Triad Regional Advisory Council

Mutual Aid Response Plan

Emergency Medical Services

Sub-Committee

Final Draft
February 9, 2005

Triad Regional Advisory Committee
EMS Mutual Aid Response Plan

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PURPOSE

The provision of adequate and continuing ambulance services is outlined in Title 10A NCAC 13P by authority of General Statue 143-508 as the responsibility of each County Board of Commissioners within their respective jurisdictions. The counties of Triad Regional Advisory Committee (T-RAC) have developed Emergency Medical Services (EMS) Systems that comply with the rules outlined in Title 10A NCAC 13P. This agreement defines the steps county systems will use to ensure continuity of service in times of overwhelming demand for emergency medical services.

EMS systems within the T-RAC are specifically designed and operated to meet the normal, day-to-day demands for service within each jurisdiction. Back-up services are generally available from one or more providers within each county for those instances when the demand for service is heavier than normal and exceeds the capacity of the primary provider for service.

There will be circumstances, however, which will require EMS resources above and beyond those available within each county. While catastrophic events occur rarely, it may be necessary for the county to obtain assistance from some outside source. No unit of government can be expected to develop and constantly maintain sufficient resources to deal with every possible situation that might arise.

When emergency assistance from a neighboring jurisdiction is needed, there are numerous factors to be taken into consideration. These include but are not limited to:

- Who is authorized to request outside assistance?
- Whom and where does the requesting county call for assistance?
- Who is authorized to provide the assistance?
- What kind of assistance can the requesting county expect?
- When and where will the assistance be provided?
- To whom does the assistance report?

Those jurisdictions responding to mutual aid requests must answer many questions as well, including:

- Who can authorize the provision of assistance outside the county?
- How much help can you provide without jeopardizing your own ongoing operations?
- Where are you expected to go and what are you expected to do?
- Under whose command and control do you operate?

This document addresses these issues, which must be considered each time a mutual aid request is made.

INTRODUCTION

The T-RAC counties have collaborated on this mutual aid agreement. Our goal is to pre-plan the details of mutual aid response so that in the event of a catastrophic event, the response will run smoothly.

Each county must plan for the management of disasters and major incidents occurring within its boundaries as outlined in Emergency Management legislation. Individual county plans detail local administrative and operational issues, including matters such as chain-of-command, and indicates when local and state resources should be mobilized to deal with any emergency situation. The regional plan does not purport to change or alter existing local plans, but to use them as a foundation for a regional plan of mutual assistance. Each county's plan takes precedence within that county, and will serve to govern all resources coming into the county for the purpose of mutual aid. Units coming into the county will be placed under the command and control of the requesting county.

The regional plan is a mechanism for bringing outside resources to a county, and addresses many of the issues required for efficient and effective response:

- Establishment and notification of staging areas for incoming units
- Identification of local command structure
- Identification of means of communication among all responding units
- Delineation of matters of common concern:
  - Advanced Life Support protocol compliance
  - "Paperwork"
  - Medical direction/standing orders issues
  - Triage planning at three levels:
    - ✓ Initial triage and tagging systems
    - ✓ On-scene triage and initial transport
    - ✓ Patient disposition for definitive care
- Use of air (helicopter) resources
- Expenses and liability issues

The T-RAC, and its signatory agencies, believes that the plan that follows addresses the changes that have occurred in these regions, and adequately supports the priorities listed above.

INDIVIDUAL COUNTY REQUIREMENTS FOR PARTICIPATION

In order to effectively develop and implement this Regional EMS Mutual Aid plan, individual counties of the T-RAC must make some key initial decisions concerning their local organization and command/control functions. Counties adjoining the T-RAC, in North Carolina, have been invited to participate in this effort as well.

The key decisions/designations needed are as follows:

1. **Identify the person(s)/position(s)/agencies authorized to request EMS mutual aid:**

   For typical day-to-day operations, the on-duty shift supervisor is responsible for requesting assistance. Large-scale incidents will require that the request come from the EMS Director, EMS Officer, Emergency Management Coordinator, Incident Commander or other designated officer through the appropriate chain-of-command.

   Each county should provide primary and secondary contact information for this/these person(s). This information is included in Appendix A.

2. **Identify the person/position/agency authorized to provide EMS mutual aid to a requesting jurisdiction:**

   As stated above, for typical day-to-day operations, the on-duty shift supervisor may approve requests for assistance. Prolonged deployments of resources to another county will require approval from the EMS Director or other designated officer through the appropriate chain-of-command.

   Primary and secondary contact information for this/these person(s) is also included in Appendix A.

3. **Adopt an INCIDENT COMMAND SYSTEM for use by EMS:**

   Participating counties must have a functional Incident Command System in place when this plan is adopted. Incident Command is mandated for use in hazardous materials incidents, and as a requirement for federal grants. Incident command is a commonly recognized and successful method for tracking resources and operations, and ensuring safety of responders during mass casualty events. This plan is based upon the National Incident Management System (NIMS).

4. **Designate a minimum of two mutual aid collection points for units responding into their county:**

   This plan minimizes the “cluster” of vehicles responding directly to the scene of a major emergency by establishing pre-determined staging areas. This fosters the organized and orderly dispatch of resources to the scene. Therefore, each county

should designate mutual aid collection points near a major point of access to the rest of the county for incoming units. Mutual aid collection points should be designated with the following in mind:

- Easily located from major highways
- One entrance and one exit
- Adequate parking
- Adequate lighting

If private property is utilized for collection points, (ex: Wal-Mart parking lot), prior approval should be received from the property owner to identify the location as a potential mutual aid collection point. Information regarding the potential impact on business should be provided prior to an incident.

5. Designate primary and secondary means of communication for dispatch and other mandatory communications for responding units:

Communications is a challenge in virtually all mass-casualty incidents, because responders do not share common communications systems. Each county must designate the most effective method for communicating with responding out of county units. A back up plan should be in place in case the primary means fail or is inaccessible by responding agencies. Options include trading radios, pairing a local paramedic (with a portable radio) with an out-of-county unit, switching to cellular, and/or using old State Rescue (155.280). By adoption of this plan, each county agrees to provide and maintain some means of inter-county communication for disaster management purposes. Planning will continue to ensure that more reliable means of inter-county communications are developed.

6. Critical Incident Stress Debriefing/ Management (CISD/CISM)

Defusing and/or post incident debriefings should be made available as needed for responders. In the event of a disaster or major mass-casualty incident where on-scene defusing is being requested, a staging area for CISM personnel should also be identified.

7. Designate a person/position/agency to which copies of all patient reports should be sent and medical questions directed:

Although the counties of the T-RAC do not have common paramedic protocols, most protocols are quite similar. It would be unrealistic and potentially dangerous to expect responding personnel to immediately change from one set of protocols to another in a disaster. For this reason, responding agencies and/or specialized teams will operate by their specific medical protocols as approved by their individual EMS system Medical Director.

Each responding agency will provide an itemized list of patient contacts and/or transports including the patient's name and date of birth to the EMS system or other designated agency/position of the county in which the mass casualty occurred. Copies of patient reports (PCR's, ACR's or other such forms) will be provided to the EMS system or other designated agency/position of the county in which the mass casualty occurred upon request for quality management purposes.

Use of approved triage tags has been common in the T-RAC and will be continued. Agencies not using the triage system for field triage decision-making are required to do so by their adoption date of this agreement. An example of the T-RAC triage tag is located in Appendix B.

Questions or issues regarding medical care rendered by field personnel will be directed to both systems' Medical Directors who will discuss and resolve these issues.

8. **Orient EMS field personnel, 9-1-1 Communications Center personnel, emergency department personnel and Emergency Management personnel to this plan:**

   By adoption of this plan, participating counties agree that they will conduct both initial and periodic in-service training on whatever elements of the plan affect the various agencies in the county.

9. **Conduct a review of any local franchise or other ordinances to ensure that they do not conflict with this plan; if needed, adopt verbiage, which permits mutual aid.**

   A number of counties have adopted franchise ordinances or other legal documents over the years to enable them to monitor the quality of emergency medical services provided on a day-to-day basis. Most of these ordinances or agreements will have verbiage, which permits non-franchised services to provide mutual aid in disasters. Each county must review its local ordinances and agreements to ensure that they do not hamper the county's ability to accept or render assistance in the event of a major mass casualty incident.

10. **Provide information on special resources in-county which may be available for regional response.**

    A number of providers have special capabilities such as disaster mobile units, dive teams, etc., which may be available on a regional basis if needed. This also includes State resources, which include but is not limited to the State Medical Response Teams (SMAT I, II & III), the State Medical Response System and State Emergency Management.

MANAGEMENT OF ON-SCENE CONFLICTS

It is understood that each county intends to manage multi-casualty incidents in an efficient, effective and professional manner. Sometimes factors may be present which hamper these efforts. These may range from unforeseen circumstances of the incident to poor judgments on the part of early on-scene personnel. If problems arise, the following conflict resolution steps should be taken:

The response agency personnel having questions/concerns about scene operations should:

- Not argue with on-scene personnel
- Contact their on-duty shift supervisor and report the situation.
- The on-duty shift supervisor will contact his/her peers in the host county's response agency and resolve the problems and/or concerns.

The host county's response and/or incident management personnel should:

- Acknowledge that mutual aid responders may operate somewhat differently than you do on a day-to-day basis.
- Accept input from mutual aid providers' supervisory personnel.
- Do nothing that compromises patient care.

If problems cannot be resolved on-scene, local protocols and best judgment bind each responder, and conflicts will be managed post-incident through medical review or quality management process.

In order to minimize the possibility of responder conflicts, counties are encouraged to respond a supervisor along with treatment and transport personnel for any incidents expected to be of extended duration (i.e., 2 – 3 hour duration).

DUTIES AND RESPONSIBILITIES OF KEY AGENCIES

The flow chart located in Appendix "D" outlines what should occur when activating the T-RAC Mutual Aid Response Plan.

POST-INCIDENT MANAGEMENT

A post-incident debriefing is required within two weeks of the incident. Representatives from participating providers will be invited to attend. The functionality of the plan should be critiqued. Notes should be made about the successes and challenges of the incident. Recommendations for improvements should be prepared as appropriate. This debriefing will not be part of the CISM/CISD process.

Each responding EMS Systems' ALS Medical Director should review their respective patient care reports (PCR's) for compliance with local protocol, policy and procedures. Questions or issues regarding medical care rendered by field personnel will be directed to both systems' Medical Directors who will discuss and resolve these issues.

The T-RAC may, at the request of any EMS provider or emergency facility, conduct a review of patient triage for major incidents within one month of the incident with the findings to be reported at the next regularly scheduled T-RAC meeting. Concerns regarding triage of patients should be directed to the appropriate EMS system Medical Director and the Triage and Transportation Officers.

GENERAL UNDERSTANDINGS

1. Expenses Incurred

The cost of a mutual aid response will vary and these guidelines spell out how costs will be shared between host counties and mutual aid responders. Most EMS agencies have a normal charge for services, which they pass along to the recipient of the services.

Providers should handle billing as they would if it were a normal call for service. If the responding provider bills for services, they should do so at the normal rates, and should attempt collection per normal practices. This arrangement will meet the needs of each agency regarding third-party payers, including Medicare/Medicaid.

If daily operations require short-term mutual aid assistance, responding agencies will operate under their own operational guidelines and absorb the cost of response for short-term mutual aid requests.

During long-term operations (days instead hours), the requesting county will assist responding agencies with logistical support including but not limited to housing, meals, medical supplies and fuel as needed. Otherwise, the responding county is responsible for the maintenance and support of their equipment and personnel and may seek/request additional assistance as needed and should explore reimbursement options for services provide through existing policies and procedures set forth in the Statewide Mutual Aid Agreement through Emergency Management.

Responding counties should track all expenses and keep all receipts in the event a disaster is declared and federal reimbursement is possible.

2. Insurance And Insurance Coverage

Providers of EMS have in effect their own insurance coverage or other funding system for potential liability, malpractice, and worker's compensation. This coverage is not generally limited to a particular geographic area, but extends with the vehicle, employee, or service to cover all legitimate and normal activities participated in regardless of the geographic area in which they occur. If a county or agency involved agrees to participate in the Regional Mutual Aid Plan, the participation becomes a part of the normal duties and as such the county maintains existing levels of coverage. EMS providers, whether full time paid or volunteer, are responsible for their own insurance coverage.

3. Loss of or Damage to Equipment

Individual EMS agencies are generally responsible for control of their own equipment. Therefore, agency insurance policies should cover the loss of or damage to equipment.

4. Medical Protocol Adherence

Field care should be virtually "automatic" on the part of responding personnel therefore, each responding agency will utilize their own system medical protocols, as approved by their EMS medical director, during a mutual aid response. While this may result in very minor differences in treatment provided, it is not expected to significantly impact the quality of patient care due to the similarity of protocols throughout the region.

5. Quality Assurance

Patient care reports will be reviewed through the normal quality assurance and improvement procedures. Questions of medical performance should be addressed through normal Quality Management channels.

The EMS medical director of the county in which the incident occurs may wish to review patient care reports from responding providers. Patient care reports will be faxed in to the primary provider following the incident upon written request. Questions or issues regarding medical care rendered by field personnel will be directed to both systems' Medical Directors who will discuss and resolve these issues.

The emergency department and medical personnel of facilities receiving patients from mass casualty situations also may have questions concerning patient care rendered by responders. Should this occur, contact the EMS Medical Director of the county in which the incident occurred. He/she can then identify the transporting agency and follow up as needed with the appropriate medical director.

The T-RAC Quality Management Committee and/or local quality management committees may conduct a general review of patient care issues for traumatic incidents at their first meeting following the incident for quality improvement purposes. During review of all patient care records, all participating agencies agree to maintain compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and agree to make available their Notice of Privacy Practices to any requesting party upon request and as needed.

Under North Carolina law, Quality/Peer Review Procedures are protected. Critiques and suggestions should be marked as protected Peer Review materials to prevent legal discovery. Diligence to protect the privacy of patient records should be maintained.

In the event that an EMS System is unable to complete a transport (i.e. unit failure during transport, etc), the system should have a patient care form or other similar worksheet available to provide to the mutual aid unit with basic information including but not limited to dispatch information, PMH, and all patient care rendered to that point including procedures performed with relevant times. A copy of a sample patient worksheet is included in Appendix "C".

6. Legal/Moral Obligations Incurred by Participation

The T-RAC Mutual Aid Response Plan represents a voluntary agreement among the participating counties and the EMS systems. No participant is legally required to provide services to another except when the Governor declares a state of emergency under provision of GS-36A SS14-2881 and orders the services to be provided. This plan specifically addresses the issue of the providing county's ability to respond without neglecting its responsibility to its local jurisdiction.

If one EMS system can, in its discretion, assist another EMS system without jeopardizing the level of service at "home", then there is only a moral obligation to provide the services. Participants in this plan agree that they will do all they can to reasonably assist other participants in the event of a mass-casualty incident, taking into consideration resource limitations and continued provision of local coverage.

AN AGREEMENT FOR EMERGENCY MEDICAL SERVICES
T-RAC MUTUAL AID

The following shall constitute an agreement in principle among EMS systems in the participating counties of the T-RAC.

Definition of Terms

Provider: Any organization, company, institution, or governmental department that is directly involved, either on a paid or voluntary basis, in emergency rescue, treatment, and/or transportation of the sick and injured.

EMS System: a coordinated arrangement of resources (including personnel, equipment, and facilities) organized to respond to medical emergencies and integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

Provisions of the Agreement

1. In recognition of our desires to best serve the needs of the sick and injured, we agree to respond across county lines or other zones of responsibility only when requested by another EMS system, or spokesman for such, under the following circumstances and conditions, and only if in our estimation, we are not thereby unduly jeopardizing services to the citizens of our county:

    - When an EMS system is overwhelmed with needs beyond their resources to manage, which would result in serious aggravation of injuries with possible loss of life; and/or

    - When the primary EMS system determines that the situation requires more immediate response than it is able to muster and sees that units in an adjacent service area are closer/more readily available; and/or

    - The agency receiving the mutual aid request can accommodate that request for assistance without jeopardizing their ability to sustain coverage in their jurisdiction, then;

2. We agree to supply mutual aid in the form of equipment and personnel. As a responding agency, we will cooperate with all other emergency rescue/treatment/ transportation providers in the event of a disaster or mutual aid situations according to the provisions of adopted local, regional, and State disaster and mutual aid plans. The requesting provider, operating in an Incident Command System, will assign tasks to incoming mutual aid resources.

3. It is understood that emergency communications will be on 155.280 MHz, the designated EMS mutual aid frequency in North Carolina, if feasible. Where 800 MHz radio systems are used, reasonable efforts will be made to coordinate communications with non-800 MHz users through patch systems at the local Communications Center.

4. EMS systems whose operations are based in North Carolina shall respond to calls for assistance with vehicles certified by the North Carolina Office of EMS and using personnel trained and credentialed to the appropriate level by the North Carolina Office of EMS and/or North Carolina Medical Care Commission. Personnel whose function is limited to rescue shall meet applicable standards set by the North Carolina Association of EMS and Rescue. Out-of-state vehicles and personnel shall meet any applicable standards established by their respective states. All EMS systems shall operate under their local system's medical protocols.

5. No EMS system participating in this agreement shall have any more or less responsibility to the sick or injured, or to the public at large, than they would if this agreement had never been entered into.

6. Reimbursement or charges to which the EMS system would otherwise be entitled shall not be affected by this agreement.

7. Existing mutual aid agreements among counties or EMS systems are not affected by this agreement.

8. This agreement may be terminated upon 30 days written notice.

Adopted this _____ day of _____, 2___:

_____ County

_____

Emergency Services / EMS Director

_____

County Manager

Appendix A – Agency Contact Information

Category	Name/or Title/Agency/Address	Contact Methods
Person/Position Authorized to Request EMS Mutual Aid	Shift Supervisor Radio Designation:	Radio: Phone: 336- 336- email: Fax: 336-
	, Director Radio Designation: 900	Radio: Phone: 336- 336- email: Fax: 336-
	, Assistant Director Radio Designation: 901	Radio: Phone: 336- 336- email: Fax: 336-
	, Operations Manager Radio Designation: 902	Radio: Phone: 336- 336- email: Fax:
Person/Position Authorized to Provide EMS Mutual Aid	ANY OF THE ABOVE	Radio: Phone: 336- 336- email:
Communications Center	Communications Center , Director , Asst. Director , Asst. Director	Phone: 336- Fax: 336- Email:
Primary Channel/PL	Rx 155.055/PL 141.3	Tx 158.895/PL 141.3
Secondary Channel	Rx 155.265/PL 141.3	Tx 155.265/PL 141.3
Alternate Means	336-374-3000	
Person/Position to Which Patient Reports Should Be Sent		Radio: Phone: 336- Email: Fax: 336-
EMS Medical Director	Dr.	Radio: Phone: 336- 336- Pager: 336- Fax: 336-

Appendix B – Triage Tag

DATE: /. /. № 17600

DISASTER TRIAGE TAG

☐ Male ☐ Female Age___ Race: B W H O

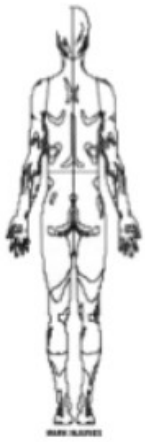
	TIME	RED	YELLOW	GREEN	BLACK
INITIAL					
HOSPITAL					
			Time Pronounced		

Name _____

Address _____

_____ Zip

Phone ( ) _____ _____



Allergies _____ ☐ NONE

Medications _____

TIME			
PULSE			
RESP			
B/P			
PUPILS			

EXAM: _____

TREATMENT:

☐ O_2 via ☐ NC ☐ FM @ ____LPM ☐ Intubated mm

IV #1: ☐ NS ☐ LR ☐ Other _____ Site _

IV #2: ☐ NS ☐ LR ☐ Other _____ Site _____

☐ Spinal Immobilization ☐ Fractures Splinted

☐ *DECONTAMINATED ON SITE*

MEDICATION	DOSE / ROUTE	TIME

DIAGNOSIS

TRANSPORTED TO: _____

TRANSPORT UNIT: _____ AGENCY: _____

TIME OUT: _____

_____ EMT / EMT-P / RN / MD

DATE: ____/____/____ № 17600

TREATING FACILITY

Facility Name: _____

Arrival Time: _____ AM PM

Decontaminated PTA? ☐ YES ☐ NO

☐ RED ☐ YELLOW ☐ GREEN ☐ BLACK

TIME			
PULSE			
RESP			
B/P			
PUPILS			

CHIEF COMPLAINT / HPI:

EXAM FINDINGS:

☐ CBC	☐ Cardiac Enzymes
☐ BMP / CMP	☐ EKG
☐ ABG	☐ HCG
☐ UA	☐ ETOH / TOX
☐ COAGS	☐ Other

☐ Intubated: _____

XRAYS:

DIAGNOSIS:

_____

DISPOSITION: ☐ Admitted to _____ Dr.

☐ Discharged: Time Out: _____

☐ Transferred to:

via: _____

_____ MD / RN / PA

HOSPITAL RECORD № 17600

NAME: _____ ☐ M ☐ F AGE:

DIAGNOSIS: _____

ARRIVAL TIME: _____ VIA UNIT: _____

☐ RED ☐ YELLOW ☐ GREEN ☐ BLACK

TRANSPORT RECORD № 17600

NAME: _____ ☐ M ☐ F AGE: ____

DIAGNOSIS: _____

TRANSPORTED TO: _____ UNIT: _____

☐ RED ☐ YELLOW ☐ GREEN ☐ BLACK

FIELD TX RECORD № 17600

NAME: _____ ☐ M ☐ F AGE:

DIAGNOSIS: _____

TREATMENT AREA: _____ UNIT: _____

☐ RED ☐ YELLOW ☐ GREEN ☐ BLACK

TRIAGE RECORD № 17600

NAME: _____ ☐ M ☐ F AGE: ____

DIAGNOSIS: _____

TIME: _____ UNIT: _____

☐ RED ☐ YELLOW ☐ GREEN ☐ BLACK

Appendix C – Patient Worksheet

Patient Worksheet

Time Rec'd:	:	Incident Location:		Dept #:	
Dispatched:	:	Patient Name:			
Enroute:	:	Address:			
On Scene:	:	City:		Age:	
Pt. Time:	:	State:		DOB:	
Enroute:	:	Zip:		Sex:	Male☐ Female☐
Hospital:	:	Phone:		SS#:	
Available:	:	Reason For Call:		MD:	
Begin Mileage:		Patient Position:			
End Mileage:		Total Mileage:		EMD Card:	

History:

Medications:

Allergies:

C/C: Initial Glucose: Repeat Glucose:

Assess Time:	:	:	:	:	:	:	:	:	:
LOC / GCS:									
Pain Scale:									
LA Stroke:									
Left Pupil:									
Right Pupil:									
Skin Color/Temp:									
ECG:									
Heart Rate:									
Blood Pressure:	/	/	/	/	/	/	/	/	/
Respirations:									
Lung Sounds:									
ET Tube Mark:	cm	cm	cm	cm	cm	cm	cm	cm	cm
Capnography:									
SP02:	%	%	%	%	%	%	%	%	%
CPAP:	Cm/H2o	Cm/H2o	Cm/H2o	Cm/H2o	Cm/H2o	Cm/H2o	Cm/H2o	Cm/H2o	Cm/H2o
02 Therapy:	Mask ☐ Cannula ☐		LPM	Ventilator:	No ☐ Yes ☐ →		Rate:		Vol:

IV #1 Start:	: hrs	Gauge:		Fluid:		Site:		Rate:	
IV #2 Start:	: hrs	Gauge:		Fluid:		Site:		Rate:	
Med. Name:		: hrs		Dose:		Route:		Effect:	
Med. Name:		: hrs		Dose:		Route:		Effect:	
Med. Name:		: hrs		Dose:		Route:		Effect:	
Med. Name:		: hrs		Dose:		Route:		Effect:	
Med. Name:		: hrs		Dose:		Route:		Effect:	
Intubation:	: hrs	Size:		Success:	Y / N	CO2 Detector Effect:		Pos. ☐	Neg. ☐
Defib. Joules:	: hrs		Defib. Joules:		: hrs		DNR?:	Yes ☐	No ☐
Defib. Joules:	: hrs		Defib. Joules:		: hrs		Rectal Temp. ☐		
Defib. Joules:	: hrs		Defib. Joules:		: hrs		Oral Temp. ☐		

Broselow Color: Gray Pink Red Purple Yellow White Blue Orange Green

Other Treatment:

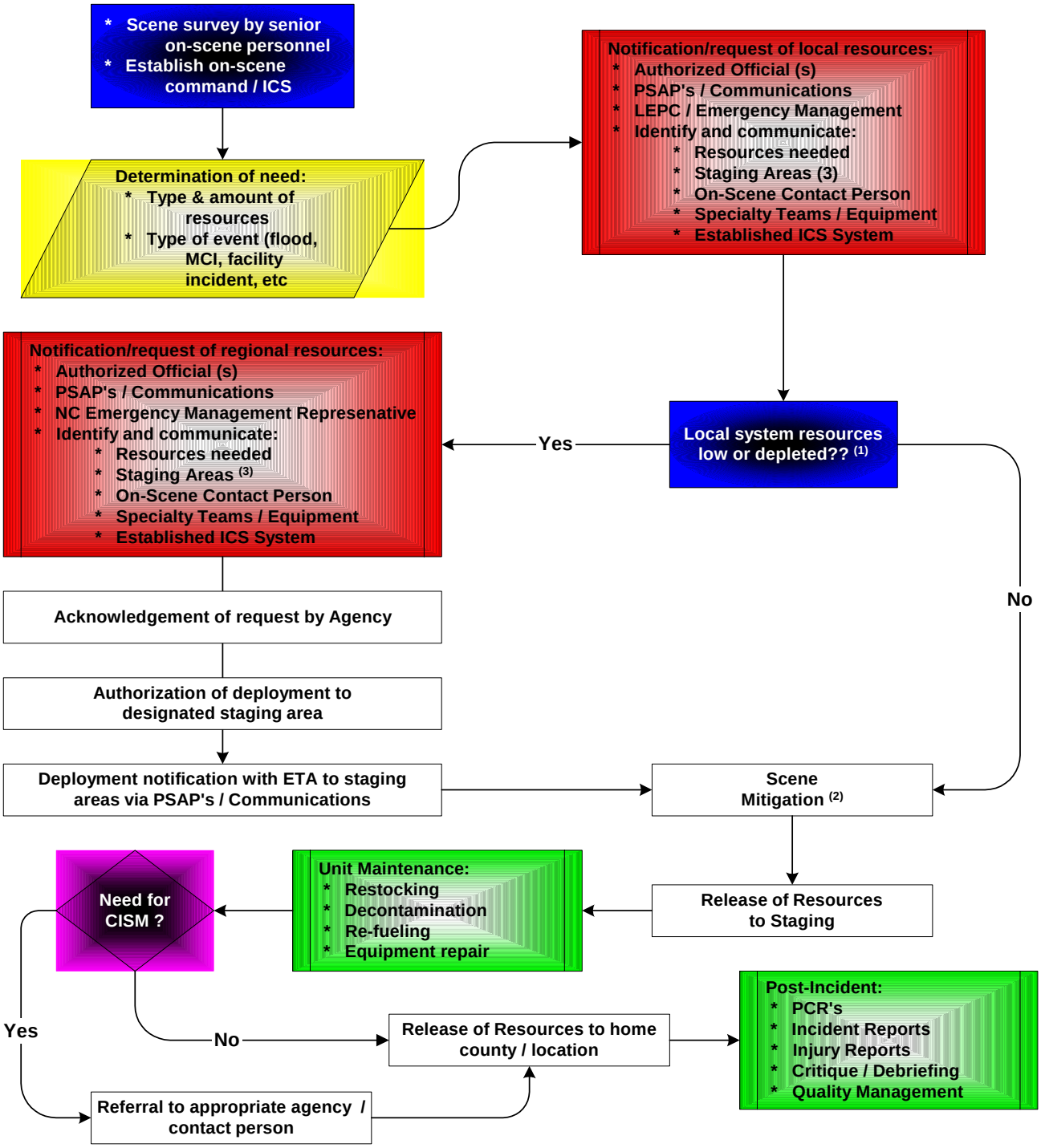
Medic Signature: Pt. Rec'd By: RN/LPN/MD

Transferring Facility: Receiving Facility:

Appendix D – Mutual Aid Guidelines

T-RAC EMS Mutual Aid Activation Guidelines

Draft 9/9/2004



Footnotes:

(1) 9-1-1 Communication centers should be aware of current unit status within their service area and should plan ahead for potential service needs.

(2) EMS Agencies responding to a request for mutual aid will operate under their current protocols and standing orders. Medical Control will ultimately remain the responsibility of the requesting county.

(3) EMS Agencies should pre-designate2 staging areas. On-scene command should assign staging area locations and 9-1-1 Communications centers should relay those locations to responding units.