City and County of San Francisco
Gavin Newsom, Mayor

Emergency Medical Services Agency
Department of Emergency Management
Division of Emergency Services

EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE

Wednesday, June 2, 2010
1:00 PM – 3:30 PM

30 Van Ness Avenue, Suite 3300, Room 307
San Francisco, CA 94102

AGENDA

I.	Call to Order	Welcome / Introductions / Announcements /	Clement Yeh	1:00 PM
II.	Action	Approval of February 10, 2010 EMSAC Minutes	Clement Yeh	1:05 PM
III.	Action	Nominations & Vote for EMSAC Chair and Vice Chair for FY 2011	Clement Yeh	1:10 PM
IV.	Discussion (See handout)	Review of public comments on revisions to Multi-casualty Incident Policy 8000 including discussion of exercise and implementation of the MCI Plan	Mary Magocsy	1:15 PM
V.	Action	Vote on revisions to EMS Multi-casualty Incident Policy 8000	Clement Yeh	1:40 PM
VI.	Discussion	2010 Policy and Protocol Revisions	John Brown	1:50 PM
VII.	Discussion	Electronic Patient Care Records for ED's	Seb Wong	2:00 PM
VIII.	Discussion	STEMI Center Planning Update	John Brown	2:10 PM
IX.	Discussion (See handout)	Revision of Ambulance Diversion Policy	Keith Loring	2:20 PM
X.	Information	Update on Open EMS System Planning	Rob Dudgeon	2:30 PM
XI.	Information	Items from the Public		2:40 PM
XII.	Action	Adjourn	Clement Yeh	2:45 PM
XIII.		Closed Quality Improvement Session	Karl Sporer	2:45 PM

Next Meeting: Wednesday, August 11, 2010 @ 1300

Contact Mary Vassar at 487-5042 or mary.vassar@sfgov.org for questions regarding the meeting.
*30 Van Ness is located is located between Market and Fell St. (on the east side of Van Ness north of the Walgreens at the intersection of Van Ness & Market St.). Parking is available in the Performing Arts Garage on Grove St. (between Franklin & Gough) or the Civic Center Parking Garage on McAllister St. (between Larkin & Polk directly across from City Hall). There are also various open lots located throughout the area with deposit boxes on site (range $10 - $12 exact change required). Public transportation: Van Ness Muni stop or Civic Center BART stop.

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San Francisco EMS Advisory Committee
Meeting Schedule for 2010

Location: 30 Van Ness, Suite 3330, Room 307

Wednesday, June 2, 2010
1:00-3:30 PM

Wednesday, August 11, 2010
1:00-3:30 PM

Wednesday, Oct 13, 2010
1:00-3:30 PM

Wednesday, December 8, 2010
1:00-3:30 PM

Meeting schedule is also posted on the EMSA web site

11/24/2009

30 Van Ness Avenue, Suite 3300 • San Francisco, CA 94102-6026
(415) 487-5000 • FAX (415) 552-0194
www.sfdem.org

EMERGENCY MEDICAL SERVICES ADVISORY COMMITTEE
Meeting Minutes
February 10, 2010
13:00 – 15:00
30 Van Ness, Suite 3300

Item	Discussion	Action
Welcome, Introductions, & Announcements	Quorum established with members present represented in **BOLD** (Attachment A, attendance log). Announcements: **Steve LaPlante:** • Nominations are being accepted for the 12th annual EMS Awards. 3rd week of May. Wednesday May 19, 2010. Nominations are due April 19, 2010. Please send nominations to Steve LaPlante via email or fax. ° EMS Field Provider ° Hospital Provider ° Dispatch Person ° Community Member Award ° Ray Lim Excellence Award **John Brown:** • Housekeeping items from Dr Brown. • February 16, 2010 Health Commission committee meeting from 2:00 PM – 4:00 PM. Location will be DPH 101 Grove St., Room 300. Medical oversight of the EMS system. Public comment is welcome. • Heart Safe City (HSC) meeting on May 17, 2010 at 30 Van Ness, Suite 3300. 1:30-2:30. Topic will include the mass CPR training to be done outside City Hall on June 1, 2010. HSC wants to increase the public knowledge of the importance of bystander CPR. • Dr Brown extended thanks to the members in the room who responded to Haiti relief efforts after the earthquake. • DMAT-6 is accepting applications for participation on their team.	Meeting called to order at 1303
Minutes December 9, 2009 meeting	Minutes from previous meeting reviewed and approved with additions to the guest attendance log. Add Rene Steinhauer and Steve Lewis	Minutes approved with additions of stated attendees
Report from Clinical Care Standards Triage Working Group	**John Brown:** See the three documents included in today's EMSAC handout. 1. Summary of Establishing Regional Clinical Triage Guidelines 2. Minutes from the Regional Triage Discussion meeting	

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	3. Tool number Seven: Clinical Triage Guidelines During Clinical Resource Stage • See flow chart on document number 2. The objective of the Clinical Care Standards Triage Working Group. Region 2 California (coastal Area). This starts at Monterey County and goes north to Humboldt County. Includes 16 counties. Each county has a MHOAC. Santa Clara County developed this tool in response to the recent influenza flu episode. The tool went through many processes for approval including review by Bay Area counties health officers. Dr Brown brought this document to the RDMHC where all the MHOAC's meet. The goal is to standardize response to medical equipment and personnel needs throughout Region 2. This will allow counties a standard way to go about securing medical equipment and support when in needed. The process is for a county in need to go to the region and ask for equipment and support. If the region is not able to fulfill the request it then goes to the state health authority. These are guidelines not standards of care the tool is for people to use this tool to make decisions during a disaster. Flow chart on number two of the handouts show the decision process to be followed. Personnel who will use the tool include dispatchers, field personnel, and triage nurses at both hospitals and alternate care sites (ACS). See chart for complete details. The SF EMS Agency would like to include this tool in relevant policies for use by the system prehospital providers. We would also like to include this in the CCSF disaster response plan around alternate care sites. We would like the private hospitals use these in their disaster response plans as well. Please read the documents and let Dr Brown know of any comments of concerns. The state did participate in the regional meetings. Asking for comments and questions. ° What is the trigger for activation of Alternate Care Sites? *Director of Health declares ACS use. EMTALA is not relieved automatically by Health Director declaration. A federal declaration is needed to relieve EMTALA requirements.*	

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	° If there is a pandemic how we will be able to use medical personnel not licensed in the state or region? *The state has a data base of volunteers for medical personnel. The Medical Reserve Corps is also another way to use personnel in a disaster.* ° Was the use of alternate dispatch protocols in a disaster discussed? *It was not specifically addressed by the Santa Clara County group. The tool developed is a framework for disaster response.*	
Update on Rapid Anticonvulsant Medication Prior To Arrival Trial.	**Karl Sporer** This study has been going on for 18 months Rapid Anticonvulsant Medication Prior To Arrival Trial (RAMPART). This is a study funded by the NIH. The goal was to enroll 800 patients who were in status epilepticus. The study is going very well at present. Enrollment is going so well that the study might end as early as August, 2010. Compliance to the protocol by prehospital providers has been going well in general with a few errors.	
2010 Field Treatment Protocol Revisions	**John Brown** ▯ See summary 2010 Field Treatment Protocol Revisions handout. 1st page is what we would like to look at for updating. ° Changing benzodiazepine from Valium to Versed ° Extending the time a stroke patient is eligible to be treated at a stroke center to 4 ½ hours ° Change in fluid resuscitation in blunt trauma verses penetrating trauma. ° Update Pediatric Assault and Abuse protocol. The contact information specifically. ° Cervical Spine Immobilization: stress exclusion criteria of c-spine immobilization because of the potential side effects of prolonged immobilization. ° (New) Agitated/Delirium Protocol to increase patient and provider safety. Using both Versed and physical restraints. 2nd page of handout is a clarification of amiodarone use. ▯ These policies and protocol will go through the usual public comment process. ▯ Discussion about the efficacy of using IO infusions in trauma patients. IO infusion verses getting patient to	

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	the hospital ASAP. Literature suggests get to definitive hospital care. Paramedics want the option of doing IV/IO lines enroute to hospital. • Discussion on the use of pain meds in the field. Whether or not to use pain meds more liberally. • If anyone has input on the topics discussed email Dr Brown with further.	

MCI Policy Revisions	**Mary Magocsy**
	MCI planning work group has been meeting:
	Mary Magocsy had a Powerpoint overview of the MCI plan.
	Goals:
	• Minimize morbidity and mortality
	• 3 sections to the plan
	  ○ Core response
	  ▪ Basic infrastructure
	  ▪ Inter-agency coordination
	  ▪ MCI Classification scheme (incident levels Level 1, 2, 3, 4) triggers notifications to appropriate personnel
	  ▪ Level One = 50-60 patients can be handled locally. (CCSF)
	  ▪ Level Two = need assistance from neighboring counties. (Region 2)
	  ▪ Level Three = Beyond the region's ability to handle alone (State/Feds)
	  ▪ Level Four = Catastrophic event
	  ▪ Link to standard system orders
	  ▪ Medical distribution group. To distribute patients efficiently to hospitals in the region.
	  ▪ Modifying 9-1-1 response during large event
	  ○ Appendices
	  ○ Annexes
	  ▪ To be developed
	• The EMS Agency hopes to get this MCI plan out for public comment by February 24, 2010. Will have it out for PC for one month.
	• Hope to get the final version of the plan out by April 16, 2010.
	• Need to establish training cycles for the EMS system	

2010 Policy Revisions Working	**John Brown** Rob Dudgeon was unable to attend this portion of the	

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Group—New Policy for Critical Care Transport—Update of Open EMS System Planning	EMSAC meeting. • 2010 Revisions Work Group: Rob Dudgeon wanted to put together a work group to be sure that our policies and procedures do not contradict each other • Policy for CCT Interfacility Transports; what type of staffing patterns and the hierarchy of turning calls over to other providers. Have a more regional approach to CCT Transport • Open EMS system planning • EMS Plan was updated to the State EMS Authority • Strategic Planning is in Process • Draft for the Five Year Plan to be released for public comment in the summer, 2010 •	

Item from the Public	**Dominic Ward**
	• Question to the SFFD: When on the scene of a fire does the SFFD have blueprints of building they respond to? If a firefighter is in trouble can he/she be easily located before loss of life is imminent.
	  ◦ *The SFFD has updated their Mobile Data Terminals which now can advise firefighters of specific issue within a building to which they respond. There is also the capability to use satellite imagery to view buildings. Technology for locating specific firefighters in a building is not yet available to the SFFD*
	• Cultural competencies of the SFFD paramedics are lacking. All patients need to be respected and treated well. During his ride-a-long with the SFFD Mr. Ward witnessed inconsiderate treatment of people in need. He would like to see mechanism to prevent this behavior
	  ◦ *Cultural sensitivity is important to the SFFD. If there is a problem with a specific unit there is a process for reporting the issues. There is also training which is mandated for every fire department employee on cultural competencies.*
	Shawna Pandya
	• CiviGuard Technologies is developing technologies for many aspects of prehospital care. She is interested in getting feedback from EMSAC members. Please contact her after the meeting for further information.	

Adjournment		1510

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Attachment A – Attendance Log

San Francisco EMS Advisory Committee February 10, 2010
Organizations, representatives, and alternates present represented in **bold**.

Organization	Primary Representative	Alternate Representative
SFGH, Base Hospital Medical Dir.	**Patricia O'Connor**	Open
SFGH Base Hospital Coordinator	**Sharon Kennedy**	Open
SFFD Medical Director	**Karl Sporer**	**Brett Powell**
SFFD EMS Provider	Seb Wong	**Pete Howes**
DEC Medical Director	**Clement Yeh**	**Lisa Hoffmann**
CPMC/Pac/ Davies/St Luke's/Cal	**Shanon Watkins**	Heather Sebanc
Chinese Hospital	Dolores Ong	Stuart Fong
Kaiser San Francisco	Peter Emblad	Lisa Jacobson
Kaiser South San Francisco	Rachel Flinn	Raymond Han
St. Mary's Medical Center	**Joanne Handley**	Patrick Hand
St. Francis Memorial Hospital	**Abbie Yant**	Theresa Edison
Seton Medical Center	Jeanne Lee	Seraphin Co
UCSF	**Andrew Maruoka**	Wayne Little
VA Medical Center	**Chauncey Roach**	Jonathon Garber
American Medical Response	**Jerry Souza**	**Brianne Canepa**
Bayshore Ambulance	David Bockholt	**William Bockholt**
King-American Ambulance	**Josh Nultemeier**	Open
Presidio Fire Department	Rachel McNary	Open
Pro Transport-1	**Dan Bobier**	**Tyler Draeger**
St. Joseph's Ambulance	**Richard Angotti**	Open
SF Emergency Physicians Assoc.	**Mickey Rokeach**	Open
SF Paramedic Association	**Richard Pekelney**	Jorge Palafox
SF ALS Field Provider	Kris Moore	Ray Crawford
SF BLS Field Provider	**James Brighton**	**James Garcia**
DPH-CHN Clinics	Marcellina Ogbu	Michael Drennan
SF Comm Clinic Consortium	Susan Huffman	Maria Powers
Public Representative	**Dominic Ward**	Open

GUESTS			EMSA STAFF
Name	**Organization**		
Barbara Haught	**ProTransport-1**		**John Brown**
Trudy Tang	**American Medical Response, Field Sup.**		**Steve LaPlante**
Shannon Nelson	**American Medical Response, Field Sup.**		**Joe Hickey**
Shawna Pandya	**CiviGuard Technologies**		**Mary Magocsy**
Rene Steinhauer	**Bayshore Ambulance**		**Mary Vassar**
Steve Lewis	**ProTransport-1**		

PUBLIC COMMENT RESPONSE

Policy #8000 Multi-Casualty Incident + MCI Plan

April 14, 2010

Commenter	Comment	EMS Agency Response
James Brighton BLS Public Rep. EMS Advisory Committee	"Should availability of air support be polled, and one or two of the preselected and designated helicopter landing sites be put in use? How would patient air transport be coordinated and tracked? How or should this be outlined in the plan? P.S. I have not had a chance to review the whole document but great work. It's a huge undertaking."	EMS policy #4020 EMS Aircraft Utilization describes how air medical services are used in San Francisco. We decided to limit the scope of the proposed MCI plan to focus on ground transport operations since those are the most frequently used services within our city limits. In future revisions, we would like to better integrate the current EMS Aircraft Utilization policy into the MCI plan. Additionally, we would also like to add more detail on air medical services – especially the use of large, fixed wing military-style transports for mass medical evacuations.
Lann Wilder SFGH	Policy and Plan look very good - significantly improved from prior version. Especially support the establishment of the Level 0 Alert and differentiation of Levels 3 and 4. Only two minor recommended changes - on page 47 of the policy / plan pdf the word "to" be apparently omitted from the distribution of Green patients. Also on page 47 - recommend changing Black category label from "Expectant" to "Deceased" to maintain consistency with all other references to this category of patients and the triage categories as described on page 67.	Agreed. Will make the recommended changes and corrections.
Rich Pekelney	***(Comments from 3/8 Workshop are not verbatim)*** Add details about the use of military aircraft since many civilian air medical services are restricted from night flight. The San Francisco Sheriff Office and DEC may have information.	EMS policy #4020 EMS Aircraft Utilization describes how air medical services are used in San Francisco. We decided to limit the scope of the proposed MCI plan to focus on ground transport operations since those are the most frequently used services within our city limits. In future revisions, we would like to better integrate the current EMS Aircraft Utilization policy into the MCI plan. Additionally, we would also like to add more detail on air medical services – especially the use of large fixed wing military-style transports for mass medical evacuations.

	(Comments from 3/8 Workshop are not verbatim) If there is a Red Alert, hospital can pick up a pre-made packet with all the MCI materials in them. We will need to identify what is in the packets.	Excellent suggestion. Some hospital Emergency Departments use these already. We will follow up on this suggestion during the implementation phase.
Jeff Myers, SFFD	***(Comments from 3/8 Workshop are not verbatim)*** Recommend the use of the SACCO triage method rather than START method. START is fine as first line triage, but it is not useful in the triage area – particularly for deciding which RED patient is the sickest. SACCO is faster to use than trying to do trauma triage criteria.	Agree with comment that there may be better triage systems available for pre-hospital use. A new triage system would require time, effort and money to re-train EMS staff. We would also have to investigate whether SACCO is compatible with triage systems used in other counties. Therefore, we disagree with substituting SACCO or START triage in the 2010 MCI Plan. We will add it to the Bin List of Items to look at for the next revision.
	(Comments from 3/8 Workshop are not verbatim) Patient distribution as proposed in the plan is a front-end solution that will not work. The military uses a back-end solution to distributing casualties that is removed from the battle. Need to do a patient distribution on the back end. We have a gap in managing the "middle-size" MCI from 100 – 400 people. Need to concentrate planning on those numbers.	San Francisco needs to develop a mechanism for the distribution of patients beyond the numbers that are pre-assigned. We agree with your identification of the planning gap. We will meet again with SFFD and DEM-DEC (911 dispatch) to identify issues associated with a field-based patient distribution system. ****Note: Meeting held on April 14. Comments noted below.**
John Cavenaugh, SFFD	***(Comments from 3/8 Workshop are not verbatim)*** Patient distribution group should not be in the field because we do not have the big picture. What you are planning for is a gap between the initial field responses to when a Medical DOC is set up. That timeframe is about 1 – 3 hours.	San Francisco needs to develop a mechanism for the distribution of patients beyond the numbers that are pre-assigned. We agree with your identification of the planning gap. We will meet again with SFFD and DEM-DEC (911 dispatch) to identify issues associated with a field-based patient distribution system. ****Note: Meeting held on April 14. Comments noted below.**
	(Comments from 3/8 Workshop are not verbatim) In the Patient Transport Area, recommend adding units for the coordination of local vs. out-of-county transport coordinators.	Agree. We request that SFFD provide details on the function of this position and who they would report to in the ICS structure. Would like to include in next revision. For this current version, this an additional line was added to the Patient Transportation Unit Leader's position description: "At his / her discretion, may add additional positions in Patient Transportation Unit to coordinate transportation to out-of-county destinations."

Pete Howes, SFFD	***(Comments from 3/8 Workshop are not verbatim)*** The current MCI alerting mechanism using Red / Yellow alerts works well. We (SFFD) do not believe it should be replaced. If you want to use the MCI alert levels as defined in the plan – we suggest retaining the Red / Yellow alerts on the *operational level* and using the proposed alerts in the plan as *administrative* alerts.	Agree to retain yellow / red alerts for operations and the alert levels described in the plan will be used as "administrative" alerts.
	(Comments from 3/8 Workshop are not verbatim) Transport Area description needs to be written with more latitude for selecting the various options for patient transport so as to not constrain operations.	Already done. See Part 2 Core Operations, Section 2.3,4 Patient Transport Area / Patient Distribution , 2nd paragraph states: Possible patient transportation options include: • Ground Ambulance • Air Ambulance • At the discretion of the Transport Unit Leader, other vehicles (e.g. buses, wheelchair vans) may be substituted for ambulances as appropriate for the patients' condition.
Sebastian Wong, SFFD	***(Comments from 3/8 Workshop are not verbatim)*** Agree with comment to retain the Red / Yellow alerts. DEC could issue a Yellow Alert at the start of an incident. It will either be not be renewed if there are no patients, or it will be renewed as a yellow alert, or go to a Red Alert.	Agree to retain yellow / red alerts for operations, but disagree with passive stopping of alerts.
	(Comments from 3/8 Workshop are not verbatim) Noted the current state structure of using the Medical-Health Operations Coordinator + Regional Medical Health Coordinator is too slow for operations. Recommend providing direct links to operations.	Agee that the current Medical-Health Operations Coordinator + Regional Medical Health Coordinator system may slow communications. However, our solution is to streamline communications at DEC (911 dispatch) to the region if it is needed. Will need to discuss with the region. This may be added in the next version of the plan.
	(Comments from 3/8 Workshop are not verbatim) Level Zero –add authorities.	Changed the authority to call a Level Zero – Medical 911 Service Disruption alert to the DEC Deck Officer or DEM Duty Officer. Level Zero is a <u>notification and assessment-based alert.</u> This means an assessment of the medical 911 system will be done and any actions will be based on the results of that assessment.
	(Comments from 3/8 Workshop are not verbatim) In the modified response, delete First Responders from doing Code 2	The EMS response patterns may be modified in a variety of ways. Using First Responders is provided as an example of how the 911 EMS responses may

	responses.	be modified and will not be deleted from the plan. Any consideration of a modification of the EMS response during a MCI is a significant decision and would only be authorized by the EMS Agency Medical Director or DEM Duty Officer in his/her absence, in consultation with the Director of Health, the SFFD Chief and the leadership of the relevant EMS providers.
	(Comments from 3/8 Workshop are not verbatim) Need to include the Coast Guard as an option for air ambulances.	The Coast Guard is in the current list of providers in EMS policy #4020 EMS Aircraft Utilization. However, we do not have well developed operational plans for their use. In future revisions, we would like to better integrate the current EMS Aircraft Utilization policy into the MCI plan. Additionally, we would also like to add more detail on air medical services – especially the use of large, fixed wing military-style transports for mass medical evacuations. We can add operational details about the use of specific providers (Coast Guard, etc.) at that time.
Lisa Hoffman DEM - DEC	***Part 1 Response Charts, page 2: Level Zero MCI Alert, DEM Duty Officer Actions*** What is an AOC? It's not in the glossary and there's no definition that I could find.	*"AOC"* is the Dept of Emergency Management – Division of Emergency Services, Administrator on-call. The DEM Duty Officer may consult with the Administrator on-call in managing any situation. Will use the full title in final revision.
	Part 1 Response Charts, page 4: Level 1 MCI Alert, Summary Concept of Operations This is DEC controlled at this point right? I think it should be spelled out.	Agree. Will add clarification.
	Part 1 Response Charts, page 5: Level 1 MCI Alert, Patient Distribution Group "Can you include, in consultation with the DEC deck officer?"	Agree. Will add to discussion about Field Incident Command / Operations Section Chief will handle patient distribution in consultation with DEC deck officer.

	Part 1 Response Charts, page 5: Level 1, DEM Duty Officer Actions "Contact DEM Administrator on Call to determine need for additional notifications or alerting to region or state. Should this be DES Administrator?"	DEM Duty Officer does refer to the Dept of Emergency Management (DEM) – Division of Emergency Services Duty Officer. However, this title is confusing to persons outside of the DEM organization. Therefore the term, "DEM Duty Officer" will be used throughout the document.
	Part 1 Response Charts, page 7: Level 2 MCI Alert, Activation Criteria "Is there a resource distribution plan set up with allied hospitals in other areas of the region? Is that agreement going to be in the annex?"	There is <u>no</u> resource distribution plan set up with allied hospitals in other areas of the region. The regional Bay Area Urban Area Security Initiative Group has just received grant funds to create a regional patient distribution center plan. Details of that plan may be included in future revisions of the San Francisco MCI Plan when it is completed.
	Part 1 Response Charts, page 7: Level 2 MCI Alert, Field Mutual Aid Resources **"Mutual aid ambulances from other Bay counties may be used.** Do we have a written agreement that can be attached for review?"	The California EMS Authority has state guidelines for ambulance strike teams. The guidelines may be downloaded from their website under the publications section, EMS #215 Ambulance Strike Teams / Medical Taskforce Guidelines (2003). The proposed MCI plan used some of the information found in that guideline. Will add that citation in the background section under authorizes and standards.
	Part 1 Response Charts, page 9: Level 2 MCI Alert, DEM Duty Officer Actions "Incident Entry into LEO" "can you add what this is and who may or may not have access. I know what it is but other readers of this document may not."	Law Enforcement On-Line (LEO) is a secure FBI website that only DEM staff may access. We will add a note that is only for DEM staff use.
	Part 1 Response Charts, page 17: Level 4 MCI Alert, DEC Actions. Listed as none due to 911 service interruption. DEC would still have radio connectivity and if nothing else would have satellite radio/phone connectivity.	Agree that DEC may have some residual communication capabilities. However, for the purposes of planning, it is assumed that DEC has a complete service disruption and is not operational during a catastrophic Level 4 MCI. We will add a note explaining that is a planning assumption.
	Part 2 Core Response Charts, page 9 – Medical Group Operations under Patient Transport Area / Patient Distribution. Second paragraph describing Medical Communications Coordinator and Patient Distribution Group communications.	Yes. Will add language to final revision.

	Will this be in consultation with DEC deck officer using EMSystems for polling?	
	Part 2 Core Response Charts – 2.4.2 Patient Distribution Group, page 14 Is the DEC Deck Officer part of this group? I think the main concern I have is that DEC can and will distribute the ambulances to the hospitals in a repeating pattern, until the hospitals tell us they have no more availability to accept patients, we just need to know if there is an overflow plan and how that would be implemented. I think this group must consist of one person from DEC the deck officer, and any number of field and EMSA personnel.	Agree with proposal.
	Part 2 Core Response Charts – 2.4.7 Patient Distribution Group Operations, page 17, comment about Receiving Unit Leader role in contacting hospitals. The field won't have direct hospital contact unless they do it by phone individually. This should be coordinated by radio with DEC, who can relay the info via EMSystems or radio communication.	Agree with proposal.
	Appendix C Patient Distribution Center Position Descriptions This person can be in DEC, and can be a DEC personnel member. As whoever in the field will have to go thru DEC to find out what resources are available and what hospitals patient counts are.	Agree with proposal.
Pete Howes, SFFD - Written comments to proposed changes listed in Public Comment cover letter. Public Comment text noted in italics. Pete's comments are noted in un-	***The development of a comprehensive single-point of reference for managing large-scale emergency medical incidents in San Francisco for all San Francisco EMS providers.*** The single point of reference should be subdivided to be applicable to the user. The field providers should see the progression of the yellow to the red alert and have an awareness of the MCI Levels. The MCI Levels are applicable to different plan users: EMT and paramedic / operators, Field managers / RCs, DOC personnel, and EOC personnel.	Agree with suggestion. As we develop local field operations guide (FOG) manuals we can target specific users. This will be a future project once we agree/trained/exercised the core plan.
	New training standards and a recommendation for annual training updates for all EMS providers. Consideration for an MCI training month culminating in a tabletop and	We are looking to re-integrate the annual hospital exercises with dispatch and ambulance providers to do EMS system exercises in the near future. The next opportunity is the statewide health and medical exercise scheduled for Nov 18, 2010.

bolded font.	then a functional exercise should be vetted with the group and the training units of both the public and private ambulances.	
	Revised MCI alert terminology for the EMS system. I believe the MCI alerting terminology should stay the same.	Agree to retain yellow / red alerts for operations and the alert levels described in the plan will be used as "administrative" alerts.
	Standard System Orders that are linked to the MCI Alerts (found in the Part 1 – Response Charts). MCI Plan Response Charts Level 0 ▪ What is the back-up for EM System failure, IT / internet failure ▪ Should involve hospital wall time issues/divert… not just ambulance shortages as the shortage may be caused by other drivers – Level 1 ▪ Diversion – Suspended only for MCI patients – Why not suspend all diversion to clear the system? ▪ Scripted patient distribution should be based on geographic and hospital proximity drivers. Each Battalion should have a distribution matrix for efficiency of getting the transport platforms turned around and back in service. Level 2 ▪ On scene incident commanders need to be more concisely defined. ▪ Forward movement of patients for this level of MCI needs more discussion. The utilization of a casualty collection point as a centralized re-triaging and distribution point should be considered. Level 3 ▪ This will require a lot of collaborative work to further develop	<u>Response to Level 0 Comments:</u> • Hospitals currently experience periodic interruptions in their IT systems or Internet access. The 800 MHz radio and / or telephone are the back-up communications for EMSystem. The HEARNet radio is also available for backup communications between DEC and hospitals. EMS Agency Policy #3010 EMS Communications Equipment and Procedures address some backup communications. We will add additional details in a future policy revision. • The activation criteria listed in the Response Charts does indicate that hospital saturation or physical plant failure may create a medical 911 service disruption. <u>Response to Level 1 Comments:</u> • The MCI workgroup suggested that it be limited to only MCI patients for a Level 1 incident. The DEM Duty Officer may invoke it for the entire system if needed. Will add this to the text. • Scripted patient distribution plans and matrix is may be done as a future project when we continue work on the operational details of patient distribution. <u>Response to Level 2 Comments:</u> • Changed activation authority to Medical Group Supervisor or Field Incident Commander • Patient distribution operations for all MCI levels need more development. This includes the use of casualty collection points. We will meet again with SFFD and DEM-DEC (911 dispatch) to identify issues associated with a field-based patient distribution system.

	the plan	Response to Level 3 Comments: Agree with comment.
	Response Charts for front-line personnel that will eventually become a condensed field operations guide (FOG) in future revisions. The SFFD has a new EMS Job Aid that has been in production utilizing HLS Grants. The Job Aid is at the printer now [3/23/2010].	SFFD has agreed to provide a copy of the Job Aid for review.
	Implementation of a Patient Distribution Group in the ICS structure. The staffing of this PDC is burdensome given the number of RCs and the training needed to implement this outside of the EMS discipline. More work needs to be done for this function to be effective.	San Francisco needs to develop a mechanism for the distribution of patients beyond the numbers that are pre-assigned. We agree with your identification of the planning gap. We will meet again with SFFD and DEM-DEC (911 dispatch) to identify issues associated with a field-based patient distribution system. ****Note: Meeting held on April 14. Comments noted below.**
	Identifies the potential use of BLS ambulances in a MCI response. Utilizing BLS assets should be worked in to Policy so that they can be trained and part of the system as an early surge asset.	Will start by including BLS ambulances in MCI exercises. Any policy changes will be done under the "open EMS system" projects.
	Better defines the roles and responsibilities for the overarching medical command and coordination of the city agencies. This needs to be TTX and process mapped for accurate time lines and expectations.	Agree that this needs a project plan.
	• Better defined procedures for medical mutual aid requests – either into or out of San Francisco. This includes ambulance strikes teams requests. ***• Provides information on mass medical evacuations.*** This should be exercised at Urban Shield 2010.	Urban Shield is a SWAT team oriented exercise with EMS participation. Planning for the exercise is well underway. We would like to develop a training and exercise schedule for the remainder of 2010 and through 2011 with the input of the MCI Implementation Team working the DEM Exercise and Training Group.
	1. Need to develop operational plans for the following: ***• Patient distribution including the use of a Medical Departmental Operations Center (DOC).*** • ***Mass medical evacuations.*** This needs full development from the ground up.	Agree. This is a future project.

	2. Need to develop the MCI Plan annexes that define EMS response to specific incident types (bombings, chemical incidents, etc.). A copy of the EMS Job aid will be provided for your review.	Agree that SFFD training materials will be included in the review of provider or expert references when the annexes are developed.
	3. Need to better define the process for integrating the finding of on-going quality improvement practices into future MCI Plan revisions and training. This should be a loop back to operations and training.	Agree. We would like to review the quality improvement "feedback loop" practices for improving the overall EMS system response to MCIs.
	1. Significant costs may be incurred for the initial and on-going staff training and annual updates. These costs may or may not include required participation in MCI exercises. HLS Grants should be able to help curb the expenses.	Great suggestion. Will follow up for next grant year.
	2. Some providers (BLS ambulance companies) who have not traditionally participated in a MCI response may incur significant costs during an actual event. If the Policy supports the participation, 3rd party billing should cover these expenses -	Great suggestion. The EMS Agency may have to change other policies to support this plan and will include adding the language about BLS providers participating in MCI responses. Individual ambulance providers will have to do their own third party billing.
Tyler Draeger – Pro Transport 1	***Policy 8000, Page 4, Section IV, Subsection B, Paragraph 2, Item e*** HazMat requirement should be consistent with Policy 2000 and with Title 29, Code of Federal Regulations (1910-120), which require First Responder Awareness (FRA) not First Responder Operations (FRO)	Agree. Will change.
	MCI Plan (PART 1) Response Charts; Level 1 MCI, BLS Ambulances We suggest modifying the plan to allow for more flexibility in the City's response capabilities. There is no reason to tie our hands if we are unable to respond units when we don't need to. We recommend changing the language to the following: 1. DEM Duty Officer may request BLS ambulances for supplementing response. 2. Consider activating Internal Emergency Response Plan. This still leaves the decision up to the DEM and furthermore does not necessitate patients being transported via a BLS level of care; however it does provide resources to the scene that may be needed such as	The MCI plan should not be construed as System Status Management Plan or confused with the "Open EMS System" projects. Any consideration of a modification of the EMS response during an MCI is a significant decision and would only be authorized by the EMS Agency Medical Director or DEM Duty Officer in his/her absence, in consultation with the Director of Health, the SFFD Chief and the leadership of the relevant EMS providers.

	physical vehicles and additional medical personnel.	
	Level IV MCI; Description; Activation Criteria ***"Catastrophic earthquake with unknown number of casualties and deaths. City response and communications infrastructure are disrupted."*** This disaster does not need to be an earthquake. In fact, if such an event were to occur, it would likely be a terrorist attack or something other than an earthquake.	Agree. The point with this definition is that the disrupted City response and communications infrastructure precludes the use of a centralized command structure. Will add other examples, but also change the definition so the reader understands this.
	MCI Plan Part III; Background; 3.1.4 Personnel Training and Competency Levels; All Field First Responders HazMat requirement should be consistent with Policy 2000 and with Title 29 Code of Federal Regulations (1910 – 120), which require First Responder Awareness (FRA) not First Responder Operations (FRO) Additionally IS-800 is not stated in Policy 2000. Otherwise, it is inconsistent.	Agree and will change to First Responder Awareness. IS-800 requirement will need to be added to Policy 2000. Also other EMS policies that need to be revised so that they are all consistent with the MCI plan.
	MCI Field Boards Hospital names need to be revised as follows to be clearer or definitions should be added to the glossary in the annexes. SFGH – Trauma UC ST M Cal Pac ST L SFGH KSF VA CHH SETON K-SSF	Disagree. Only senior field staff will be using these boards and should be trained and familiar with the hospitals prior to their use in the field.

Below are comments from the 4/14 DEM – SFFD meeting to discuss issues associated with a field-based patient distribution system.		
Lisa Hoffman, DEC Comments from 4/14 DEM – SFFD Patient Distribution meeting	***(Comments from 4/14 DEM – SFFD Patient Distribution meeting are not verbatim)*** DEC can handle the patient distribution. We need specific details as to what tasks must be done when the SF hospitals are filled. DEC needs to have the authority to contact other counties for patient distribution if the DEM Duty Officer cannot immediately make those calls. Move some of the Regional-Medical Health Operations Coordinator function down to operations. Need to have the field MCI boards at dispatch plus phone numbers for out-of-county hospitals.	Agree with DEC. Need to develop: 1. Details as to what tasks must be done when the SF hospitals are filled. 2. DEC authority to contact other counties for patient distribution if the DEM Duty Officer cannot immediately make those calls. 3. Coordinate patient distribution with the Regional-Medical Health Operations Coordinator. 4. Provide field MCI boards at dispatch plus phone numbers for out-of-county hospitals.
Jeff Myers, SFFD Comments from 4/14 DEM – SFFD Patient Distribution meeting	***(Comments from 4/14 DEM – SFFD Patient Distribution meeting are not verbatim)*** Need to create an "emergency packet" of materials that can be pulled off the shelf in a large incident and used by field, dispatch and hospitals staff to start their response. The packets could include the same MCI status boards.	Agreed to do as project after the MCI Plan is done.
Compilation of from 4/14 DEM – SFFD Patient Distribution meeting	• More work needs to occur at the regional level to quickly notify other counties about the incident and identify open beds. • Need to be able to add more transport vehicles. • SFFD has an agreement with counties for supplementing engines, but none exists for ambulances. • Optimally, DEC, EMS transport providers, hospitals and the DEM Duty Officer all do scripted actions to increase the number of transport vehicles and find open beds for patients. • SFFD can increase ambulances by holding or calling in staff / cancelling trainings. • Private ambulances can do the same and in the first few hours also suspend inter-facility transfers. • Muni buses must be added to the response. It's best to pre-determine their drop-off routes for patients. Also use air medical resources. • Hospitals must take their pre-assigned patients plus invoke emergency plans to make room for more patients.	Agree with suggestions to create a **Patient Distribution <u>System</u>** where all providers participate in moving/receiving patients.

	• DEC can put out pages for notification and should be allowed to contact the region if the DEM Duty Officer cannot do it in the first few hours. • The DEM Duty Officer should immediately contact the region for additional transport vehicles plus hospital beds.	

PROPOSED FUTURE MCI RELATED PROJECTS

POLICY REVISIONS

- Revise other EMS policies and protocols to be consistent w/MCI plan (e.g. Add IS-800 to Policy 2000).

WORKING GROUP + PROJECT MANAGMENT

- Multi-disciplinary MCI Operations Working Group to work on Annexes and Other MCI Related Projects

NEXT MCI PLAN REVISION

- Develop annexes that define the EMS response to specific incident types (bombings, chemical incidents, etc.).
- Continue to refine the Part 1 Response Chart with the future goal of creating a Field operations guide (FOG)
- Review SACCO triage method and others to supplement or substitute for the START method. The Regional Trauma Coordinators are also working on standardized trauma triage guidelines. Need to integrate their work into an overall MCI triage plan.

CREATE COMMON "MCI PACKETS"

These would be pre-made packet with all the MCI materials in them to manage the MCI response.

- Hospitals – some may have packets already made. Goal would be to create and standardize packets across all SF EDs.
- Ambulances - Current EMS policy requires ambulance providers to stock MCI kits on the ambulances. Would like to review kits to create separate field staff vs. MGS supervisor kits.
- Dispatch – Need to create packets that contain forms for tracking hospital availability / patient transports / contact information for hospitals in SF and perhaps the region.

RELATED PLANS

- Develop detailed operational plans for Patient distribution including the use of a Medical Departmental Operations Center (DOC).
- Mass Medical Evacuations - Details on air medical services - especially the use of large, fixed wing military-style transports. This plan needs to integrate with current EMS Aircraft Utilization policy. This may be grant project coordinated with other counties. Incorporate details of the Bay Area Urban Area Security Initiative Group's regional patient distribution center plan when it is completed.

EXERCISE & TRAINING

- Do "Triage Tuesdays" and other drills to integrate MCI practices into daily work.
- Re-integrate other EMS providers into the annual hospital exercises to do EMS system exercises (next opportunity is the statewide health and medical exercise scheduled for Nov 18, 2010)

- Create 2 – 3 year training and exercise plan for EMS specific training and exercises as well as exercises with other public safety and city agencies.

- Exercise medical mutual aid requests for ambulance strike teams – either into or out of San Francisco.

QUALITY IMPROVEMENT

- Better define the process for integrating the finding of on-going quality improvement practices into future MCI Plan revisions and training. Agree. We would like to review the quality improvement "feedback loop" practices for improving the overall EMS system response to MCIs.

FUNDING

- Explore grant funding for EMS MCI training and exercises

- Third party Billing for BLS participation in MCI response . The EMS Agency may have to change other policies to support this plan and will include adding the language about BLS providers participating in MCI responses. Individual ambulance providers will have to do their own third party billing.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES SECTION

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Review: January 1, 2006
Supercedes: 2/1/04

DIVERSION POLICY

Note: This is draft of proposed revisions from Feb 2004 Working Group which were not implemented. Policy is now being revisited for discussion at 6/2/2010 EMSAC Meeting.

I. PURPOSE

A. To establish criteria to determine when Receiving Hospital Emergency Departments will divert ambulance patients.
B. To define procedures for communicating changes in diversion status.
C. To establish procedures for ambulance provider operations when a Receiving Hospital is on diversion.

II. AUTHORITY

A. California Health and Safety Code, Sections 1797.204; 1797.220; 1797.222.
B. California Code of Regulations, Sections 70737 and 70746.

III. POLICY

A. Ambulance personnel shall utilize *EMSEO Section Policy #5000, Ambulance Destination Policy***,** which considers the patient's condition, the patient's location, the patient's requested hospital, and the hospital's capabilities to determine the patient's destination.
B. Diversion shall be based solely on the physical ability of a hospital to care for patients and shall not be initiated as a result of ED overload or to manage volume.
C. The Base Hospital Physician retain the authority to determine ambulance destination. The Base Hospital Physician may override an Emergency Department's Partial Diversion status if, in his or her judgement, the patient's condition would worsen of bypassing a Receiving Hospital on diversion.
D. Receiving Hospitals shall report diversion status and subsequent changes on the HART, as described in Section VI and VII of this policy.
E. The ECD shall use the HART System to obtain the diversion status of Receiving Hospitals and communicate this status to on-duty ambulance personnel.
F. The ECD and Receiving Hospitals shall have personnel trained to operate the HART System on-duty 24 hours a day, seven days a week.
G. The Trauma Center may go on Trauma Bypass as described in EMSEO Section Policy.

IV. HOSPITAL DIVERSION STATUS

A. All Receiving Hospitals in the San Francisco EMS System shall be designated "OPEN" or on "TOTAL DIVERSION", based upon the criteria in this policy.

V. OPEN

A. A Receiving Hospital shall be designated "OPEN" when it is capable of receiving all patients who request that hospital and/or would be transported to that hospital according to *EMSEO Section Policy #5000, Ambulance Destination Policy*.
B. A Receiving Hospital that is open must display their three-letter facility indicator in the color "green" on the HART System.

VI. TOTAL DIVERSION

A. A receiving hospital may declare Total Diversion only when the Emergency Department or other area of the hospital has suffered a physical plant or equipment failure that renders the facility incapable of caring for patients. In declaring total diversion, the hospital shall:

1. The Hospital must institute its internal disaster plan.
2. The ED must be closed to all new patients, including those from interfacility transfers and walk in traffic.
3. The hospital administrator or his /her designee shall immediately inform the California Department of Health Services via telephone.

B. A Receiving Hospital shall be on "TOTAL DIVERSION" when they display their three-letter facility indicator in the color "red" on the HART System AND the displays the words "Total Diversion" on their hospital message line on the HART System.
C. If the diversion status is entered, as described in Section VII B., no ambulance shall transport a patient to that hospital.
D. If the diversion status is NOT noted on the HART status screen, hospitals shall be considered open for receiving patients and any patient transport to that facility shall be completed.
E. The hospital will immediately notify the EMSEO Duty Officer, through the ECD, and provide the following information:

1. The reason for the Total Diversion;
2. The actions taken to mitigate the situation; and
3. The anticipated time of ending Total Diversion.

F. The Hospital shall update hourly, the EMSEO Duty Officer, and provide any necessary information. In the event of a prolonged period of Total Diversion due to catastrophic physical plant or equipment failure, longer update intervals may be arranged as appropriate.
G. The Hospital shall determine the cause of the Total Diversion, the impact on the EMS System, and identify actions they will take to avoid future failures of the same type. The hospital shall forward this report to the EMSEO Medical Director within 15 days.

VII. DIVERSION OPERATIONAL PROCEDURES

A. Hospital Role in Diversion Status Change

1. Hospital personnel shall enter the hospital's appropriate diversion status in the HART System.
2. Hospital personnel shall immediately change their diversion status to OPEN on the HART System, as soon as their hospital is able to receive patients.
3. If the HART System fails, hospital personnel shall immediately report the problems to the HART System Support Line and follow the Back-up Telephone Procedure.
4. Hospital personnel shall notify the EMSEO Duty Officer as required.
5. Hospital Administrator shall make required DHS notifications.

B. ECD Role in Diversion Status Change

1. The ECD shall announce to all ambulance personnel by radio and mobile data terminals when a change in diversion status is entered into the HART System.
2. The ECD shall make diversion status announcements by radio and mobile data terminals to all ambulance personnel no less than every two hours when a hospital is on divert.

C. Ambulance Role in Diversion Status Change

1. An Ambulances enroute to a hospital that declares Total Divert must transport to a different hospital.
    a) Paramedics may consult the Base Hospital Physician if assistance is needed in determining an appropriate destination.

D. Back-up Telephone Communications if the HART System is Inoperable

1. The Receiving Hospital shall notify the ECD of any diversion status changes via telephone.
2. The ECD shall announce any diversion status changes to ambulance personnel by radio any time a change in diversion status is called in. ECD shall also routinely announce diversion status by radio at no less than two hour intervals.
3. The ECD shall announce any diversion status changes to the Base Hospital and hospital personnel via radio when there is a change in diversion status and every two hours.

VIII. QUALITY ASSURANCE AND RECORD KEEPING

A. Problems related to this policy shall be reported to the EMSEO Section through the Unusual Occurrence Report System.
B. EMSEO Section staff shall review hospital diversion activity and will report to the appropriate EMSEO Section committee.
C. The EMSEO Section, at their discretion, may conduct site visits while a hospital is on diversion status.