary of Medical Response Actions, Roles, and Responsibilities For Level I, II, and III Medical Incidents			
	Level I	Level II	Level III
Notification/Activation (MHOAC, LEMSA*, OES, RDMHC/S, MHCC)	Optional notification and activation of MHOAC and LEMSA per local EMS policy	Mandatory notification and activation of MHOAC, LEMSA, RDMHC/S and MHCC	Mandatory notification and activation of MHOAC, LEMSA, RDMHC/S, and MHCC
Incident Assessment	On-site Personnel	LEMSA* is responsible for assessing medical and EMS needs and capabilities	LEMSA* with State and/or Federal Assistance Teams
Medical Transportation and Hospital Resource Availability Assessment	On-site Personnel	The LEMSA* is responsible for assessing field and hospital resource availability and needs	MHOAC/RDMHC with State and/or Federal Assistance Teams
Resource Request	Through EMS Dispatch per local protocols and as approved by IC	All medical resource requests are forwarded to the MHOAC	Through MHOAC/RDMHC and OA/REOC
Mobilizing Resources	EMS Dispatch	MHOAC	MHOAC/RDMHC with State and/or Federal Assistance
Resource Tracking	EMS Dispatch	MHOAC	MHOAC/RDMHC with State and/or Federal Assistance
Demobilization	On Site IC(s)	On Site IC(s) and MHOAC	On Site IC(s) and MHOAC/RDMHC with State and/or Federal Assistance

* Or Designee. (Some LEMSAs may not have contractual authority over all elements of the local disaster medical response system; these responsibilities may be delegated to another county entity. However, the LEMSA is responsible to ensure these positions are in place and activities are accomplished).

VI. PATIENT DISTRIBUTION

A. Overview

This section outlines the plans and procedures of California's Disaster Medical System for distribution of disaster patients to:

- Destinations across multiple OAs within an impacted Mutual Aid Region
- Destinations within the state but outside of the impacted region
- Out-of-state destinations

Local EMS systems have protocols for the distribution of patients transported from sites of day-to-day emergencies to approved local receiving facilities (hospitals and specialty care centers). During most mass casualty incidents, most facilities have the ability to expand their patient intake capabilities by instituting in-house surge plans. However, if local demand for emergency department resources exceeds capacity, local EMS systems will need to expand the patient receiving capacity of healthcare facilities.

Patient surge within OAs, as well as the distribution of patients to other areas may be supported by mutual aid resources provided by other OAs and state and federal governments. See **Attachment 2** for a description of these resources and their capabilities.

B. Medical Surge

Surge plans can be activated by a decision of the OA in the course of responding to a mass casualty incident or through pre-established automatic triggers. Local medical response systems use two mechanisms to expand capacity: use of non-traditional facilities within OAs or receiving facilities outside the OA.

1. Surge within the OA

Plans for patient surge within OAs may use additional, non-traditional receiving facilities within the OA including: clinics, urgent care centers, long-term care facilities, surgical facilities, military facilities, Alternate Care Sites, etc., to receive less acute patients directly from the field or as a step-down from higher acuity facilities. Surge response within the OA also includes expanding capacity by requesting licensed bed and staffing waivers from the CDPH for hospitals and other facilities.

LEMSAs and LHDs may also develop guidelines for modified levels of services which:

- Set priorities for the types of EMS calls which will receive an ambulance response
- Limit the type and number of patients transported to receiving facilities
- Modify other standards for patient destination

2. Use of External Resources

A mass casualty incident may require use of out-of-county receiving facilities beyond normal day-to-day levels to receive patients from the field or from evacuations of medical facility. The impacted OA may simultaneously distribute patients to facilities both within and outside the OA or rely exclusively on facilities outside the OA if there is sufficient patient care capacity.

OA requests to send patients outside the OA involve inter-jurisdictional coordination which is facilitated when patient distribution protocols among OAs, regions, and the state use common or complementary terminology, activation and notification procedures, patient distribution protocols, and tracking methodologies.

C. Patient Distribution Roles and Responsibilities

1. Medical/Health Operational Area Coordinator (MHOAC)

The OAPDC notifies the MHOAC for:

- Incidents requiring receiving destinations outside of the OA
- Incidents involving hospital evacuation
- Incidents requiring implementation of modified levels of care in the field, in hospitals, or system wide
- Inability of the OAPDC to conduct patient distribution activities within the OA
- Other criteria established by the LEMSA or MHOAC

A MHOAC may also be activated by the RDMHC/S for receiving patients from an incident outside the MHOAC's OA or region.

For local incidents that create health care needs that exceed the capacity of facilities within the OA, the MHOAC:

- Contacts the RDMHC/S to monitor and facilitate intra-region patient distribution with the OAPDC and RPDC
- Assists in coordinating the EMS transportation

For incidents occurring outside the region, the RDMHC coordinates with MHOACs within his/her region to establish Patient Reception Area (PRA). When contacted to establish a PRA, the MHOAC:

- Notifies the County OES Coordinator to activate and support the PRA, including the establishment of an ICS structure, Medical Branch Director, and Patient Tracking process
- Confirms with the OAPDC the need for patient distribution and patient tracking
- Mobilizes local EMS providers to support PRA operations, including medical transportation
- Monitors HAAS to ensure receiving facility capacities are accurately reflected
- Maintains communications with the RDMHC to facilitate patient distribution
- Ensures final patient tracking information is provided to the RDMHC for feedback to the impacted MHOAC

2. Regional Disaster Medical Health Coordinator/Specialist (RDMHC/S)

When patient requirements exceed the capacity of an OA, its MHOAC may request the RDMHC/S to assist with intra-regional patient distribution.

For mass casualty incidents that require medical resources that exceed the capacity of facilities within the region, the RDMHC/S contacts the MHCC to request assistance with inter-region patient distribution.

For incidents occurring outside the region, a RDMHC coordinates with the region's MHOACs to establish temporary Patient Reception Areas (PRAs) and works with the RPDC to assess receiving facility capacities and coordinate patient distribution.

When requested by the SPDC to receive airlifted patients from outside the region, the RDMHC/S:

- Identifies locations for establishing Patient Reception Areas (PRA) (e.g., major airports for receiving military aircraft)
- Contacts MHOAC(s) to activate PRAs
- With the RPDC, creates a regional announcement in HAAS(s) to notify local facilities of the event and need for patient distribution and tracking
- Monitors CDMN to ensure receiving facility capacities are accurately reflected
- Maintains communications with the SPDC and MHOAC(s) to facilitate patient movement and patient distribution by the State, Regional and OA PDCs
- Ensures patient-tracking information is provided to the requesting agency

3. Operational Area - Patient Distribution Center (OAPDC)

a. Function

The OAPDC is designated by the LEMSA and serves as the single point of contact with the RPDC and the state patient distribution system for intra- and inter-region distribution of patients. It also serves as the single point of contact for receiving patients into the OA from mass casualty incidents occurring outside the OA and distributing them to OA facilities. (See Figure 5)

The designated OAPDC may be a hospital, dispatch center, local warning center or other entity that has the staffing and capabilities to complete the assigned tasks on a 24 hour, seven days a week basis. The OAPDC may be located outside the OA it serves and a single OAPDC may serve multiple counties.

LEMSAs should establish a memorandum of understanding or other formal agreement with the OAPDC that defines minimum capabilities, mutual responsibilities and preparedness and response protocols. In addition, the LEMSA should establish local policies to ensure receiving facilities within the OA participate in the patient distribution plan.

Communication Links for Patient Movement Information

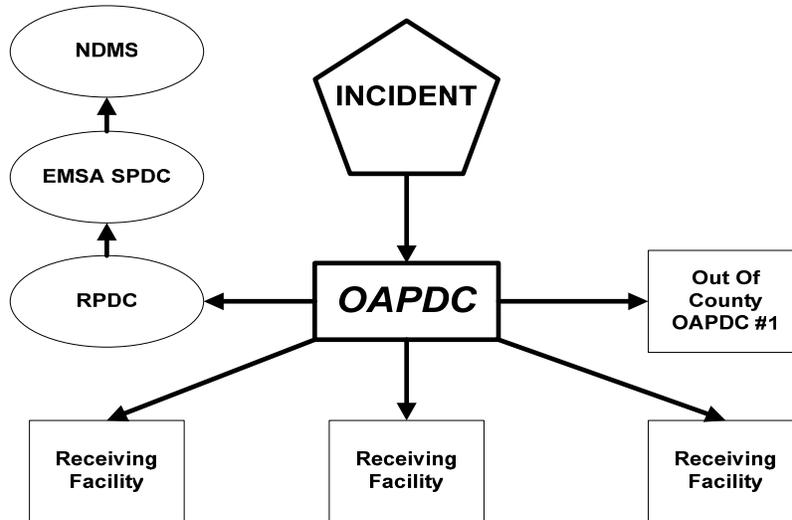


Figure 5

b. Recommended Capabilities

OPDCs should have the following capabilities:

- Sufficient personnel and equipment to perform OAPDC duties
- Designated liaison to local receiving facilities and LEMSA which are notified when staff for this position changes
- Personnel trained in the local mass casualty incident plan, HAAS, patient distribution plan, primary and back-up communication systems (radio, telephone, etc.), and patient tracking system(s)
- Communication protocol that identifies OAPDC in communications by the county name, followed by PDC (e.g., San Diego PDC)
- A Hospital Alert and Assessment System (HAAS) (e.g., EMSsystems, Reddinet, etc.) which can:
 - Alert all local hospitals
 - Assess capabilities of local hospitals to receive immediate, delayed and minor patients directly from the scene of a mass casualty incident
 - Assess in-house capabilities of hospitals using California HAvBED Plus standards
- Communications equipment/capability that includes:
 - Dedicated landline telephone system

- Emergency two-way radio system
 - Auxiliary radio hook-up (amateur radio)
 - UHF Med Channel* for communication with incoming ambulances from other OAs
 - Communication capabilities with Transportation Group Supervisors at the scene of the incident(s), or the EOC in the event of a non-specific site incident, via a pre-assigned frequency
 - Redundant communication capabilities with all receiving facilities in the operational area, with the RPDC and the OA EOC
 - Other communications devices or systems as required by LEMSA protocol
- Participation in the development of OA medical/health patient distribution exercises and drills

4. Regional Patient Distribution Center (RPDC)

a. Function

The RDMHC in every OES mutual aid region assigns/designates a RPDC with the concurrence of the region's MHOACs. The RPDC serves as the single point of contact between the OAPDCs of impacted counties, other OAPDCs within the region, other RPDCs within the state, and the State Patient Distribution Center. It also serves as the single point of contact for receiving patients into the region from incidents occurring elsewhere in the state or nation.

The RPDC may be located at the office of RDMHC/S, a hospital, dispatch center, local warning center, or other organization that has the staffing and capabilities to complete the assigned tasks on a 24 hour, seven days a week basis. The RDMHC may choose to designate an OAPDC to function as both the OAPDC and RPDC if that facility has the depth in staffing and communication capabilities to serve in the dual role. A formal agreement or MOU should be established between the RDMHC and RPDC that includes the following capabilities.

b. Recommended Capabilities

The RPDC should have the following capabilities:

- Sufficient personnel and equipment to perform OAPDC duties
- Designated liaison to OAPDCs and the RDMHC/S which are notified when staff for this position changes
- Personnel trained in the regional mass casualty incident plan, CDMOM, CDMN, HAAS, patient distribution plan, primary and back-up communication systems (radio, telephone, etc.), and patient tracking system(s)
- Communications protocol to identify RPDC by the Region name, followed by PDC (e.g., Region VI PDC)
- Internal protocols, consistent with this document and RDMHC/S policy that define the facility's role and responsibilities during a patient distribution event

* Med Channel to be developed

- A HAAS capable of:
 - Alerting all OAPDCs and hospitals of an incident (preferably with an audible alerting mechanism)
 - Assessing capabilities of hospitals in region's OAs to receive Immediate, Delayed, and Minor patients directly from the scene of a mass casualty incident
 - Assessing in-house capabilities of hospitals using California HAvBED Plus standards
 - Access to CDMN
- Communications equipment/capability that includes:
 - Dedicated landline telephone system
 - Emergency two-way radio system
 - Satellite Phone (optional)
 - Auxiliary radio hook-up (amateur radio).
 - UHF Med Channel for communication with incoming ambulances from OAs outside of region
 - Multiple redundant communication capabilities with all OAPDCs within the operational area
 - Redundant communication capabilities with SPDC
 - Communication with the RDMHC/S
 - Other communications devices or systems as required by RDMHC protocol
- In cooperation with the RDMHC/S, participation in the development of local and regional medical/health patient distribution exercises and drills

5. State Patient Distribution Center (SPDC)

a. Function

If a large-scale mass casualty incident occurs which requires distribution of patients to multiple regions throughout the state or to other states, the California EMS Authority will play a key coordination role, through the SPDC, in the distribution of patients. If multiple regions are directly impacted by an incident, or if more than one major incident occurs within the state simultaneously, the EMS Authority may also need to set priorities for the use of limited resources during the event(s).

b. Recommended Capabilities

Recommended capabilities for the SPDC include:

- Sufficient personnel and equipment to perform SPDC duties
- Designated liaison to OAPDCs and the RDMHC/S which are notified when staff for this position changes
- Personnel trained in the California Disaster Medical Response Plan (CDMRP), CDMOM, CDMN, state patient distribution plan, primary and back-up communication systems (radio, telephone, etc.), and patient tracking system(s)

- Communication protocol that identifies the SPDC by the term “State PDC”
- Internal protocols, consistent with this document and State policy that define the SPDC’s role and responsibilities during a patient distribution event
- Access to CDMN
- Communications equipment/capability that includes:
 - Dedicated landline telephone system
 - Emergency two-way radio system
 - Satellite Phone (optional)
 - Auxiliary radio hook-up (amateur radio).
 - Multiple redundant communication capabilities with all RPDCs
 - Redundant communication capabilities with SPDC
 - Redundant communications capabilities with the MHCC
 - Communication with the RDMHC/S
 - Other communications devices or systems as required by the EMS Authority
- In cooperation with the EMS Authority, participation in the development of local, regional, and state medical/health patient distribution exercises and drills.

D. Patient Distribution Process

1. Notification / Activation

Initial notification of the OAPDC and activation of the OA Patient Distribution System is accomplished according to local protocol.

For out-of-county incidents, the OAPDC may be activated by the MHCC, RDMHC/S, LEMSA, or RPDC.

2. Communications and CDMN Information Management Procedures

a. Creating a Mass Casualty Incident

When notified that a mass casualty incident has occurred, the OAPDC:

- Creates a mass casualty incident event in CDMN and alerts all hospitals in the OA using the HAAS and other systems as identified by LEMSA policy. If HAAS is unavailable, uses back-up communications protocols.
- Locates the mass casualty incident on facility maps, and identifies the facilities for receiving Immediate patients. (If any of those hospitals are located in an adjacent OA or region, notifies and activates the RPDC.)
- Maintains communications with the field Med.Comm (or other patient information source, e.g., Regional PDCs, MHOAC, etc.).

b. Receiving Facility Status Reports

Each receiving facility notified by the OAPDC of a mass casualty incident completes a Receiving Facility Capacity Worksheet in their OA’s HAAS and

reports their status to the OAPDC (Target timeframe: within 5 minutes of receiving notification).

The OAPDC tracks and updates receiving facility capacities as patients are assigned to various receiving facilities. (See example diagram below).

Zone 1 (Sacramento)	1. Immediate	2. Delayed	3. Minor	4. Decon Facility	5. Surgeon Availability
Kaiser South	0	0	5	Yes	No
Methodist Hospital	0	2	0	Yes	Yes
Sutter General	0	1	6	Yes	No
Summary	1	3	15	N/A	N/A

Figure 6

c. Mass Casualty Incident Communications

OAPDCs are referred to by County Name + PDC (e.g., Fresno PDC).

While the mass casualty incident is in progress, all EMS radio traffic should be routed through the OAPDC, even for non-mass casualty incident patients (Refer to local policy).

Patient reports are not transmitted directly to receiving facilities by transporting units.

d. Updating the Mass Casualty Incident

The OAPDC updates mass casualty incident information in its HAAS any time new information is received from the field, e.g., total patient count by triage category, patient destinations, etc.

The OAPDC confirms the total number of transport resources available, and begins the Patient Destination Worksheet.

e. Back-Up Communications

The OAPDC should maintain redundant communications capability and establish a communications-failure algorithm that would allow it to:

- Notify all hospitals of the incident
- Inform hospitals that HAAS or EMS Radio System will not be used for the collection of receiving facility capacity reports and patient dispersal
- Conduct facility assessment and patient distribution processes

E. Level II or III Medical Incident - Distribution of Patients outside the County

1. Overview

If there is insufficient receiving facility capacity within the OA to meet the patient distribution needs of a mass casualty incident, the OAPDC considers distribution to other OAs within the region (*Level II Medical Incident*). Out-of-region or out-of-state destinations may be required for large mass casualty incidents. Distribution of patients to destinations outside the OA, if not routine or governed by prior agreement, requires MHOAC notification and involvement for coordination and approval of patient distribution plans.

The MHOAC notifies relevant agencies within the OA (LEMSA, OES, etc.) and notifies/activates the RDMHC.

2. Level II Medical Incident - Procedures

Following notification of the MHOAC, the OAPDC contacts the RPDC to request additional hospital destinations within the region. The RPDC activates the HAAS for the other OAs in the region and notifies the OAPDCs in those counties to activate local hospital assessment/patient distribution systems.

- Hospitals in receiving OAs report their capability to the RPDC.
- The RPDC forwards patient destinations to the impacted OAPDC.
- The OAPDC advises the field Med.Comm of the hospital destinations.
- The Med.Comm advises the OAPDC that patients are en route and provides the unit number; number of patients; patient triage category and injury type (for Immediates only); and ETA. (In the event of a medical facility evacuation, California HAvBED Plus information is communicated in place of triage category.)
- The OAPDC forwards this information to the RPDC.
- The RPDC forwards this information to the receiving OAPDC that, in-turn, notifies the receiving facility.

Regions that use the same HAAS system may use HAAS for all notifications.

If receiving facilities in an adjacent region are closer to the incident site than receiving facilities in the impacted region, the impacted region RPDC may activate the adjacent region's RPDC to coordinate patient distribution into that region as long as only one adjacent region is involved. The receiving region's RPDC will notify that region's RDMHC/S who will notify receiving OA's MHOACs. All communication from the adjacent region's RPDC will be routed through the impacted RPDC to the impacted OAPDC.

NOTE: If the impacted county only needs to distribute patients to one adjacent OA, it may request the RPDC (and the RPDC of the receiving OA if that OA is located in an adjacent region) to permit the sending OAPDC to communicate directly with the receiving OAPDC for patient distribution. If approved, the RPDC(s) will monitor activities but will not become directly involved in the distribution of patients.

3. *Level III Medical Incident* - Procedures

a. General Patient Distribution Procedures

If mass casualty incident patients require transport to other regions within the State, or to other states through the ASPR federal patient distribution system (*Level III Medical Incident*), the impacted region's RPDC will notify and activate the SPDC.

When the state patient distribution system is activated, patient distribution information is communicated from the impacted OAPDC to its RPDC, and then to the SPDC. The SPDC communicates with RPDCs throughout the state and with the federal ASPR contact point, if federal distribution is necessary.

Patient distribution related communication under a *Level III Medical Incident* transmits the same data and uses the same information exchange protocols as in a *Level I or II Medical Incident*.

1. Hospitals in the receiving OAs, report their capability to their respective RPDCs.
2. Receiving RPDCs report availability to the SPDC that provides availability information to the RPDC of the impacted region.
3. The impacted region RPDC forwards patient destinations to the impacted OAPDC(s).
4. The impacted OAPDC(s) advises the field Med.Comm of hospital destinations.
5. The Med.Comm advises the OAPDC that patients are en route and provides the ambulance unit number; number of patients; patient triage category and injury type (for Immediates only); and ETA. (In the event of a medical facility evacuation, HAvBED Plus information will be communicated in place of triage category.)
6. The OAPDC forwards patient information to the impacted region's RPDC.
7. The OAPDC patient information is forwarded to the SPDC, this information is conveyed to the receiving RPDC, who provides the patient information to the OAPDC responsible for notifying the receiving facility.

b. Communication Limitations

In a *Level III Medical Incident* (or a large *Level II Medical Incident*), the sending OAPDC may not be able to communicate a specific facility destination for patients transported to other OAs or regions. In this instance, the OAPDC may tell the field MCC to direct transporting units to a county (OA) or a region. When the transporting units reach radio communication distance of the receiving OA or Region, they contact the OAPDC or RPDC on a UHF Med Channel with no private line (PL). Each receiving OAPDC and RPDC will monitor this frequency, and when contacted by the incoming transport units, provide hospital destinations and directions. Cell phone contact with the receiving OAPDC or RPDC may also be an option for transporting units if telephone contact information is provided at the time of transport.

c. Airlift of Mass Casualties

In a large scale event, the field IC or the OA EOC may establish a CDP at a local airport to support patient distribution using large helicopters and fixed wing aircraft. Receiving regions and OAs, in turn, may establish PRA at or near airports to receive patients evacuated by air.

The same patient information is collected and communicated for air-evacuated patients as for those evacuated by ground, except specific facility destinations will likely not be known until arrival at the PRA. Instead, the SPDC will establish a patient distribution plan based on the most current hospital assessment data throughout the state.

The SPDC coordinates with the RDMHC/Ss of the receiving regions, who in turn coordinate with the MHOAC in each receiving OA to identify the airport location(s) for establishment of PRAs. The MHOAC coordinates with emergency responders within the OA or requests mutual aid response teams to establish an ICS structure at each CDP to receive the incoming casualties. Each CDP is treated locally as a local event site for the purpose of local and regional patient distribution.

When patients arrive at the PRA, the MCC contacts the OAPDC and patients are distributed through the OAPDC or RPDC as if it were a *Level II Medical Incident*. This evacuation plan requires that the RPDC (in conjunction with the RDMHC/S) receive patient identification information and identify destinations from the impacted OA's OAPDC prior to their arrival. If this information is not available, the receiving RPDC will determine hospital bed availability and assign patient destinations after patients arrive and their condition determined.

F. Receiving Patients from Outside the County

When the OAPDC or RPDC is activated to support patient distribution from a mass casualty incident that has occurred outside the county or region, the RPDC initiates a hospital capability assessment through HAAS. The RPDC remains the regional point of contact with the impacted OA, the region in a *Level II Medical Incident*, or the SPDC in a *Level III Medical Incident*.

Hospital capability information is gathered, disseminated, and used in decision making as in an in-county or regional event. Patient destination information is transmitted from the receiving county's OAPDC to the RPDC and then to the requesting OAPDC, RPDC, or SPDC. Patient distribution information flows from the impacted RPDC or SPDC to the receiving RPDC and then to the OAPDC.

For events requiring patient distribution out-of-state, the EMS Authority requests the ASPR to rapidly assess other states' receiving facility capacities and coordinate patient distribution.

VII. ADMINISTRATIVE SUPPORT

Level II and III Medical Incidents that require extensive mutual aid or extended operations can stress the OA administrative resources required to manage them. The administrative support tasks may include:

- Defining needs for multiple sites over extended periods.
- Coordinating with responding mutual aid resources.
- Coordinating logistical support for those resources.
- Conducting needs assessments, developing progress reports, creating incident action plans, and tracking progress.
- Maintaining time and cost records.
- Demobilizing resources.

Additionally, these tasks may need to be performed at varying levels of intensity over extended periods.

LEMSAs and Local Health Departments have several internal options for augmenting personnel resources to accomplish these tasks:

- Existing medical and public health personnel with EOC/DOC training and experience.
- Staff with training and experience borrowed from other agencies in the OA.
- Just-in-time EOC/DOC training for personnel with administrative backgrounds.
- Trained personnel from outside the OA.

During the emergency management preparedness phase, LEMSAs and Local Health Departments should provide all employees with basic awareness of EOC/DOC operations. Management and emergency response personnel should receive extensive training including NIMS 100, 200, 300, 400, and 700 and IS 800 level courses and should participate in exercises at least annually.

Administrative resources may also be requested through normal mutual aid channels. As with other mutual aid requests, the requesting OA should be specific about the tasks to be addressed by the resource; preferred levels of training; the anticipated length of time the personnel will need to be committed; and lodging, transportation, and other logistic support the requesting OA will provide.

ATTACHMENT 1

Responsibility / Duty Sheets

- a. LEMSA**
- b. MHOAC**
- c. RDMHC and RDMHS**
- d. State Regional Medical Coordination Center**
- e. State EMS Authority**
- f. OA (Local) EMS Dispatch Center**
- g. Regional Medical Dispatch Center**
- h. OA Patient Dispatch Center**
- i. Regional Patient Dispatch Center**
- j. State Patient Dispatch Center**

Local EMS Agency (LEMSA)

MISSION: Provide overall direction and coordination of the medical response operations within the operational area (OA).

PREPAREDNESS:

- Establish local mass casualty incident field protocols consistent with Firescope.
- Require EMS approved training in Firescope Medical Branch operations for all field medical personnel.
- Develop field and patient destination protocols to be used during all mass casualty incidents.
- Develop redundant communication methods for communicating with medical service providers, EMS Dispatch, the patient distribution center (PDC), and other staff for gathering field and facility information.
- Develop policies for personal protective equipment (PPE), transport, and secondary hospital decontamination for chemical, radiological and biological incidents.
- Develop protocols for initial treatment of decontaminated patients in the Warm Zone when appropriate.
- Develop policies defining triggers for mandatory notification of the Medical/Health Operational Area Coordinator (MHOAC) during mass casualty incidents.
- Establish auto aid agreements and policies for activation and use of auto aid ambulances with LEMSAs in adjacent counties.
- Designate for each OA served by the LEMSA:
 - an EMS dispatch center to serve as the single point of contact for coordinating ambulance mutual aid resources
 - a PDC to serve as the single point of contact for coordinating patient distribution
- Determine the number of ambulances from within its OA(s) that are pre-approved for immediate response to adjacent OAs.
- Develop policies to notify the Regional Medical Dispatch Center (RMDC) when the number of immediate response resources changes.
- Develop protocols for onsite assessment of incident sites or medical provider or facility capability when communications capabilities are diminished.
- Establish capability to inform medical community and local government of the status of the EMS/medical system during disasters.
- Designate the Operational Area Patient Distribution Center (OAPDC) and develop an agreement defining the respective roles and responsibilities of the LEMSA and OAPDC.
- Develop protocols for out-of-OA distribution of patients.
- Develop policies to ensure participation of in-county receiving facilities in resource assessment and patient distribution systems.
- Establish protocols for orienting and equipping out-of-area responders.

RESPONSE:

Activation/Notification (On Call LEMSA Staff)

Immediate — **ESTABLISH COMMUNICATION LINK WITH MHOAC**
Receive notification / activation from the Medical/Health Operational Area, or if received from any other source, notify the MHOAC immediately.

Local EMS Agency (LEMSA)

Incident Assessment/Status

- Immediate**
- **ESTABLISH COMMUNICATION LINK WITH EMS DISPATCH / PDC / OES**
When notified of an in-county mass casualty incident, contact the OA EMS Dispatch Center, PDC and, if necessary, Office of Emergency Services (OES) to obtain an initial status assessment of the incident.
 - **ESTABLISH “QUICK INCIDENT REPORT” IN CDMN**
For in-county incidents; establish a “Quick Incident” report in the California Disaster Medical Network (CDMN) that provides an initial incident status report. For out-of-county incidents, check CDMN to determine if an incident summary has been established by the affected county.
 - **PARTICIPATE IN THE INITIAL SIT-STAT CONFERENCE CALLS**
For in-county incidents, receive notification to participate in the initial State and regional sit-stat conference calls. During the call, present the situation status, current resource status, and projected resource needs.
- Ongoing**
- **UPDATE STATUS REPORT ON CDMN**
For in-county incidents, monitor the medical status of the incident through communication with the field or OA EMS Dispatch Center (for field status), and PDC (for hospital status) and update the situation status report on CDMN as new information becomes available.
 - **UPDATE LOCAL AGENCIES**
Ensure that the Emergency Operations Center (EOC), Departmental Operation Center (DOC), OES, local hospitals, and local EMS service providers are kept abreast of the status of the medical situation.
 - **PARTICIPATE IN SCHEDULED SIT-STAT CONFERENCE CALLS**
Impacted and assisting LEMSAs participate in regularly scheduled conference calls established by the Medical/Health Coordinating Center (MHCC) and RDMHC/S.

Medical Resource Assessment

- Immediate**
- **REVIEW HOSPITAL AND EMS TRANSPORT ASSESSMENT INFORMATION**
Ensure that all local hospitals and EMS providers have updated their information when / if requested by the MHCC or RDMHC/S.
- Ongoing**
- **ASSIST THE MHOAC TO ASSESS HOSPITAL AND PRE-HOSPITAL MEDICAL RESOURCE NEEDS**
Assist the MHOAC to conduct ongoing assessments of hospital and pre-hospital resource needs. Submit all requests for medical resources to the MHOAC for approval and forwarding to the OA EOC and RDMHC/S.

Resource Request

- Ongoing**
- **ESTABLISH EMS RESOURCE APPROVAL LINK WITH MHOAC**
Submit all medical resource requests directly to the MHOAC. Establish a communication link with the MHOAC to ensure that requests for EMS resources are approved by the LEMSA prior to their deployment outside the OA (except for automatic aid).
 - **MONITOR RESOURCE AVAILABILITY ON CDMN**
Monitor the status of EMS transportation resources and hospital bed capacity within the OA and assist the MHOAC to ensure information is current.

Local EMS Agency (LEMSA)

Mobilizing Resources

Ongoing



SUPPORT RESOURCE MOBILIZATION

Assist the MHOAC to ensure that deployed resources are properly assembled, provided with order/request and travel information, and appropriately equipped (PPE, communications, water, etc.) prior to departure.

Resource Tracking

Ongoing



SUPPORT RESOURCE TRACKING

Assist the MHOAC to ensure that CDMN resource status information (en route, on-scene, released) for OA resources is accurate and up-to-date. In cooperation with the MHOAC, obtain current incident and resource information from local hospitals and medical transportation agencies.

Demobilization

Ongoing



SUPPORT RESOURCE DEMOBILIZATION

Assist the MHOAC with resource demobilization activities, including: liaison with local medical transportation providers, return of resources, cost recovery, and incident debriefings.

Medical/Health Operational Area Coordinator (MHOAC)

MISSION: Establish local medical response policies, plan and prepare for the movement of medical resources into and out of the Operational Area (OA) during disasters or in response to mutual aid requests, and act as the single point of contact during mass casualty incidents for coordination with the Regional Disaster Medical Health Coordinator and Specialist (RDMHC/S), Medical/Health Coordinating Center (MHCC), EMS Authority and California Department of Public Health (CDPH).

PREPAREDNESS:

- Coordinate the development of OA plans and policies for disaster medical response.
- Designate a 24-hour contact method for activating the MHOAC or his/her designee.
- Establish a 24-hour contact method for receiving medical mutual aid requests and activations.
- Establish criteria and protocols for notifying the MHCC during mass casualty incidents.
- Establish capability to inform local government and the local medical community of the status of the EMS services and the disaster medical system.
- Develop protocols for approving of utilization of local medical resources.
- Ensure staff and system capability adequate to perform the response operations listed, below.

RESPONSE:

Activation / Notification

- Immediate** _____ **ESTABLISH COMMUNICATION LINK WITH LEMSA**
 When notified of a mass casualty incident; notify the designated 24-hour dispatch center, the RDMHC, the OA Emergency Operations (EOC), and the Operational Area Patient Distribution Center (OAPDC) of the activation of the Departmental Operations Center (DOC) activation. Provide a brief situation summary and relay the status of available communications equipment and preferred method of communications.
- _____ **ESTABLISH COMMUNICATION LINK WITH MHCC**
 When notified of an incident; contact the MHCC to initiate State response and to schedule the initial situation status conference call.

Incident Assessment

- Immediate** _____ **ESTABLISH COMMUNICATION LINK WITH LOCAL AGENCIES**
 When notified of an in-county incident, contact the Local EMS Agency (LEMSA), OAPDC, and if necessary Office of Emergency Services (OES) to obtain an initial status assessment of the incident.
- _____ **PARTICIPATE IN THE INITIAL SIT-STAT CONFERENCE CALLS**
 For in-county incidents; participate in the initial State and regional sit-stat conference call. The impacted LEMSA presents the initial situation status, current resource status, and projected resource needs.
- Ongoing** _____ **UPDATE LOCAL AGENCIES**
 Ensure that the EOC, LEMSA, OES, and local medical/health service providers are kept current on the status of the incident and the medical response.
- _____ **PARTICIPATE IN SCHEDULED SIT-STAT CONFERENCE CALLS**
 Impacted and assisting MHOACs participate in regularly scheduled conference calls established by the MHCC and RDMHC/S.

Medical/Health Operational Area Coordinator (MHOAC)

Medical Resource Assessment

- Immediate** _____ **MEDICAL TRANSPORTATION ASSESSMENT**
 Coordinate with the LEMSA to ensure that local medical transportation resource status is current, reported to the Regional Medical Dispatch Center (RMDC) and recorded in the California Disaster Medical Network (CDMN).
- _____ **HOSPITAL BED CAPACITIES**
 Coordinate with the LEMSA and PDC to ensure that current hospital status and bed capacities are being reported in the local Hospital Alert/Assessment System (HAAS).
- Ongoing** _____ **ASSESS HOSPITAL AND PRE-HOSPITAL MEDICAL RESOURCE NEEDS**
 Conduct ongoing assessments of hospital and pre-hospital resource needs.

Resource Request

- _____ **RECEIVE REQUEST**
 Receive requests via approved methods.
- _____ **CONFIRM REQUEST**
 Confirm requests by telephone within 5 minutes, if possible. Complete a *Resources Request Form*. MUTUAL AID REQUESTS ARE UNDERSTOOD TO BE FOR NON-REIMBURSED VOLUNTARY RESOURCES UNLESS OTHERWISE INDICATED.
- _____ **RELAY REQUEST**
 Enter medical/health resource requests for outside assistance in CDMN and notify the RDMHC/S by phone or radio. Relay requests for resources received from another county through the RDMHC/S to the appropriate provider agencies and to OES according to local policy.

Mobilizing Resources

- Ongoing** _____ **PREPARE RESOURCES FOR MOBILIZATION**
 Ensure deployed resources are properly assembled, provided with order/request and travel information, and appropriately equipped (PPE, communications, water, etc.) prior to departure.

Resource Tracking

- Ongoing** _____ **MAINTAIN RESOURCE STATUS**
 Coordinate with the RDMHC/S, RMDC, and LEMSA to ensure that CDMN resource status information (en route, on-scene, released) for OA resources is accurate and up-to-date. Obtain current incident and resource information from local hospitals and medical transportation agencies.

Demobilization

- Ongoing** _____ **RETURN OF RESOURCES**
 Coordinate with local medical provider agencies to ensure the return of equipment and supplies assigned to the incident.
- _____ **COST RECOVERY ACTIVITIES**
 With local, regional, state, and federal authorities to assist local medical providers to recover response costs.
- _____ **INCIDENT DEBRIEFING**
 Schedule and conduct incident debriefings in cooperation with the LEMSA, OES, PDC, local hospitals, local medical transportation agencies, and other local response agencies.

Regional Disaster Medical/Health Coordinator/Specialist (RDMHC/S)

MISSION: Establish regional medical response plans, plan and prepare for the movement of medical resources into and out of the Region during disasters or in response to mutual aid requests, and act as the Regional single point of contact during mass casualty incidents for coordination with the Medical/Health Operational Area Coordinators (MHOACs), Medical/Health Coordinating Center (MHCC), EMS Authority, and California Department of Public Health (CDPH).

PREPAREDNESS:

- Coordinate the development of regional medical response plans.
- Designate a 24-hour contact point for activating the RDMHC/S or his/her designee.
- Establish a 24-hour contact method for receiving medical mutual aid requests and activations.
- In conjunction with Local EMS Agencies (LEMSAs) in the OES mutual aid region, designate a Regional Patient Distribution Center (RPDC) and establish an agreement and protocols for RPDC operations.
- In conjunction with other LEMSAs in the OES mutual aid region, develop protocols for the RPDC.
- Ensure staff and system capability adequate to perform the response operations listed below.

RESPONSE:

Activation / Notification

— **ESTABLISH COMMUNICATION LINKS WITH REGIONAL RESPONSE ELEMENTS**
When notified of a mass casualty incident by a MHOAC; notify the designated 24-hour dispatch center, the Regional Emergency Operations Coordinator (REOC), and the RPDC of the RDMHC activation. Provide a brief situation summary and relay the status of available communications equipment and preferred method of communications.

Incident Assessment

Immediate

— **ESTABLISH COMMUNICATION LINK WITH MHCC**
Once notified of an in-region incident, ensure the MHCC was notified to schedule the initial State sit-stat conference call.

— **PARTICIPATE IN THE INITIAL STATE SIT-STAT CONFERENCE CALL**
For in-region incidents; participate in the initial State sit-stat conference call set up by the MHCC. The impacted LEMSA presents the situation status, current resource status, and project resource needs.

— **NOTIFY LOCAL AGENCIES**
For in-region incidents, the impacted RDMHC/S notifies the MHOACs, LEMSAs, and Regional Fire Coordinator (RFC) to participate in the initial Regional Sit-Stat conference call via blast paging or other agreed upon notification system. For out-of-region incidents, the RDMHC/S notifies MHOACs and LEMSAs that may be asked to provide assistance and the RFC to participate in the initial Regional Sit-Stat conference call via blast paging or other agreed upon notification system.

— **CONDUCT INITIAL REGIONAL SIT-STAT CONFERENCE CALL**
For in-region incidents, the impacted LEMSA presents the situation status, current resource status, and projected resource needs. For out-or-region incidents, the RDMHC/S presents information received from the MHCC sit-stat conference call.

Regional Disaster Medical/Health Coordinator/Specialist (RDMHC/S)

- Ongoing**
- **UPDATE LOCAL AGENCIES**
Update MHOACs, LHDs, LEMSAs, and the RFC on the status of the incident and the medical response.
 - **PARTICIPATE IN SCHEDULED STATE SIT-STAT CONFERENCE CALLS**
The impacted RDMHC/S and supporting county MHOACs participate in regularly scheduled conference calls established by the MHCC.
 - **SCHEDULE REGIONAL SIT-STAT CONFERENCE CALLS**
The RDMHC/S schedule and conduct conference calls with MHOACs and LEMSAs that may provide assistance, and the RFC.

Medical Resource Assessment

- Immediate**
- **MEDICAL TRANSPORTATION ASSESSMENT**
Coordinate with the LEMSAs to ensure that local medical transportation resource status is current, reported to the RMDC and recorded in the California Disaster Medical Network (CDMN).
 - **HOSPITAL BED CAPACITIES**
Coordinate with the LEMSA and RPDC to ensure that current hospital status and bed capacities are being reported in the local Hospital Alert/Assessment System (HAAS).
- Ongoing**
- **ASSESS HOSPITAL AND PRE-HOSPITAL MEDICAL RESOURCE NEEDS**
Conduct ongoing assessments of hospital and pre-hospital resource needs.

Resource Request

- **RECEIVE REQUEST**
Receive requests via approved methods.
- **CONFIRM REQUEST**
Requests for medical/health resources are entered by the requesting MHOAC or LEMSA into CDMN. The request notification is relayed to the RDMHC/S by phone or radio. **MUTUAL AID REQUESTS ARE UNDERSTOOD TO BE FOR NON-REIMBURSED VOLUNTARY RESOURCES UNLESS OTHERWISE INDICATED.**
- **RELAY REQUEST**
Forward requests for resources to the MHOACs, when resources are available within the mutual aid region. Forward resource requests to the EMS Authority when insufficient resources are available within the mutual aid region. CDMN Mission/Tasking Requests may be “split” and forwarded when resource requests will be filled by more than one OA.

Mobilizing Resources

- Ongoing**
- **PREPARE REGIONAL RESOURCES FOR MOBILIZATION**
Coordinate with the RMDC and MHOACs to ensure that regional resources (Strike Teams, Task Forces, Regional Caches) are properly assembled; provided with order/request and travel information; and appropriately equipped (PPE, communications, water, etc.) prior to departure.

Resource Tracking

- Ongoing**
- **MAINTAIN RESOURCE STATUS**
Coordinate with the RMDC and LEMSAs to ensure that CDMN resource status information (en route, on-scene, released) for within-region resources is accurate and up-to-date. Coordinate with the RPDC and RMDC to obtain current incident and resource information from hospitals and medical transportation agencies.

Regional Disaster Medical/Health Coordinator/Specialist (RDMHC/S)

Demobilization

Ongoing

RETURN OF RESOURCES

Coordinate with MHOACs within the mutual aid region to ensure the return of equipment and supplies assigned to the incident.

INCIDENT DEBRIEFING

Schedule and conduct incident debriefings with MHOACs, LEMSAs, RFC, Regional Medical Dispatch Center (RMDC), RPDC, the EMS Authority and other local or state agencies.

Medical Health Coordination Center (MHCC)

MISSION: Assist impacted OAs to rapidly acquire immediately needed resources by supporting Regional Disaster Medical/Health Coordinators/Specialists (RDMHC/S) to: (1) identify available resources in areas near the impacted OA and (2) respond immediately to medical resource requests.

PREPAREDNESS:

- Identify and make available a telephone contact number for medical mutual aid requests with requesting agencies
- Maintain a list of emergency notification contact numbers for the EMS Authority, RDMHC/Ss, Regional Medical Dispatch Centers (RMDC), Regional Patient Distribution Centers (RPDC), Medical/Health Operational Area Coordinators (MHOAC), and Local EMS Agencies (LEMSA).
- Establish protocols to identify which agencies should be notified for various incidents based on size, location, and type of incident.
- Coordinate with RDMHC/Ss and RPDCs to establish and maintain protocols for activating local Hospital Alert/Activation Systems (HAAS) in order to rapidly assess hospital capacities.
- Ensure that all MHCC staff is trained in the response operations listed below.

RESPONSE:

Activation / Notification

Immediate

- **SCHEDULE INITIAL SIT-STAT CONFERENCE CALL**
When notified by a MHOAC that a Level II or III Medical Incident has occurred, the MHCC will notify the EMS Authority, State Office of Emergency Services (OES), and impacted RDMHCs, MHOACs, LEMSAs, and Regional Fire Coordinators (RFC) of the time and call-in information for a conference call which should be scheduled to take place as soon as practical.
- **INITIAL SIT-STAT CONFERENCE CALL ELEMENTS**
- **ROLL CALL**
The MHCC is the call leader and ensures necessary participants are on the call, announces when the conference call officially begins, takes roll, takes notes, manages the call agenda and timeframe with a completion goal of 15-20 minutes.
- **SITUATION STATUS REPORT**
The impacted LEMSAs provide a brief summary of the incident, including: incident name, incident location(s), level and type of incident, description of incident, estimated number of casualties, general infrastructure involvement, medical infrastructure status, incident trend predictions, and LEMSAs and MHOAC contact information.
- **RESOURCES AVAILABLE WITHIN THE OA**
The impacted LEMSAs describe currently available resources, including personnel, equipment, transportation, and hospitals/receiving facilities,
- **ANTICIPATED MEDICAL RESOURCE NEEDS**
The impacted LEMSAs describe anticipated resource needs, the ordering numbering system to be used for requests, and the location of incident staging areas and/or mobilization points, if known.

Medical Health Coordination Center (MHCC)

— **UPDATE CDMN INFORMATION**

The Medical/Health Coordination Center (MHCC) summarizes information currently available on the California Disaster Medical Network (CDMN), identifies information expected to be available, and emphasizes the importance of impacted area agencies regularly updating incident status, incident site map, and staging area maps on CDMN.

— **REVIEW OF ASSIGNMENTS AND ACTION STEPS**

Review assignments and action steps. Identify others who should be involved in future calls.

— **SCHEDULE SUBSEQUENT CONFERENCE CALLS CONTACT**

Contact and update essential personnel who did not participate on the conference call and provide them with time of next conference call.

— **MEETING SUMMARY**

The MHCC creates and distributes a summary of the meeting via e-mail and CDMN within an hour of the end of the call.

Ongoing

— **CONDUCT SUBSEQUENT CONFERENCE CALLS**

The MHCC schedules and conducts subsequent conference calls on regular intervals or as needed.

California Emergency Medical Services Authority (EMS Authority)

MISSION: The EMS Authority provides leadership for the disaster medical system response, ensures the coordination of the Disaster Medical System (DMS) response elements, ensures rapid delivery of disaster medical resources to impacted areas, ensures that State and local medical response elements provided to affected areas receive necessary logistic support, manages information essential for an effective coordinated response, and coordinates the evacuation of injured persons to medical facilities outside affected areas.

PREPAREDNESS:

- Maintain the California Disaster Medical Response Plan and related policies, procedures and other guidance and tools.
- Exercise the State medical response plan in cooperation with the Regional Disaster Medical/Health Coordinators and Specialists (RDMHC/S), Medical/Health Operational Area Coordinators (MHOAC), and Local EMS Agencies (LEMSA).
- Designate a 24-hour contact point for contacting the EMS Authority duty officer.
- Develop and maintain a 24-hour Medical Health Coordination Center (MHCC).
- Develop training, instructor qualifications, and credentialing requirements for each position in the field Incident Command System (ICS) Medical Branch.
- Ensure staff, organization and system capability sufficient to perform the response operations listed below.

RESPONSE:

Activation / Notification

— **ALERT EMS AUTHORITY PERSONNEL**
Notify appropriate EMS Authority personnel when alerted by the MHCC.

Incident Assessment

Immediate — **PARTICIPATE IN THE INITIAL STATE SIT-STAT CONFERENCE CALL**
For in-state incidents, the MHCC notifies the EMS Authority duty officer to participate in the initial State sit-stat conference call. The impacted LEMSA presents the situation status report (See MHCC duty statement). For out-of-state incidents, the initial sit-stat report is provided by an EMS Authority representative.

Ongoing — **UPDATE STATE AGENCIES**
Distribute sit-stat reports to conference call invitees and participants and especially to state Office of Emergency Services (OES), California Department of Public Health (CDPH), the State Operations Center (SOC) and other affected state agencies.

— **PARTICIPATE IN SCHEDULED STATE SIT-STAT CONFERENCE CALLS**
Participate in regularly scheduled and ad hoc MHCC calls.

Medical Resource Assessment

Immediate — **MEDICAL TRANSPORTATION ASSESSMENT**
Coordinate with the RDMHC/Ss to ensure that assessments of local medical transportation resources are reported to Regional Medical Dispatch Centers (RMDC) and recorded in the California Disaster Medical Network (CDMN).

California Emergency Medical Services Authority (EMS Authority)

- **HOSPITAL BED CAPACITIES**
 Coordinate with the State Patient Distribution Center (SPDC) to ensure that hospital status and bed capacities are recorded in CDMN through local Hospital Alert/Assessment Systems (HAAS).
- Ongoing** — **ASSESS HOSPITAL AND PRE-HOSPITAL MEDICAL RESOURCE NEEDS**
 Coordinate with the RDMHC/Ss to perform ongoing assessments of hospital and pre-hospital resource needs and capabilities and to update CDMN with results.
- Resource Request**
- Ongoing** — **RECEIVE RESOURCE REQUESTS**
- **CONFIRM REQUEST**
 The RDMHC/S will notify the EMS Authority of resource requests that cannot be filled within the mutual aid region. **MUTUAL AID REQUESTS ARE UNDERSTOOD TO BE FOR NON-REIMBURSED VOLUNTARY RESOURCES UNLESS OTHERWISE INDICATED.**
- **RELAY REQUEST**
 When resources are available within the impacted mutual aid region, the EMS Authority forwards requests for resources to RDMHC/S in unaffected areas. Mission/Tasking Requests on CDMN may be “split” and forwarded when resource requests will be filled by more than one mutual aid region.
- Mobilizing Resources**
- Ongoing** — **PREPARE REGIONAL RESOURCES FOR MOBILIZATION**
 Coordinate with the MHCC and RDMHC/Ss to ensure that state resources (CAL-MATs, mobile field hospitals, State caches) are properly assembled; provided with order/request and travel information; and appropriately equipped (Personal Protective Equipment (PPE), communications, water, etc.) prior to departure.
- Resource Tracking**
- Ongoing** — **MAINTAIN RESOURCE STATUS**
 Coordinate with the MHCC and RDMHC/Ss to ensure that CDMN resource status information (en route, on-scene, released) is accurate and up-to-date. Coordinate with the MHCC and SPDC to obtain current incident and resource information from hospitals and medical transportation agencies.
- Demobilization**
- Ongoing** — **RETURN OF RESOURCES**
 Coordinate with RDMHC/Ss to ensure the return of state equipment and supplies assigned to the incident.
- **INCIDENT DEBRIEFING**
 Schedule and conduct incident debriefings in cooperation with the RDMHC/Ss. State OES, MHCC, SPDC, ASPR and other state and federal agencies.

Operational Area (Local) EMS Dispatch Center

MISSION: Provide “Initial Need” ambulances to the impacted Operational Area (OA) or adjacent OAs, and coordinate the arrival, tracking and release of out-of-OA immediate and planned need medical resources for Level II and *Level III Medical Incidents* within the OA.

PREPAREDNESS:

- Establish a telephone number and Med-Net radio frequency for medical mutual aid communications with requesting agencies and mobilized resources.
- Maintain a list of ambulances, and their dispatch information, which are available in each OA within the region for rapid deployment to “immediate need” requests. Establish protocols for updating the list when Local EMS Agencies (LEMSA) withdraw the availability of some or all of their resources.
- Establish protocols for tracking status and response times of resources responding from outside the region to planned need resource requests and update their status in the California Disaster Medical Network (CDMN), including: time of arrival in the region, time on-scene, time released, and estimated time of arrival at home base.
- Establish protocol for out-of-region medical resources to contact the Regional Disaster Medical/Health Coordinator and Specialist (RDMHC/S) when released from their assignment but prior to beginning travel to their home base, to determine if there are additional assignments. If reassigned, the RDMHC/S records the time and status for their new assignment in CDMN.
- Ensure staff, organization, and system capability sufficient to perform the response operations listed below.

RESPONSE:

Activation / Notification

Immediate _____ **RECEIVE NOTIFICATION**
Receive incident notification from the Medical/Health Operational Area Coordinator (MHOAC), LEMSA, Regional Medical Dispatch Center (RMDC), local provider (for in-county incidents) or other source. Complete the Resource Request Form for in-county requests for mutual aid transportation resources, (i.e. requestor, resource requested, when needed, where to report, etc.).

Medical Resource Assessment

Immediate _____ **ASSESS MEDICAL TRANSPORTATION RESOURCES**
When requested by the RMDC or LEMSA, contact medical transportation providers to assess availability to respond to planned need (available in 3 or 24 hours) resource requests.

_____ **RELAY MEDICAL TRANSPORTATION AVAILABILITY**
Relay status of medical transportation resources within the OA to the RMDC or LEMSA.

Resource Request

Immediate _____ **IMMEDIATE NEED REQUESTS**
Relay immediate need requests to one neighboring OA EMS Dispatch Center or to the RMDC.

_____ **NOTIFY MHOAC FOR MUTUAL AID REQUESTS**
Notify the MHOAC or LEMSA duty officer for mutual aid requests that exceed pre-established thresholds for auto-aid.

Operational Area (Local) EMS Dispatch Center

Mobilizing Resources

Ongoing

PREPARE RESOURCES FOR MOBILIZATION

Coordinate with the MHOAC and RMDC to ensure that medical transportation resources are properly assembled; provided with order/request and travel information; and appropriately (Personal Protective Equipment (PPE), communications, water, etc.) prior to departure.

Regional Medical Dispatch Center (RMDC)

MISSION: Provide initial need ambulance resources to an impacted county within the region or adjacent region, and coordinate the arrival, tracking and release of out of region immediate and planned need medical resources for Level II and *Level III Medical Incidents* occurring within the region.

PREPAREDNESS:

- Establish a telephone number and Med-Net radio frequency for medical mutual aid communications with requesting agencies and mobilized resources.
- Maintain a list of ambulances, and their dispatch information, which are available in each Operational Area (OA) within the region for rapid deployment to “immediate need” requests. Establish protocols for updating the list when LEMSAs withdraw the availability of some or all of their resources.
- Establish protocols for tracking status and response times of resources responding from outside the region to planned need resource requests and update their status in California Disaster Medical Network (CDMN), including: time of arrival in the region, time on-scene, time released, and estimated time of arrival at home base.
- Establish protocol for out of region medical resources to contact the Regional Disaster Medical/Health Coordinator and Specialists (RDMHC/S) when released from their assignment but prior to beginning travel to their home base, to determine if there are additional assignments. If reassigned, the RDMHC/S records the time and status for their new assignment in CDMN.
- Ensure that all regional dispatch staff are trained in the response operations listed below.

RESPONSE:

Activation / Notification

Immediate **RECEIVE NOTIFICATION**
 Receive incident notification from the Medical Health Coordination Center (MHCC), RDMHC/S, or OA EMS Dispatch Center (for in-region incidents) or other source. Complete the Resource Request Form for in-county requests for mutual aid transportation resources, (i.e. requestor, resource requested, when needed, where to report, etc.).

Medical Resource Assessment

Immediate **ASSESS MEDICAL TRANSPORTATION RESOURCES**
 When requested by the MHCC or RDMHC/S; contact OA EMS Dispatch Center to assess availability of resources to respond to planned need (available in 3 or 24 hours) resource requests.

RELAY MEDICAL TRANSPORTATION AVAILABILITY
 Relay status of medical transportation resources within the OAs to the MHCC or RDMHC/S.

Resource Request

Immediate **IMMEDIATE NEED REQUESTS**
 Relay immediate need requests to appropriate OA EMS Dispatch Centers.

NOTIFY MHOAC FOR MUTUAL AID REQUESTS
 Notify the MHCC or RDMHC/S for requests for mutual aid that exceed pre-established thresholds for auto-aid.

Regional Medical Dispatch Center (RMDC)

Mobilizing Resources

Ongoing

—

PREPARE RESOURCES FOR MOBILIZATION

Coordinate with the RDMHC/S and OA EMS Dispatch Center to ensure that medical transportation resources are properly assembled; provided with order/request and travel information; and appropriately (Personal Protective Equipment (PPE), communications, water, etc.) prior to departure.

Resource Tracking

Ongoing

—

MAINTAIN RESOURCE STATUS

Ensure that CDMN resource status information (en route, on-scene, released) for deployed resources is accurate and up-to-date.

Demobilization

Ongoing

—

RELEASE OF RESOURCES

When resources are released from an incident, coordinate with RDMHC/Ss to ensure they are not needed elsewhere within the region, prior to releasing the resources to return to their home base.

—

UPDATE CDMN

Ensure that CDMN resource status information for demobilized resources is accurate and up-to-date.

Operational Area Patient Distribution Center (OAPDC)

MISSION: Coordinate the distribution of casualties within the Operational Area (OA)

PREPAREDNESS:

- Enter into agreement or Memorandum of Understanding (MOU) with the Local EMS Agencies (LEMSA) to perform the duties of the OAPDC.
- Develop and maintain protocols for out-of-OA distribution of patients.
- Establish a 24-hour contact point for the OAPDC duty officer.
- Appoint an OAPDC supervisor to act as liaison to local receiving facilities and the LEMSA. Notify local receiving facilities and the LEMSA when this position changes and provide updated contact names and telephone numbers.
- Maintain an electronic Hospital Alert / Assessment System (HAAS) (e.g., EMSsystems, Reddinet, etc.) able to (1) alert hospitals; (2) assess their capability to accept immediate, delayed, and minor patients from a mass casualty incident site; and, (3) assess hospital capabilities using California HAvBED Plus standards.
- Ensure staff and system capability adequate to perform the response operations listed below. Ensure personnel are trained in the OA Patient Distribution Plan, California's Medical Mutual Aid Plan, HAAS operations, use of primary and back-up communication systems (radio, telephone, etc.), and patient tracking system(s) in accordance with LEMSA and state protocols.
- Maintain multiple redundant communication capabilities between with the OAPDC and all OA receiving facilities. Establish communications failure protocol.
- In cooperation with the LEMSA, participate in the development of OA medical/health patient distribution exercises and drills.
- Develop and maintain internal protocols, consistent with the California Disaster Medical Operations Manual (CDMOM) and LEMSA policy outlining the facility's role and responsibilities during a patient distribution incident.

RESPONSE:

Activation / Notification

Immediate

RECEIVE NOTIFICATION

For incidents within the OA, the OAPDC may be notified or activated by the EMS Dispatch Center, field personnel, or local hospital. For incidents outside the OA, notification may be received from the LEMSA, Medical/Health Operational Area Coordinator (MHOAC), Regional Patient Distribution Center (RPDC), or Medical Health Coordination Center (MHCC).

ASSIGN STAFF

When notified of a mass casualty incident, assign staff to coordinate information from the incident and provide information to receiving facilities.

CREATE MASS CASUALTY INCIDENT IN CDMN

Create a mass casualty incident and alert all hospitals in the OA via HAAS and other systems according to LEMSA policy. If HAAS is unavailable, use back-up communications protocol.

IDENTIFY RECEIVING FACILITIES

Map location of incident and identify receiving facilities to receive patients triaged immediate. Notify the RPDC to use hospitals in an adjacent OA or region.

MAINTAIN COMMUNICATIONS

Maintain communications with the field Med.Comm or other patient information source (e.g., RPDCs, MHOAC, etc.).

Operational Area Patient Distribution Center (OAPDC)

Ongoing — **UPDATE INCIDENT INFORMATION**
Update HAAS information when new information is received from the field.

Assess Facility Capacities

Immediate — **RECEIVING FACILITY CAPACITIES**
Each receiving facility notified by the OAPDC of a mass casualty incident completes a Receiving Facility Capacity Worksheet in the HAAS and reports their status to the OAPDC according to local policy.

Ongoing — **MAINTAIN FACILITY STATUS**
Update capacities of receiving facilities as patients are assigned to various facilities.

Mass Casualty Incident Communications

Immediate — **LIMITED FIELD COMMUNICATIONS**
During response, all EMS radio traffic is routed through the OAPDC, including for non-incident patients (Refer to local policy). Transporting units should not report patient information directly to receiving facilities.

— **DOCUMENT PATIENT INFORMATION**
When notified by the field Med.Comm that patient triage is complete, document patient information on the Patient Destination Worksheet and confirm total number of available transport resources.

Patient Destinations

Immediate — **IMMEDIATE PATIENTS**
Distribute immediate patients according to local protocol.

— **DELAYED PATIENTS**
Distribute delayed patients according to local protocol.

— **MINOR PATIENTS**
Distribute delayed patients according to local protocol.

— **AUSTERE CARE**
When there are more patients within any triage category than available teams to accept those patients, consider requesting receiving facilities to increase patient capacity; sending more patients to local teams than standard guidelines recommend; or sending patients beyond the standard transport radius.

— **NOTIFY FACILITIES OF INCOMING PATIENTS**
Notify the receiving facilities of incoming patients.

Ending a Mass Casualty Incident

Ongoing — **FINAL SUMMARY**
When all patients are distributed, the OAPDC provides a final summary of the mass casualty incident, including patient destinations, to participating receiving facilities. After providing the summary of the incident, the OAPDC ends the incident and notifies all participating facilities.

— **MASS CASUALTY INCIDENT CRITIQUE**
When the incident is ended, the OAPDC and all participating receiving facilities complete a mass casualty incident critique and file incident paperwork. (Refer to local protocol)

Operational Area Patient Distribution Center (OAPDC)

AFTER ACTION REVIEW

The OAPDC supervisor may coordinate an after action review with the LEMSA. (Refer to local protocol.)

Regional Patient Distribution Center (RPDC)

MISSION: Coordinate the distribution of patients within the mutual aid region during a mass casualty incident.

PREPAREDNESS:

- Enter into agreement or Memorandum of Understanding with the Regional Disaster Medical/Health Coordinator and Specialist (RDMHC/S) to perform the duties of the RPDC.
- Develop and maintain protocols for out-of-region distribution of patients.
- Establish a 24-hour contact point for the RPDC duty officer.
- Develop and maintain internal protocols, consistent with this document and RDMHC policy outlining the RPDC's role and responsibilities during an incident requiring patient distribution.
- Appoint a RPDC Supervisor to act as liaison to the Operational Area Patient Distribution Center (OAPDC), Regional Disaster Medical/Health Coordinator and Specialist (RDMHC/S), and State Patient Distribution Center (SPDC). Notify the SPDC, RDMHC/S, and OAPDCs when this position changes and provide updated contact names and telephone numbers.
- Ensure staff and system capability adequate to perform the response operations listed below. Ensure personnel are trained in the region's patient distribution plan, the California Medical Mutual Aid Plan, use of primary and back-up communication systems (radio, telephone, etc.), and patient tracking system(s) in accordance with RDMHC/S and state protocols.
- Maintain multiple redundant communication capabilities with the SPDC and all OAPDCs within the mutual aid region.
- In cooperation with the RDMHC/S, participate in the development of regional medical/health patient distribution exercises and drills.

RESPONSE:

Activation / Notification

Immediate

RECEIVE NOTIFICATION

For incidents within the Region, the RPDC may be notified or activated by OAPDCs, Medical/Health Operational Area Coordinators (MHOAC), and the RDMHC/S. For incidents outside the Region, notification may be received from the RDMHC/S, MHCC, or SPDC.

DISTRIBUTION TO ADJACENT OA

If the impacted county requires distribution of patients to only one adjacent OA, its OAPDC may request the RPDC (and the RPDC, the receiving OA if that OA is located in an adjacent region) to permit the sending OAPDC to coordinate patient distribution directly with the adjacent county's OAPDC. If approved, the RPDC(s) monitors activities but is not directly involved in the distribution of patients.

DISTRIBUTION TO ADJACENT REGION

If receiving facilities in an adjacent region are closer to the incident site than facilities in the impacted region, the RPDC may activate that region's RPDC to coordinate distribution into that region if only one adjacent region is involved. All communications from the adjacent region's RPDC are routed through the impacted RPDC to the impacted OAPDC.

ASSIGN STAFF

When notified of a mass casualty incident, assign staff to coordinate information from the incident and provide information to the OAPDCs.

Regional Patient Distribution Center (RPDC)

- **CREATE MASS CASUALTY INCIDENT IN CDMN**
Create a mass casualty incident and alert all hospitals in the region via Hospital Alert/Assessment Systems (HAAS) and other systems according to RDMHC/S policy. If HAAS is unavailable, use back-up communications protocols.
- **IDENTIFY RECEIVING FACILITIES**
Map location of incident and identify receiving facilities to receive patients triaged immediate. Notify the SPDC.
- **MAINTAIN COMMUNICATIONS**
Maintain communications with the OAPDC or other patient information source (e.g., RDMHC/S, SPDC, MHCC, etc.).
- Intermediate** — **UPDATE INCIDENT INFORMATION**
Extended Update HAAS information when new information is received from the field.

Assess OA Capacities

- Immediate** — **RECEIVING FACILITY CAPACITIES**
Each Receiving Facility notified by the RPDC of a mass casualty incident completes a Receiving Facility Capacity Worksheet in their HAAS and reports their status to the RPDC.
- **DOCUMENT OA CAPACITIES**
Document OA capacities on the Patient Destination Worksheet and confirm total number of available transport resources.
- Ongoing** — **MAINTAIN OA CAPACITIES**
Track and update the OA capacities as patients are assigned to OAs and receiving facilities.

Patient Destinations

- Immediate** — **RECEIVE PATIENT DESTINATIONS**
When OA capacities are identified, coordinate the distribution of patients to facilities for each OA in the Region, in coordination with the OAPDCs according to OA patient destination guidelines.
- **RELAY DESTINATIONS TO IMPACTED OAPDC**
Relay patient destinations to the impacted OAPDC. The impacted OAPDC advises the field Med.Comm of the hospital destination.
- **RELAY PATIENT INFORMATION TO RECEIVING OA**
When Med.Comm advises the OAPDC that patients are en route, the OAPDC will forward the unit number, number of patients, patient triage category and injury type (for Immediate only); and ETA to the RPDC. (For a medical facility evacuation, California HAvBED Plus categories are communicated rather than triage category). The RPDC notifies the receiving OAPDCs which in-turn notifies receiving facilities. Regions that use the same HAAS system may use HAAS for all notifications, as appropriate.
- **NOTIFY OAPDC OF INCOMING PATIENTS**
Notify the OAPDC of patients en route to facilities within the OA.
- **OUT-OF-REGION INCIDENT**
Hospital capability information is generated in the same manner as in in-county/regional incidents: from the receiving county's OAPDC to the RPDC and then to the requesting OA, Region, or SPDC. Patient distribution information is transmitted from the impacted RPDC or SPDC, to the receiving RPDC and then to the OAPDC.

Regional Patient Distribution Center (RPDC)

Ending a mass casualty incident

**Intermediate
Extended**

— **FINAL SUMMARY**

When all patients have been distributed, the RPDC provides a final summary of the mass casualty incident to participating OAPDCs and receiving facilities, including patient destinations. After providing the incident summary, the RPDC ends the incident, and notifies all OAPDCs.

— **AFTER ACTION REVIEW**

The RPDC supervisor coordinates an after action review with the RDMHC/S. (Refer to regional protocol)

State Patient Distribution Center (SPDC)

MISSION: Coordinate the distribution of patients with the six mutual aid regions in California during a mass casualty incident.

PREPAREDNESS:

- Enter into agreement or Memorandum of Understanding with the California EMS Authority to perform the duties of the RPDC.
- Develop and maintain protocols for in-state and out-of-state distribution of patients.
- Establish a 24-hour contact point for the SPDC duty officer.
- Develop and maintain internal protocols, consistent with this document and EMS Authority policy outlining the SPDC's role and responsibilities during an incident requiring patient distribution.
- Appoint a SPDC Supervisor to act as liaison to the Regional Patient Distribution Center (RPDC), EMS Authority, and ASPR. Notify EMS Authority, RPDCs, and ASPR when this position changes and provide updated contact names and telephone numbers.
- Maintain multiple redundant communication capabilities with ASPR and RPDCs.
- Ensure staff and system capability adequate to perform the response operations listed below. Ensure personnel are trained in the Region's Patient Distribution Plan, Ensure personnel are trained in the patient distribution plan, California Medical Mutual Aid Plan, California Disaster Medical Network (CDMN), primary and back-up communication systems (radio, telephone, etc.), and patient tracking system(s) in accordance with State protocols.
- In cooperation with EMS Authority, participate in the development of state medical/health patient distribution exercises and drills.

RESPONSE:

Activation / Notification

Immediate

- **RECEIVE NOTIFICATION**
For incidents within the State, the SPDC may be notified or activated by RPDCs, RDMHC/Ss, and EMS Authority. For incidents outside the state, notification may be received from the EMS Authority, the Medical Health Coordination Center (MHCC), or ASPR.
- **DISTRIBUTION TO ADJACENT REGIONS**
If the impacted region requires distribution of patients to only one adjacent region, it may request the SPDC (and the SPDC, the receiving RPDC if that RPDC is located in an adjacent region) to permit the sending RPDC to coordinate patient distribution directly with the adjacent region's RPDC. If approved, the SPDC will monitor activities but is not directly involved in the distribution of patients.
- **DISTRIBUTION TO ADJACENT STATE**
If receiving facilities in an adjacent state are closer to the incident site than in-state facilities, the SPDC may request that state's patient distribution system to coordinate distribution into that state. All communication from the adjacent state's facilities may be routed through the impacted RPDC to the impacted Operational Area Patient Distribution Center (OAPDC).
- **ASSIGN STAFF**
Once notified of a mass casualty incident, assign appropriate staff members to coordinate information from the incident, and information provided to RPDCs.

State Patient Distribution Center (SPDC)

<p>Intermediate Extended</p>	<p>— CREATE MASS CASUALTY INCIDENT IN CDMN Create a <i>Quick Incident</i> in CDMN if not already created. Contact the appropriate RPDCs to create a mass casualty incident in the mutual aid region utilizing HAAS to assess emergency department or inpatient bed capacities. If Hospital Alert/Assessment Systems (HAAS) is unavailable, use back-up communications protocols.</p> <p>— IDENTIFY RECEIVING FACILITIES Map location of incident and identify receiving facilities to receive patients triaged immediate. (If any of those hospitals are located in an adjacent state, notify the appropriate patient distribution authority).</p> <p>— MAINTAIN COMMUNICATIONS Maintain communications with the RPDC (or other patient information source, e.g., EMS Authority, Medical Health Coordination Center (MHCC), Regional Disaster Medical/Health Coordinators and Specialists (RDMHC/S), ASPR, etc.).</p> <p>— UPDATE INCIDENT INFORMATION Update the mass casualty incident information in the CDMN and relay updates to the RPDCs to update local HAAS when new information is received from the field.</p>
<u>Assess OA Capacities</u>	
<p>Immediate</p>	<p>— RECEIVING FACILITY CAPACITIES Each receiving facility notified by the RPDC of a mass casualty incident completes a Receiving Facility Capacity Worksheet in their HAAS and reports their status to the RPDC.</p> <p>— DOCUMENT OA CAPACITIES Document capacities by mutual aid region on the Patient Destination Worksheet and confirm total number of available transport resources.</p>
<p>Ongoing</p>	<p>— MAINTAIN OA CAPACITIES Track and update the regional capacities as patients are assigned to various mutual aid regions and OAs.</p>
<u>Patient Destinations</u>	
<p>Immediate</p>	<p>— RECEIVE PATIENT DESTINATIONS When region capacities are identified, coordinate the distribution of patients to facilities within each OA within the mutual aid region in coordination with the RPDCs according to receiving OA patient destination guidelines.</p> <p>— RELAY DESTINATIONS TO IMPACTED RPDC Relay patient destinations to the impacted RPDC. The impacted RPDC advises the OAPDC to notify the field Med.Comm of the hospital destination.</p> <p>— RELAY PATIENT INFORMATION TO RECEIVING OA When Med.Comm advises the OAPDC that patients are en route, the OAPDC will forward the unit number; number of patients; patient triage category and injury type (for Immediate only); and ETA to the RPDC. (For a medical facility evacuation, California HAvBED Plus categories are communicated rather than triage category). The SPDC notifies the receiving RPDC which in-turn notifies the OAPDC, which then notifies the receiving facility. Regions that use the same HAAS system may use HAAS for all appropriate notifications.</p> <p>— OUT-OF-STATE INCIDENT Hospital capability information is generated in the same manner as an in-state incident (i.e. from the OA to the RPDC to the SPDC). Patient distribution information is transmitted from the impacted area (or ASPR) to the SPDC, to the receiving RPDC, and then to the OAPDC.</p>

State Patient Distribution Center (SPDC)

Ending a mass casualty incident

**Intermediate
Extended**

— **FINAL SUMMARY**

When all patients have been distributed, the SPDC provides a final summary of the mass casualty incident to participating RPDCs and OAPDCs, including patient destinations. After providing the Summary of the Incident, the SPDC ends the incident, and notifies all RPDCs.

— **AFTER ACTION REVIEW**

The SPDC supervisor coordinates an after action review with the EMS Authority and RDMHC/S. (Refer to state protocol)

ATTACHMENT 2

Local, Regional, State and Federal Resource List

Local, Regional, State and Federal Resource List:

Resource Name	Source	Organization Placement	Description	Capability / Capacity	Resources Initial & Extended	Other Considerations
Sites						
Field Treatment Sites	OA - EMS	OA EOC Medical/Health Branch (EMS)	Surge capacity in medical disasters	48 hour operations Capacity varies	Ad hoc or preplanned teams Locally acquired supplies	
Alternate Care Sites	OA – Public Health	OA EOC Medical/Health Branch (Public Health)	Surge capacity in public health emergencies	Mass prophylaxis		
Shelters – Medically Fragile	OA – Varies (Public Health, EMS, Red Cross)	OA EOC Care and Shelter Branch (EMS)	Shelter facilities for medically fragile	Number varies Maintenance for medically fragile including utilities May include nursing care	OA EOC varies	Usually have minimal medical staff
Mobile Field Hospitals	State or Federal	OA EOC Medical/Health Branch (EMS)	Temporary hospital capacity expansion	200 patients X 3 California hospitals	Initially self sufficient: staff, equipment, medications, supplies Resupply: state	Unit operational 24-48 hours
Casualty Reception Point	Unaffected OA	Field Site Incident Command	Airfield site for receiving evacuated ill/injured from impacted areas	Receive and distribute to area hospitals Capacity varies		

CALIFORNIA DISASTER MEDICAL OPERATIONS MANUAL

Resource Name	Source	Organization Placement	Description	Capability / Capacity	Resources Initial & Extended	Other Considerations
Casualty Distribution Point	Impacted OA CAL-MAT / DMAT team	Field Site Incident Command	Airfield site for staging ill/injured for evacuation to unaffected areas	Holding and evacuation capacity (TBA)		
Personnel						
Spontaneous Unaffiliated Volunteers	OA	Field Site or Facility Incident Command - Logistics	Augment medical response personnel	Varies		Should not be used without supervision and should be used only if CAL-MED registered personnel are not available
California Medical Assistance Teams (CAL-MAT)	State	Field Site Incident Command - Operations	Organized, equipped and supplied team of licensed and trained health professionals			
Civil Support Teams (CST)	State					
Disaster Medical Assistance Teams (DMAT)	Federal	Field Site Incident Command - Operations	Organized, equipped and supplied team of licensed and trained health professionals			
Disaster Health Care Volunteers of California	State OA	OA EOC Medical/Health Branch (EMS)	System to access and rapidly mobilize volunteer health professionals with already confirmed licenses			

CALIFORNIA DISASTER MEDICAL OPERATIONS MANUAL

Resource Name	Source	Organization Placement	Description	Capability / Capacity	Resources Initial & Extended	Other Considerations
National Medical Response Teams (NMRT)	Federal	OA EOC Liaison				
Local Teams	OA	OA EOC Medical/Health Branch (EMS)	Varies	As designed		
Incident Management						
Mission Support Teams	State EMS Authority	Field Site Incident Command - Logistics	Provides logistic, administrative and liaison support to response teams	Teams vary in size and capability according to incident. Can be scaled to provide full logistical support	Initial: Self contained Extended: May request support from OA	
Medical Emergency Management Teams	State	OA EOC (medical)	Provides emergency management support to local EMS agencies during disasters	Teams vary in size and capability according to need Can be scaled to operate DOC	Will require support from requesting OA	
Discipline-specific overhead teams	Varies		Provides logistic support to response teams (usually fire and law)		Initial: Self-contained Extended: May use local resources if available	

CALIFORNIA DISASTER MEDICAL OPERATIONS MANUAL

Resource Name	Source	Organization Placement	Description	Capability / Capacity	Resources Initial & Extended	Other Considerations
Equipment						
Disaster Medical Support Units (DMSUs)	OA State		Provides logistic and communication support to Ambulance Strike Teams		Initial: self-contained Extended: Will require fuel, lodging, and food	
Local equipment caches	OA		Varies		As designed	
Ambulance Strike Teams	OA Region State	Field Site Incident Command - Logistics	Rapidly deployed patient transport resources	State teams consist of 5 vehicles plus DMSU		
Supplies						
CHEMPACK	OA	OA EOC - Logistics	Caches of nerve agent and organophosphate antidote pharmaceuticals pre-deployed throughout the State		Inventories vary according to the purpose of the caches, often including antibiotics, antivirals, nerve agent antidotes, and others Those near nuclear power facilities may include potassium iodide	

