

**UNIFIED SAN DIEGO COUNTY
EMERGENCY SERVICES ORGANIZATION
OPERATIONAL AREA EMERGENCY PLAN**

ANNEX D

MULTI-CASUALTY OPERATIONS

September 2006

UNIFIED SAN DIEGO COUNTY EMERGENCY SERVICES ORGANIZATION

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MULTI-CASUALTY OPERATIONS

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UNIFIED SAN DIEGO COUNTY EMERGENCY SERVICES ORGANIZATION

ANNEX D

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ANNEX D

MULTI-CASUALTY OPERATIONS

I. GENERAL

The Multi-Casualty Operations Annex to the Operational Area Emergency Plan describes the basic concepts, policies and procedures for providing a coordinated medical care response to any multi-casualty incident. This Annex serves as the unifying document for the emergency plans of local hospitals, cities and emergency service agencies. The Emergency Services Agreement, between and among the County of San Diego and the cities in the Operational Area, provides for a county wide medical emergency services program.

A. Purpose

1. The purpose of this Annex is to establish a disaster medical system and prescribe responsibilities and actions required for the effective operation of the medical response to disasters.

B. Goals and Objectives

1. The overall goals of disaster medical operations are to:

- a. Minimize loss of life, subsequent disability, and human suffering by ensuring, through an all hazards approach, timely and coordinated medical assistance, to include evacuation of severely ill and injured patients.
- b. Coordinate the utilization of medical facilities and the procurement, allocation, and distribution of medical personnel, supplies, communications, and other resources.
- c. Provide a system for receipt and dissemination of information required for effective response to, and recovery from, the effects of a major disaster.

2. The objectives of this Annex are to:

- a. Describe the concept of operations, organization, and medical response system to implement this Annex.
- b. Establish procedures for activating and deactivating this Annex.
- c. Provide a system for prompt medical treatment of disaster victims.
- d. Provide for the management of medical services, facilities, activities, and resources.

- e. Provide a basis with which County departments and local agencies establish support plans and standard operating procedures.

C. Concept of Operations

For the purposes of this Annex, a medical multi-casualty incident applies primarily to a major medical emergency situation, or potential situation, creating sufficient casualties to exceed the capabilities of the local medical system.

D. Plan Utilization

Utilization (Alert, Activation, and Termination) of this Annex shall be at the direction of (1) the County's Chief Administrative Officer (CAO) in that capacity, or as Area Coordinator of the Unified San Diego County Emergency Services Organization; (2) a designated Deputy CAO; (3) the Director, Office of Emergency Services or designated representative; (4) Public Health Officer (5) Director, Emergency Medical Services or designee; (6) the Incident Commander; (7) the Facilitating Base Hospital or (8) Sheriff's Communication Center (SCC).

The on-scene Incident Commander or his/her designee (e.g. the Medical Coordinating Unit), shall notify their dispatch center to alert/activate Annex D. The Medical Coordinating Unit's dispatch center then contacts the Sheriff's Communications Center (SCC) and requests the alert/activation of Annex D. The Facilitating Base Hospital may also exercise this option. The Sheriff's Communication Center shall notify all affected agencies of these announcements as follows:

ALERT

ALERT FOR ANNEX D shall be announced upon report of an event or potential event that is suspected (but unconfirmed) to constitute a multi-casualty incident which exceeds the capabilities of (1) the immediately available emergency response contingent, or (2) the patient care capabilities of proximate medical facilities.

ACTIVATION

ACTIVATION OF ANNEX D shall be declared under the following conditions:

1. A confirmed event has occurred that is a multi-casualty incident that exceeds the capabilities of the immediately available responding emergency contingent, or the patient care capabilities of proximate medical facilities.
2. An event is imminent, or has occurred, of such magnitude in a populated area that extensive casualties are inevitable, (e.g. structure collapse, major transportation emergency, hazardous materials release or infectious/communicable diseases outbreak).

3. Notification from cognizant authority that a disaster, local or general, is imminent or has occurred, which requires mobilization of the emergency organization and indicates the expectation that extensive casualties will result.
4. Notification from cognizant authority that a significant number of casualties from outside the Operational Area are expected to be brought into the Operational Area via the State Mutual Aid System or the National Disaster Medical System (NDMS) (e.g., casualties from domestic or international war).

TERMINATION

TERMINATION OF ANNEX D shall be announced at such time that the situation has stabilized, and operations under the multi-casualty annex are no longer required. In general, all patients have been transported or are enroute to definitive care, and the event is de-escalating.

II. ORGANIZATION

The operations described in this Annex address all levels of disaster management from the scene to medical receiving facilities, Field Treatment Sites (FTSs), First Aid Stations (FAS), and the EOC. The plan enables all agencies involved in the medical response and their respective roles, to provide for an effective disaster medical system.

A. At the Scene

1. The authority for the management of the scene of an emergency shall rest in the appropriate public safety agency having primary investigative authority.
2. When primary investigative responsibility is with a law enforcement agency, that agency assumes the scene manager role. This role entails overall function and management of the scene but does not imply internal direction or manipulation of other responding agencies.
3. The local fire department assumes the role of Incident Commander under the Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS) criteria and manages medical operations within the statewide fire management system known as the Incident Command System (ICS). The Multi-Casualty Branch operates as part of the ICS, under the Incident Commander. As multi-casualty incidents overwhelm the initial responding resources, the Incident Commander delineates and expands operational procedures. This system assures that emergency pre-hospital care and the prevention of further injury to victims, the public, and public safety personnel are provided.

4. The medical organizational structure is designed to utilize all aspects of emergency medical service response resources, including on-scene physician medical direction.

B. Emergency Operations Centers (EOC)

1. City EOCs

- a. Each city has a central facility designated as an EOC. From the EOC disaster operations are coordinated. City plans may call for a medical liaison representative to be present when their EOC is activated. In each city, the City Manager is designated as Director of Emergency Services, by ordinance, and manages emergency operations from the EOC.

2. County/Operational Area EOC

- a. The County/Operational Area EOC serves the same function for the county as the city EOCs for their cities, with the Chief Administrative Officer serving as Coordinator of Emergency Services. The County EOC is also used as the central point for resource acquisition and allocation, as well as coordination.
- b. The medical section of the EOC (Figure 1) is normally activated when the EOC is fully activated. It is staffed by pre-designated emergency medical personnel and augmented by representatives from the Red Cross. The section coordinates the emergency medical response for the Operational Area. The EOC medical staff serves as medical advisor to the CAO, as well as make decisions about resource allocation, priorities, and other medical matters.
- c. Chief Administrative Officer (CAO) - directs, or coordinates, the emergency services organization and the emergency management program. In a disaster located entirely within the County unincorporated area, the CAO directs emergency operations. In a disaster involving more than one jurisdiction, the CAO serves as coordinator of emergency operations.
- d. Director, HHSA - reports to the CAO and is responsible for all policy decisions involving operational and logistics disaster health services.
- e. Public Health Officer – Reports to the CAO and is responsible for all public health related decisions to protect the health and safety of the community.

- f. EMS Director or Chief - reports to the Health Officer, and in consultation with the EMS Medical Director, is primarily responsible for directing the medical response and EMS system operations for the Operational Area. The EMS Director assesses the EMS system problems, identifies and anticipates the resources needed, and allocates the resources accordingly. If medical mutual aid is needed, the EMS Director makes requests to the Regional Disaster Medical/Health Coordinator (RDHMC) via the Medical and Health Operational Area Coordinator (MHOAC) in accordance with the state guidelines, and advises the EMS Medical Director of medical mutual aid status. In public health events, the EMS Director is responsible for implementing the directives of the Public Health Officer. Other duties include coordinating and providing support to medical activities at the disaster scene(s), Field Treatment Sites, and First Aid Stations. These activities include the coordination of requests for Triage/Treatment Teams, transportation coordination and liaison with Red Cross, Hospital Association, Ambulance Association, rescue teams, and the Blood Bank.

- g. EMS Medical Director – The EMS Medical Director is an alternate position, necessary during a disaster that has a medical component to it. This position is a liaison between EMS and the County Operational Area Ops section/division, and acts as the incident medical director. EMS works under that physician's license.

- h. Medical & Health Operational Area Coordinator (MHOAC) - Reports to the EMS Director and EMS Medical Director, and is responsible for the disaster medical operational functions within the Operational Area (OPAREA), including:
 - 1. Providing authorization and direction for activation of the medical/health branch of the operational area EOC and ensuring management systems are in place for managing the Medical/Health Branch of the Operational Area EOC.
 - 2. Coordinating the procurement and allocation of public and private medical, health and other resources required to support disaster medical and health operations in affected areas.
 - 3. Communicating requests for out-of-county assistance to and responding to requests from the Regional Disaster Medical Health Coordinator (RDMHC).
 - 4. Developing a capability for identifying medical and health resources, medical transportation, and communication resources within the Operational Area.

5. Maintaining liaison with the Operational Area Coordinators of other relevant emergency functions, e.g., communications, fire and rescue, law, transportation, care and shelter, etc.
6. Ensuring that the existing Operational Area medical and health system for day-to-day emergencies is augmented in the event of a disaster requiring utilization of out-of-area medical and health resources.

III. ROLES AND RESPONSIBILITIES (Figure 2)

A. All Affected Agencies

1. Prepare Standard Operating Procedures (SOPs) and functional checklists for response to a multi-casualty incident, including a system for automatic reporting of pre-designated personnel to assigned disaster posts. All participating agencies must comply with State and Federal training requirements for the effective use of SEMS and the National Incident Management System (NIMS).
2. Train personnel and alternates.
3. Maintain an active liaison with the San Diego Healthcare Disaster Council, the Unified Disaster Council (UDC), San Diego Fire Chief Association – EMS Section and other Operational Area planning committees.
4. Maintain an active liaison with HHS Emergency Medical Services.

B. San Diego Health Care Disaster Council

The San Diego Healthcare Disaster Council shall address issues that effect emergency preparedness by:

1. Encouraging the development and application of effective practices, including, but not limited to planning, education, and evaluation as they relate to disaster preparedness.
2. Promoting quality in the delivery of disaster patient/victim care services.
3. Supporting the needs of healthcare organizations/agencies while ensuring that the needs of the community are met.
4. Reviewing and recommending changes in County policies and procedures, including, but not limited to, Annex D.

5. Promoting professional interaction and collaboration with organizations and interchange of ideas among members, i.e. American Red Cross, law enforcement, fire, ambulances and the National Disaster Medical System (NDMS).
6. Liaison with state and local agencies.
7. Function as NDMS Steering Committee for San Diego patient reception area.

C. Sheriff's Communication Center

1. Notifies affected agencies of alerts and activation of Annex D as well as termination of the disaster.
2. Can assist in the coordination of communications between the facilitating Base Hospital and the area receiving hospitals.
3. Provides information to the EOC.

D. RACES/ARES

RACES/ARES will provide back-up/redundant communications support at the scene, the hospitals, the EMS Departmental Operations Center/Medical Operations Center (DOC/MOC) and the EOC, as well as throughout the Operational Area as needed.

E. Fire Department

1. Acts as Incident Commander.
2. Notifies Sheriff's Communications Center of the Annex D activation through dispatch.
3. Establishes the ICS Multi-Casualty Branch.
4. Provides fire fighting.
5. Provides extrication.
6. Provides rescue.
7. May provide gross decontamination operations.
8. Provides initial triage and medical support.
9. Maintains communications with the EOC.

10. Coordinates air operations at the scene.
11. Determines need for treatment teams on scene.
12. Determines the need for all additional resources and orders them as necessary.

F. Law Enforcement Agency

1. Provides crowd and traffic control.
2. Provides aeromedical support.
3. Provides tactical communications.
4. Establishes and maintains ingress and egress routes for emergency vehicles.
5. Provides perimeter control.
6. Provides security at the scene.
7. Provides and implements evacuation coordination.
8. Assists with emergency transportation of blood, blood products, and other needed medical supplies, as resources are available.
9. Conducts investigations and gathers evidence.
10. Responsible for obtaining alternative transportation resources.
11. California Highway Patrol (CHP) has the primary responsibility for the ground transport of medical teams and emergency medical supplies when resources permit.
12. CHP assumes scene management for incidents within CHP jurisdiction, when incident dictates.

G. Facilitating Base Hospital (Figure 4)

1. Upon activation from the Field Medical Coordinating Unit, coordinates area hospital disaster response, including utilization of regional trauma system.
2. Coordinates medical communications with Medical Communication Leaders and hospitals, and provides information of hospital resources and status to Med Comm Leader.

3. Provides medical direction of care by Advanced Life Support (ALS).
4. Provides information of hospital resources and status to the Treatment Unit Leader.
5. Activates and dispatches area Treatment/Triage Teams, as outlined in this document, when requested from the scene.
6. Controls hospital 800 MHz communication network.
7. In conjunction with the EMS Director or designee, assists in coordinating community medical resources for evacuation of medical facilities.

H. Hospital

1. Provides care for victims from the incident.
2. Advises Facilitating Base Hospital of bed capacity and other status information.
3. Will provide FTSS with medical staff when/if staffing permits.
4. Provides predesignated Treatment/Triage Teams when staffing permits.
5. Provide care for victims from the incident as appropriate in a primary care setting.
6. Advise the Council of Community Clinics and EMS Coordinator on triage capability and non-urgent care as well as current victim numbers.
7. Provide volunteer physicians, nurses and other staff when staffing permits.
8. Hospitals shall maintain up to date evacuation plans (as required by the Joint Commission for the Accreditation of Healthcare Organization [JCAHO]).

I. Hospital Association

1. Assists with coordination of hospitals (in EMS Departmental Operations Center/Medical Operations Center [DOC/MOC]).
2. Provides current hospital resource directory.
3. Provides staff to HHSADOC and EMS DOC/MOC upon request.

J. Council of Community Clinics

1. Serves as a communication liaison between the County of San Diego and community health centers.
2. Provides current emergency contact information for key leadership.
3. Provides staff to HHSADOC and EMS DOC/MOC upon request.

K. Ambulance Agencies/First Responders

1. Upon request, will provide appropriate personnel to staff any role or position under ICS in transportation, communication, and medical assistance.
2. Coordinates ambulance transportation of victims.
3. Coordinates medical communications at the scene and the ambulance-bus staging and loading areas.

L. Ambulance Association (Private Ambulances)

1. Coordinates private industry ambulance resources (Private Ambulance Coordinator).
2. Provides staff to HHSADOC and EMS DOC/MOC upon request

M. Aeromedical

1. Provides aeromedical assistance, which may be in the form of treatment, Triage Teams, or transportation, as requested.

N. Emergency Medical Services

1. Writes and updates the Multi-Casualty Operations Annex and any other medical emergency plans and procedures.
2. Provides staff to the SDHDC, San Diego County Fire Chiefs Association – EMS Section and other planning and response committees for assistance in coordinating area exercises.
3. Coordinates disaster medical operations within the Operational Area.
4. Coordinates the procurement and allocation of the medical resources required to support disaster medical operations.

5. Coordinates the transporting of casualties and medical resources to health care facilities, including FTSs, within the area and to other areas, as requested.
6. Develops and organizes a system for staffing and operation of FTSs and Disaster Support Areas which can include Clinical Disaster Service Workers (CDSW).
7. Requests and responds to requests from the Regional Disaster Medical/Health Coordinator (RDMHC) for disaster assistance.
8. Develops and maintains a capability for identifying medical resources, transportation, and communication services within the Operational Area.
9. Maintains liaison with the Red Cross, volunteer service agencies, Clinical Disaster Services Workers (CDSW), and other representatives within the Operational Area.
10. Maintains liaison with the coordinators of other emergency functions such as communications, fire and rescue, health, law enforcement, military and traffic control, transportation, care and shelter, etc.
11. Coordinates and provides support to medical activities at the scene.
12. Assists with contacting and coordinating critical incident stress management providers through County Behavioral Health Services.
13. Participates in the development and planning of all operational area exercises/drills.
14. EMS and the Healthcare Disaster Council maintain an EOC contact list that is updated monthly or as needed.
15. Activates and Manages the EMS DOC/MOC.

O. Public Health

1. The overall goal of disaster Public Health operations is to minimize loss of life and human suffering, prevent disease and promote optimum health for the population by controlling public health factors that effect human health, and by providing leadership and guidance in all disaster public health related activities.

2. The overall objectives of Disaster Public Health operations are to:
 - a. Provide preventive health services.
 - b. Coordinate health-related activities among other local public and private response agencies or groups.
 - c. Advise in the rapid assessment or evaluation of disease or exposure potentially related to Bioterrorism or mass health threats of uncommon origin.
 - d. Has primary responsibility for the activation, organization, and staffing of shelters.

P. Environmental Health

1. Provides specialists to perform inspections and assess conditions at designated treatment/triage, first aid stations, or FTSS.
2. Provides hazardous materials assistance from the Hazardous Materials Division.
3. Provide technical assistance (decontamination) to Emergency Department staff for incidents involving self-referral victims contaminated with hazardous materials.

Q. Public School Districts

1. Coordinate with EMS in the designation of schools as FTSS and First Aid Stations.

R. American Red Cross

1. Activates Red Cross First Aid Stations and staffs them with HHSA personnel and volunteers.
2. HHSA provides personnel to Red Cross Mass Care Centers.
3. Upon request, blood and blood products are made available for disaster victims through the nearest Red Cross regional blood center.
4. Serves as the central point of contact for victim information in a Mass Casualty Incident.
5. Will provide care and shelter for Clinical Disaster Service Workers, i.e.

Medical Reserve Corps.

S. Blood Bank

1. Mobilizes resources to cope with disaster needs, according to its disaster plan.
2. Provides blood on a priority basis.

T. County Office of Emergency Services (OES)

1. Assists with medical multi-casualty planning and training.
2. Coordinates efforts to obtain resources, both within and outside of the Operational Area, including supplies and logistical support.
3. Requests/obtains military assistance in accordance with military plans and procedures.
4. Activates and manages the Operational Area EOC.
5. Serves as Operational Area Coordinator for mutual aid other than fire, law enforcement, medical and medical examiner.
6. Assists with recovery efforts, particularly in obtaining State and Federal reimbursement funds.

U. San Diego County Behavioral Health Team (SDCBHT)

1. Provides on-scene defusing and post-incident debriefings. Request SDCBHT support via Sheriff's Communications Center (SCC) or the County EMS Duty Officer.
2. Develops a network of behavioral health workers that include County staff and staff from other agencies, and private practitioners. These behavioral health workers will work with behavioral health staff in planning and providing behavioral health outreach services during and after a disaster. Creates and maintains roster of this personnel. (See Annex M for more details.)
3. Responds to requests for critical incident support by arranging for and conducting debriefing of the impacted emergency workers by a team composed of behavioral health professional(s) and peer members.
4. Responds to requests for on-scene support by activating a behavioral health team to respond to the Emergency Command Post and/or Rehab site for rapid defusing service.
5. Provides pre-event orientation training for emergency responders to assist in

recognizing critical incidents and how to access behavioral health services.

V. Clinical Disaster Workers/Medical Reserve Corps

1. Clinical Disaster Service Workers (CDSW): It is the policy of the County of San Diego, Health and Human Services Agency, that upon the orders of the Public Health Officer, the Medical/Health Branch Manager at the EOC, or the EMS Duty Officer through the EMS DOC/MOC, will activate CDSW volunteers during an event in which local established clinical resources are exceeded.

W. San Diego County Medical Society

1. Assist in notification of CDSW/Medical Reserve Corps (MRC).
2. Assist in notification of Physicians in San Diego.

X. State

1. Responds to requests for resources from the Operational Area (OES).
2. Coordinates medical mutual aid within the State.
3. Coordinates the evacuation of injured persons to medical facilities throughout the State.
4. Assists the Operational Area in recovery efforts.

Y. National Guard

1. Provides support for field treatment of casualties.
2. Provides evacuation of casualties to medical facilities.
3. Provides communication and logistics support for the medical response.

Z. Federal Government

1. As shortfalls occur in State resources, Federal agencies make their resources available, coordinated by the Federal Emergency Management Agency (FEMA) or through the Department of Homeland Security (DHS).
2. In a major disaster, the National Disaster Medical System (NDMS) would be activated, and patients from this Operational Area would be sent to other counties and states for treatment.

3. Federal Military

- a. Provides support such as supplies, equipment, ground vehicles (trucks), personnel, helicopters, and sites for disaster support areas.
- b. Provides air-sea lift.

4. Disaster Medical Assistance Teams (DMAT)

- a. DMAT San Diego CA-4 is one of 30 deployable DMATs throughout the U.S. that is affiliated with the National Disaster Medical System (NDMS).
- b. DMAT CA-4 is part of a national response system to augment the local EMS and healthcare system when local and state agencies require outside Federal assistance.
- c. A DMAT can be activated through NDMS and ESF#8 via request to the State of California EMSA, or to the ESF #8 EOC.
- d. A DMAT can perform the following:
 - 1) Field Treatment Site(s) (FTS)
 - 2) Regional Evacuation Points (REP) or
 - 3) Patient Reception Points (PRP), when the hospital bed component of NDMS is activated.
 - 4) Hospital staff relief or augmentation
 - 5) Shelter care
 - 6) Mass prophylaxis
- e. DMAT San Diego CA-4 will provide a team member if requested to advise the EOC on possible NDMS resources and the capabilities of other DMATs and Specialty teams.
- f. Other response teams available from the National Disaster Medical System (NDMS) are:
 - 1) NMRT-WMD – National Medical Response team with specialty capabilities in decontamination and weapons of mass destruction.

- 2) DMORT – Disaster Mortuary Operations Response Team
- 3) Mental Health Specialty Teams - for large scale CISD
- 4) Burn Specialty Teams
- 5) Pediatric Specialty Teams
- 6) Mine Rescue Specialty Team

5. FEMA Urban Search and Rescue (US&R) Response System

The FEMA Urban Search and Rescue (US&R) Response System development is based upon providing a coordinated response to disasters in the urban environment. Special emphasis is placed on the capability to locate and extricate victims trapped in collapsed buildings, primarily of reinforced concrete construction. The task force functional organization and associated terminology are predicated on, and will operate within, the National Interagency Management System (NIMS). San Diego US&R Team - 8 is coordinated by the San Diego Fire-Rescue Department. Additional information can be found in Annex B.

AA. Metropolitan Medical Strike Team (MMST)

The San Diego Operational Area Metropolitan Medical Strike Team (MMST) is available to respond to Weapons of Mass Destruction (WMD) incidents that involve Chemical, Biological, Radiological, Nuclear or Explosive (CBRNE) agents. The team consists of medical, fire service, law enforcement and public health personnel in addition to environmental and hazardous materials specialists. They are trained and outfitted to perform field level response efforts for the consequences of the terrorist use of weapons of mass destruction. This team forms the technical nucleus of a comprehensive response capability to NBC terrorism. It includes specialized personnel to direct and coordinate immediate response, mitigation and recovery operations at the incident scene.

IV. FUNCTIONS

A. Notification

There is a two-tiered system of medical disaster notification in the Operational Area. This system, "Alert" and "Activate", allows hospitals, transporting agencies, and other components of the emergency medical system to prepare for multi-casualty incidents. This system can be initiated at either of the tiers, depending on the circumstances, by the field Incident Commander, the Medical Coordinating Unit, or the Facilitating Base Hospital.

1. Alert

When a multi-casualty incident is suspected, but not confirmed, the affected agencies/health care providers are notified of an ALERT. At this point, designated hospitals and agencies only consider notifying their personnel and making other necessary preparations.

2. Activate

a. The on-scene Incident Commander or his/her designee (e.g. the Medical Coordinating Unit) shall notify their dispatch center to Alert/Activate Annex D. This dispatch center then contacts the Sheriff's Communications Center (SCC) and requests the Alert/Activation of Annex D. SCC then makes the necessary notifications. The first arriving ambulance at scene will contact the Facilitating Base Hospital and advise of the incident and that an Annex D Alert/Activation has been declared. The following agencies will be notified by the Sheriff Communication Center (SCC) of an activation/alert, and will be given pertinent information (such as the nature of the emergency, the location and the number of dead or injured). (Figure 3)

- 1) Private ambulance coordinator
- 2) Emergency Medical Services (EMS) – Duty Officer
- 3) Office of Emergency Services (OES) – Duty Officer
- 4) ARES: Amateur Radio Emergency Service

b. Upon notification, all agencies follow their Standard Operating Procedures for activation, and respond if requested. Once the initial notification of the lead agencies is made through SCC, further notification activities take place:

- 1) Designated hospitals notify their Treatment Teams and stand-by staff if requested by Multi-Casualty Branch Director.
- 2) Private Ambulance Coordinator notifies other ambulance companies as needed and coordinates resources.
- 3) EMS notifies the EMS Medical Director, the Regional Disaster Medical/Health Coordinator, if needed, and other medical/health staff as necessary.

- 4) The EMS Director or designee, to include the EMS Duty Officer, establishes contact with SCC and confirms notification of the Red Cross and Blood Bank, if necessary.
- 5) OES notifies the Chief Administrative Officer, State OES, and EOC staff, if needed.

B. Communications

1. All hospitals in the San Diego County Operational Area are on the Regional Communications System (RCS). The Regional Communications System, (RCS) consists of a north and south simulcast cell, and 29 inteli-repeaters east of Alpine and Ramona.
2. Please refer to the Unified San Diego County Emergency Services Organization Operational Area Emergency Plan, Annex I, for more information regarding the Regional Communications System (RCS).

C. Multiple Site Incidents

1. In the event of a multiple site multi-casualty incident, or more than one incident at a time, there is a sufficient amount of flexibility to handle all the incidents. All hospitals participating in the event and the Medical Communications Coordinator at the scene can be on the same talk group as the Facilitating Base Hospital. In the event of an Operational Area wide disaster, the EOC is activated and acts as a clearinghouse for all incoming information and coordinates resource allocation at disaster sites.
2. Back-up Communications
 - a. See the San Diego County Mutual Aid Radio Plan.
 - b. Amateur radio operators may be called upon to act as back-up communicators at the scene, hospitals, first aid stations, blood banks, mass care centers, Red Cross Service Centers, EOC, and the EMS DOC/MOC.

D. Incident Command

The Incident Command System (ICS) is used to provide a management structure and system for conducting on-scene multi-disciplinary operations (in this case, a multi-casualty incident that involves concurrent tactical field interactions between fire, law enforcement, and medical personnel). The ICS, because of its standardized organizational structure and common organizational and operational terminology, provides a useful and flexible management system that

is particularly adaptable to incidents involving multi-jurisdictional response such as multi-casualty incidents. ICS provides the flexibility to rapidly activate and establish an organizational structure around the functions that need to be performed. For all emergencies, the Field Operations Guide (ICS 420-1) and any future revisions shall be utilized.

The ICS organizational structure develops in a modular fashion based upon the kind and size of an incident. The organization's staff builds from the top down with responsibility placed initially with the Incident Commander, who is the senior fire department officer on scene. The specific organization structure established for any multi-casualty incident is based upon the management of the incident and personnel available to fill functional positions. However, all functions are assigned.

1. Incident Commander - coordinates all incident activities including the development and implementation of strategic decisions and approves the ordering and releasing of resources.
2. Operations Chief - activates and supervises the organization elements and is responsible for the management of all operations at the scene.
3. Multi-Casualty Branch Positions
 - a. First arriving medical unit - makes the preliminary medical assessment. The pre-hospital provider with the highest level of certification/authorization assumes the Treatment Unit Leader role. If a fire company is on scene and has established "command", the medical unit reports to the Incident Commander, and establishes contact with the facilitating base hospital. The second pre-hospital provider on scene with the highest level of training assumes the Medical Communications Coordinator role.
 - b. Multi-Casualty Branch Director - establishes, commands and controls the activities within the Multi-Casualty Branch in direct liaison with the Incident Commander.
 - c. Medical Group Supervisor - controls triage management, treatment, and coordination of all casualties.
 - d. Medical Supply Coordinator - identifies, collects, and distributes supplies available at the scene and is responsible for obtaining additional supplies (from hospitals or other sources).
 - e. Triage Unit Leader - ensures triage on-scene and designates casualties accordingly.

- f. Treatment Unit Leader - ensures assessment of patients and treatment of casualties.
 - g. Patient Transportation Group Supervisor - communicates with the Multi-Casualty Branch Director and closely coordinates with the Medical Group Supervisor; may be responsible for communicating with helicopters, ambulances from a variety of different agencies, and the staging area. As personnel become available, the Patient Transportation Group Supervisor fills and supervises the following positions: Medical Communications Coordinator and the Ambulance Staging Managers.
 - h. Treatment Dispatch Manager - coordinates the transportation of patients out of the treatment area with Patient Transportation Group Supervisor.
 - i. Medical Communications Coordinator - maintains communications and coordinates information with Facilitating Base Hospital(s) to ensure patient transportation and destinations.
 - j. Ambulance Staging Managers - manage air and ground ambulance/emergency vehicle staging areas.
4. Multi-Casualty Branch Implementation
- a. Once command is established, the implementation of the Medical Group is determined by the medical size-up. This assessment is conducted by the first arriving medical unit. The medical size-up includes the following:
 - b. Determine the nature of the incident and special hazards.
 - c. Estimate number of victims and severity of injuries.
 - d. Estimate additional medical resources needed.
 - e. Identify access routes for incoming EMS units.
 - f. Identify locations for triage, treatment, ambulance/bus loading, and staging areas.
 - g. Notify the Sheriff's Communications Center if this has not been done or if the first medical coordinating unit is on scene by themselves.

- h. Determine the need to activate this Annex.
- i. All of these actions are coordinated with the Incident Commander. Once the medical size-up is completed, the first medical unit assumes its role in the ICS Multi-Casualty Branch.

5. On Scene Operations

- a. The location of a multi-casualty incident will determine, to a large extent, how the scene is set up.
- b. The Incident Commander establishes a staging area for all incoming emergency vehicles. Personnel and apparatus are then called from the staging area to the scene in a controlled and organized manner.
- c. Multi-Casualty Branch personnel need to be visibly and clearly identified, by positions, so that they can easily be spotted in a crowd of rescuers.
- d. Patients are collected into a single area to provide maximum care with limited resources. They are placed in the treatment area according to the severity of their injuries: immediate patients (I) on one side; delayed patients (II) on another.
- e. The Incident Commander and the Multi-Casualty Branch Director determine whether agencies such as the Red Cross are needed at the scene and/or at First Aid Stations for initial care of the "Minor" (walking wounded).

E. Triage/Treatment

1. Triage

- a. Triage is the process of sorting the injured on the basis of urgency and type of injury presented, so they can be transported to medical facilities equipped for their care. The Medical Group Supervisor has the overall responsibility for coordinating triage management and treatment of casualties
- b. Primary triage is the first sorting of victims at the scene without moving them. This phase of triage determines the order of evacuation from the field. Primary triage utilizes the Simple Triage and Rapid Treatment (START) criteria. Ideally, primary triage is done by Emergency Medical Technician-I (EMT-I) personnel.

- c. Secondary triage is the second phase of sorting victims and is done in the triage/treatment area. At this time a victim's primary triage category may be changed, based on further assessment. Stabilizing treatment may be initiated while awaiting transportation, however, transport should not be delayed for treatment.
2. Tagging of victims is accomplished using the following categories and corresponding colors:
 - a. Immediate (Red tag) - most in need of care and should receive first priority for evacuation
 - b. Delayed (Yellow tag) - will need hospital care, but can wait until the more critically injured have been stabilized and transported.
 - c. Minor (Green tag) - these patients have been referred to as "walking wounded". They may need first aid, but may or may not need transportation.
 - d. Dead/Non-Salvageable (Black tag) - once tagged, are ignored until there are enough rescuers to move them without compromising the care to the living.
 - e. Contaminated (side tag) on these patients are to be considered as potentially exposed to chemical, radiological or biological agents or toxins. These patients, pre procedure, are decontaminated at the scene. The tag indicates initial exposure.
3. Treatment
 - a. The sophistication of treatment rendered in the field is dependent upon personnel and supplies. Treatment at the scene is generally limited to stabilization, treatment of shock, and a continual reassessment of conditions, while awaiting transport. Transport should not be delayed for purposes of treatment.
 - b. The Medical Group Supervisor has the overall responsibility for field treatment.
4. Treatment Teams
 - a. Primary - Advanced Treatment Teams, consisting of a licensed physician, nurse, Public Health nurse, Medical Reserve Corps, and a recorder, can be assigned from predestinated hospitals, local community clinics, or CDSWs. When requested, the teams

are transported by ground or through the use of air resources, which may include the California Highway Patrol (CHP), military ground/air assets or other aerial assets from local or regional law enforcement and/or fire agencies. Upon arrival at the scene, the Team reports to the Incident Commander for assignment within the Multi-Casualty Branch or Group.

- b. Secondary - Treatment Teams consist of a physician and two nurses, and they report either to the scene or a Field Treatment Site, as requested.
 - 1) At the scene, the team reports to the Multi-Casualty Branch Director.
 - 2) At the Field Treatment Site, the team physician assumes medical control. The team coordinates with other support personnel and practices austere medical treatment, to facilitate casualty evacuation.

F. Transportation

- 1. The coordination of ambulance transportation from the scene to local medical facilities, and from damaged to operational medical facilities, is the responsibility of both the jurisdiction's providing agency, for medical units, and the Ambulance Association, for private ambulances coordinator.
- 2. Ambulance transportation includes the equipment and personnel to provide Basic Life Support (BLS) and Advanced Life Support (ALS) services.
- 3. Basic Life Support is a set of non-invasive medical skills including cardiopulmonary resuscitation, hemorrhage control, splinting, bandaging, immobilization, and extrication.
- 4. Advanced Life Support includes basic life support skills plus intravenous therapy, parenteral drug administration, cardiac monitoring, cardiac defibrillation and cardioversion, endotracheal intubation, and any additional skills that are locally defined.
- 5. Once Annex D has been activated, patients who have received ALS care in the field, (e.g. IV, advanced airway or medication) may be transported without being accompanied by ALS personnel. BLS personnel may accompany these patients to the hospital.
- 6. As casualty transportation resources will be in great demand, casualties are transported on the basis of medical triage priorities. Patients requiring immediate transportation will have priority for ground or air transportation,

with other transportation (e.g. buses, trucks, and automobiles) used for the minimally injured.

7. At the Scene

Based on hospital capability inventories, transportation resources and severity of injuries, the Patient Transportation Group Supervisor has the overall responsibility for the coordination of all patient transportation at the scene.

8. Transportation Resources

a. There currently exist two systems of ambulance transportation in the Operational Area; (1) local jurisdiction's medical response system and, (2) in a multi-casualty situation, supplemental private ambulance resources which may be requested through SCC, by the Incident Commander.

b. Jurisdictions

Each jurisdiction has a varied amount and type of medical units. In most jurisdictions, the direction and administration of medical units is under the Fire Department. However, in some areas of the Operational Area, County Service Areas (CSA) and San Diego County, EMS-contracted transporting agencies have response capability.

c. Private Ambulance Resources

Private industry ambulance response is directed by the Private Ambulance Coordinator. Upon notification from SCC, the Private Ambulance Coordinator:

- 1) Establishes contact with IC dispatch center
- 2) Notifies participating ambulance companies
- 3) Polls agencies' available resources to include:
 - a) Number and type of units available
 - b) Units already responding to the incident
 - c) Number and type of units that could be activated
 - d) Number and type of units for back-fill of depleted areas

as requested

9. Transporting Responders Responsibilities

- a. Upon notification, transport units ascertain the exact location of incident staging areas and access routes. Special hazards or road closures may necessitate specific routing instructions.
- b. Upon arrival at the scene, units report to the ambulance staging area unless otherwise directed by the Ground Ambulance Staging Manager.
- c. Ambulances are systematically sent into the patient loading area by the Ground Ambulance Staging Manager to avoid congestion of the scene. Ambulances are assigned patients and destination as directed by the Patient Transportation Group Supervisor.
- d. As minimal stabilization is administered at the scene to effect transportation in a timely fashion, it is essential that continued medical care be provided in route.
- e. Hospital communication is not required from transporting units, as the Medical Communications Coordinator at the scene is responsible for this function. When patient turnover to the hospital is completed, and the unit has been requested (by the Patient Transportation Group Supervisor) to return to the scene, requested personnel or supplies may be transported back to the scene by that unit.

G. Field Treatment Sites/First Aid Stations

1. Field Treatment Sites (FTS)

- a. FTS are designated sites for the congregation, triage, prophylaxis/immunization, austere medical treatment, and stabilization for evacuation of casualties during a major disaster or large-scale public health emergency. They are an extension of the disaster medical response operations when the evacuation of casualties is substantially delayed by depletion of resources, road closures, damage to hospitals, or when sites are needed to provide community based mass prophylaxis/immunization operations, etc.
- b. Medical FTS are utilized to provide only the most austere medical treatment, directed primarily to the moderately/severely injured or ill, who will require later definitive care and who have a substantial probability of surviving until they are evacuated to other medical facilities. FTS should not be viewed as first aid stations for the minimally injured, although provisions may be made to refer them to a

nearby site for first aid. Nor should FTS be viewed as only short-term staging areas because evacuation of casualties from the FTS may be delayed due to limited availability of transportation. Given the uncertainty of the flow of casualties, the availability of supplies and personnel, and the timeliness and rate of casualty evacuation, managers of FTS must be cautious in the allocation of resources (especially during the first 24 hours of operation).

c. Designation of FTS

- 1) The designation, establishment, organization, and operation of FTS are the responsibility of County government. Regional and state resources will become available to resupply and augment FTS operations, but are generally unavailable to activate a FTS during the initial response phase.
- 2) In selecting FTS locations, consideration is given to: proximity to areas which are most likely to have large numbers of casualties; distribution of locations in potential high-risk areas throughout the affected area; ease of access for staff, supplies and casualties; ease of evacuation by air or land; and the ability to secure the area. FTS sites will be designated at the time of activation by the County of San Diego Emergency Medical Services (EMS) based on the availability of appropriate structures, facilities, and supplies.

d. FTS Functions

- 1) FTS should be designed to perform the following tasks; not necessarily in the order indicated below.
- 2) Congregation and registration of casualties for efficient treatment and evacuation.
- 3) Triage of casualties to ensure scarce treatment and transportation resources are given to those for whom they will do the most good.
- 4) Austere medical care to ensure that the maximum number of casualties who require life saving medical care receive it.
- 5) Mass Immunization/Prophylaxis
- 6) Casualty holding to maintain the stability of casualties awaiting evacuation.

- 7) Evacuation of casualties to the Disaster Support Areas (DSA) or other facilities for further medical care.
- 8) Support functions needed for FTS to meet medical care requirements include:
 - a) Communications
 - b) Security and crowd control
 - c) Sanitary facilities for casualties and staff
 - d) Food and water for casualties and staff
 - e) Logistics (equipment, supplies, inventory maintenance)
 - f) Administration and record keeping
- 9) The ability of a particular FTS to implement these functions depends on:
 - a) The number and type of staff available.
 - b) Availability of equipment and supplies.
 - c) The number and severity of casualties.
 - d) The rapidity with which casualties arrive.
 - e) The speed with which casualties are evacuated.
- e. Medical resources at FTS should be directed toward stabilization for transport and relief of pain and suffering. Supplies, personnel, and conditions will not usually allow definitive care of even minor or moderate injuries. Care is ordinarily limited to:
 - 1) Controlling/managing airway, breathing and circulation (ABCs)
 - 2) Splinting of fractures
 - 3) Maintenance or improvement of hemodynamic conditions by intravenous solutions
 - 4) Pain relief

f. FTS Operations

- 1) The flow of casualties into a FTS is unpredictable depending on its distance from casualties, the success of public information efforts, its accessibility, and the pace of search and rescue operations.
 - a) If delay is lengthy, reconsideration of triage of the seriously injured and a higher level of pre-hospital care at FTS may be needed.
 - b) Supplies from outside the disaster area to the FTS may be delayed.
 - c) Water, power, and other resources may be scarce, limiting the type of medical treatment feasible at a FTS.
 - d) Inclement weather and other atmospheric conditions can hinder helicopter delivery of personnel and supplies and evacuation of casualties.
 - e) Mass Prophylaxis/Immunization Operations should follow the San Diego Metropolitan Medical Response System (MMRS) Mass Prophylaxis Plan under the direction of Health Officer.
- 2) The public, fire, and police agencies are notified by Operational Area officials of the location of functioning FTS.
- 3) Status reports are made by each FTS to the Disaster Medical Coordinator, describing: numbers and triage category of casualties; medical supply needs; personnel status and needs; and accessibility by helicopter and ground transportation.
- 4) Patient tracking begins at FTS, using a Patient Tracking Tag which is attached to the patient during triage operations and then this information is entered into the Quality Assurance Collection Network System (QCS). This tag remains with the patient until the final medical treatment facility is reached.

2. First Aid Stations

- a. The County of San Diego Public Health Services has the primary responsibility for the activation, organization and staffing of First Aid Stations. These stations are primarily set up for casualties requiring

minimum to no medical care. If requested, and if available, the Red Cross will support these First Aid Stations. Both stationary and mobile Red Cross First Aid Stations may be established in coordination with the Medical and Health Operating Area Coordinator (MHOAC), the County Health and Human Services Agency and the Red Cross.

- b. First Aid Station(s) will be supervised by a Registered Nurse under the direction of a physician, and staffed by emergency first aid response teams, known as Health Services Teams (HST).
- c. When activated, HST report to the scene and coordinate the dispatch of wounded to the Red Cross First Aid Stations.
- d. Additionally, Red Cross may provide family services, psychological counseling, and spiritual support.
- e. County Behavioral Health Services may also provide/coordinate counseling.

H. Hospital System

1. Facilitating Base Hospitals (Figure 4)

- a. The Facilitating Base Hospital shall have the secondary responsibility of notifying the Sheriff Communication Center (SCC) of an Alert or Activation of Annex D, if the following occurs:
- b. The Facilitating Base Hospital feels that the incident the medical coordinating unit is reporting meets the criteria for an Alert or Activation.
- c. The Facilitating Base Hospital or the receiving hospitals within the Operational Area are or may soon be overwhelmed with incoming patients.

2. Plan Activation

- a. Once notified by the field to "activate" this plan, facilitating base hospitals are responsible notifying the satellite receiving hospitals in their area and obtaining the following information: (Table 1)
 - 1) Hospital status, including essential services such as utilities, laboratory, x-ray, surgery, and bed counts.
 - 2) Treatment Team availability for hospitals with predesignated teams if requested by Multi-Casualty Branch Director or Incident Commander. (Table 2)

- 3) Number of Emergency Department beds available and, if requested:
 - a) Number of total beds available
 - b) Number of beds that could be made available through early discharges
 - c) Blood inventory
 - d) Operating Room functional
 - e) Critical resource needs both personnel and supplies
- b. Once the responding Treatment Teams are determined, requests for transport to the scene is made to California Highway Patrol or Sheriff ASTREA through Sheriff's Communications Center (SCC).
- c. Additional areas of consideration in coordinating the area response include:
 - 1) Adequate ambulance support en route
 - 2) Assistance from other EMS planning areas for response
 - 3) Alternate means of transportation
 - 4) Additional supplies and equipment
 - 5) Utilizing Phase I kits (Supplemental bandage supplies to augment resources at the scene)

After the initial response is made and if the EMS DOC/MOC is operating, the Facilitating Base Hospitals are also responsible for providing area updates to the Disaster Medical Coordinator at the DOC/MOC.

I. State Medical Mutual Aid

1. Mutual Aid Region

- a. The State of California is divided into six mutual aid regions. The San Diego County Operational Area is in Region VI which also includes the Mono, Inyo, San Bernardino, Riverside and Imperial Operational Areas. In the event local medical resources are unable to meet the medical needs of disaster victims, the Operational Area may request assistance

from neighboring jurisdictions through the Regional Disaster Medical Health Coordinator (RDMHC) or the State of California Office of Emergency Services (OES) regional office. The Regional Coordinator coordinates the provision of medical resources to the Operational Area and the distribution of casualties to unaffected areas as conditions permit. In addition, a Medical Mutual Aid Plan exists in Region VI and all counties in Region VI have signed this Plan and the Medical Mutual Aid Agreement. If a state response is indicated, the Regional Coordinator functions are subsumed under the overall State medical response.

2. Mutual Aid Implementation

- a. The following information is required for disaster medical mutual aid requests:
 - 1) The number, by triage category, and location of casualties.
 - 2) The location and helicopter accessibility of FTS.
 - 3) Land route information to determine which FTS may be evacuated by ground transportation.
 - 4) The resource needs of affected areas.
 - 5) Location, capabilities, and patient evacuation needs of operational medical facilities in and around the affected area.
- b. Information is consolidated at the Operational Area EOC and provided to the Regional Coordinator who transmits it to the Emergency Medical Services Authority (EMSA) Staff at the State Operations Center (SOC). (Attachment A).
- c. The Regional Coordinator will:
 - 1) Coordinate the acquisition and allocation of critical public and private medical and other resources required to support disaster medical care operations.
 - 2) Coordinate medical resources in unaffected counties in the Region for acceptance of casualties.
 - 3) Request assistance from the Emergency Medical Services Authority (EMSA) and/or California Department of Health Services (CDHS), as needed.

J. Federal Medical Mutual Aid

1. Federal aid is normally available only upon declaration of a national disaster requested by the governor when local, regional and state assets are inadequate to cope with a situation. Upon such a declaration, the Federal Emergency Management Agency (FEMA) would set up a Disaster Field Office (DFO) with a Federal Coordinating Officer (FCO) in charge. The DFO staff would have access to resources in all 12 Emergency Support Functional areas including medical. Through California state officials, our requests for federal assistance would be submitted to the DFO.
2. Part of the Medical Support Functional (ESF #8) is the National Disaster Medical System (NDMS). NDMS could provide Disaster Medical Assistance Teams (DMAT) of about 35 medical and support personnel with organic equipment to set up field treatment stations or to augment our medical infrastructure as needed. If a DMAT team were activated to assist, it would most probably be one from another area of the country as opposed to the San Diego team. Casualty evacuation for definitive medical care (hospitals) in other areas of the country is another NDMS function. Should NDMS assistance be required, it would be requested through the DFO, normally via state officials.
3. Naval Medical Center San Diego (NMCSD) is the Federal Coordinating Center for the San Diego county area. Its NDMS functions mainly to receive and distribute disaster victims from other areas brought here for definitive treatment.
4. As a hospital, in local multi-casualty disasters, NMCSD would be a full participant as specified in other areas of this plan. Should NDMS be activated to evacuate victims from San Diego, NMCSD would assist in every way possible. It would not be in charge of patient departure operations. The only defined role for Federal Coordinating Center is to liaison with Global Patient Movement Requirements Center (GPMRC) primarily through TRAC2ES web-based patient regulating system. GPMRC is the US Air Force command which would arrange/schedule transportation (primarily USAF aircraft) for evacuees.

In the event that a disaster occurs in this area, stabilized patients would be taken from the FTS to the Disaster Support Area (DSA) for transport to other counties or states. Should the Operational Area become a receiving site, this Annex could be activated to move patients to local hospitals. As NDMS Federal Coordinating Center, NMCSD would be in charge of patient reception operations.

a. Medical Evacuation/Disaster Support Area (DSA)

- 1) Medical Evacuation - Medical evacuation of casualties is necessary when one or more of the following conditions exist:

- a) Hospitals are damaged.
 - b) Hospitals are threatened by an imminent disaster.
 - c) The total Operational Area hospital bed capacity is overwhelmed.
- 2) Damaged or threatened hospitals evacuate patients to other medical facilities identified in their areas, as coordinated by the Facilitating Base Hospitals. FTS or First Aid Stations can be activated as the numbers and extent of injuries warrant.
 - 3) In the event a major disaster severely affects the ability of the Operational Area to provide medical care, large numbers of casualties may be evacuated to medical facilities in the Region. The coordination of the medical care, triage, and distribution of these evacuated casualties is a function of the Regional FCC Coordinator and the EMS Director or designee.
- b. Disaster Support Area (DSA)
- 1) The designated Disaster Support Area (DSA) for San Diego Operational Area is the Marine Corps Air Station, Miramar, Thomas Brothers page 1229, C-3. The alternate DSA is Brown Field, Thomas Brothers page 1351, E-1.
 - 2) The DSA is a pre-designated facility established on the periphery of a disaster area where disaster relief resources (personnel and material) are received, stockpiled, allocated and dispatched into the disaster area. A segregated portion of the facility serves as a medical staging area where casualties requiring hospitalization are transported to medical facilities in the region. A "leap frog" concept is used in evacuating casualties and providing mutual aid resources. Under this concept, casualties are evacuated from Field Treatment Sites (FTS) to the DSA and then to a distant medical facility. Mutual aid resources both personnel and supplies, are then transported to the DSA on the return trip.
 - 3) Medical function responsibilities at the DSA include:
 - a) Planning the organization and layout of the medical section of the DSA.
 - b) Establishing procedures for patient flow.

- c) Directing the establishment of the medical site and implementation of patient care procedures.
 - d) Providing orientation for personnel staffing the DSA medical function.
- 4) The DSA also serves as the site for the receipt, storage, and disbursement of medical resources. Satellite medical operations (medical DSA) may be created by the EMSA near large pockets of casualties depending on the amount of resources available.
- c. Organization and Support of Personnel
- 1) Physicians and other licensed medical personnel arriving at the DSA sign a log sheet listing their names, specialties, and license numbers. Medical personnel need to carry some proof of licensure with them. This information is used by the Disaster Medical Coordinator to organize medical assistance teams with appropriate skills. Each team triages and provides austere treatment to an average of 200 casualties per eight-hour shift at FTS (if needed) or at the DSA. Each team consists of:
 - a) Two physicians with specialties in emergency medicine, surgery, orthopedics, family practice, or internal medicine.
 - b) Four registered nurses (RNs).
 - c) Two physician assistants or nurse practitioners. (May substitute RNs or paramedical personnel, if necessary.)
 - d) One medical assistance personnel (dentist, veterinarian, etc.).
 - e) Four Licensed Vocational Nurses (LVN) or aid
 - f) Two clerks.
 - 2) As soon as medical personnel arrive at the DSA, they are provided with orientation material (e.g., disaster tags, triage and austere medical care guidelines, and DSA/FTS organization and operations material).

K. Resources

1. Emergency Medical Services (EMS) develops and maintains a capability for identifying medical resources, transportation and communication services within the Operational Area. Additionally, EMS coordinates the procurement, allocation and delivery of these resources, as required to support disaster medical operations.

2. Medical Resources

a. Sources of Personnel:

- 1) Local emergency medical services personnel.
- 2) Clinical Disaster Service Workers/MRC
- 3) State employed physicians and nurses.
- 4) Local volunteer physicians, nurses, dentists, veterinarians, etc.
- 5) Law enforcement and fire EMT personnel, if available.
- 6) Medical school residents and teaching staff from throughout the state.
- 7) Volunteers through professional societies (California Medical Association, California Nurses Association, California Ambulance Association, etc.).
- 8) Nursing School students
- 9) Other volunteer medical personnel from throughout the state.
- 10) California National Guard.
- 11) U.S. Armed Forces.
- 12) Veterans Administration personnel.
- 13) Volunteer medical personnel from other states.

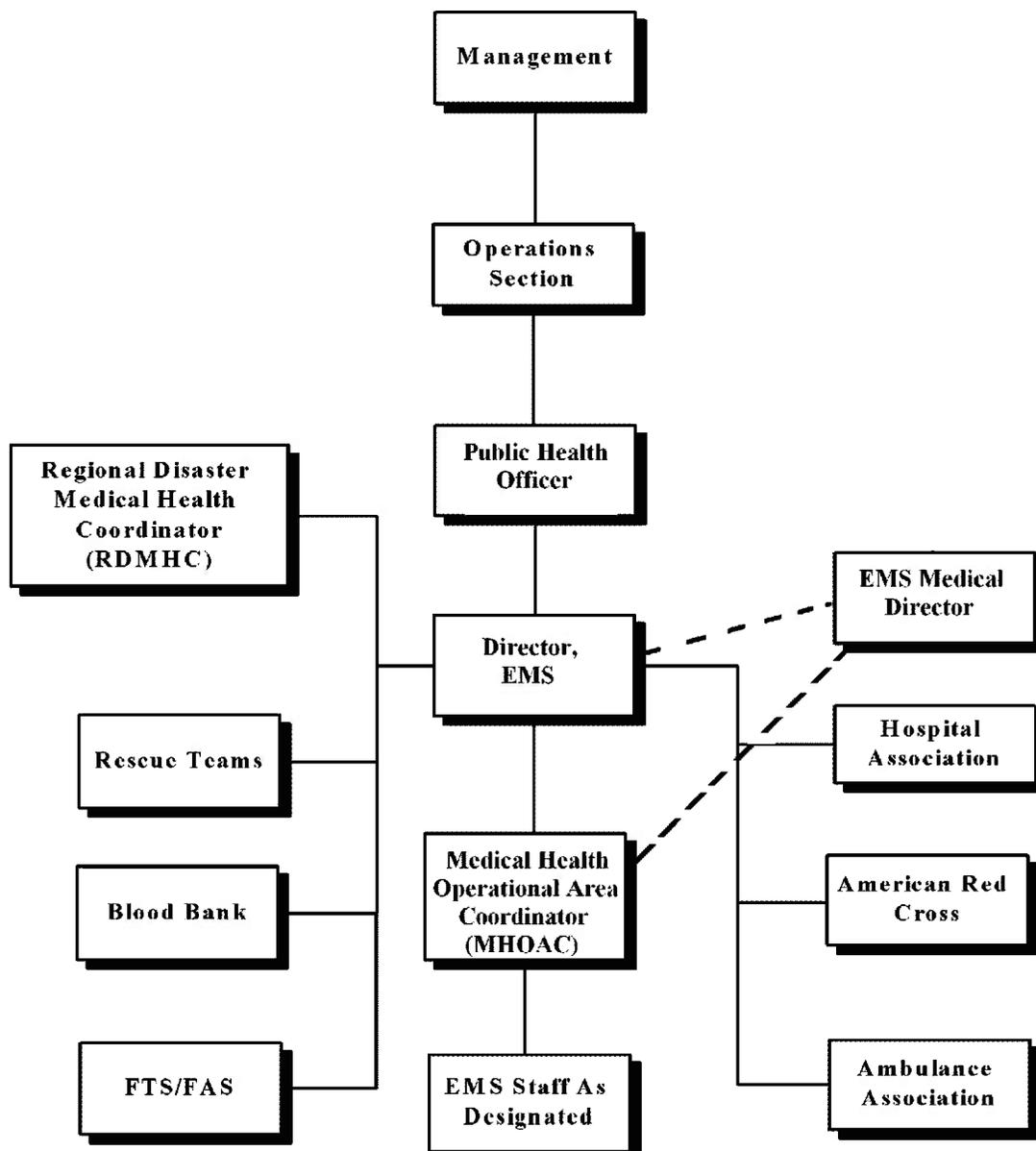
b. Supplies and Equipment

- 1) Medical supplies and equipment are needed for:
 - a) Initial supply and resupply of FTS.
 - b) Initial supply and resupply of DSA.

- c) Resupply of functioning hospitals in the affected areas.
 - d) Resupply of hospitals outside the disaster area receiving casualties.
- 2) Sources of medical supplies and equipment:
- a) U.S. Department of Homeland Security (DHS), Department of Defense, Department of Health and Human Services, and Veterans Administration (through the Federal Emergency Management Agency and California Office of Emergency Services).
- c. Blood and blood derivatives:
- 1) Whole blood and plasma are supplied to the DSA by the California Blood Bank Association.
 - 2) Supplies are transported to the DSA by suitable available transportation. The State Disaster Medical Coordinator may request the provision of refrigeration trucks to act as storage facilities for the blood and blood products.
 - 3) Personnel are requested from the California Blood Bank Association to operate a blood bank at the DSA in coordination with the National Guard Medical Brigade.
 - 4) Since the DSA will not have resources for the storage of large quantities of blood, only a 24-hour supply is stored there.
 - 5) Blood and blood products are used primarily at the DSA and at hospitals in the affected and reception areas. Blood should be sent to FTS only under extraordinary circumstances.

Figure 1

**MEDICAL OPERATIONS AT THE SAN DIEGO COUNTY
OPERATIONAL AREA
EMERGENCY OPERATIONS CENTER**

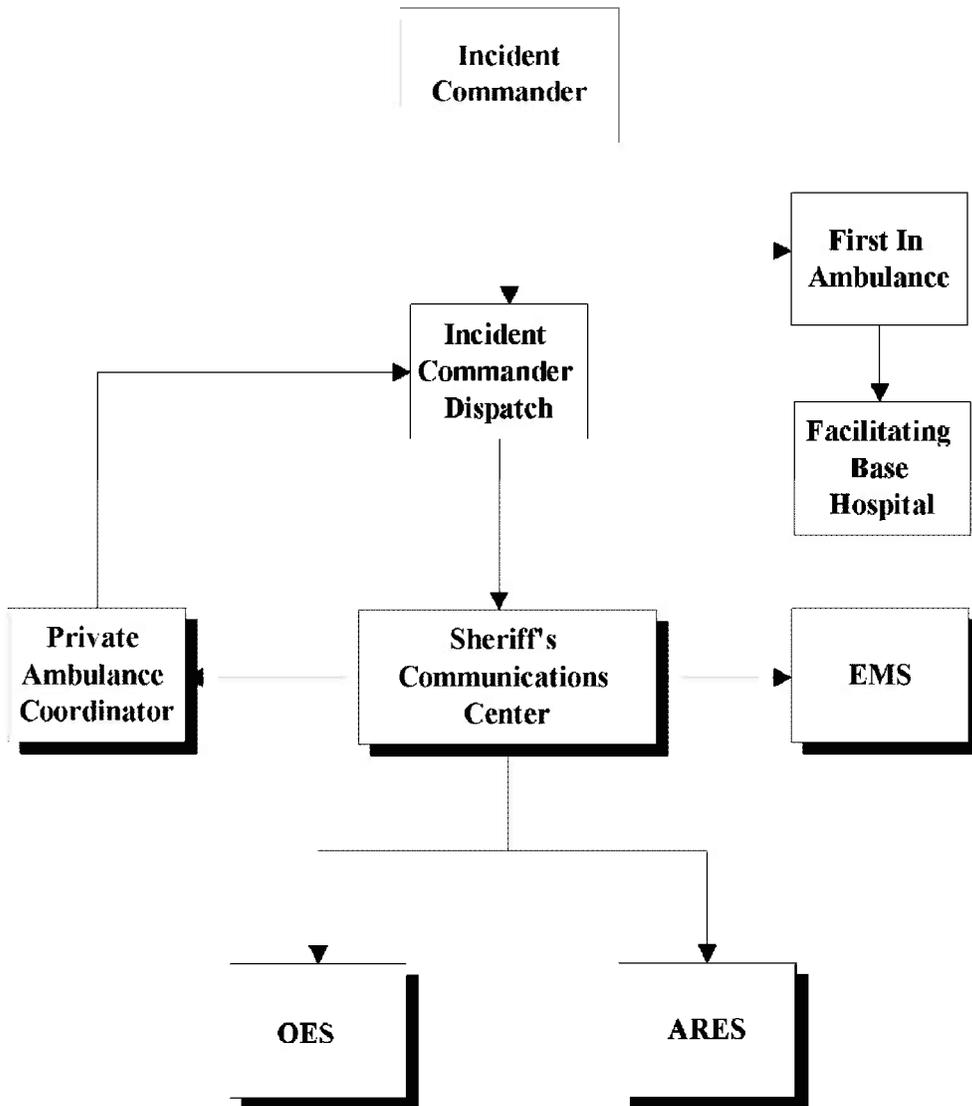


**Figure 2
 MULTI-CASUALTY OPERATIONS
 RESPONSIBILITY CHART**

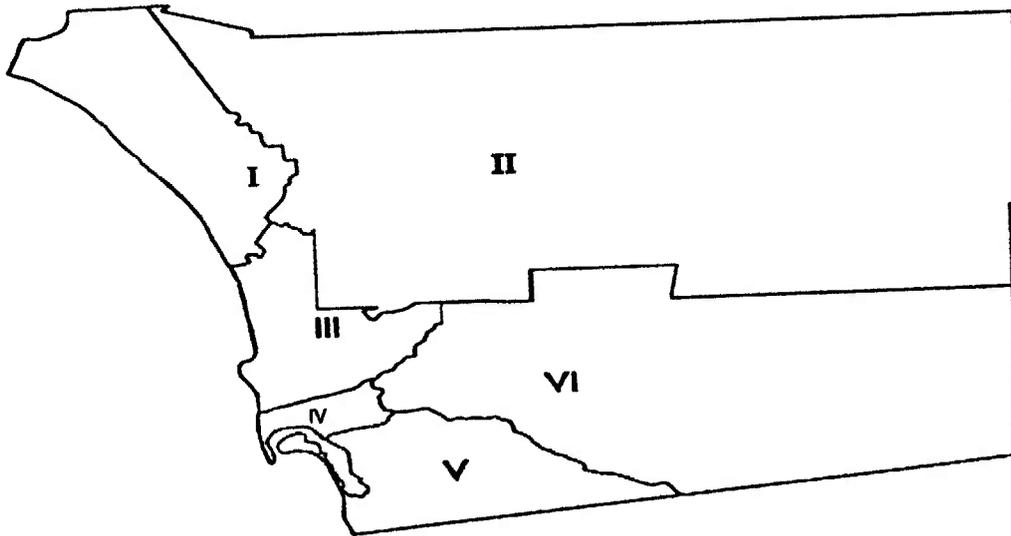
AGENCIES	Planning, training & exercising	Notifications	Communications	Incident Command/ Scene Management	Triage & Treatment	Transportation	Field Treatment Site	First Aid Stations	Medical Evacuation	Special Resources	County EOC	Medical Mutual Aid
All Affected Agencies	X											
SDHDC	X											
Sheriff's Communications Center		X	X			X						
RACES/ARES		X	X									
Fire Departments	X	X	X	X	X	X	X			X	X	X
Law Enforcement		X	X	X		X			X	X	X	
CHP				X		X			X			
Base Hospitals	X	X	X		X		X		X			
Hospitals	X	X	X		X		X		X			
Healthcare Association			X								X	
Ambulance Association			X			X			X			
Aeromedical	X		X		X	X						
EMS	X	X	X				X		X	X	X	X
Public Health/EP	X	X	X				X	X		X	X	
Public School Districts							X	X				
American Red Cross								X	X	X	X	
Blood Bank										X		
OES		X								X	X	X
State		X								X	X	X
Military/National Guard										X		X
Federal		X		X						X		X
Community Health Centers					X							
Council of Community Clinics		X	X									
San Diego County Medical Society		X	X									

Figure 3

Annex D Notification Flowchart



**Figure 4
 BASE HOSPITALS BY EMS PLANNING AREA**



BASE HOSPITALS BY EMS PLANNING AREA THOMAS BROTHERS COORDINATES

I	Tri City Medical Center 4002 Vista Way Oceanside, CA 92054	1107 B-1
II	Palomar Medical Center 555 East Valley Parkway Escondido, CA 92025	1130 A-1
III	Scripps Memorial Hospital, La Jolla 9888 Genessee Avenue La Jolla CA 92037	1228 B-2
III	Sharp Memorial Hospital 7901 Frost St. San Diego, CA 92123	1249 B-5
IV & V	UCSD Medical Center 220 W. Arbor Dr. San Diego, CA 92103	1269 A-4
IV & V	Scripps Mercy Hospital 4077 Fifth Ave. San Diego, CA 92103	1269 A-5
VI	Sharp Grossmont Hospital 5555 Grossmont Center Dr. La Mesa, CA 91941	1251 A-7

Table 1

SAN DIEGO COUNTY HOSPITALS

HOSPITAL	ADDRESS	Thomas Bros
Alvarado Hospital	6655 Alvarado Rd., San Diego 92120	1270-D1
Children's Hospital (T)	3020 Children's Way, San Diego 92123	1249-B5
Fallbrook Hospital	624 Elder St., Fallbrook 92028	1027-G3
Kaiser Permanente Hospital	4647 Zion Ave. San Diego 92120	1249-J6
Naval Hospital Camp Pendleton	Camp Pendleton, 92055	1085
Naval Med. Cntr San Diego	34800 Bob Wilson Dr., San Diego 92134	1289-C1
Palomar Medical Center (T) (B)	550 E. Grand Ave., Escondido 92025	1130-A2
Paradise Valley Hospital	2400 E. 4th St., National City 91950	1290-B7
Pomerado Hospital	15615 Pomerado Rd., Poway 92064	1170-C6
Scripps Green Hospital	10666 N. Torrey Pines Rd., San Diego, 92037	1207-J6
Scripps Memorial Hospital Chula Vista	435 H St., Chula Vista 91910	1330-J2
Scripps Memorial Hospital Encinitas	354 Santa Fe Dr., Encinitas 92024	1167-D1
Scripps Memorial Hospital La Jolla (T) (B)	9888 Genessee Ave., San Diego 92037	1228-B1
Scripps Mercy Hospital (T) (B)	4077 5 th Ave. San Diego, 92103	1269-A5
Sharp Chula Vista Hospital	751 Med. Center Crt., Chula Vista 91911	1330-J2
Sharp Coronado Hospital	250 Prospect Pl., Coronado 92118	1289-A6
Sharp Grossmont Hospital (B)	5555 Grossmont Ctr Dr. La Mesa, 91942	1251-A7
Sharp Mary-Birch Hospital for Women	3003 health Center Dr., San Diego, 92123	1249-B5
Sharp Memorial Hospital (T) (B)	7901 Frost St., San Diego 92123	1
		249-B5
Tri-City Medical Center (B)	4002 Vista Way, Vista 92056	1107-B1
UCSD Medical Center (T) (B)	200 W. Arbor Dr., San Diego 92103	1269-A4
UCSD MC Thornton Hospital	9300 Campus Point Dr., La Jolla 92037	1228-B1
Veteran's Affairs Medical Center	3350 La Jolla Village Dr., San Diego 92161	1228-A2
University Community Hospital	5550 University Ave., San Diego 92105	1270-B5

(B) Designated Base Hospital
(T) Designated Trauma Center

Table 2

HOSPITALS WITH PREDESIGNATED TREATMENT TEAMS

PRIMARY TREATMENT TEAMS

<u>EMS AREA</u>	<u>UNIT</u>
I	Tri-City Medical Center
II	Palomar Medical Center Naval Hospital, Camp Pendleton
III	Sharp Memorial Hospital Scripps Memorial Hospital - La Jolla
IV	UCSD Medical Center Naval Hospital, San Diego Scripps Mercy Hospital
V	Scripps Memorial Hospital of Chula Vista Paradise Valley Hospital Sharp Hospital Chula Vista
VI	Sharp-Grossmont Hospital

SECONDARY TREATMENT TEAMS

I	Scripps Memorial Hospital, Encinitas (2)
II	Pomerado Hospital (2) Fallbrook Hospital
III	Veterans Administration Hospital (2) Children's Hospital (Pediatric Incidents)
IV	Kaiser Foundation Hospital (2) UCSD Medical Center
V	Sharp Hospital of Chula Vista Coronado Hospital
VI	Alvarado Hospital Sharp-Grossmont Hospital

**ATTACHMENT A
STATE AND FEDERAL MEDICAL SUPPORT FUNCTIONS AND AGENCIES**

State

The following state agencies are responsible for providing the disaster medical care services:

Emergency Medical Services Authority (EMSA)

The EMSA Director (State Disaster Medical Coordinator) is, in coordination with the State Department of Health Services and OES, responsible for:

- Coordinating state emergency medical response.
- Allocating medical resources, both public and private, from outside the affected area.
- Authorizing emergency travel and related expenditures and allied personnel, both public and private.
- Responding to requests for emergency medical assistance from Regional Coordinator and/or County Health Officers.
- Coordinating the evacuation of injured persons to medical facilities statewide using all available ground and air transportation resources.
- Assisting local government to develop effective disaster response plans.
- Assisting local government to restore essential emergency medical services.

Department of Health Services

- Provides staff support to the EMSA in disasters resulting in mass casualties.
- Provides staff support to the Joint Medical/Health EOC in Sacramento including: medical personnel unit; patient deployment unit; facilities liaison unit; and medical supplies unit.
- Staffs various administrative functions including: record keeping; finance; transportation liaison; communications; and medical personnel.
- Technical support for emergent infectious disease outbreaks

Military Department

Provides, as directed by the Governor at the request of OES:

- Medical support for the emergency field treatment of casualties.

ATTACHMENT A
STATE AND FEDERAL MEDICAL SUPPORT FUNCTIONS AND AGENCIES
(Continued)

- Evacuation of casualties to appropriate disaster medical facilities as required.
- Emergency medical care and treatment.
- Communication and logistics support for medical response.

Other State Agencies

- Department of Finance
- Department of Forestry
- Department of General Services
- Department of Youth Authority
- California Conservation Corps
- Department of Social Services

Federal

Federal agencies operating under their own statutory authority may render direct assistance; however, following a Presidential Declaration, the Department of Homeland Security, through the Federal Emergency Management Agency (FEMA), will coordinate the federal response system supporting emergency medical needs resulting from disasters. FEMA is supported by the Sixth U.S. Army Headquarters, the Department of Homeland Security, the Department of Health and Human Services, and the Department of Defense.

As State shortfalls occur, federal agencies will make their resources available to support state/local medical response efforts.

APPENDIX D-1

MEDICAL

EMERGENCY ACTION CHECKLIST

RESPONSE TO A MAJOR EARTHQUAKE

<u>Action</u>	<u>Responsibility</u>
Determine condition and capacity of hospitals; request hospitals to activate Disaster Plans.	EMS
Determine availability and condition of medical supplies; take appropriate action to maintain inventories or resupply.	All Agencies
Determine availability and condition of blood supplies; take appropriate action to maintain inventories or resupply.	Blood Bank
IF THERE ARE ONLY A FEW OR NO CASUALTIES, PREPARE TO SUPPORT MORE HEAVILY DAMAGED JURISDICTIONS.	
IF THERE IS EXTENSIVE DAMAGE AND A LARGE NUMBER OF CASUALTIES, TAKE THE FOLLOWING ACTIONS AS APPROPRIATE:	
Take action to expand hospital care capacity.	Hospitals
Augment personnel.	All Agencies
Obtain emergency supplies.	EMS
Provide emergency power to undamaged facilities.	SDG&E
Periodically poll health facilities to determine patient load and support requirements.	Hospital Association
Activate plans to obtain supplementary services such as public information, records, reports, etc.	OES

**Medical
Earthquake Response**

<u>Action</u>	<u>Responsibility</u>
Inform the Emergency Public Information Officer of current information for dissemination to the public.	EMS
Activate Field Treatment Sites.	EMS
Provide field medical care, including triage, near or in affected areas.	All Responding Agencies
Determine number and location of casualties that require hospitalization.	EMS
Determine transportation needs and capabilities.	EMS
Have units dispatched to pick up injured.	Ambulance Providers
Allocate casualties to hospitals to make best use of facilities.	Incident Commander Facilitating Base Hospital
Determine availability and location of medical personnel.	EMS
Allocate personnel to medical facilities as required.	EMS
Request assistance from the Regional Disaster Medical Health Coordinator (RDMHC), as required.	EMS

APPENDIX D-2

MEDICAL EMERGENCY ACTION CHECKLIST

RESPONSE TO HAZARDOUS MATERIAL INCIDENT

<u>Action</u>	<u>Responsibility</u>
Determine if specialized equipment is needed for medical personnel operating in the affected area. This may include activation of the San Diego Metropolitan Medical Strike Team (MMST).	HAZMAT Incident Response Team (HIRT)/IC
Determine number and location of casualties that require hospitalization.	Incident Commander
Activate hazard identification procedures.	HIRT
If a large number of casualties have occurred, request establishment of Field Treatment Site (FTS) and provide field medical care, including triage, near or in affected areas.	Incident Commander
Determine capabilities and capacity of hospitals.	Facilitating Base Hospital
Request hospitals to activate disaster plans if there is a large number of casualties.	EMS
Dispatch units to transport injured.	Ambulance Providers
Allocate casualties to hospitals to make best use of facilities.	Facilitating Base Hospital
Coordinate distribution of specialized medical supplies.	EMS

**Medical
Hazardous Material Response**

<u>Action</u>	<u>Responsibility</u>
Periodically poll medical facilities to determine caseload and support requirements.	Hospital Association
Activate plans for supplementary services such as public information, records, and reports.	OES
Inform the Emergency Public Information Officer of current information for public dissemination.	DEH, Hazardous Materials Division
Request assistance from the Regional Disaster Medical Health Coordinator (RDMHC) as required.	EMS
Coordinate with the Transporting Coordinator, the movement of patients from any medical facility threatened by a hazardous material release.	EMS

APPENDIX D-3

MEDICAL EMERGENCY ACTION CHECKLIST

RESPONSE TO IMMINENT/ACTUAL FLOODING

FLOODING EXPECTED

<u>Action</u>	<u>Responsibility</u>
Identify facilities subject to flooding and prepare to relocate people from facilities.	OES
Arrange to have standby emergency power at medical facilities.	Each Facility
Accelerate patient releases from facilities in flood-prone areas.	Each Facility
Designate an acute care facility to handle the medical needs of flood victims.	Facilitating Base Hospital
Store water for medical facilities.	Each Facility
Place medical personnel on standby status.	Each Facility
Assign medical liaison to the Emergency Operating Center (EOC), if activated.	EMS
Plan for alternate communications.	EMS/S.C.C
Begin evacuation of medical facilities if flood conditions worsen.	Incident Commander
Coordinate patient evacuation with Transportation Coordinator.	Local Law Enforcement
Provide evacuation assistance to non-institutionalized persons who require medical/nursing support.	Local Law Enforcement
Relocate ambulance services from flood-prone areas.	Ambulance Providers
Evacuate flood-prone medical facilities, or move all patients and personnel to floors above flood waters.	Each Facility

**Medical
Flood Response**

FLOODING OCCURS

<u>Action</u>	<u>Responsibility</u>
Initiate alternate communications, if needed.	EMS/SCC
Determine number and location of casualties that require hospitalization.	Facilitating Base Hospital
If required activate Field Treatment Sites (FTS) and coordinate resources for field medical care.	EMS
Request assistance from the Regional Disaster Medical Health Coordinator (RDMHC), as required.	EMS

APPENDIX D-4

MEDICAL

EMERGENCY ACTION CHECKLIST

RESPONSE TO IMMINENT/ACTUAL DAM FAILURE

DAM FAILURE IMMINENT

<u>Action</u>	<u>Responsibility</u>
Put medical care personnel on standby.	All Agencies
Identify medical care facilities subject to inundation.	OES
Evacuate patients from facilities, if necessary.	Local Law Enforcement
Arrange to have standby emergency power on hand at medical facilities.	All Facilities
Move pharmaceuticals out of inundation areas.	All Facilities
Plan for alternate communications.	EMS/SCC
Coordinate the evacuation of patients with the Transportation Coordinator.	EMS
Provide evacuation assistance to non-ambulatory patients in private residences.	Local Law Enforcement

**Medical
Dam Failure Response**

DAM FAILURE OCCURS

<u>Action</u>	<u>Responsibility</u>
Mobilize medical care personnel.	All Agencies
Reconfigure shifts as necessary.	All Agencies
Relocate all ambulance services from inundation area.	Ambulance Providers
Evacuate flood-prone medical facilities.	Local Law Enforcement
Move patients and personnel to floors above flood waters.	All Facilities
Initiate alternate communications, if needed.	EMS/SCC
Activate Field Treatment Sites (FTS) on high ground and coordinate resources for field medical care if required.	EMS
Determine number and location of casualties that require hospitalization.	Facilitating Base Hospital
Request assistance from the OES Mutual Aid Region Disaster Medical/Health Coordinator, as required.	EMS/OES