

CAL-EMA MUTUAL AID REGION III



MCI PATIENT DISTRIBUTION PLAN (Manual 2)

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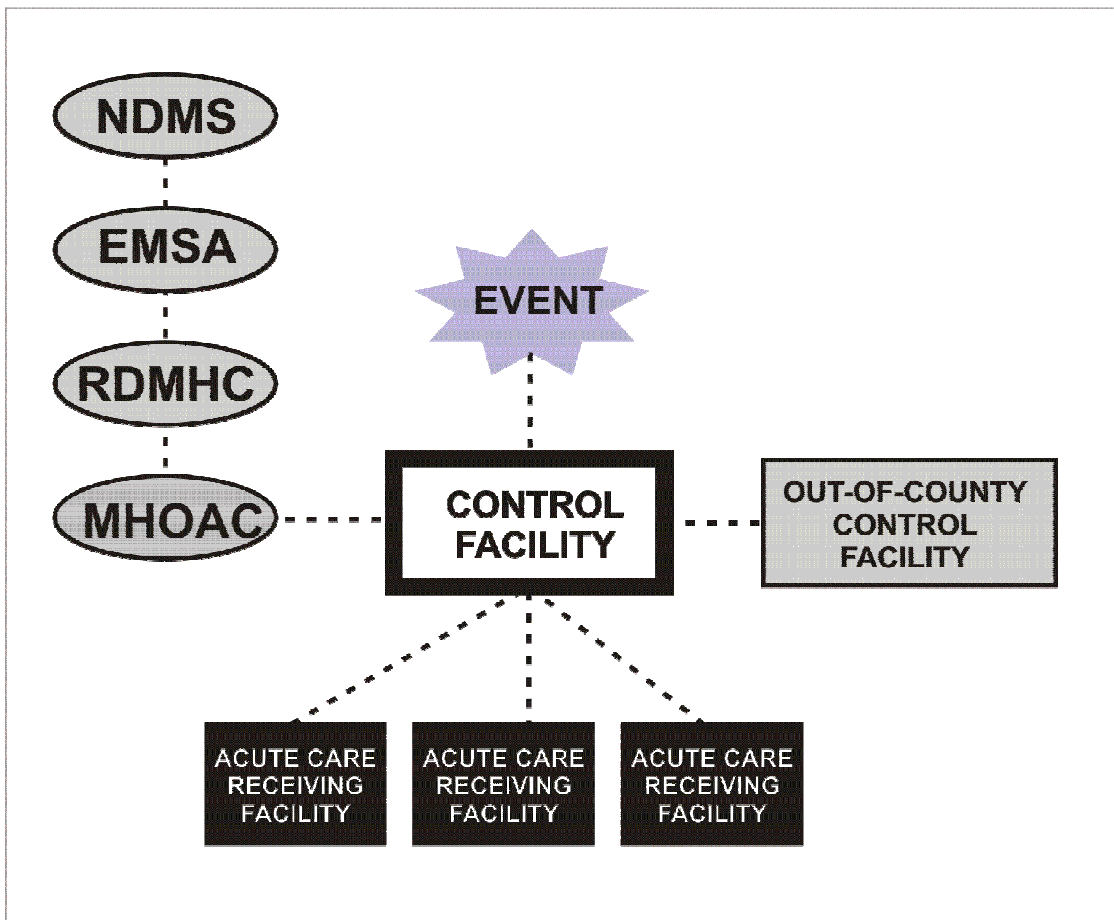
INTRODUCTION

A. PURPOSE

The purpose of this document is to outline a plan under the Standardized Emergency Management System (SEMS) and the National Incident Management System (NIMS) for the distribution of patients during a multi- or mass casualty incident:

- within an Operational Area,
- within multiple Operational Areas in the Mutual Aid Region, and
- to destinations outside of the Mutual Aid Region.

The need to distribute patients may arise from various man-made or natural disasters or emergencies. This manual is intended to be an all-hazard plan for the distribution of patients regardless of the cause or event. The first section addresses the day-to-day responsibilities of the Control Facility for patient distribution within an Operational Area, the subsequent sections address the roles and responsibilities of the Operational Area (LEMSA / MHOAC), Regional Disaster Medical Health Coordinator (RDMHC/S), the state EMS Authority (EMSA), and the National Disaster Medical System (NDMS).



B. AUTHORITY

Division 2.5, Health and Safety Code, Sections 1797.220 The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system. The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements.

C. BACKGROUND

The principles and procedures in this document are based upon the California Disaster Medical Operations Manual (CDMOM). The CDMOM, approved in 2008 by the California EMS Commission, requires local EMS agencies in California to establish a Patient Distribution Center (PDC). The PDC is equivalent to the Control Facility concept used throughout the Cal-EMA Mutual-Aid Region IV, which fulfills the PDC function. The CDMOM further describes the roles of a Regional PDC and a state PDC. The regional and state facilities and concepts have not been fully implemented in California as of this writing.

In 2002 many hospitals and EMS systems began implementing web-based information system for rapid assessment of hospital statuses and capabilities. EMSsystem is the current web-based system used in most counties of Northern California. Other hospital-interoperability communications systems used in California include: ReddiNet, StatusNet911, and QANet.

Although most EMS systems in California have implemented electronic web-based applications for assessing and communicating with hospitals, there is currently no process for linking these systems or information together. Therefore, in order to obtain information from outside facilities or systems, this must be done manually by telephone, radio, email, or other traditional system.

SECTION 1: Control Facility Operations

A. *Pre-Event Responsibilities*

1. Control Facilities shall be authorized within each Operational Area by the local EMS Agency for the purpose of coordinating patient dispersal during an MCI or other event requiring coordination of patient destinations within the EMS system.
2. Staff & Resources
Control Facilities shall maintain adequate personnel and equipment to perform the duties outlined in this section.
3. Communications
Control Facilities shall maintain the following minimum communications equipment:
 - a. EMSsystem located in the facility where audio alerts may be heard and responded to 24 hours per day, 365 days per year.
 - b. Dedicated land-line telephone system
 - c. Emergency two-way radio systems
 - UHF MedNet
 - VHF HEAR radio
 - d. Auxiliary radio hook-up (Amateur radio)
 - e. Other communications devices or systems as required by local EMS agency protocol
4. Liaison/Coordination
 - a. Each Control Facility shall appoint a Control Facility Supervisor who shall act as liaison to the local Receiving Facilities and EMS Agency.
 - b. The Control Facility shall notify the local Receiving Facilities and EMS Agency when this position changes and provide the updated contact name and telephone number.
5. Training
 - a. In cooperation with the EMS Agency, the Control Facility Supervisor or designee shall participate in the development of local medical/health Patient Distribution Exercises and Drills.
 - b. In cooperation with the EMS Agency, the Control Facility shall participate in Patient Distribution Exercises and Drills.
 - c. The Control Facility Supervisor shall ensure that all Control Facility personnel are adequately trained in the Patient Distribution Plan, EMSsystem operations, Back-up systems (radio, telephone, etc.), and Patient tracking system(s)

SECTION 1: CONTROL FACILITY

B. MCI Response

1. Creating an MCI Event

- a. An MCI Event shall be created by the Control Facility when information is received regarding the potential need to coordinate patients among multiple receiving facilities. This information may be received from a variety of sources, including:
 - i. EMS response personnel
 - ii. Dispatch agencies
 - iii. Local government (threat or potential threat)
 - iv. Another Control Facility
 - v. EMS Agency or MHOAC
- b. The Control Facility may also initiate an MCI Event due to a sudden influx of patients at receiving facilities within the Operational Area.
- c. Once it is determined that an MCI Event is necessary, the Control Facility shall:
 - i. Assign appropriate staff members to coordinate information from the event, and information provided to receiving facilities.
 - ii. Create an MCI Event in EMResource (see EMSsystem User Guide). If EMResource is unavailable, utilize the Back-up Communications protocols (see Appendix C).
 - iii. Locate the MCI on facility maps, and identify the Receiving Facilities within 30 miles (30 minutes travel time), for receiving potential Immediate victims.
 - iv. Maintain communications with the field Medical Communications Coordinator on-scene (or other patient information source, e.g. out-of-county Control Facility, EMS AGENCY, etc.).

Sample Field to Control Facility Communications

Initial Notification:

- “We are on scene at Highway 99 and East Avenue with a multi-vehicle collision with approximately 12 victims. We’ve got 4 ground ambulances and 2 air ambulances. We’re calling this the Hwy 99/East Incident. We’ll re-contact you when triage is complete.”
- “*Thank you, Hwy 99/East Medical, we’ll collect hospital statuses and stand-by for your patient information. _____ Control Clear.*”

- d. In the event that Receiving Facilities are needed outside the Operational Area, the Control Facility shall contact the Control Facilities in neighboring jurisdictions to coordinate patient distribution activities.

- e. In the event that the number of patients exceeds the capacity of facilities within the OA and in neighboring jurisdictions, the Control Facility shall immediately notify the MHOAC or EMS Agency Duty Officer to activate regional or statewide patient distribution systems.
- f. In the event the Control Facility is unable to perform the patient distribution activities, they shall immediately contact a neighboring Control Facility to assume operations or notify the local EMS Agency to arrange for alternate Control Facility operations.

2. Receiving Facility Status Reports

- a. Each Receiving Facility that has been notified by the Control Facility of an MCI Event will manually complete a Receiving Facility Capacity Worksheet (see “Appendix A.1”) and report their status electronically to the Control Facility within 5 minutes of receiving notification.
- b. The Control Facility shall track the Receiving Facility capacities by printing the EMResource Event Summary and updating the capacities manually as patients are disbursed (see 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

3. MCI Communications

- a. The field Medical Communications Coordinator shall be referred to by Incident Name + Medical . (e.g. “Hwy 50/Sunrise Medical”), NOT by ambulance unit, ambulance company, nor personal name.
- b. Control Facilities shall be referred to by County Name + Control (e.g. Stanislaus Control).
- c. All EMS radio traffic needing patient destinations shall be routed through the Control Facility, even for non-MCI patients, since all ambulance traffic will potentially affect receiving facility capacities.
- d. Patient reports shall not be given directly to the Receiving Facilities by the transporting units.

4. Updating the MCI Event

- a. The Control Facility shall update the MCI Event information in EMResource any time new information is received from the field, including: total patient count by triage category, patient destinations, etc.
- b. The Control Facility shall confirm the total number of transport resources available, and begin the Patient Destination Worksheet (see “Appendix A.2”).
- c. When transport times or on-scene times are extended, consider re-assessing Receiving Facility capabilities regularly.

5. Patient Destinations

- a. When the Control Facility is notified by the field Medical Communications Coordinator that patient triage is complete, the Control Facility shall document Patient Information on the Patient Destination Worksheet (see “Appendix A.2”).

Sample Field to Control Facility Communications

Triage Completed

- “_____ Control, we’ve got 3 Immediates, 3 Delayed, and 6 Minors, where would you like them to go?”
- “*Hwy 99/Hatch Medical, we copy 3 Immediates, 3 Delayed, and 6 Minors. What are the major injuries of your 3 Immediates?*”
- “_____ Control, we’ve got 1 Head, 1 Chest, and 1 multi-system trauma. The Immediate Head and Chest are just about ready for transport. It’s going to be awhile to extricate the other Immediate.”

- b. When contacted by the field for patient destinations, the Control Facility shall assign destinations using the Patient Destination Guidelines below.
- c. The Control Facility shall notify the Receiving Facility of incoming patients using the Patient Dispersal Form in EMResource (see EMSsystem User Guide for more information).

Sample Field to Control Facility Communications

Patient Destinations:

- “_____ Control, this is Hwy 99/East Medical. The Immediate Head and Immediate Chest are ready for transport.”
- **“Copy Hwy 99/East Medical. Please transport your Immediate Head by air to Trauma Center A, and your Immediate Chest by air to Trauma Center B.”**
- “_____ Control, I copy. The Immediate Head is departing now in LifeFlight1 with a 5 minute ETA, and the Immediate Chest will be departing in about 5 minutes in CalStar1 with a 10 minute ETA to Trauma Center B.”
- **“We copy, the Immediate Head is departing now with a 5 minute ETA to Trauma Center A by LifeFlight1 . Please re-contact us when the Immediate Chest departs for Trauma Center B with their departure time.**
- “_____ Control, we will contact you when the Immediate Chest departs scene. We are ready for destinations for our 3 Delayed and 6 Minors.”
- **“Hwy 99/Hatch Medical, please take 2 Delayed to Hospital C, 1 Delayed and 1 Minor to Hospital D, and the other four Minors to Hospital E.”**
- “I copy, _____ Control. I’ll contact you when they depart scene with their departure times and ETAs. Hwy 99/Hatch Medical, clear.”

6. Patient Destination Guidelines

a. Immediate Patients

- i. Send to Immediate Teams at facilities within 30 minutes (30 miles) transport time from the incident whenever possible.
- ii. Send Immediate Trauma Patients to nearest Trauma Centers when possible (following local EMS protocols).
- iii. Send Immediate Pediatric Patients to Pediatric Centers when possible (following local EMS protocols).
- iv. When more patients exist than available teams to accept those patients, consider:
 - Requesting local Receiving Facilities to increase patient capacity.
 - Sending more patients to local teams than standard guidelines.
 - Sending patients beyond the standard transport radius.

b. Delayed Patients

- i. Send to Delayed or Immediate Teams within 60 minutes (60 miles) transport time from the incident whenever possible.
- ii. When more patients exist than available teams to accept those patients, consider:
 - Requesting local Receiving Facilities to increase patient capacity.
 - Sending more patients to local teams than standard guidelines.
 - Sending patients beyond the standard transport radius.

c. Minor Patients

- i. Send to local hospital EDs. These patients can typically be assessed by hospital triage personnel and await definitive care.

- ii. When more patients exist than available teams to accept those patients, consider:
 - Requesting local Receiving Facilities to increase patient capacity.
 - Sending more patients to local teams than standard guidelines.
 - Sending patients beyond the standard transport radius.

- d. Air Transport
 - i. When sending patients by air ambulance or air rescue to receiving facilities out-of-county, assess whether the Patient Transport Unit has obtained destination information from the flight crew (i.e. based on environmental conditions, fuel, etc.; flight crews may have pre-determined their best destination).

 - ii. Consider sending patients by air transport to farthest appropriate facilities (those with helipads within the transport time radius), allowing ground units to transport to nearer appropriate facilities.

7. Ending an MCI Event

- a. Once all patients have been distributed, the Control Facility shall update the MCI Event in EMSSystem, providing a final Summary of the Event to participating Receiving Facilities; including patient destinations.

- b. After providing the Summary of the Event (approximately 5 minutes), the Control Facility shall end the event, and notify all participating facilities.

- c. Once the event has been completed, the Control Facility and all participating Receiving Facilities shall complete an MCI Critique (see "Appendix A.4") and file all MCI paperwork.

- d. The Control Facility Supervisor shall coordinate an After Action review with the local EMS agency for any unusual event or MCIs with greater than 10 patients.

C.HAvBED Poll

The purpose of the Hospital Available Beds in Emergencies and Disasters (HAvBED) program is a standardized "real-time" hospital bed and resource availability information system that can be used by decision makers, planners, and emergency personnel at the local, State, regional, and federal levels.

- a. Upon request of the MHOAC or EMS Agency, the Control Facility shall create a HAvBED event in EMResource.
- b. Monitor hospital responses, and contact any facility that has not responded within 30 minutes of the request to obtain necessary information.
- c. Create a "Snapshot" report, showing the results from each hospital (see EMSystem User Guide for more information).
- d. Forward the results of the HAvBED poll to the requesting party.

D.Operational Area (Regional) Announcement

An Operational Area Announcement is an event within EMResource that allows for the notification of any number of facilities. Announcement may be made by the MHOAC, a local Public Health Department, EMS Agency, or Control Facility.

Examples of Announcements might include: Information regarding a Hazardous Materials Spill; Incident Information from a local, regional, or statewide Public Health warnings. Creating an Announcement Event is much like creating an MCI Event. (see EMResource User Guide)

- a. Upon request of the MHOAC or EMS Agency, the Control Facility shall create an Operational Area Announcement in EMResource.
- b. Select Receiving Facilities to include in Notification, and "Save" the event.
- c. When there is no longer a need for the Announcement information, or the incident/event is being managed by the RDMHC/S, the Operational Area Announcement event shall be canceled.

SECTION 2: Receiving Facilities

A. *Pre-Event Responsibilities*

1. Receiving Facilities shall be authorized within each Operational Area by the local EMS Agency for the purpose of receiving patients transported by ambulance.
2. Staff & Resources
Receiving Facilities shall maintain adequate personnel and equipment to perform the duties outlined in this section.
3. Communications
Receiving Facilities shall maintain the following minimum communications equipment:
 - a. EMSsystem computer and speakers located in the facility where audio alerts may be heard and responded to 24 hours per day, 365 days per year.
 - b. Dedicated land-line telephone system
 - c. Emergency two-way radio systems
 - UHF MedNet
 - VHF HEAR radio
 - d. Auxiliary radio hook-up (Amateur radio)
 - e. Other communications devices or systems as required by local EMS agency protocol
4. Liaison/Coordination
 - a. Each Receiving Facility shall appoint a liaison to the local Control Facility and EMS Agency. The Receiving Facility shall notify the local Control Facility Supervisor and EMS Agency when this position changes, and provide the updated contact name and telephone number.
5. Training
 - a. In cooperation with the EMS Agency and Control Facility, each Receiving Facility shall participate in Patient Distribution Exercises and Drills.
 - b. The Receiving Facility Liaison shall ensure that all Receiving Facility personnel are adequately trained in the Patient Distribution Plan, EMSsystem operations, Back-up systems (radio, telephone, etc.), and Patient tracking system(s)

B. *Facility Status Updates*

1. Each Receiving Facility shall update the facility status in EMResource whenever the facility status changes, and at least once every 24-hours.
2. EMResource will automatically prompt each Receiving Facility to

SECTION 2: RECEIVING FACILITIES

update the status each day at 8 a.m. (see EMS System User Guide for more information.)

C. Responding to an MCI Event

1. MCI Alert

Once an MCI Alert has been received, facility personnel shall:

- a. Determine Facility Capacity
(see *Appendix: Forms: Receiving Facility Capacity Worksheet*)
 - Always determine capacity for the highest level of care using the following guide for forming teams:
 - Immediate Team (able to treat single patient)
-At least one ED physician and two nurses
 - Delayed Team (able to treat two patients)
-At least one ED physician and one nurse
 - Minor Team (able to treat at least 10 patients)
-At least one nurse
 - If staff/resources are available to receive 2 Immediate Patients, report "2 Immediates," even if there are only Delayed patients on scene.)
 - Remember that patient conditions may change, and the Control Facility understands that an Immediate Team can treat Delayed and Minor patients.
- b. Verify Surgeon availability for Immediate trauma patients.
- c. Enter the Facility Capacity in EMResource for: Immediate, Delayed, and Minor patients within 5 minutes of the request.
- d. Notify Charge Nurse of the Event.

2. Monitor Updates

- a. Monitor incident information and updates in EMResource.
- b. Keep Charge Nurse and House Supervisor updated as to incident status and department staffing/resource availability.

3. Receive Patients

- a. When notified by the Control Facility of an incoming patient, print or document the patient information and assign to treatment team(s) to prepare for receiving the patient(s).

- b. Notify trauma or surgical services regarding ETA of incoming patients requiring the respective services.

D. HAvBed Poll

The purpose of the Hospital Available Beds in Emergencies and Disasters (HAvBED) program is a standardized "real-time" hospital bed and resource availability information system that can be used by decision makers, planners, and emergency personnel at the local, State, regional, and federal levels.

- a. HAvBED polls may be generated locally by the Control Facility, MHOAC, or EMS Agency to assess local resources, or may be generated by the RDMHC/S to assess resources throughout the region.
- b. Each hospital ED Charge Nurse, or designee, will request the House or Nursing Supervisor to provide the availability for each of the HAvBED categories using EMResource within 30 minutes of request.

Section 3: Operational Area (LEMSA/ MHOAC)

- A. The EMS AGENCY shall be notified by the local Control Facility for:
 - 1. Events requiring receiving facilities beyond those currently listed in EMResource
 - 2. Events involving hospital evacuation
 - 3. Events requiring Austere Care
 - 4. Inability of the Control Facility to conduct patient distribution activities within the Operational Area
 - 5. Other criteria established by the local EMS agency or MHOAC
- B. Any EMS Agency or MHOAC may be activated by the RDMHC/S for receiving patients from an event outside the mutual-aid region.
- C. For local events that exceed the capacity of facilities within the mutual-aid region, the EMS Agency or MHOAC shall:
 - 1. contact the RDMHC/S to facilitate inter-region patient distribution.
 - 2. coordinate the transportation needs of the field responders as necessary.
- D. For events occurring outside the region, the RDMHC will coordinate with MHOACs within the region to establish temporary Field Treatment Sites (FTS)/Patient Reception Areas (PRA) as necessary, while working with the Control Facilities to rapidly assess Receiving Facility capacities and coordinate the patient distribution. When contacted to establish a FTS/PRA, the MHOAC shall:
 - 1. Notify the County OES Coordinator to activate and support the FTS/PRA, including the establishment of an ICS structure, Medical Branch Director, and accurate Patient Tracking
 - 2. Notify the local Control Facility of the event, and need for patient distribution and patient tracking
 - 3. Notify local EMS providers to support the FTS/PRA, including any medical transportation needs
 - 4. Monitor EMResource to ensure Receiving Facility capacities are accurately reflected
 - 5. Maintain communications with the RDMHC to facilitate patient movement and patient distribution
 - 6. Ensure final Patient Tracking information is provided to the RDMHC for feedback to the requesting MHOAC.

SECTION 3: OPERATIONAL AREA

SECTION 4: Regional Disaster Medical/Health Coordinator/Specialist

The RDMHC is responsible for the coordination of medical and health mutual aid among the operational areas within the mutual aid region. The Regional Disaster Medical/Health Specialist (RDMHS) is staff to the RDMHC, and works under the general guidelines and objectives issued by the State EMS Authority.

- A. The RDMHC/S shall be activated by an EMS Agency or MHOAC for assistance with inter-regional/state patient distribution when a local event exceeds the capacity of Receiving Facilities listed in EMResource(or into a neighboring jurisdiction).
- B. For local events that exceed the capacity of facilities within the region, the RDMHC/S shall contact the state EMS Authority (EMSA) to facilitate inter-region or inter-state patient distribution.
- C. For events occurring outside the region, the RDMHC/S will coordinate with the MHOACs to establish temporary Field Treatment Sites (FTS)/Patient Reception Areas (PRA) as necessary, while working with the Control Facilities to rapidly assess Receiving Facility capacities and coordinate the patient distribution.
- D. When contacted by EMSA to receive patients from outside the region, the RDMHC/S shall:
 - 1. Identify locations for establishing FTS/PRA as necessary (e.g. major airports for receiving military aircraft)
 - 2. Contact MHOAC(s) to activate FTS/PRA as necessary
 - 3. Create a Regional Announcement in EMResource (see Appendix F) to notify local facilities of the event, and need for patient distribution and patient tracking
 - 4. Monitor EMResource to ensure Receiving Facility capacities are accurately reflected
 - 5. Maintain communications with the EMSA and MHOAC(s) to facilitate patient movement and patient distribution
 - 6. Ensure final Patient Tracking information is provided to the requesting agency.
- E. For events requiring patient distribution out-of-state, the EMSA will coordinate with the National Disaster Medical Service (NDMS) to rapidly assess other states' Receiving Facility capacities and coordinate the patient distribution to other states.

SECTION 4: RDMHC/S

SECTION 5: GLOSSARY

“Austere Care”: Condition in which the resources or services are not available to provide the same Standard of Care provided during normal operations.

“Control Facility (CF)”: A facility identified and authorized by the local EMS agency to assume primary responsibility for determining patient destinations during a multiple casualty incident or facility evacuation requiring the coordination of patient destinations. Also referred to as PDC

“Delayed Patient”: Patients whose medical care can be held one to two hours without detriment. Patients without life-threatening injuries who cannot be sent to the waiting room will be triaged as delayed patients.

“EMSystem / EMResource”: An internet-based system that lists the resources within a geographic region & constantly monitors the status of each. (System Requirements: 200 MHz processor, 128 Mb RAM, 1024 x 768 video card, sound card w/ speakers, high-speed internet)

“Event”: A triggering circumstance requiring communication and coordination among various system participants. EMResource Events include: MCI Events, Regional Announcements, and Inpatient Bed Polls.

“EMS Authority” (EMSA): The state department with responsibility to coordinate, through local EMS agencies, medical and hospital disaster preparedness with other local, state, and federal agencies and departments having a responsibility relating to disaster response.

“Immediate Patient”: Patients with life threatening injuries that will most likely need medical intervention within the hour.

“Medical Group Supervisor (MGS)”: Staff person from the field responsible for medical operations. May assign Medical Communications Coordinator to contact the Control Facility.

“Medical Health Operational Area Coordinator (MHOAC)”: A role shared by the Public Health Officer and EMS Agency Administrator or an individual designated by a County Health Officer and EMS Agency Administrator who is responsible, in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of medical and health resources within the Operational Area (county).

“Minor Patient”: Ambulatory patient whose medical care can be held two hours or more without detriment.

“Multi-Casualty Incidents (MCI)”: Incident that involves more patients than initial responding pre-hospital units can render appropriate care.

“National Disaster Medical System (NDMS)”: The federal organization

SECTION 5: GLOSSARY

responsible to augment the Nation's emergency response capability.

“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 victims in a domestic disaster, emergency, or military contingency.

“Patient Distribution Center (PDC)” The PDC is a center designated to coordinate the distribution of casualties. Within the OA, the PDC is designated by the LEMSA, and is commonly referred to as a Control Facility; within a mutual-aid region the PDC is designated by the RDMHC/S; and at the state the PDC is designated by the EMS Authority. (see also Control Facility)

“Regional Disaster Medical/Health Coordinator (RDMHC)”: The EMS Authority and CDPH jointly appoint the RDMHC in each mutual-aid region. The RDMHC coordinates disaster information and medical/health mutual-aid and assistance between the MHOACs within that mutual-aid region and response to other mutual-aid regions in the state. The RDMHC provides the day-to-day planning and coordination of medical and health disaster response within the mutual-aid region. During disaster response, the combined RDMHC/S Program is the point-of-contact for MHOAC Programs within the mutual-aid region, as well as for the CDPH and EMSA.

“Regional Disaster Medical/Health Specialist (RDMHS)”: A staff person in a LEMSA where that agency has agreed to manage the regional medical and health mutual aid and emergency response system for the Cal-EMA Mutual Aid Region. Responsibilities are to manage and improve the region medical and health mutual aid and mutual cooperation systems; coordinate medical and health resources; support development of the Operational Area Medical and Health Disaster Response System; and, support the State medical and health response system through the development of information and emergency management systems.

SECTION 6: APPENDICIES

SECTION 6: APPENDICIES

Appendix A: FORMS

- 1. Receiving Facility Capacity Worksheet**
- 2. Patient Destination Worksheet**
- 3. MCI Critique – Receiving Facility**
- 4. MCI Critique – Control Facility**

Appendix A-1

RECEIVING FACILITY CAPACITY WORKSHEET

1. PLACE INITIALS, OR A CHECK MARK, FOR EACH PERSON/BED AVAILABLE FOR MEDICAL TREATMENT BEGINNING WITH "IMMEDIATE TEAM" COLUMNS. WORK LEFT TO RIGHT.
2. SURGEONS NAMES MUST BE PROVIDED (for MCI Trauma). SURGEONS MUST BE IMMEDIATELY AVAILABLE TO REPORT TO THE RECEIVING FACILITY.
3. PLACE TOTAL NUMBER OF COMPLETE IMMEDIATE TEAMS IN "COMPLETE TEAMS" COLUMN AND "TOTAL PATIENTS" COLUMN.
4. TRANSFER CHECK MARKS TO "DELAYED TEAM" COLUMNS FROM INCOMPLETE "IMMEDIATE TEAMS" OR ADDITIONAL STAFF.
5. MULTIPLY COMPLETE "DELAYED TEAMS" BY 2, AND PLACE TOTAL IN "TOTAL PATIENTS" COLUMN.
6. TRANSFER CHECK MARKS TO "MINOR TEAM" COLUMNS FROM INCOMPLETE "DELAYED TEAMS" OR ADDITIONAL STAFF.
7. MULTIPLY COMPLETE "MINOR TEAMS" BY 10, AND PLACE TOTAL IN "TOTAL PATIENTS" COLUMN.

TEAMS			Complete Teams	Total Patients
IMMEDIATES			<i>(1 PATIENT PER TEAM)</i>	
ED PHYSICIAN _____ *SURGEON _____ NAME _____ MICN/RN _____ ICU/ED LVN _____ Resp Tech _____ 1 Ed Bed _____	ED PHYSICIAN _____ *SURGEON _____ NAME _____ MICN/RN _____ ICU/ED LVN _____ Resp Tech _____ 1 Ed Bed _____	ED PHYSICIAN _____ *SURGEON _____ NAME _____ MICN/RN _____ ICU/ED LVN _____ Resp Tech _____ 1 Ed Bed _____		
DELAYED			<i>(2 PATIENTS PER TEAM)</i>	
PHYSICIAN _____ MICN/RN _____ ICU/ED LVN _____ 2 Ed Beds _____	PHYSICIAN _____ MICN/RN _____ ICU/ED LVN _____ 2 Ed Beds _____	PHYSICIAN _____ MICN/RN _____ ICU/ED LVN _____ 2 Ed Beds _____		
MINOR			<i>(10 PATIENTS PER TEAM)</i>	
MICN/RN _____	MICN/RN _____	MICN/RN _____		

MCM 407 (9/06)

PATIENT DESTINATION WORKSHEET

Total Transport Units Available: Air: _____ Ground: _____

Total Patients: _____ Total Deceased: _____ Total Refused: _____

Immediate: _____

Delayed: _____

Minor: _____

	Age/ Sex	Tag Number	Major Injury	Destination	Mode/Unit	Departure Time	ETA	Facility Notified
I					A G			
D								
M								
I					A G			
D								
M								
I					A G			
D								
M								
I					A G			
D								
M								
I					A G			
D								
M								
I					A G			
D								
M								

I = Immediate, D = Delayed, M = Minor A = Air, G = Ground

Completed by: _____

MCI CRITIQUE - RECEIVING FACILITY

Date: _____ Time: _____

HOSPITAL: _____

GIVEN TIME TO PREPARE A STATUS REPORT: Yes [] No []

GIVEN ENOUGH INFORMATION: Yes [] No []

HEARD ALERT: Yes [] No []

DID YOU ACTIVATE ANY PORTION OF INTERNAL DISASTER PLAN? Yes [] No []

COMMENTS/SUGGESTIONS:

IF YOU RECEIVED PATIENTS, PLEASE COMPLETE THE FOLLOWING SECTION:

FIELD TRIAGE	CRITERIA* (SEE BELOW)	TRANSPORT UNIT	AGE/SEX	HOSPITAL TRIAGE	CRITERIA** (SEE BELOW)	ADMIT	WHERE	DIAGNOSIS
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:

* CRITERIA – FIELD TRIAGE		** CRITERIA – HOSPITAL TRIAGE	
IMMEDIATE	- CODE 3 TRANSPORT - MAJOR TRAUMA CRITERIA	IMMEDIATE	- ADMISSION TO SPECIALTY UNIT/EMERGENCY SURGERY
DELAYED	- NON AMBULATORY - CANNOT GO TO WAITING ROOM	DELAYED	- ADMIT MED-SURG - NON-AMBULATORY ON ARRIVAL
MINOR	- AMBULATORY AND CAN GO TO WAITING ROOM IF NECESSARY	MINOR	- AMBULATORY

Return to address on reverse or FAX to # _____

COMPLETED BY: _____

MCI CRITIQUE - CONTROL FACILITY

Date: _____ DRILL: [] ACTUAL: []

PATIENT DISPERSAL OFFICER: _____

ALERT: Yes [] No [] TIME: _____ BY WHOM: _____

INCIDENT NAME: _____ LOCATION: _____

FACILITY STATUS OFFICER: _____

TIMES (RECV. HOSP. ALERT): _____ (CONFERNECE CALL): _____

INCIDENT NEEDS REVIEW: Yes [] No [] HOSPITAL ACTIVATED: YES [] NO []

SUPERVISOR NOTIFIED: _____

COMMENTS/SUGGESTIONS:

IF YOU RECEIVED PATIENTS, PLEASE COMPLETE THE FOLLOWING SECTION:

FIELD TRIAGE	CRITERIA* (SEE BELOW)	TRANSPORT UNIT	AGE/SEX	HOSPITAL TRIAGE	CRITERIA** (SEE BELOW)	ADMIT	WHERE	DIAGNOSIS
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:
IDM				IDM		Y N		DX:

* CRITERIA – FIELD TRIAGE		** CRITERIA – HOSPITAL TRIAGE	
IMMEDIATE	- CODE 3 TRANSPORT - MAJOR TRAUMA CRITERIA	IMMEDIATE	- ADMISSION TO SPECIALTY UNIT/EMERGENCY SURGERY
DELAYED	- NON AMBULATORY - CANNOT GO TO WAITING ROOM	DELAYED	- ADMIT MED-SURG - NON-AMBULATORY ON ARRIVAL
MINOR	- AMBULATORY AND CAN GO TO WAITING ROOM IF NECESSARY	MINOR	- AMBULATORY

COMPLETED BY: _____

DIRECTORY**(i) STATE AUTHORITIES**

0800-1700 Monday thru Friday:

CA Dept. of Health Services (CDPH)	(800) 554-0354
CDPH Licensing and Cert (L&C)	(916) 229-3400
L&C District Supervisor (Sacramento)	FAX: (916) 229-3465

After Hours and Weekends:

CDPH Duty Officer	(916) 814-3441
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(ii) COUNTY AUTHORITIES

Medical/Health Operational Area Coordinators:

County	Contact
Butte County	Mark Lundberg, MD Butte County Office of PH 202 Mira Loma Drive Oroville, CA 95965-3500 Bus: 530.538.7581 Fax: 530.538.2164 Emer: 530.538.7581 Pager: 530.540.1559 Cell: 530.370.0766 mlundberg@buttecounty.net
Colusa County	Bonnie Davies Colusa County DHHS 251 East Webster St. Colusa, CA 95932 Bus: 530.458.0266 Fax: 530.458.4136 Emer: 530.458.0200 (Disp.) Cell: 530.713.1007 bdavies@colusadhhs.org
Glenn County	James Corona, MD / Dr. Jared Garrison Glenn County Health Services 240 N. Villa Ave Willows, CA 95988 Bus: 530.865.6430 Fax: 530.934.6438 Emer: 530.865.6430

	<p>Pager:530.828.6017 drcorona@glenncountyhealth.net igarrison@glenncountyhealth.org</p>
Lassen County	<p>Joanna Zimmermann, PHN Director Lassen Co. Public Health Dept. 1445 Paul Bunyan Rd. Susanville, CA 96130 Bus: 530.251.8183 Fax: 530.251.2668 Emer: 530.257.6121 (Disp.) Cell: 530.310.2524 zimmermann@co.lassen.ca.us</p>
Modoc County	<p>Kelly Crosby, PHN Modoc County Health Dept. 441 N. Main St. Alturas, CA 96101 Bus: 530.233.6311 Fax: 530.233.5754 Emer: 530.640.8622 (cell) Pager:530.233.4416 (S.O.) kellycrosby@co.modoc.ca.us</p>
Plumas County	<p>Tina Venable RN, PHN Plumas Co. Public Health Agy. 270 County Hospital Rd., Ste. 111 Quincy, CA 95971 Bus: 530.283.6346 Fax: 530.283.6110 Emer: 530.616.0595 Pager:530.280.9233 tinavenable@countyofplumas.com</p>
Sierra County	<p>Kenneth Cutler, MD, MPH Health Officer Sierra County Public Health PO Box 7 Loyalton, CA 96118 Bus: 530.993.6701 Fax: 530.993.6790 Emer: 530.289.3700 (SO) Cell: kcutler@sierracounty.ws</p>
Siskiyou County	<p>Luanne Cummings, MD Siskiyou County Public Health 806 S. Main Street Yreka, CA 96067 Bus: 530.841.2145 Fax: 530.841.4092 Emer: 530.841.2900 (Disp.) Cell: 530.598.0671 lcummings@co.siskiyou.ca.us</p>

Sutter County	Dr. Samuel Sanders / Amerfit Bhattal Sutter County Health Division 1445 Veterans Memorial Circle Yuba City, CA 95993 Bus: 530.822.7215 Fax: 530.822.7223 Emer: 530.822.7307 (Disp.) Cell: 530.330.3869 SSanders@co.sutter.ca.us
Tehama County	Richard Wickenheiser, MD Tehama Co. Health Services Agy PO Box 400 Red Bluff, CA 96080 Bus: 530.527.6824 Fax: 530.527.0362 Emer: 530.529.7400 (ans svc) Pager: 530.384.9636 rwickenheiser@lassenmedical.com
Trinity County	Elise Osvold-Doppelhauer, PHN, Director Trinity Co. Dept. of Public Health PO Box 1470 Weaverville, CA 96093 Bus: 530.623.8215 Fax: 530.623.1297 Emer: 530.623.2611 (Disp.) Cell: 530.623.0589 eosvolddoppelhauer@trinitycounty.org
Yuba County	Joseph Cassady, D.O. Yuba County Public Health 5730 Packard Ave., Ste. 100 Marysville, CA 95901 Bus: 530.749.6781 Fax: 530.749.6839 Emer: 530.682.8648 Cell: 530.682.8648 joecassady@co.yuba.ca.us

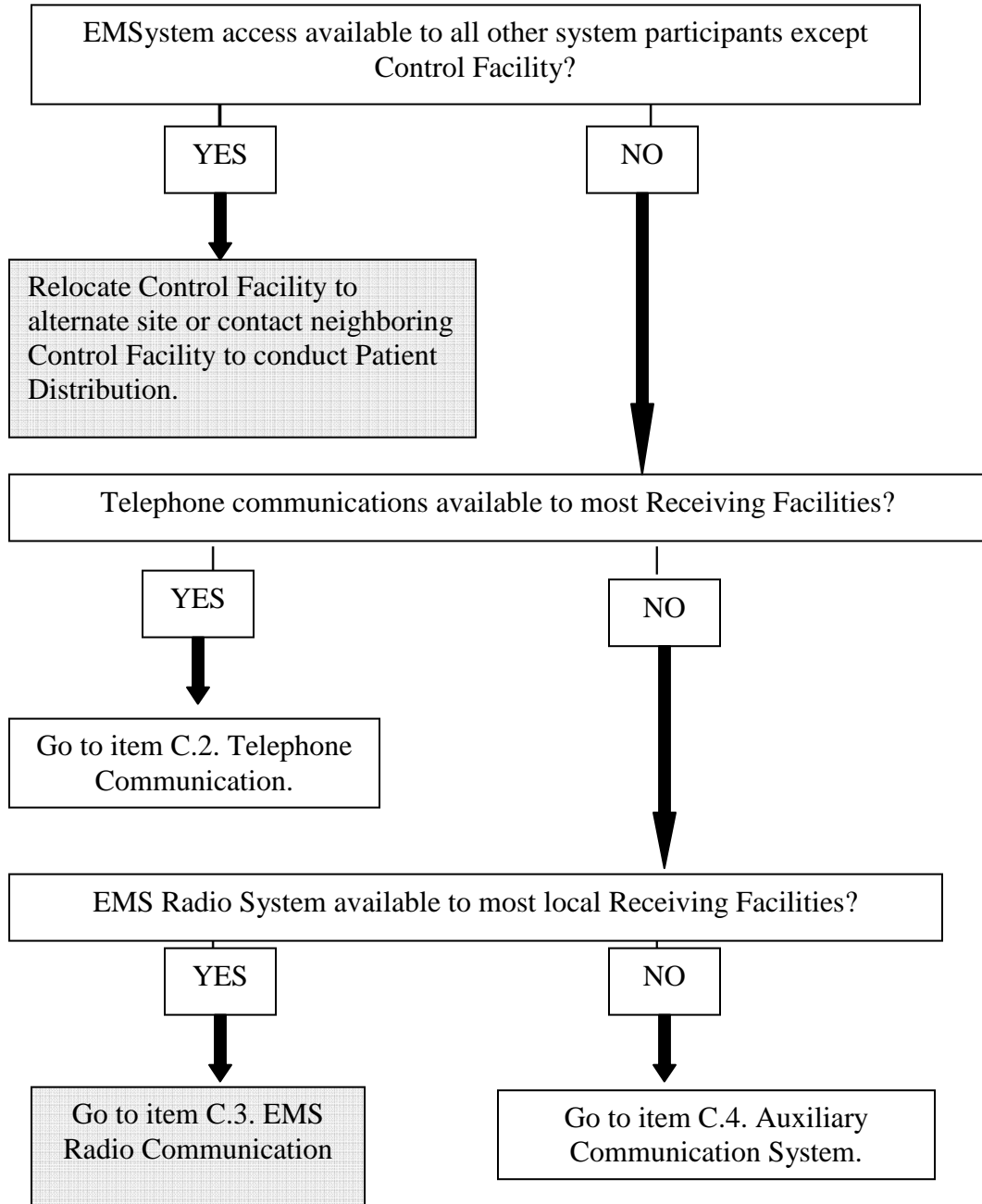
(iii) HOSPITALS / CONTROL FACILITIES

[INSERT HOSPITAL / CONTROL FACILITY DIRECTORY]

BACK-UP COMMUNICATIONS

In the event of EMSystem failure, either due to loss of internet connection, or loss of EMSystem access, the Control Facility shall implement back-up Communications with the Receiving Facilities using the following algorithm.

1. Communication Failure Algorithm.



2. Telephone Communications

In the event that EMSystem and the local EMS Radio System are unavailable to the Control Facility for obtaining Receiving Facility status reports, the Control Facility shall conduct patient dispersal

activities over the telephone system.

- i. Notify all hospitals of the event over the telephone system (or blast conference telephone system where available).
 - Notify the hospitals of the event and that EMS System or EMS Radio System will not be used for the collection of Receiving Facility Capacity reports and patient dispersal
 - Request that each facility complete the Receiving Facility Capacity Report
 - Notify facilities that they will be recontacted in 5 minutes to obtain their facility capacity reports
 - ii. Locate the MCI on facility maps, and identify the Receiving Facilities within 30 minutes travel time, for receiving potential Immediate victims.
 - iii. Maintain communications with the field Medical Communications Coordinator (or other patient information source, e.g. out-of-county county Control Facility, MHOAC, etc.).
 - iv. Update Receiving Facilities any time new information is received from the field, including: total patient count by triage category, patient destinations, etc.
 - v. Confirm total number of transport resources available, and begin Patient Destination Worksheet.
 - vi. Document Patient Information on the Patient Destination Worksheet.
 - vii. Assign Patient Destinations using the Patient Destination Guidelines in Section 3. A.: Control Facilities, part 2. A. (15) MCI Events.
 - viii. Notify individual Receiving Facilities as patients are dispersed, including patient triage category, major injury, age, unit number, and ETA.
 - ix. Upon completion of the Event:
 - Notify the hospitals that the Event has ended
 - Request that each facility complete and fax the Receiving Facility Critique
3. EMS Radio Communications
- In the event that EMS System is unavailable to the Control Facility for obtaining Receiving Facility status reports, the Control Facility shall conduct patient dispersal activities over the local EMS Radio system.
- i. Notify all hospitals of the event over the H.E.A.R. Radio System
 - Conduct roll-call of the facilities
 - Notify the hospitals of the event and that EMS System will not be

used for the collection of Receiving Facility Capacity reports
-Request that each facility complete the Receiving Facility Capacity Report
-Notify all facilities that they will be recontacted in 5 minutes to obtain their facility capacity reports

- ii. Locate the MCI on facility maps, and identify the Receiving Facilities within 30 minutes travel time, for receiving potential Immediate victims.
- iii. Maintain communications with the field Medical Communications Coordinator (or other patient information source, e.g. out-of-county county Control Facility, MHOAC, etc.).
- iv. Update Receiving Facilities any time new information is received from the field, including: total patient count by triage category, patient destinations, etc.)
- v. Confirm total number of transport resources available, and begin Patient Destination Worksheet.
- vi. Document Patient Information on the Patient Destination Worksheet.
- vii. Assign Patient Destinations using the Patient Destination Guidelines in Section 3. A.: Control Facilities, part 2. A. (15) MCI Events.
- viii. Notify individual Receiving Facilities as patients are dispersed, including patient triage category, major injury, age, unit number, and ETA.
- ix. Upon completion of the Event:
 - Conduct roll-call of the facilities
 - Notify the hospitals that the Event has ended
 - Request that each facility complete and fax the Receiving Facility Critique

4. Auxiliary Communications System (ACS)
In the event that EMS System, the local EMS Radio System, and telephone systems are unavailable to the Control Facility for obtaining Receiving Facility status reports, the Control Facility shall conduct patient dispersal activities over the ACS (Amateur Radio).
 - i. The MHOAC shall contact the local Office of Emergency Services to ensure that ACS is activated or deployed to the Control Facility and each Receiving Facility within the Operational Area.
 - ii. Once the ACS has been established, the Control Facility shall notify all hospitals of the event over the ACS.
 - Notify the hospitals of the event and that the ACS will be used for the collection of Receiving Facility Capacity reports and patient dispersal
 - Request that each facility complete the Receiving Facility Capacity Report
 - Notify facilities that they will be re-contacted in 5 minutes to obtain their facility capacity reports
 - iii. Locate the MCI on facility maps, and identify the Receiving Facilities within 30 minutes travel time, for receiving potential Immediate victims.
 - iv. Maintain communications with the field Medical Communications Coordinator (or other patient information source, e.g. out-of-county county Control Facility, MHOAC, etc.).
 - v. Update Receiving Facilities any time new information is received from the field, including: total patient count by triage category, patient destinations, etc.
 - vi. Confirm total number of transport resources available, and begin Patient Destination Worksheet.
 - vii. Document Patient Information on the Patient Destination Worksheet.
 - viii. Assign Patient Destinations using the Patient Destination Guidelines in Section 3. A.: Control Facilities, part 2. A. (15) MCI Events.
 - ix. Notify individual Receiving Facilities as patients are dispersed, including patient triage category, major injury, age, unit number, and ETA.
 - x. Upon completion of the Event:
 - Notify the hospitals that the Event has ended
 - Request that each facility complete a Receiving Facility Critique

Regional Map

