

**Comments on Proposed Revisions to Marin Multiple Patient Management Plan
August 1, 2011 through August 31, 2011
Draft Combined Comments **Draft****

SECTION # PAGE #	AGENCY	COMMENT	LEMSA RESPONSE
	Comm Center	Add SRFD	We will add them.
	Comm Center	Consider adding EMD capability to plan	We will add to the appropriate table in Appendix C.
Page 4 Competency Levels	SNR Fire	Is there anything that would be appropriate in this section specific to Law Enforcement?	We will review with Law enforcement.
Page 6 Roles and Responsibilities	SNR Fire	CHP and MCSO roles are clearly defined for their jurisdictional areas. Consideration for the inclusion of a section for roles of local (municipal) law enforcement agencies and their PSAP's	We will add Law Enforcement Agencies
Page 6 Roles and Responsibilities	SNR Fire	Consider inclusion/reference to the roles and responsibilities of Marin County Fire Dispatch (Woodacre)	We will review with MCFD
Page 7 Other Public Agencies	SNR Fire	Department of Public Works, and Cal Trans should be considered for addition due to their responsibilities especially on the roadways during Haz Mats	We will add them.
Standards, Pg 5	SRFD	FOG Guide, new edition 2007, Ch 15 is MCI	We will update with newest edition available at time of release. (new edition due out soon)
Lvel III Trauma Ctr, Pg 7	SRFD	<p>Transferring duties/communications from one facility to another in the middle of an MCI is asking for pure chaos, regardless of a consultation. It's obvious that the level III, or any other facility would be overwhelmed with an MCI, but transferring duties would compound the incident.</p> <p>In the fire service, transfer of command during an incident is a "Watch out" situation.</p>	We understand and agree. This decision should be made at the onset of the incident and is a training issue. We included this so there are redundancies built into this segment of coordinating patient distribution.

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Fire Service Amb Providers, Pg 13	SRFD	<p>Instead of xport from treatment area to the hospital, possibly more appropriate statement may be "Transport to definitive care" Trauma is a surgical disease and may require xport out of county for best results/outcomes for the patients.</p> <p>Everyone who reviewed this document noted that very little provision was made for evacuating urgent surgical/critical pts to other trauma facilities that are not that far away by air. Regardless of what each hospital's brochure says or this county document, what drives true urgent/surgical trauma care is how many ORs and surgical teams are available, ie... 3PM and ORs are full of elective pts vs 0300 and one team is "on call". More emphasis should be placed on getting those critical pts to appropriate definitive care,</p>	<p>We will add a section regarding the use of air ambulance. It is our intent in these types of incidents to move patients as quickly and efficiently as possible, when conditions, weather, patient surge and traffic allow access to trauma care that's fine. Often especially with high patient surge the use of the trauma system even regionally will not be available and these patients will need to be transported to any available facility.</p>
Activation Plan Pt destination, Pg 18	SRFD	<p>See above. Especially ref lower level MCI responses. Why would we transport one immediate pt to each of the 3 hospitals in Marin Co, when they may be evacuated to more appropriate facilities with greater capability nearby? The statement in "Local MCI" plan ref "Pts may be routed to any in-county hospital as appropriate" is a little confusing if the Trauma Triage Criteria is going to be waved. What is deemed appropriate and who decides?</p> <p>The same question should be applied to level 1, 2, and 3. Are we really going to wait until 24 pts hit the Marin Co hospitals during a level 3 until</p>	<p>See previous statement, we do intend to use out of county facilities and appropriate agreements will need to be made with those counties. This also needs to be addressed through training.</p>

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		LEMSA routes pts out of county?	
	MGH	<p>We are in agreement with the basic premise of the plan. It is agreed that we are the best hospital to manage the initial phase of a big patient related event, with help coming from com center. We will have the best sense of the resources available from a trauma standpoint.</p> <p>One of the biggest concerns we have is making sure that our staff is ready to manage a large incident and the distribution of large numbers of patients at the same time they are preparing to receive multiple patients. Obviously, this can all be solve with training and education. We will take responsibility for educating our staff and being prepared to take the appropriate action if this becomes the plan. We will however ask that the EMS agency and com center assist us in getting ready for such an event by assisting with this education as is seen appropriate. MGH is enthusiastic about being the go to hospital for major events and look forward to working with all the appropriate agencies to make this happen.</p>	We do intend to provide training to all system users, some of the comments that we have heard and read can be resolved through the training process, so we look forward to developing a better understanding of this plan through training.
Pages 3,5	SRFD	References to START (ex. p.4 and p5), the definitions should be consistent – either Simple Triage and Rapid Treatment/Transport or Simple Triage and Rapid Transport.	This should read Simple Triage and Rapid Treatment
	SRFD	Once an Alert has been initiated, there are several actions listed under EMS System	This section was updated to clarify responsibilities

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		<p>Actions. The document does not state who in the EMS System is responsible for performing these actions, which are actions that would be taken in the earliest stages of an incident. For example who queries the fire and private ambulance services for units available or who prompts the hospitals to complete bed availability query. Is it the responsibility of a LEMSA representative?</p>	
	SRFD	<p>ACTIVATION LEVEL SUMMARY (p.12) should be where the specific quantity range of patients should be defined for quick reference. Examples could still be used in addition to the definition but should be consistent with the definition. The example stated for the Level 1 activation on p.12 reads 30-40 patients. The description of Level 1 on p. 14 specifically says more than 15 and up to 30. They need to be consistent.</p>	<p>We will make the patient range consistent.</p>
	SRFD	<p>ACTIVATION ACTION PLANS p.13 – This section does not define how the Level III trauma center or EDAT becomes advised that the ALERT has been upgraded to an ACTIVATION and that they will likely be assuming patient distribution responsibilities. I would think this would be a responsibility of County Communications but there is no mention under the Roles and Responsibilities of Dispatch or any other agency for that matter.</p>	<p>We have clarified that the Comm Center will update the hospitals on alert and activation status.</p>
	SRFD	<p>Verify cache locations. There is no cache at</p>	<p>The attachments will be updated</p>

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		SRFD Station 3. There is a cache at Station 7 and I am not sure if there is one at Station 4	at a later date.
	SRFD	1. Written as though LEMSAs/MHOAC agents or representatives would immediately be available 24/7 for Level I or greater incidents to determine patient destinations.	Current law and EOM implies MHOAC 24/7, currently available by phone/remotely.
	SRFD	2. Who is the Coordinating hospital? The Coordinating hospital should only direct patient destination for Level I or greater activations.	Discussed earlier.
	SRFD	3. No mention of the TRAUMA TRIAGE TOOL for patient destination. Refer to San Francisco County, Alameda, Contra Costa, and Sonoma County MCI Plans as it refers their triage tool as a destination guideline. 100% of all responding agencies within Marin County know the Marin County Trauma Triage Tool. Utilization of this tool could simplify the learning curve during a MCI.	We have added a paragraph explaining this, there will also need to be training done to understand the transition from patient based care to population based care; the triage tool becomes ineffective with more than 8 trauma patients.
	SRFD	4. Plan states hospital informed via REDDINET and or Hospital Talk-Group. a. REDDINET doesn't include hospitals that would be appropriate initial destinations per our TRAUMA TRIAGE GUIDE. I.e. Level I/II Trauma Centers, Kaiser Richmond, etc. b. After querying several RN's at MGH/KTL no one knew about a Hospital Talk-Group or Coordinating Hospital responsibilities.	Implementation of this plan will require training in this area for the coordinating hospital and the MHOAC system. Training has been provided on ReddiNet and MERA in the past so refresher training is in order.

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	SRFD	<p>5. ICS Flow Chart/FOG Guide. Strike "Medical Supply Coordinator." "Medical Supply" falls under "Logistics," Referenced 15-17 FOG GUIDE. Medical supplies are ordered by the "TREATMENT UNIT LEADER via MEDICAL GROUP SUPERVISOR."</p> <p>a. Responding First Responders and Mutual Aid agencies will ultimately follow the FOG GUIDE.</p> <p>b. Strike "GROUND AMBULANCE," there is no such wording in the FOG GUIDE.</p> <p>c. Add "AIR OPERATIONS BRANCH DIRECTOR" to all IA (Initial Attack) incidents.</p> <p>d. Page 6...Strike under Fire Service... "In addition, the Marin County Urban"...This is a Marin County Sheriff subgroup.</p>	<p>FIRESCOPE is currently updating this section; this plan will be updated to recognize the new changes. We also wrote the plan in a manner that adopts new editions of documents without the need to re-write the plan. Some of the job action sheets will need to include actions that are specific to this plan and Marin; we will try to maintain the integrity of FIRESCOPE whenever possible. FIRESCOPE has added Air Ambulance Coordinator, in discussion with MCFD Marin doesn't have anyone qualified to do Air Ops Branch Director. On page 6 we were referring to Urban Search and Rescue, not Sheriffs Office Search and Rescue.</p>
	SRFD	<p>6. Overload at the Level III Trauma Center. To transfer responsibilities to an EDAT after consultation is the beginning of a disaster. It should be the responsibility of the Coordinating Hospital, Level III or greater to maintain communication/direction for the entirety of the incident.</p>	<p>See response above</p>
	SRFD	<p>a. Page 13...Fire Service Ambulance Providers...notifies MHOAC...ambulance</p>	<p>Depending on call volume system may become depleted</p>

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		<p>shortage. Should only be notified or implemented after Level I or greater. b. Page 13...delete extra space in 3rd bullet sentencing.</p>	<p>with a local MCI. We will have the final draft proof read and edited.</p>
	SRFD	<p>a. Page 13...Fire Service Ambulance Provider, last bullet, notify MHOAC? This creates a potential liability for units not following policy. Should follow under Incident Commander notifications. b. Page 14...Hospital...3rd bullet, delete extra spacing. c. Page 15....LEMSA/MHOAC, all seven bullets are unrealistic for after hours incidents. I.e. Do all EMSA agents have code III vehicle capabilities, current radio frequencies such as MERA,VHF, and or protective clothing, etc?</p>	<p>We updated this section. The new EOM document has improved the activities that are required by the MHOAC and EMS so we are adapting to the new changes. Currently the MHOAC is on "administrative call" 24/7 and any response would either be by phone, or to an EOC/DOC or in the capacity of an Agency Rep. to the Liaison Officer.</p>
	SRFD	<p>a. Page 16...First 4 bullets are unrealistic. I.e. No mentions of "Out of County Hospitals" until Level III incidents. Where is Region II, and how does this align with their MCI/Mutual Aid Policy? <i>What is MHOAC scene time to any incident?</i> b. Page 19...LEMSA/MHOAC conflicts with "Local MCI" on page 15.</p>	<p>We are adapting to new changes made by the state and by law, this is the process as described in the CPHMEOM (EOM) & H&S Code</p>
	SRFD	<p>a. Page 23....remain consistent with "FOG" Manual. Change "Medical Group" title with "Multi-Casualty." Delete "Area Manager" titles, not found in ICS/FOG Manuals. Suggest</p>	<p>This was discussed above, we will update the patient worksheet and the reference to the use of out of county hospitals, we</p>

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		<p>removing grey color background for clarification...unable to read "Delayed."</p> <p>a. Delete pages 24-42. REFER TO "FOG" Manual.</p> <p>b. Page 44....Patient Routing Worksheet. Delete colors, difficult to see even in optimum lighting conditions.</p> <p>c. Page 44-45....Provide 1 worksheet similar to Level II/III.</p> <p>1. "Local MCI," 1-15 patients...all critical...a majority of patients would be transported OUT OF COUNTY.</p> <p>d. Page 51...Outdated information</p>	<p>should use out of county facilities but we can't currently assign a pre-designated number of patients to those facilities, that will need to be coordinated with the Coordinating Hospital. The appendices will be updated at a later date.</p>
	MCFD	1. References to START. The last T is for "treatment", not transport.	This was addressed above.
	MCFD	2. Page 4. Reference to the number of patients "requiring transport". Is this ground or ground and air?	Transports may be by Ground or air as resource become available.
	MCFD	3. Page 5. Latest version of FOG is 2007.	We will update
	MCFD	4. Page 8. third paragraph. Is the reference for >5 "transportable" patients?	yes
	MCFD	5. Page 12. Add number of patients to left column for quick reference.	We agree and have added that to the document.
	MCFD	6. Page 13. Does ECC at Woodacre manage the incident? Reference is to just Comm Center.	We have incorporate broader language to include ECC

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	MCFD	7. Page 18. No PCRs for 6 patients? Not recommended. Need PCRs for billing.	Starts at 15 patients, understand billing concern, need discussion
	MCFD	8. Page 18. Significant shift in having Med Comm call each receiving hospital. Not sure that elimination of the coordinating hospital is a good idea.	We have rewritten this, it was not are intent to eliminate the Coordinating Hospital.
	MCFD	9. Page 19. ID who orders resources in a Level 1 activation	The IC, we clarified this in the plan.
	MCFD	10. Page 19. Add buses to Level 1 incidents.	Will add alternate modes of transportation
	MCFD	<p>11. Page 19. PSAP. How does the Woodacre ECC fit into this for incidents in MCFD response area All tables and worksheets need work to include removal of shading (or lessen) for readability. Many of these forms are under revision by FIRESCOPE.</p> <p>All references to activation levels should have patient ranges noted. Add appendix related to medical caches to include location and mechanism for ordering.</p>	<p>This was addressed above.</p> <p>Will add</p> <p>We will address the appendices at a later time.</p>