Regional Mass Casualty Incident Plan

FOR THE

Western Virginia EMS Council
Blue Ridge EMS Council
in collaboration with
Near Southwest Preparedness Alliance

APPROVAL & IMPLEMENTATION

Regional Mass Casualty Incident Plan

This plan is hereby approved for implementation and supersedes all previous editions.

WVEMS Executive Director	Date
WVEMS Board Chair	Date
BREMS Executive Director	Date
BREMS Board Chair	Date
NSPA Executive Director	Date
NSPA Coalition Chair	Date
Regional MCI Plan Committee Chair	Date

RECORD OF CHANGES

Regional MCI Plan

Change #	Date of Change	Entered By	Date Entered

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REGIONAL MCI PLAN

I. AUTHORITY

A. Regional

The Western Virginia and Blue Ridge EMS Councils represent two of eleven Regional EMS Councils established within the State Code of Virginia, § 32.1-111.11. Created in 1975 and 1976 respectively, WVEMS and BREMS are charged by the code of Virginia "with the development and implementation of an efficient and effective regional emergency medical services delivery system" to include the regional coordination of emergency medical disaster planning and response.

Working in tandem with the Near Southwest Preparedness Alliance, the designated regional healthcare preparedness program coalition comprising both WVEMS and BREMS regions, the three agencies have joined to realize this plan's region wide implementation and ongoing maintenance.

The Board of Directors of these three agencies have assigned this plan to a committee referred to as "The Regional MCI planning committee", hereinafter referred to as the (MCIPC). Furthermore, the respective boards have endorsed the MCIPC to create and fill positions on relevant sub-groups. It is the responsibility of the MCIPC to produce and maintain on an annual basis the regional MCI Plan.

Each Jurisdiction shall develop and implement, as part of their state-mandated Emergency Operations Plan, as Outlined in § 44-146.19, Letter E, a local and/or regional MCI plan to address each type of MCI. This plan should include:

- √ List of local target hazards
- √ Incident/Event hazard analysis for their jurisdiction
- √ Mutual aid agreements and matrix of agency response
- √ The jurisdiction's Emergency Operations Center activation
- √ A list traditional and non-traditional resources
- √ A reference to THIS Regional MCI Plan and the integration and adoption of this plan's concepts when the capabilities of the local plan are exceeded.

The intention of this plan is to serve as a means to draw together localities and community based organizations, namely, Healthcare, to enhance the local MCI plan based on a regional accepted standard.

B. Local

1. **Interlocal Agreements and Contracts.**

2. **Adoption of Plan & Memorandum of Understanding**

    a. Participation in the plan shall be through the adoption by the appropriate governing body and signing by an authorized representative of the municipality or agency to the Regional Memorandum of Understanding/Mutual Aid, as most recently revised.

    b. Copies of the Regional MCI Plan shall be provided to each locality and hospital either through WVEMS, BREMS or NSPA. A copy of the plan should be maintained within each Hospital and all licensed EMS commander vehicles. The field guide is maintained by WVEMS and BREMS. This field guide is available thru the respective EMS Offices. The MCIPC encourages that all licensed EMS Responders in the regions maintain a copy of the field guide.

Copies of the plan shall be filed by WVEMS and BREMS with the Virginia Office of Emergency Medical Services. NSPA will file a copy of the plan with the Virginia Department of Health and Virginia Hospital & Healthcare Association.

In the case of a hospital, a resolution of adoption shall include an attachment that provides for appropriate adjunctive or emergency privileges to be accorded to attending physicians during an MCI. Required of Joint Commission accredited hospitals – JC Std: EM.02.02.13 EP1-2

II. PURPOSE and SCOPE

A. Purpose

The purpose of this plan is to outline our approach to Mass Casualty Incident Management. It provides general guidance for MCI Management activities and an overview of our methods of mitigation, preparedness, response, and recovery.

The need for regional coordination and a common framework for addressing mass or multi casualty incidents is imperative. In the interest of capitalizing on synergies known to the Blue Ridge EMS Council, Western Virginia EMS Council and Near Southwest Preparedness Alliance, this plan will provide guidance for regional healthcare activities in a mass or multi casualty incident.

This plan, in design, is aimed to ensure an effective utilization of the various human and material resources from various jurisdictions and healthcare agencies involved in a regional mutual aid EMS and Healthcare agency response to a disaster or MCI that affects a part of, or the entire region. This plan aims to support each municipalities Mass casualty plan by providing for next-level support for incidents in scope and significance that surpass the capabilities addressed in a local plan.

B. Scope

The Blue Ridge EMS Council, Western Virginia EMS Council, and Near Southwest Preparedness Alliance Regional MCI Plan will address the regional response to a mass or multi casualty incident within our region. This plan, in scope, will cover operations for the first two consecutive 12 hour operational periods. This plan will accomplish standard MCI incident levels with common actions and triggering points for each level. It is understood that each hospital and EMS agency has varying capabilities. Each agency will implement this plan at the appropriate level based on the agency's current capabilities. This plan is intended to be an 'All hazards' guide to meet the incidents needs regardless of cause.

This document will provide an overarching framework that will identify resources and guide response. Response guidance will be supported with an operational focused field guide and resource document accessible to field staff. Due to the unique and complex nature of pandemic, non Bio-terrorism events, this plan will not address the EMS Response to pandemics.

III. EXPLANATION OF TERMS

A. Acronyms

BREMS	Blue Ridge EMS Council, Inc.
CBRNE	Chemical, Biological, Radiological, Nuclear and Explosive
C-SALTT	Size, Amount, Location, Type, and Time
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operations or Operating Center
Haz-Mat	Hazardous Materials
ICP	Incident Command Post
ICS	Incident Command System
MCI	Mass or Multi Casualty Incident
MCIPC	Mass Casualty Incident Planning Committee
MOU	Memorandum of Understanding
NIMS	National Incident Management System
NRF	National Response Framework
NSPA	Near Southwest Preparedness Alliance
OCME	Office of the Chief Medical Examiner
OEMS	The Virginia Office of Emergency Medical Services
PIO	Public Information Officer
RHCC	Regional Healthcare Coordination Center
SOGs	Standard Operating Guidelines
VDH	Virginia Department of Health
VHHA	Virginia Hospital & Healthcare Association
WVEMS	Western Virginia EMS Council, Inc.

B. Definitions

1. Blue Ridge EMS Council. One of 11 non-profit EMS Councils serving the City of Lynchburg, the Town of Bedford and the Counties of Amherst, Appomattox, Bedford and Campbell

2. C-SALTT. Capability – Size - Amount - Location - Type - Time.

3. Hazardous Materials. Any material or substance that could adversely affect the health and safety of the public.

4. Inter-local agreements. Inter-local agreements are collaborative contracts/agreements between public entities/agencies that strive to provide more efficient public services to municipalities served.

5. Mass Casualty Incident. Mass casualty incidents are incidents resulting from man-made or natural causes resulting in injuries or illnesses that exceed or overwhelm the EMS and hospital capabilities of a locality, jurisdiction, or region. A mass casualty incident is likely to impose a sustained demand for health and medical services rather than a short, intense peak demand for these services typical of multiple casualty incidents.

6. Multiple Casualty Incidents; Multiple casualty incidents are incidents involving multiple victims that can be managed, with heightened response (including mutual aid, if necessary), by a single EMS agency or system. Multi-casualty incidents typically do not overwhelm the hospital capabilities of a jurisdiction and/or region, but may exceed the capabilities of one or more hospitals within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents

7. Near Southwest Preparedness Alliance. Referred to as “NSPA”, this is a consortium of healthcare emergency managers and counterparts working to further prepare the BREMS and WVEMS Regions for healthcare disasters.

8. National Incident Management System: a structured framework used nationwide for both governmental and non-governmental agencies to respond to natural disasters and or terrorist attacks at the local, state, and federal levels of government

9. Regional Healthcare Coordination Center. The Regional Healthcare Coordination Center, or RHCC, is a coordinating entity that is tasked with surveillance and coordinating a defined geographic regions response to a healthcare emergency. The RHCC is a central answering point for healthcare needs possess the capabilities to communicate and collaborate with entities in its region and abroad.

10. START & JumpSTART. Simple Triage And Rapid Treatment is the triage algorithm recognized by the Va Office of EMS as the primary triage pattern. JumpSTART is a version of the START algorithm that primarily deals with Pediatric patients.

11. VHASS. Virginia Healthcare Alerting and Status System

12. WebEOC. A web based tool that holds "boards" and other methods of messaging and is used broadly in the Emergency Management community to communicate between EOCs, RHCCs, Hospitals, and other entities.

13. Western Virginia EMS Council. One of eleven non-profit EMS Councils supporting the counties of Alleghany, Craig, Botetourt, Floyd, Franklin, Giles, Henry, Montgomery, Roanoke, Patrick, Pittsylvania, and Pulaski; and the cities of Covington, Danville, Martinsville, Radford, Roanoke, and Salem.

IV. SITUATION & ASSUMPTIONS

A. Situation

1. All disasters are considered local. All Virginia jurisdictions are required by the Code of Virginia to have an Emergency Operations Plan (EOP). The EOP for each jurisdiction will delineate the Scope, Jurisdiction and Authority of each entity in their plan. This planning tool is not meant to take the place of the jurisdiction's Emergency Operations Plan. This document is intended to be a supplement to planning already taking place and should be integrated into those efforts. The Regional Mass Casualty Incident Planning Committee, hereinafter referred to as the MCIPC encourages EMS response agencies and hospitals to stay involved with their locality in developing and enhancing the jurisdictional Emergency Operation Plans. The committee also requests EMS response agencies and hospital's staff, to include the emergency department, stay current in the National Incident Management System training.

2. Our area is vulnerable to a number of hazards. These hazards could result in a mass or multiple casualty incidents.

3. Medical and health care facilities that remain in operation after a mass casualty incident and have the necessary utilities and staff could be overwhelmed by the "walking wounded" and seriously injured victims transported to facilities in the aftermath of a disaster.

4. Use of nuclear, chemical, or biological weapons of mass destruction could produce a large number of injuries requiring specialized treatment that could overwhelm the local health and medical system.

B. Assumptions

1. All agencies and other entities and/or jurisdictions will operate during an Incident or Evacuation under the National Incident Management System (NIMS) as endorsed by the MCIPC and taught within the WVEMS, BREMS and NSPA region.

2. In most multiple or mass casualty incidents (MCIs), the following ICS functions/positions should be staffed: incident command, staging area, extrication, triage, treatment and transportation. In a small scale incident, one person may assume more than one function, (i.e., triage and treatment may be done by the same person or transportation and staging may be handled by the same person.) In a larger incident, the Incident or Unified Commander may establish a Medical Group or Medical Branch to oversee some

or all of the above functions. The RHCC and the hospitals involved will interact with and support the Medical Branch as requested by the Unified Command. In multi area events or widespread disaster situations, the RHCC may serve as the Medical branch if requested by Unified Command or designee.

3. The incident command structure will expand or contract as necessary based on the size and complexity of the incident, and maintain the span of control. Only those functions/positions that are necessary will be filled and each element must have a person in charge.

4. START and JumpSTART Triage criteria will be utilized by pre-hospital EMS and hospital agencies.

5. The resources needed to mitigate multiple simultaneous incidents are dependent on the size and complexity of the incidents as well as their location. Expected mutual aid resources may not be available or may be significantly delayed. Providers must be prepared to sustain their patients for long periods of time. Non-traditional modes of transportation and alternate patient transport destinations will need to be considered.

6. Jurisdictions and/or other agencies will respond to a mutual aid request from the host locality with appropriate personnel and equipment as available when the MCI Plan is activated. However, the response will be dispatched by the local Emergency Communications Center (ECC) and will not reduce any locality's own EMS response capabilities below established, predetermined levels. Each Locality should outline the acceptable resource allocation in a mutual aid event and maintain that with the ECC.

7. Hospital and pre-hospital components in the region should participate in annual training exercises of the MCI Plan. Inclusion of other healthcare entities, such as LTCs, Behavioral Health, and coordinating entities like the RHCC and VDH is encouraged.

8. The proximity and capabilities of appropriate health care facilities will be the primary considerations of MCI Medical Control when designating the health care facilities to which patients are sent during any local or regional emergency situation that results in the activation of the MCI Plan. The coordinating Emergency room or designee will interact with the RHCC to verify bed availability and transport destinations.

V. CONCEPT OF OPERATIONS

A. Objective

The objective of our mass casualty incident plan is to provide resources to the MCI response that will support life safety, incident stabilization, and incident mitigation while doing the greatest amount of good for the greatest number of people.

B. General

1) It is our responsibility to protect public health and safety and preserve property by preparing for Mass or Multiple casualty events. We have the primary role in identifying and mitigating hazards, preparing for and responding to, and managing the recovery from a Mass Casualty Incident that affects our community.

2) Local government is responsible for organizing, training, and equipping local emergency responders, Healthcare workers and emergency management personnel, providing appropriate emergency facilities, providing suitable warning and communications systems. WVEMS, BREMS, and NSPA, along with the state and federal governments offer programs that provide some assistance with portions of these responsibilities.

3) To achieve our objectives, we have adopted this Regional Mass Casualty Incident plan that is both integrated (employs the resources of government, organized volunteer groups, and businesses) and comprehensive (addresses mitigation, preparedness, response, and recovery). This plan is one element of our preparedness activities.

4) This plan is based on an all-hazard approach to emergency planning. It addresses general functions that may need to be performed during any Mass Casualty Incident situation and is not a collection of plans for specific types of incidents.

5) Managing MCIs can produce significant stressors for responders and the community. CISM Teams comprised of volunteers within the region are available and are encouraged to be used to by agencies for post-incident stress management. These services are free and confidential and free to the emergency services community. Teams for each EMS Council have their own activation procedures. WVEMS 24/7 Dispatch: 1-888-377-7628; BREMS CISM Team: 434 947 5934 or by email: **Janet Blankenship (**j.blankenship@bedfordcountyva.gov); **Mary Kathryn Allen (**mkallen@vaems.org)

6) Care must be taken to meet the communication, mobility, cognitive and other needs of victims with special needs. Responders must make certain that assistive devices and equipment are transported with the victim or patient. (e.g. glasses, hearings aids, and mobility devices such as walkers and wheel chairs.) Theses items should be labeled with the patient's name if known or the patient's Virginia Triage Tag number. Patients should not be separated from their assistance animal. Assistance animals are vital to the recovery of these patients and their prompt return to the activities of daily living. If the patient must be transported to a health care facility then arrangements must be made for the housing and care of the assistance animal. Information of the location of the animal must be provided to the patient and/or their family or other care giver. This also applies to working dogs such as canine law enforcement officers (e.g. drug dogs, bomb detection dogs), search and rescue dogs, and cadaver dogs.

7) Mass Casualty Incident Management Goals: **Manage scarce resources. Do not relocate the disaster.**

8) Departments and agencies tasked in this plan are expected to develop and keep current standard operating procedures that describe how emergency tasks will be performed. Departments and agencies are charged with ensuring the training and equipment necessary for an appropriate response are in place. WVEMS, BREMS, and NSPA will support regional training activities and as able, equipment purchases in support of this plan.

9) We have adopted the National Incident Management System (NIMS) in accordance with the President's Homeland Security Directive (HSPD)-5. Participating agencies will conform to the NIMS Systems as defined.

C. Operational Guidance

There will be four levels that classify Mass or Multiple casualty incidents within the WVEMS, BREMS and NSPA regions. In utilizing the NIMS typing matrix, the levels move from the most significant and demanding of resources ("Level 1") to the least significant ("Level 4").

1. Levels for MCI Response

MCI Level 4 (up to 15 Ill/Injured Victims) (4-10 HazMat Patients requiring Gross Decon)

Resources:

MCI Level 3 (16-30 Ill/Injured Victims) (11-20 HazMat Patients requiring Gross Decon)

Resources:

MCI Level 2 (31-100 Ill/Injured Victims) (21-40 HazMat Patients requiring Gross Decon)

The RHCC will be contacted and work collaboratively with Emergency Department MedComs to provide patient placement support for this level.

Resources: Plan activation strongly recommended

MCI Level 1 (101 or more Ill/Injured Victims) (40 or more HazMat Patients requiring Gross Decon**)**

The RHCC will be contacted and work collaboratively with Emergency Department MedComs to provide patient placement support for this level.

Resources: Plan activation strongly recommended

2. Implementation of ICS and Triage

a. The first local emergency responder to arrive at the scene of a potential Mass Casualty Incident will implement the incident command system and serve as the incident commander until relieved by a more senior or more qualified individual.

b. The State of Virginia, and the WVEMS and BREMS Regions have adopted and trained on the 'START' triage system of patient assessment and scene management. When the incident is deemed a MCI or Multiple Casualty event, START or JumpSTART triage will be initiated by the first arriving, appropriately medically trained units.

c. Prompt communication of assessment of the MCI and communicating needs is essential. The Incident commander or a designee will assess the situation, and based on the current known or estimated patient count, notify hospitals proximate to the Scene, and if indicated, the RHCC.

d. Requesting resources and communicating an assessment of the scene will be done through a communications plan (see Attachment 11).

e. For some types of emergency situations, a specific incident scene may not exist in the initial response phase and the EOC may accomplish initial response actions, such as mobilizing personnel and equipment and issuing precautionary warning to the public. As the potential threat becomes clearer and a specific impact site or sites identified, an incident command post may be established, and direction and control of the response transitioned to the Incident Commander.

3. Source and Use of Resources.

a. Each agency will use its own resources, all of which meet the requirements for resource management in accordance with the NIMS, to respond to emergency situations. In general, Resource requests should follow a common progression: Local resource, County / Municipal, Mutual Aid, Regional Resource, State resource, Federal resource.

b. Each resource request must specify the size, amount of the resource, location where the resource is needed, the type of resource required, and the time the resource is needed (C-SALTT). Resource requests will be submitted using the processes and ICS forms required by the IC/IMT.

c. Regional mutual aid resources should be requested via the IC/IMT using existing EMS agency, hospital, or jurisdiction policies and standard operating procedures. State and Federal resources must be requested via your local jurisdiction's Emergency Operations Center (EOC). The request will then be sent to the Virginia State Emergency Operations Center (VaEOC) by calling 1-800-468-8892.

d. When external agencies respond to a MCI in any jurisdiction, they are expected to conform to the guidance and direction provided by the incident commander, which will be in accordance with the NIMS.

e. Tracking Resources will be managed by the IMT/IC, or their designee using existing ICS forms (i.e. ICS form 308, ICS form 310, ICS form 312, etc.)

f. When indicated, the IC/IMT will establish refueling and emergency vehicle maintenance locations and procedures. Vehicle refueling and emergency maintenance/repairs should be requested using the procedures established by the IC/IMT

D. Activating the Plan

1. The determination to activate the plan will be made by the on scene designated Incident Commander or designee (i.e. Emergency Communications Center), affected Hospital/Healthcare facility and/or locality EOC.

2. Activation of the plan should occur once the local area has exceeded its capabilities

3. The decision to activate the plan will engage the NSPA RHCC and Regional Healthcare entities, including Hospitals, Long Term Care, Behavioral health, OCME, EMS agencies,

etc. Activation of the plan will provide for mutual aid ambulances (and other resources) initiate a CLINICAL STATUS update for all seventeen (17) NSPA region hospitals, allow for readiness steps to be taken by receiving hospitals, and provide for regional situational awareness.

4. The emergency department(s) closest to the scene will be contacted by EMS and bed availability will be assessed and provided in the Start Triage Categories of Red/Yellow/Green. Once the closest 1 or 2 hospitals have been contacted, EMS and the contacted hospital(s) should weigh the need for contacting the RHCC and the activation of the MCI PLAN. The hospital, or the EMS Agency may contact the RHCC. The RHCC will alert regional contacts of an MCI. *The RHCC Dispatch center may assist EMS in contacting ERs close to the scene if requested by EMS*.

    a. SUGGESTED ACTIVATION GUIDANCE: The plan should be activated (By EMS or by Hospital) and It is recommended to engage the RHCC as early as possible into an incident response as possible. The RHCC should be consulted and assist as the regional guide for patient capacity and placement for EMS when any of the below conditions are met:

        1) The number of patients requiring transport and definitive medical care requires more than two hospitals be involved
        2) Patients will be taken to hospitals out of the state (due to a disaster response only)
        3) For any Level 2 or Level 1 (highest acuity) MCI
        4) A large portion of the patients exceed the capabilities or the scope of the hospital proximate to the scene (such as complex Trauma, Pediatrics, etc).
        5) The scene requires RHCC assistance with resources
        6) When multiple, simultaneous incidents are producing patient surge that taxes EMS and local Hospital resources.
        7) When a Healthcare facility is evacuating patients

5. Decision to activate: Activation should be accompanied with the assessed level (Section V, Letter C, Bullitt 1.) and an assessment of resources needed. The NSPA RHCC should be notified when the plan is activated by calling 1-866-679-7422, regardless of the need for patient placement support. When Calling, You will be asked the following questions:

    a. Entity (Locality, Agency, EOC) requesting MCI Plan activation
    b. Point of Contact Name
    c. Point of Contact Number
    d. Type of Incident (Patient Surge or Evacuation)
    e. Resource needs from the RHCC
        - Please specify to the Dispatcher whether or not you will need patient placement support and the Emergency Room(s) that have already been contacted
    f. Actions you've taken so far (Such as calling a local Emergency Room, Deploying a MCI trailer, or notifying a neighboring Jurisdiction)
    g. A brief summary of the incident to include "What happened"

6. *Smaller Level MCI's, such as Level 4 and 3, may not require the activation of this plan or require the support of the RHCC.*

VII. DIRECTION & CONTROL

A. General

1. The localities Public Safety entity shall direct and coordinate the efforts of local emergency medical services and agencies, and other response organizations during the field response portion of major emergencies and disasters requiring.

2. Hospitals and LTC facilities will maintain an EOC and internal command structures based on incident needs.

3. Command and coordination entities (EOCs, On Scene Command, RHCCs, Etc.) will work together in mitigating the incident.

4. Each participating entity will work under the immediate control of their own supervisors. Supervisors will conform to the incident command system for the location they are working under.

IX. ADMINISTRATION & SUPPORT

A. Reporting

1. In addition to reports that may be required by their parent organizations, health & medical elements participating in emergency operations should provide appropriate situation reports to the Incident Commander, or if an incident commands operation has not been established, to the Health Officer in the EOC. The Incident Commander will forward periodic reports to the EOC.

2. Pertinent information from all sources will be incorporated into the Initial Emergency Report and the periodic Situation Report that is prepared and disseminated to key officials, other affected jurisdictions, and state agencies during major emergency operations.

B. Maintenance and Preservation of Records

1. Maintenance of Records. Health and medical operational records generated during an emergency will be collected and filed in an orderly manner. A record of events must be preserved for use in determining the possible recovery of emergency operations expenses, response costs, settling claims, assessing the effectiveness of operations, and updating emergency plans and procedures.

2. Documentation of Costs. Expenses incurred in carrying out health and medical services for certain hazards, such as radiological accidents or hazardous materials incidents, may be recoverable from the responsible party. Hence, all departments and agencies should maintain records of personnel and equipment used and supplies consumed during large-scale health and medical operations.

3. Preservation of Records. Vital health & medical records should be protected from the effects of a disaster to the maximum extent possible. Should records be damaged

during an emergency situation, professional assistance for preserving and restoring those records should be obtained as soon as possible.

C. Post Incident Review

For large-scale emergencies and disasters, the locality emergency manager, in cooperation with designees from WVEMS, BREMS, and NSPA shall organize and conduct a review of emergency operations. The purpose of this review is to identify needed improvements in this annex, procedures, facilities, and equipment. Health and medical services that participated in the emergency operations being reviewed should participate in the post-incident review.

D. Exercises

Local drills, tabletop exercises, functional exercises, and full-scale exercises based on the hazards faced by our [county/city] will periodically include health and medical services operations. Additional drills and exercises may be conducted by various agencies and services for the purpose of developing and testing abilities to make effective health and medical response to various types of emergencies.

E. Resources

1. A list of local health & medical facilities is provided in Attachment 1.

2. A list of deployable health and medical response resources is provided in Annex M, Resource Management.

X. ANNEX DEVELOPMENT & MAINTENANCE

A. Plan Development

The WVEMS, BREMS, and NSPA are responsible for approving and promulgating this MCI Annex.

B. Review

Any MCI Annex shall be reviewed annually by the Regional MCI Planning team. The Regional MCI Planning Team will establish a schedule for annual review of planning documents by those tasked in them. The schedule for annual review will be approved by WVEMS, BREMS, and NSPA

C. Update

1. This plan should be periodically updated considering deficiencies identified during actual emergency situations and exercises and when changes in threat hazards, resources and capabilities, or government structure occur.

2. This MCI annex must be reviewed and/or updated at least once every year. Responsibility for revising or updating this MCI annex is assigned to the MCIPC. Responsibility for revising or updating the annexes to this plan is outlined in Section VI.B, Assignment of Responsibilities, as well as in each attachment.

3. Revised or updated planning documents will be provided to all departments, agencies, and individuals tasked in those documents.

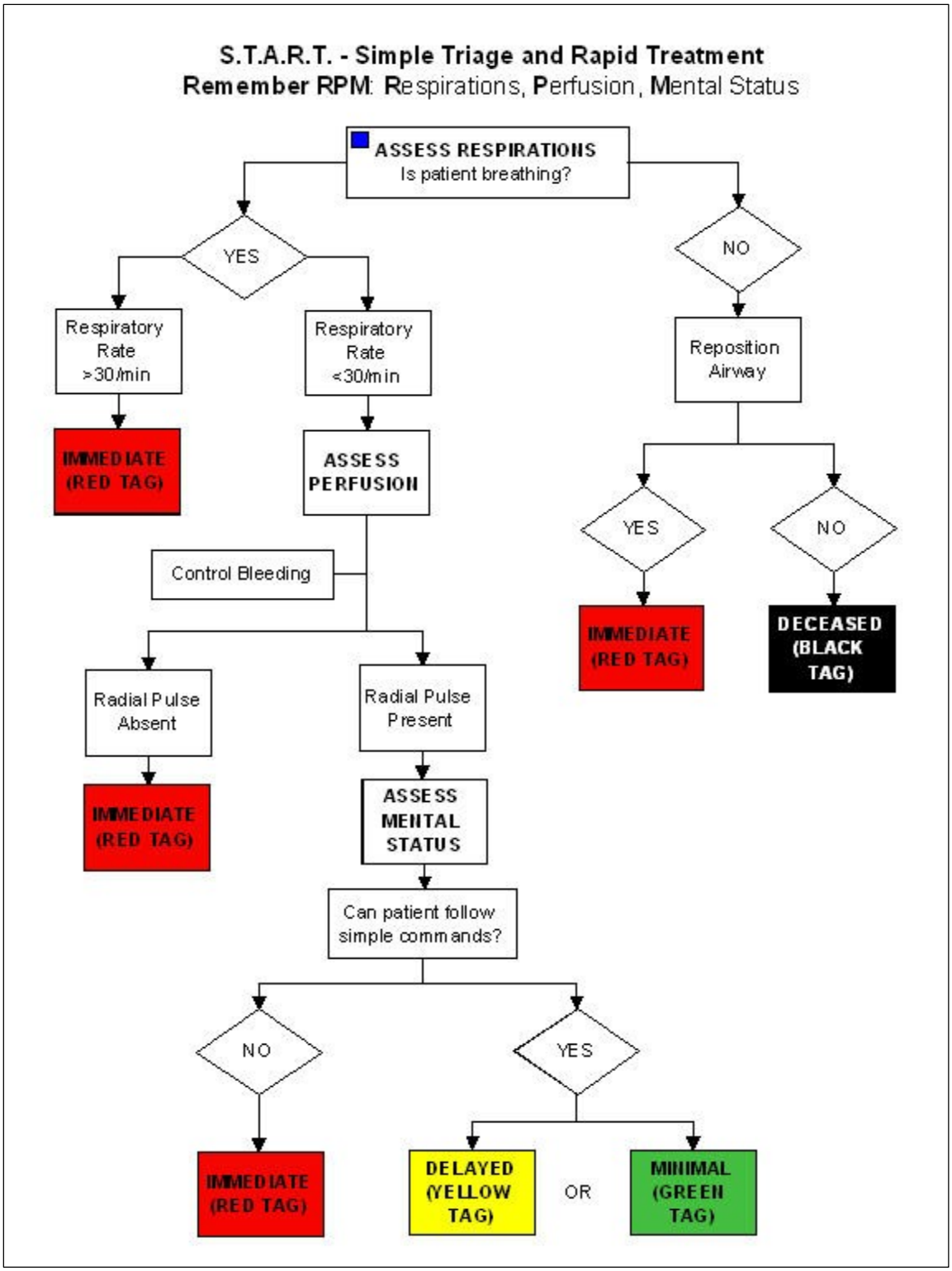
XI. ATTACHMENTS

ATTACHMENT 1

LOCAL HEALTH & MEDICAL FACILITIES LISTING

1. Hospitals

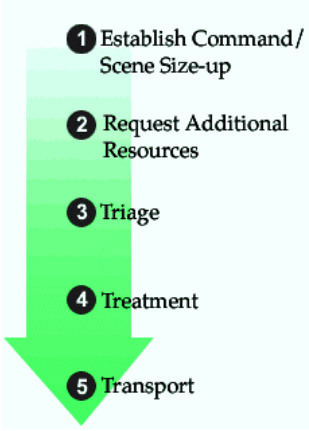
Organization Name	Address 1	City	Zipcode	Main Phone	24H Phone	Trauma Designation
Near Southwest						
Southern Virginia Mental Health Institute	382 Taylor Drive	Danville	24541	(434) 799-6220	(434) 773-4250	None
Veterans Affairs Medical Center -- Salem	1970 Roanoke Blvd.	Salem	24153	(540) 982-2463 2173	(540) 982-2463 2667	None
Virginia Baptist Hospital	Virginia Baptist Hospital	Lynchburg	24503	(434) 200-4000 3135	(434) 200-3211 3156	None
Catawba Hospital	5525 Catawba Hospital Dr.	Catawba	24070	(540) 375-4200	(540) 375-4711	None
Bedford Memorial Hospital	1613 Oakwood Street	Bedford	24523	(540) 586-2441	(540) 586-2441	None
Memorial Hospital of Martinsville & Henry Co	320 Hospital Dr	Martinsville	24112	(276) 666-7200	(276) 666-7200	None
LewisGale Hospital - Montgomery	3700 South Main Street	Blacksburg	24060	(540) 951-1111	(540) 953-5112	**Level 3**
LewisGale Hospital - Pulaski	2400 Lee Highway	Pulaski	24382	(540) 994-8100	(540) 994-8100	None
Pioneer Community Hospital	18688 Jeb Stuart Highway	Stuart	24171	(276) 694-8600	(276) 694-8600	None
Danville Regional Medical Center	142 South Main Street	Danville	24541	(434) 799-2100	(434) 799-2100	None
LewisGale Medical Center	1900 Electric Rd.	Salem	24153	(540) 776-4000	(540) 776-4000	None
Lynchburg General Hospital	Lynchburg General Hospital	Lynchburg	24501	(434) 200-3000	(434) 200-3000 3135	**Level 2**
LewisGale Hospital - Alleghany	One ARH Lane	Low Moor	24457	(540) 862-6011	(540) 862-6011	None
Carilion Franklin Memorial Hospital	180 Floyd Avenue	Rocky Mount	24151	(540) 483-5277	(540) 483-5277	None
Carilion Giles Community Hospital	159 Hartley Way	Pearisburg	24134	(540) 921-6000	(540) 921-6000	None
Carilion New River Valley Medical Center	2900 Tyler Road	Christiansburg	24073	(540) 731-2000	(540) 731-2000	**Level 3**
Carilion Medical Center (CRMH and CRCH)	1906 Belleview Ave	Roanoke	24014	(540) 981-7000	(540) 981-7140	**Level 1**


S.T.A.R.T. - Simple Triage and Rapid Treatment
Remember RPM: Respirations, Perfusion, Mental Status
ASSESS RESPIRATIONS
Is patient breathing?
YES
NO
Respiratory Rate >30/min
Respiratory Rate <30/min
Reposition Airway
IMMEDIATE (RED TAG)
ASSESS PERFUSION
YES
NO
Control Bleeding
IMMEDIATE (RED TAG)
DECEASED (BLACK TAG)
Radial Pulse Absent
Radial Pulse Present
IMMEDIATE (RED TAG)
ASSESS MENTAL STATUS
Can patient follow simple commands?
NO
YES
IMMEDIATE (RED TAG)
DELAYED (YELLOW TAG)
OR
MINIMAL (GREEN TAG)

The purpose of triage is to assign treatment and transportation priorities to patients by separating the victims into easily identifiable groups. The method of initial field triage to be utilized is the Simple Triage and Rapid Treatment (START) method for adult patients. Pediatric patients, ages 8 and under, will be better served by using the JumpSTART triage method.

There are some incidents where START Triage may not be the most appropriate tool to sort patients. Patients who have been exposed to various HAZMAT or CBRNE may need to be triaged using guidelines that are specific to the agent to which they have been exposed. Patients who have been exposed to certain CBRNE weapons may have different triage needs than trauma patients. **START Triage is the preferred tool for sorting trauma patients.**

Initial Triage



Provisions must be made for the following:

1) Establishment of a medical command post at the disaster site.
2) Coordinating health & medical response efforts.
3) Triage of the injured, if appropriate.
4) Medical care and transport for the injured.
5) Identification, transportation, and disposition of the deceased.
6) Holding and treatment areas for the injured.
7) Isolating, decontaminating, and treating victims of hazardous materials

The initial triaging of victims must begin right where the patients lie. The EMS Provider must begin to triage patients where they enter the scene and then progress in a deliberate and methodical pattern to ensure that all of the victims are triaged. When using both the START and JumpSTART triage methods all ambulatory patients are initially directed to a designated Green/Minor treatment area where they will be assessed and further triaged as personnel become available. For all remaining patients, triage personnel must quickly triage each patient and apply the appropriate color-coded triage ribbons (surveyor's tape).

The initial triage of the victims establishes the order in which non-ambulatory patients will be moved to the treatment area. Red Tagged/Immediate victims should be moved first, Yellow Tagged/Delayed second. All Green Tagged patients should already be in the Green/Minimal Treatment Area as outlined above by moving ambulatory patients first. Deceased victims (Black Tagged/Deceased) are left where they are found unless they must be moved to gain access to living patients or if the remains are in danger of being destroyed.

Secondary Triage

Secondary triage includes a more traditional assessment of patients and is based on the clinical experience and judgment of the provider. Secondary triage is performed on the way to the treatment area (entry point), in the patient treatment area, and/or en route to the hospital. The Virginia Triage Tag and work sheets are utilized to document assessment and treatment.

In some cases a patient may be reclassified as red, yellow, or green after secondary triage. Findings from secondary assessment will further determine priorities. For example a “yellow” abdominal trauma patient will take priority over a “yellow” patient with an ankle injury.

Catastrophically injured patients who still have signs of life may be classified as “yellow prime” and designated with a “P” or “///” on the yellow tape or triage tag. These patients have a low probability of survival even with immediate treatment and transport and should be placed in a separate in the delayed / yellow prime treatment area.

Ongoing triage is then performed continually as a part of the patient assessment until the patient arrives at an Emergency Department/hospital.

Triage and Mass Patient Care

Providers can expect to face a non-traditional multiple or mass casualty incident resulting from a man-made biological event (e.g. anthrax attack), a natural occurring pandemic disease event (e.g. influenza), natural disaster or other event resulting in a large number of victims becoming ill, or where patients with preexisting conditions become increasing ill due to the exacerbation of their illness or condition.

ATTACHMENT 4
Scene Setup and Patient Management

First Arriving Unit Actions

The first arriving unit on a potential MCI must restrain themselves from rushing into the scene. The first arriving unit should use the "5-S's" to properly assess the scene and report the information to their dispatch center. This step is vital to initiate a response appropriate to the size and complexity of the MCI. Notifications (to the appropriate entities) must be made as soon as possible.

The Incident Scene

Initial triage must be conducted at the incident scene if it is safe to do so.

- All injured victims must be rapidly triaged.
- Make certain that triage ribbons are applied.
- Ambulatory(Green Tagged/Minimal) patients must be directed to a safe place as soon as one is identified.
- Green Tagged/Minimal patients should be asked to assist other patients if they are able to do so.
- Non-ambulatory patients are removed from the scene to the Treatment Area by porters in the following order: Red Tagged/Immediate, Yellow Tagged/Delayed, Yellow Prime/Catastrophically Injured.
- Deceased victims (Black Tagged/Deceased) are left where they are found, unless they must be moved to gain access to living patients or if the remains are in danger of being destroyed.
- All incident victims must be accounted for. This includes victims who may be uninjured, trapped, or who have been rescued or extricated.

Continual Evaluation

Patients in the treatment area must be continuously reevaluated (re-triaged) throughout their stay in the treatment area.

Designating and Marking the Treatment Area

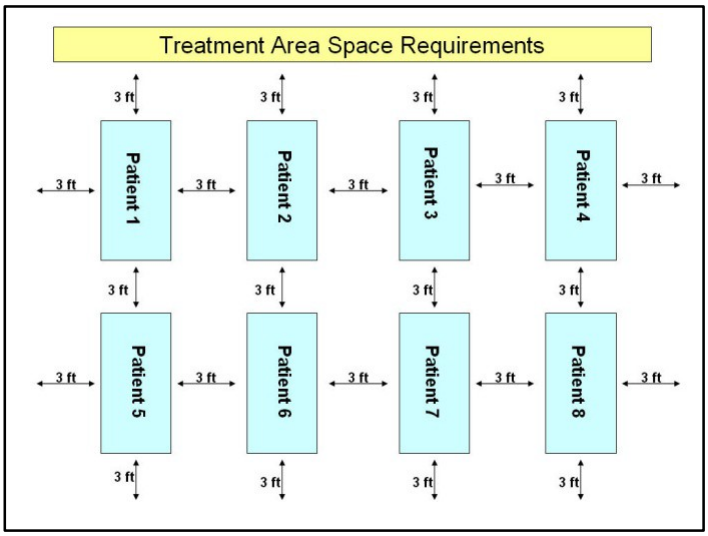
Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority. The Treatment Area is usually divided into separate areas for the care of Red Tagged/Immediate, Yellow Tagged/Delayed, Yellow Prime/Catastrophically Injured, and Green Tagged/Minimal patients. Personnel, equipment and supplies are allocated to patients based on their triage priority.

Careful consideration should be given to selecting the location of the Treatment Area. If there is inclement weather or temperature extremes consideration should be given to locating the Treatment Area indoors, whereas lighting of the Treatment Area will be a consideration during night operations. In addition, the location of the treatment area should be visible to porters. The Treatment Area should be marked with color coded (red, yellow, green, and black) flags, tarps, and/or colored chemical lights.

Designate a separate, secure and isolated area for the Incident Morgue. The incident morgue is for the placement of victims who die en route to, or in the Treatment Area. An EMS provider must be assigned to this area to confirm death and track patients transported to and from this area. The Incident Morgue/Black Tagged Area should be secured by Law Enforcement Officers, not EMS providers.

Treatment Area Space Requirements

It is important to provide enough space between patients to allow providers room to place, treat, and move safely between patients.



The Transportation Area

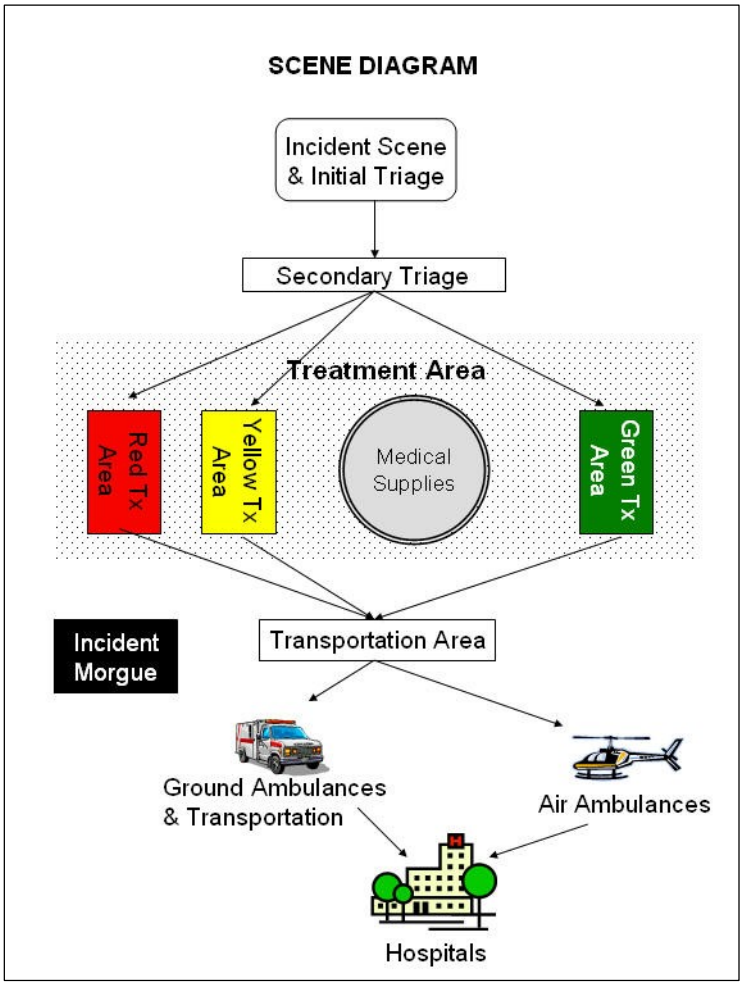
The Transport Group Supervisor/Unit Leader or Medical Communications Coordinator must be in contact with the ED or the RHCC. The entity the Medical Communications coordinator is speaking to is based on magnitude of the event.

Patient transports to receiving Emergency Departments are documented on the Virginia Triage Tag and the MCI Patient Tracking Form located in this document. If time and resources allow medical care should also be documented on the Pre-hospital Patient Care Report (PPCR).

Scene Layout

It is important for responders to establish an orderly flow of patients from the incident scene through the transport area. The way a scene is organized will depend on scene security & location, terrain, weather, the number of patients, and other factors.

Uncontaminated Patient Flow Diagram



HAZ MAT PATIENTS

First Arriving Unit Actions

(In addition to non-haz-mat situation actions)

Request the Regional HAZMAT Team to respond. The first arriving unit should also make an effort to control the scene by designating a “danger zone” and a “safe zone”. Consult the Emergency Response Guide (ERG) for initial isolation distances.

Weapons of Mass Destruction, CHEMPACKS

If WMD antidotes are needed, coordinate with local hospital based Emergency Departments to obtain additional pharmaceuticals and supplies from the Strategic National Stockpile Emergency Medical Services CHEMPACKS.

Designation of the Hot, Warm, and Cold Zones

Upon arrival the HAZMAT Team will assess the incident scene and designate a “Hot Zone, “Warm Zone” and a “Cold Zone”.

I. Hot Zone

The hot zone is the area that immediately surrounds a hazardous materials incident. Patients may receive antidotes and other lifesaving treatments in the hot zone.

II. Warm Zone

The warm zone is the area where personnel and equipment decontamination and hot zone support takes place. The warm zone is the first place that patients will be decontaminated. Patients may receive antidotes and other lifesaving treatments in the warm zone. Once patients have been decontaminated, they will be transferred into the care of EMS Providers in the cold zone.

III. Cold Zone

The cold zone serves as the control zone for a hazardous materials incident. The cold zone contains the Incident Command Post and other incident support facilities. This zone is also referred to as the clean zone or support zone.

In some cases victims may remove themselves from the contaminated area. It is important to channel these victims into a hasty decontamination corridor consisting of the strip, flush, and cover activities. This action may be necessary to save lives and protect first responders before a more formal contamination reduction corridor can be established.

Decontamination

Patient decontamination, if required, should be carried out in the warm zone by properly trained personnel wearing appropriate chemical-protective clothing and respiratory equipment. (i.e. Regional HAZMAT Team, etc.)

Refer to established protocols to:

- Determine the potential for secondary contamination, the necessity for and extent of decontamination.
- Select appropriate personal protective equipment for wear by personnel in the warm zone.
- Decontaminate patients when the exposure is to an unidentified gas, liquid, or solid material.
- Provide emergency decontamination for patients with critical injuries and illness requiring immediate patient care or transport.
- Identify and consider crime scene related issues such as the preservation of evidence, chain of custody, etc.

IV. Packaging Radiologically Contaminated Patients for Transport

In this instance the rendering of life saving treatment takes precedence over decontamination. Unstable ALS patients requiring immediate transport can be "packaged" to reduce the likelihood of spreading contamination to providers, the ambulance or the hospital.

Follow these steps to wrap the patient for transfer or transport:

- Cover ground or floor up to location of patient.
- Place two sheets on a clean (Uncontaminated) ambulance cot/stretcher.
- Bring in the clean ambulance cot/stretcher.
- Transfer the patient to the clean ambulance cot or stretcher.
- Wrap one sheet around patient, then the other.
- Perform radiological monitoring of the ambulance cot/stretcher and wheels to reduce the spread of contamination.

A properly packaged radiologically contaminated patient.

V. Transportation Considerations

Clinically unstable, radiologically contaminated patients must be transported via ground ambulance to an Emergency Department. These patients should be packaged as outlined above and the receiving Emergency Department must be notified that they will be receiving a contaminated patient.

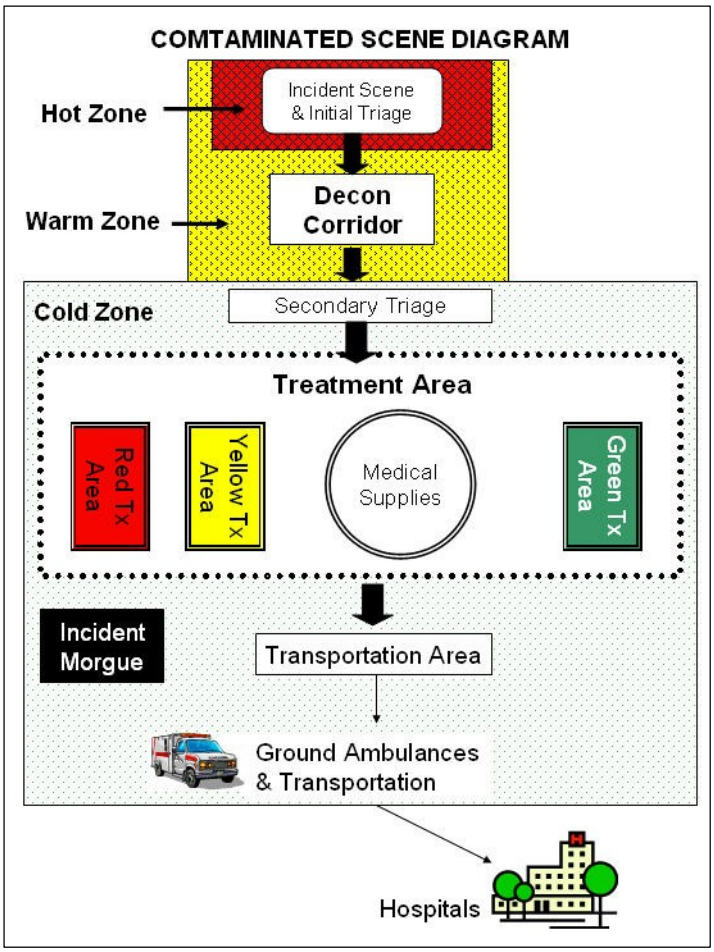
Air ambulances will **NOT** transport contaminated patients of any kind. If there are any questions as to whether or not a patient is safe to fly, consult with the pilot of the responding air ambulance. The pilot has the final authority as to whether or not the patient will be accepted.

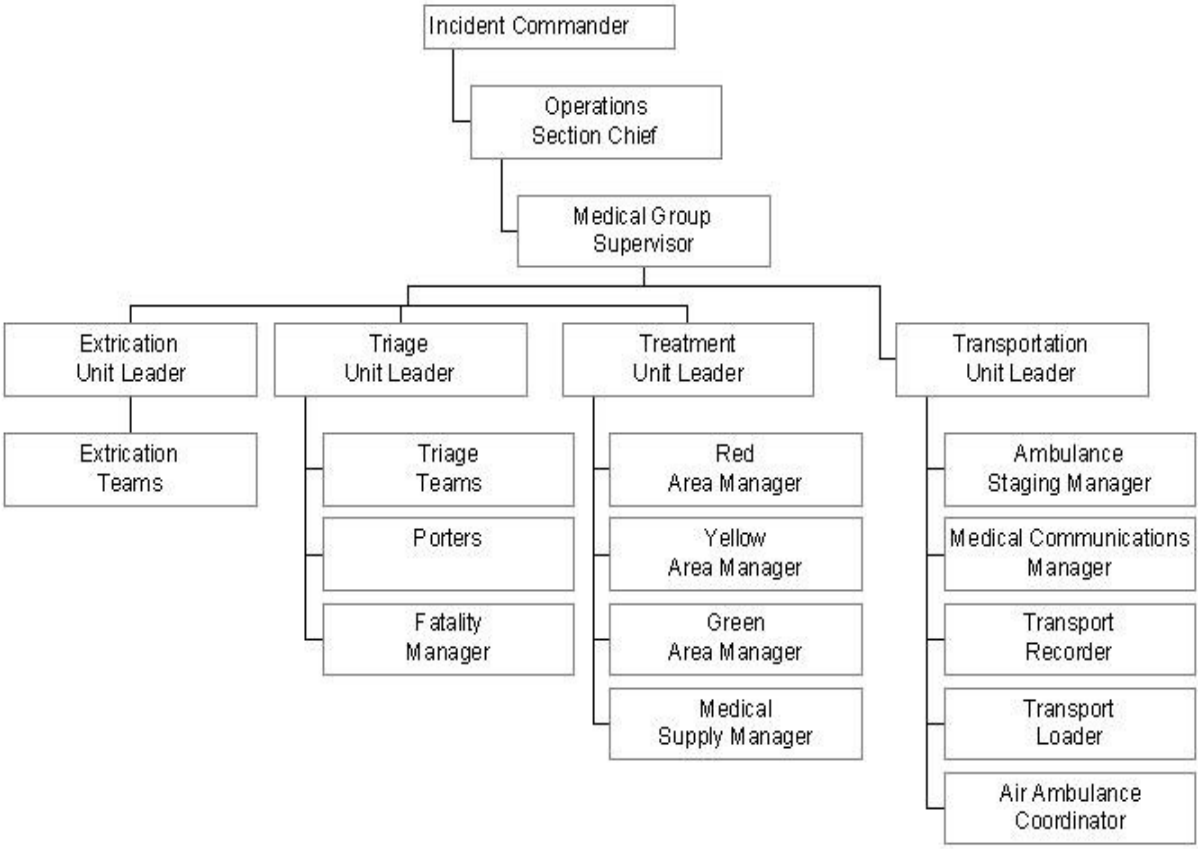
VI. Scene Layout

It is important for responders to establish an orderly flow of patients from the incident scene in the hot zone, through the warm zone, and then through the cold zone to the transport area.

Ultimately the way a scene is organized will depend on scene security & location, terrain, weather, presence and type of hazardous materials, the number of patients, and other factors.

VII. Contaminated Patient Flow Diagram




Incident Commander
Operations Section Chief
Medical Group Supervisor
Extrication Unit Leader
Triage Unit Leader
Treatment Unit Leader
Transportation Unit Leader
Extrication Teams
Triage Teams
Porters
Fatality Manager
Red Area Manager
Yellow Area Manager
Green Area Manager
Medical Supply Manager
Ambulance Staging Manager
Medical Communications Manager
Transport Recorder
Transport Loader
Air Ambulance Coordinator

MASS CASUALTY PATIENT FLOW

1. INCIDENT SCENE

- First actions done at close to the same time.
  - Direct walking patients to a supervised area.
  - Locate all victims.
  - Quickly triage patients using START and apply triage ribbons.
  - Start extrication of trapped victims.
- Complete initial patient count.
- Decontaminate patients if needed prior to leaving the incident scene.
- Move walking GREEN patients with escort to TREATMENT.
- Move RED and YELLOW patients by porter to TREATMENT.
- Leave BLACK victims where they lie.

2. TREATMENT AREA

- Re-triage arriving patients (secondary triage) and apply triage tags.
- Put patients in RED, YELLOW, or GREEN areas.
- Give stabilizing or definitive care based on Triage priority (RED then YELLOW then GREEN).
- Assign Providers, equipment, and supplies to patients based on Triage priority.
- Continuously re-triage patients.
- Move patients who die to separate BLACK area.
- Select patients to move from scene to hospitals based on severity (RED first, then YELLOW).

3. TRANSPORTATION AREA

- Contact Command Hospital to start patient distribution decisions.
- Assign patients to ambulances or air medical helicopters based on severity and most appropriate vehicles available.
- Move GREENs early on vehicles such as buses if available.
- Porters move patients from TREATMENT through TRANSPORTATION to ambulances.
- Advise hospitals of patient movement before departure.
- Ambulance crews provide emergency care and reassessment on way to hospital.

VIII. FIRST EMERGENCY MEDICAL UNIT ON SCENE

OBJECTIVE: Safely initiate patient assessment and start operations for the Medical Group.

_____ 1. **SAFETY** Assessment - observe for hazards.

a. Fire.
b. Electrical hazards.
c. Flammable liquids.
d. Hazardous materials.
e. Other situations threatening lives of rescuers and patients.

_____ 2. **SURVEY** the scene - determine how many injured and how bad.

a. Type or cause of the incident.
b. Approximate number and location of patients.
c. Severity of injuries (Major or Minor).

_____ 3. **SEND** information and request help and resources.

a. Contact dispatch with SURVEY information.
b. Declare mass casualty incident.
c. Request resources and mutual aid as needed.
d. Advise COMMAND HOSPITAL.

_____ 4. **SET-UP** scene to handle patients.

a. Identify COMMAND on scene and brief on actions.
b. Unless otherwise instructed, assume MEDICAL GROUP role until relieved. Announce on radio.
c. Identify best location for STAGING and direct incoming resources to it.

_____ 5. Begin **START** triage**.**

SECOND EMERGENCY MEDICAL UNIT ON SCENE

OBJECTIVE: Expand incident management; continue initial patient assessment and treatment.

_____ 1. Second unit reports to first unit on scene for briefing and assignment. If appropriate, relieve as MEDICAL GROUP Supervisor.

_____ 2. MEDICAL GROUP Supervisor assigns Ambulance STAGING Officer and directs establishment of STAGING Area.

   a. Coordinate with COMMAND or Incident STAGING to locate away from scene with easy access.

_____ 3. MEDICAL GROUP Supervisor assigns key functions as required:

   a. EXTRICATION. Coordinate with agency providing extrication if not an EMS function.
   b. TRIAGE.
   c. TREATMENT.
   d. TRANSPORTATION.
   e. MEDICAL COMMUNICATIONS.
   f. AMBULANCE STAGING
   g. Others as required.

_____ 4. Each function puts on vest and starts to carry out their checklist.

INCIDENT COMMAND

NOTE: EMS will not usually command a major incident. However, as first-in resource you are in command until relieved. Use this checklist and FIRST and SECOND EMERGENCY MEDICAL UNIT ON SCENE checklists to guide your actions.

OBJECTIVE: Coordinate incident response to save lives, stabilize the incident, save property, and keep the rescuers safe.

_____ 1. As first unit on scene, assume command.
   a. Announce on radio with your location.
   b. Put on INCIDENT COMMANDER vest.

_____ 2. Set up command post in a safe location where you can easily be seen and with a clear view of the incident area. Stay at the command post and use the vehicle mobile radio.

_____ 3. Assess situation and provide size-up to dispatch.
   a. What has happened and number of victims.
   b. Potential hazards.
   c. What resources are on scene and what are they doing.
   d. What help you need.

_____ 4. Develop initial strategy of:
   a. What has to be done to make area safe to work in.
   b. What priorities are for rescuing and caring for the injured.
   c. What has to be done to reduce chances of additional casualties.

_____ 5. Assign existing resources to jobs and monitor the work in progress. Appoint as soon as possible:
   a. STAGING Area Manager.
   b. SAFETY Officer.
   c. GROUP, DIVISION, SECTOR Supervisors.
   d. PUBLIC INFORMATION Officer.

_____ 6. Account for all personnel assigned to the incident.

_____ 7. Make a clean hand-off to your successor. Brief on what you know about the incident. Brief on resources committed, available, and responding. Brief on strategy and tasks in progress.

MEDICAL GROUP SUPERVISOR

OBJECTIVE: Manage all Medical Group functions to safely and quickly extricate, triage, treat, and transport all patients according to the incident medical objectives.
WORKS FOR: OPERATIONS Section Chief or COMMAND (if no OPERATIONS).

_____ 1. Put on the MEDICAL GROUP vest.

_____ 2. Set up MEDICAL GROUP in a location where you are visible and you have a clear view of the working area.

_____ 3. Coordinate with COMMAND on incident objectives and plans. Set MEDICAL GROUP objectives and make sure all unit leaders know them. Consider Activation of the RHCC.

_____ 4. Start using Tactical Worksheets to record key information and help manage the response.

_____ 5. Ensure STAGING and traffic flow established for arriving resources. Coordinate with OPERATIONS or COMMAND.

_____ 6. Assign personnel to jobs based on available people and time the function will be needed. Consider following order for assignments.
   a. STAGING, EXTRICATION (if done by EMS), TRIAGE
   b. TREATMENT
   c. TRANSPORTATION
   d. MEDICAL COMMUNICATIONS

_____ 7. Request added resources as needed and assign new resources to tasks quickly. Keep resources with no assignment in STAGING.

_____ 8. Monitor work and progress toward incident objectives.

_____ 9. Monitor condition of assigned personnel. Request relief crews as needed to keep people safe and reduce incident stress and to keep moving toward MEDICAL GROUP objectives.

_____ 10. Account for all assigned personnel.

_____ 11. Keep OPERATIONS Section Chief or COMMAND informed.

TRIAGE UNIT LEADER

OBJECTIVE: Locate, initially assess, and sort patients to establish priorities for TREATMENT, move patients to TREATMENT, and safeguard the dead. **WORKS FOR:** MEDICAL GROUP Supervisor.

_____ 1. Put on TRIAGE vest.

_____ 2. Set up TRIAGE on site or at closest safe area if site is too dangerous. Locate where you can be seen and have a clear view of the incident.

_____ 3. Identify a safe place to have GREEN patients walk to. Order them to start walking toward that place.

_____ 4. Identify TRIAGE Teams and dispatch them to begin START.
   a. Have them work through the site in a systematic way.
   b. If necessary, subdivide site and assign teams to each division.
   c. Use START algorithm and tag patients with surveyor tape.

_____ 5. Establish PORTER Teams. Obtain backboards and straps from STAGING or MEDICAL SUPPLY for the PORTER Teams.

_____ 6. PORTER Teams follow TRIAGE teams and start moving patients to TREATMENT on backboards with C-Spine precautions.
   a. If area permits, move REDs first, then YELLOWs.
   b. Do not have porters wait for REDs to be tagged if there are YELLOWs waiting.

_____ 7. Designate FATALITY MANAGER.
   a. Have FATALITY MANAGER log BLACK patient locations.
   b. Do not authorize movement of BLACK patients prior to MEDICAL EXAMINER approval unless to protect remains.

_____ 8. Monitor condition of assigned personnel. Request relief crews as needed to keep people safe, reduce incident stress and maintain progress toward TRIAGE objectives.

_____ 9. Account for all personnel assigned.

_____ 10. Keep MEDICAL GROUP, EXTRICATION, and TREATMENT informed.

FATALITY MANAGER

OBJECTIVE: To locate and safeguard remains of the deceased and personal effects pending arrival of the MEDICAL EXAMINER. **WORKS FOR:** TRIAGE Unit Leader.

_____ 1. Put on FATALITY MANAGER Vest.

_____ 2. Locate and tag remains of incident casualties in the incident area. Plot approximate positions on Tactical Worksheet and record description of the remains.

_____ 3. Establish a BLACK casualty area separate from TREATMENT. BLACK area should be accessible with 2-wheel-drive vehicles.

_____ 4. Coordinate with TREATMENT and TRIAGE for porters to move to the BLACK area any patients who die in TREATMENT.

_____ 5. Maintain records of patients dying in TREATMENT, including identify (if known), triage tag number, situation and time of death, and description of clothing and personal effects.

_____ 6. Safeguard remains and personal effects. Do not leave remains unattended or unobserved. Request assistance of law enforcement if necessary.

_____ 7. Where appropriate to preserve privacy or to protect the remains, cover remains with disposable non-absorbent or fluid barrier sheets.

_____ 8. Keep TRIAGE and TREATMENT informed.

_____ 9. Turn over responsibility for remains to the MEDICAL EXAMINER.

TREATMENT UNIT LEADER

OBJECTIVE: Continually assess patients, stabilize patients and begin definitive treatment based on priorities and resources, and determine priority for transport to medical facilities. **WORKS FOR:** MEDICAL GROUP Supervisor.

_____ 1. Put on TREATMENT vest.

_____ 2. Set up Treatment area. Consider: (1) safety, (2) portering distance, (3) space, (4) weather, (5) lighting, (6) TRANSPORTATION access.

_____ 3. Inform TRIAGE and MEDICAL GROUP of Treatment location.

_____ 4. Determine how to do secondary triage - assign a Secondary Triage Officer and funnel patients through Secondary Triage.

_____ 5. Arrange Treatment Area for parallel rows of patients.
   a. Allow room for RED and YELLOW areas to grow outward.
   b. Consider separate location for GREEN area.

_____ 6. Assign Treatment Teams with RED, YELLOW, GREEN Managers.

_____ 7. Set up MEDICAL SUPPLY. Assign MEDICAL SUPPLY Officer.

_____ 8. Consider use of Special Procedures Teams for common treatments (Airway, IV, Splinting, etc.) if needed and resources available.

_____ 9. Supervise prehospital patient care per approved protocol. Supervise regular reassessment of patient conditions and priorities.

_____ 10. Isolate emotionally disturbed patients if possible.

_____ 11. Determine patient transport order and best means.

_____ 12. Monitor condition of assigned personnel. Request relief crews as needed to keep people safe and reduce incident stress and to maintain progress toward TREATMENT incident objectives.

_____ 13. Account for all assigned personnel.

_____ 14. Keep MEDICAL GROUP and TRANSPORTATION informed.

MEDICAL SUPPLY MANAGER

OBJECTIVE: Provide Porters and Treatment Area supplies and equipment needed to move and treat the injured. **WORKS FOR:** TREATMENT Unit Leader.

_____ 1. Put on MEDICAL SUPPLY vest.

_____ 2. Set up within easy reach of the TREATMENT Unit.

_____ 3. Coordinate with Ambulance STAGING Officer to have crews bring extra supplies from vehicles to the MEDICAL SUPPLY area (keep essential equipment on vehicles). Request:

Backboards and rescue baskets and straps
Splints
Oxygen and airway kits
IV sets
Bleeding control supplies
Pre-packed disaster kits

_____ 4. Sort supplies and arrange for easy access. Determine points in inventory at which more supplies will have to be ordered.

_____ 5. For night time operations, coordinate with MEDICAL GROUP Supervisor and Ambulance STAGING Officer to have portable lighting brought to TREATMENT Unit.

_____ 6. Issue supplies as needed within the TREATMENT Unit.

_____ 7. Contact TRANSPORTATION to arrange for returning vehicles to bring additional supplies when order points are reached.

_____ 8. On completion of operations collect unused supplies and equipment and attempt to return to owning agency (if marked). Make arrangements for distribution or return of unmarked supplies and equipment.

TRANSPORTATION UNIT LEADER

OBJECTIVE: Coordinate all patient transportation and maintain all records of patient and unit movement. **WORKS FOR:** MEDICAL GROUP Supervisor.

_____ 1. Put on TRANSPORTATION vest.

_____ 2. Set up TRANSPORTATION Unit at exit from TREATMENT Unit.

_____ 3. As needed appoint AMBULANCE STAGING MANAGER, MEDICAL COMMUNICATIONS MGR, TRANSPORT RECORDER(s), TRANSPORT LOADER(s), AIR AMBULANCE COORDINATOR.

_____ 4. Set up vehicle flow from STAGING to Transportation to Hospitals.

_____ 5. Contact COMMAND HOSPITAL through COMMUNICATIONS to determine hospital capabilities to accept patients in each category.

_____ 6. Select mode of transportation based on patient needs and available air and ground ambulance resources.

_____ 7. Order ambulances from STAGING for patients in TREATMENT area.
   a. Load RED patients first, then YELLOW, then GREEN.
   b. Depending on hospital capacity load mixed patients.
   c. If non-ambulance transport is available early move GREENs.

_____ 8. Ensure ambulances are parked parallel to each other. Avoid end-to-end. If end-to-end must be used, load first in the line first.

_____ 9. Request porter teams from TRIAGE to move patients from TREATMENT and assist in loading.

_____ 10. Coordinate with COMMAND HOSPITAL for destination for each ambulance dispatched to hospitals.

_____ 11. Brief ambulance crews on destination hospital and route (if needed).

_____ 12. Record patient and unit movements on tactical worksheet.

_____ 13. Keep MEDICAL GROUP and TREATMENT informed.

AMBULANCE STAGING MANAGER

OBJECTIVE: Maintain EMS manpower and ground vehicle resources ready for dispatch at a location separated from the incident (may be collocated with incident STAGING). **WORKS FOR:** TRANSPORTATION Unit Leader.

_____ 1. Put on STAGING vest.

_____ 2. Establish ambulance STAGING in coordination with OPERATIONS Section Chief or incident STAGING. Site is away from scene and should:
   a. Be large enough to hold the needed number of units.
   b. Have easy road access from major transportation routes.
   c. Have easy access to TRANSPORTATION Unit.

_____ 3. Direct arriving vehicles to stage for easy departure. Parallel staging for pull through should be used unless space does not permit.

_____ 4. Ensure personnel on staged vehicles remain with their unit.

_____ 5. Park vehicles used to transport scene staff out of traffic flow.

_____ 6. Update TRANSPORTATION on available vehicles and personnel.

_____ 7. Ensure ambulance cots are not removed from units.

_____ 8. As needed, remove medical supplies from ambulances for relocation to MEDICAL SUPPLY:
   Backboards and straps
   Splints and bandages
   Blankets/ Portable oxygen equipment and supplies
   Airway equipment
   IV sets

_____ 9. Coordinate for REHABILITATION (food, drink) for staged crews.

_____ 10. As ordered dispatch vehicles to the TRANSPORTATION Unit.

_____ 11. Track the status, number, and types of ambulances in STAGING. Use the Tactical Worksheet.

MEDICAL COMMUNICATIONS MANAGER

OBJECTIVE: Establish, maintain, and coordinate medical communications at the incident scene between TRANSPORTATION, the COMMAND HOSPITAL, and the MEDICAL GROUP. **WORKS FOR:** TRANSPORTATION Unit Leader.

_____ 1. Put on COMMUNICATIONS vest.

_____ 2. Set up close to TRANSPORTATION Unit. Check for good radio contact with repeater or other simplex users.

_____ 3. Establish initial communications with the COMMAND HOSPITAL or nearest receiving hospital using public safety radio, cellular telephone, or amateur radio (if available).

_____ 4. Break out tactical worksheets and use to track information.

_____ 5. Get initial information from MEDICAL GROUP. Give hospital initial report. Be accurate. Identify estimates. Do not speculate.

   a. CATEGORY or level of Mass Casualty Incident.
   b. CAUSE of incident.
   c. NUMBER of patients.
   d. SEVERITY of injuries.

_____ 6. Get hospital emergency capacity information. Provide to TRANSPORTATION and MEDICAL GROUP.

_____ 7. Coordinate with COMMAND HOSPITAL to determine to which facility ambulances should be dispatched. Provide transport reports to COMMAND HOSPITAL on departure. Include:

   a. UNIT transporting.
   b. DESTINATION hospital.
   c. NUMBER of patients.
   d. PATIENT INFORMATION (triage category, chief complaint, age, sex)

_____ 8. Monitor equipment status - replace batteries as needed.

TRANSPORT RECORDER

OBJECTIVE: Ensure proper documentation of patient and vehicle movements.
WORKS FOR: TRANSPORTATION Unit Leader.

_____ 1. Put on TRANSPORT RECORDER vest.

_____ 2. Set up at patient loading point in the TRANSPORTATION Area.

_____ 3. Record patient movement information on tactical worksheet.

_____ 4. Give COMMUNICATIONS following information on every patient leaving TREATMENT.

UNIT transporting
DESTINATION hospital
NUMBER of patients
PATIENT INFORMATION (triage category, age, sex, chief complaint)
ETA at destination

_____ 5. Give other information to COMMUNICATIONS for relay to hospital.

TRANSPORTATION LOADER

OBJECTIVE: Ensure proper loading of patients on ground vehicles and provide directions to receiving hospitals. **WORKS FOR:** TRANSPORTATION Unit Leader.

_____ 1. Put on TRANSPORTATION LOADER vest.

_____ 2. Get local area maps and directions to receiving hospitals.

_____ 3. Set up at the patient loading point in TRANSPORTATION Unit.

_____ 4. Make sure patients selected for ground transportation by TRANSPORTATION are:
   a. Ready for movement.
   b. Loaded on the correct ambulance - cross check numbers with RECORDER.

_____ 5. Provide instructions to vehicle drivers:
   a. Directions to the designated hospital.
   b. Actions to take (Return to Staging or Return to Home) after delivering patients.

_____ 6. Keep TRANSPORTATION and RECORDER informed.

AIR AMBULANCE COORDINATOR

OBJECTIVE: Establish helicopter landing zone and coordinate helicopter operations into and out of the landing zone. **WORKS FOR:** TRANSPORTATION Unit Leader.

_____ 1. Put on AIR AMBULANCE COORDINATOR vest.

_____ 2. Select Landing Zone site.

a. Select area large enough for safe operations:

	DAY	NIGHT
small helicopter	60' x 60'	100' x 100'
medium helicopter	75' x 75'	125' x 125'
large helicopter	125' x 125'	200' x 200'

b. Landing surface is flat and firm and free of debris.
c. Landing zone not close to TREATMENT.
d. Clear approach path.
e. Upwind of hazardous materials scenes.

_____ 3. Assign people to assist in establishing the Landing Zone.

_____ 4. Mark the Landing Zone.
a. Other light sources are preferred to flares (source of ignition).
b. At night, make sure spotlights, floodlights, vehicle headlights, and other white lights are not pointed toward the helicopter.

_____ 5. Advise flight crew before their landing approach of:
OBSTRUCTIONS (towers, power lines, buildings, etc.)
WIND DIRECTION and any gusting
SPECIAL HAZARDS

_____ 6. Coordinate patient loading and movement with TRANSPORTATION.

_____ 7. Keep operations safe and secure. Do not allow anyone to approach the aircraft who is not accompanied by a flight crew member.

_____ 8. Keep TRANSPORTATION and HELICOPTER CREWS informed.

STAFFING CHART - TREATMENT AND PORTERS

PURPOSE: Quick reference chart of desired numbers of providers for mass casualty incidents. Total column gives number by Treatment Area and an overall total.

PATIENTS		**ALS**	**BLS**	**PORTERS**	**TOTAL**	
10	2 RED	2	2		4 area	2 YELLOW
	1 2			3 area		
	6 GREEN	0	2		2 area	
		3	**6**	8	17	
20	4 RED	4	4		8 area	
	4 YELLOW	1	4		5 area	
	12 GREEN	0	4		4 area	
		5	**12**	8	25	
50	10 RED	10	10		20 area	
	10 YELLOW	3	10		13 area	
	30 GREEN	0	10		10 area	
		13	**30**	20	63	
100	20 RED	20	20		40 area	
	20 YELLOW	6	20		26 area	
	60 GREEN	0	20		20 area	
		26	**60**	40	126	

BASIC STAFFING RATIOS:

RED TREATMENT AREA	1 ALS Provider and 1 BLS Provider per patient.
YELLOW TREATMENT AREA	1 BLS Provider per patient. 1 ALS Provider per 3 patients.
GREEN TREATMENT AREA	1 BLS Provider per 3 patients
PORTERS	1 per RED or YELLOW patient

TACTICAL WORKSHEET BOOK

TACTICAL WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management Rev 1	MCI 1
Incident	Date	Time

Time	Task	Scene Sketch:
	Scene Safe	
	Survey/Size-Up	
	Send Help	
	Contact IC	
	Set-up Medical	
	Staging	
	Extrication	
	Porter Teams	

	Treatment	UNIT	Assignment	UNIT	Assignment
	Medical Supply				
	Brief Hospital				
	Transportation				
	Landing Zone				
	REDs First				
	Move GREENs				
	Manage BLACKs				
	Release Units				

CASUALTIES						HOSPITAL CAPABILITIES					
Time	RD	YE	GN	BK	Trans	Facility	RD	YE		GN	Trans
Totals											

EMS INCIDENT ACTION PLAN	Commonwealth of Virginia Mass Casualty Incident Management	MCI 10

Incident	Date	Time

For Operational Period From: To:

INCIDENT COMMANDER GOALS:			
INCIDENT COMMANDER STRATEGY:			

Scene Sketch

TACTICAL PRIORITIES:	(1)	By:
	(2)	By:
	(3)	By:
	(4)	By:
	(5)	By:

HAZARDS AND LIMFACS:	

ASSIGNMENTS:	(1)	(4)
	(2)	(5)
	(3)	Other:

STAFFING WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	Rev 1	MCI 11

Incident	Date	Time

Position		Agency:	Person:
INCIDENT COMMAND			
OPERATIONS SECTION CHIEF			
	MEDICAL GROUP SUPV		
	EXTRICATION UNID LDR		
	Extrication Team Leader		
	Extrication Team Leader		
	TRIAGE UNIT LEADERS		
	Triage Team Leader		
	Triage Team Leader		
	Triage Team Leader		
	Fatality Manager		
	TREATMENT UNIT LEADER		
	Red Area Manager		
	Yellow Area Manager		
	Green Area Manager		
	Medical Supply Manager		
	TRANSPORTATION UNIT LDR.		
	Ambulance Staging Mgr		
	Medical Communications		
	Transport Recorder		
	Transport Loader		
	Air Ambulance Coord.		

Accountability Worksheet	Commonwealth of Virginia Mass Casualty Incident Management	MCI 12

Incident | Date | Time

Unit	Assignment	Released	Accountability Checks					
			1	2	3	4	5	6

Action Taken:

EXTRICATION WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 2

Incident	Date	Time

Scene Sketch:

No.	Patients	Problem	Unit	Start	Complete

Notes:

Special Resources	

Time	Task	Time	Task		
	Set Up		Treatment		
	Assign Resources		Monitor Personnel		
	Locate Victims		Account for personnel		
	Triage		Complete		

TRIAGE WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 3

Incident	Date	Time

Scene Sketch:

TRIAGE TEAM REPORTS

Team	RED	YELLOW	GREEN	BLACK	Total	Notes
	TOTALS					

Time	Task	Time	Task
	Assign Triage Teams		Safeguard BLACKS
	START		Personnel Count
	Assign Porter Teams		Patient Count
	Clear Scene		

FATALITY WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 31

Incident	Date	Time

Scene Sketch:

Number	Sex	Description	Condition

Individual Completing: Agency:

TREATMENT WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 4

Incident	Date	Time

RED TEAM		YELLOW TEAM		GREEN TEAM		MEDICAL SUPPLY	
Patients	Time	Patients	Time	Patients	Time		
Staff	Time	Staff	Time	Staff	Time		

Notes:

Time	Task	Time	Task
	Set up area		Move to Transport
	Secondary triage		Monitor staff
	Assign Teams		Personnel count

TREATMENT LOG	Commonwealth of Virginia Mass Casualty Incident Management	MCI 41

Incident	Date	Time

Unit (Optional Use):

Patient	Status	Priority	Notes	To Transport
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				
Name: Bar Code:				

TRANSPORTATION WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management rev 1	MCI 5

Incident	Date	Time
Hospital (Optional Use):		

Patient	Status	Hospital	Unit	Time
Name				
Name				
Name				
Name				

COMMUNICATIONS LOG	Commonwealth of Virginia Mass Casualty Incident	MCI 51
Incident		Date

Frequencies or Means				
A:	B:	C:	D:	E:

Time	Station Calling	Freq	Message

LANDING ZONE WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 52

Incident	Date	Time

LZ Sketch

AIRCREW BRIEFING

LZ Lat:

LZ Lon:

Landmark:

Approach From:

Size:

Hazards:

Lighting:

Aircraft	Type	Patients	Operational

Winds:

Visibility:

Precip:

Other:

AIRSPACE RESTRICTION

Time From:

Time To:

By:

Contact:

Altitudes:

Area:

HOSPITALS RECEIVING PATIENTS BY AIR

Facility	From Scene:

Notes:

STAGING WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management rev 1	MCI 53

Incident	Date	Time

In	Agency / Unit	Crew	Class	Assignment	Out

Notes and Special Instructions	Supplies to Scene	
	IX. Blankets	Backboard
	Oxygen	Dressings
	IV Sets	Splints
	Airway	

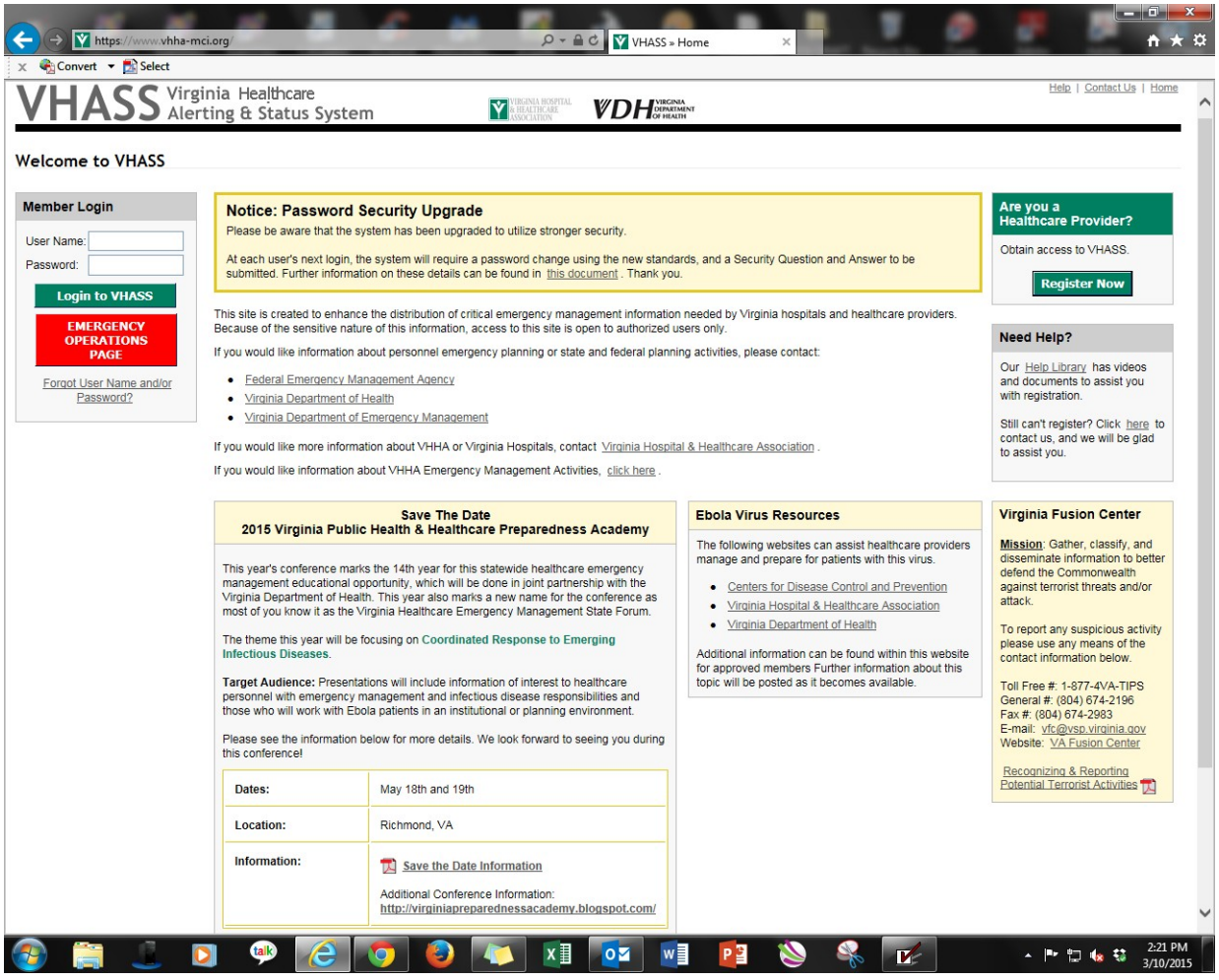
How do I register a user account?

Register Now

Open your browser and go to the VHASS Website (http://www.vhha-mci.org). You may need to type the full web address out in the address bar the first time you go to the site.

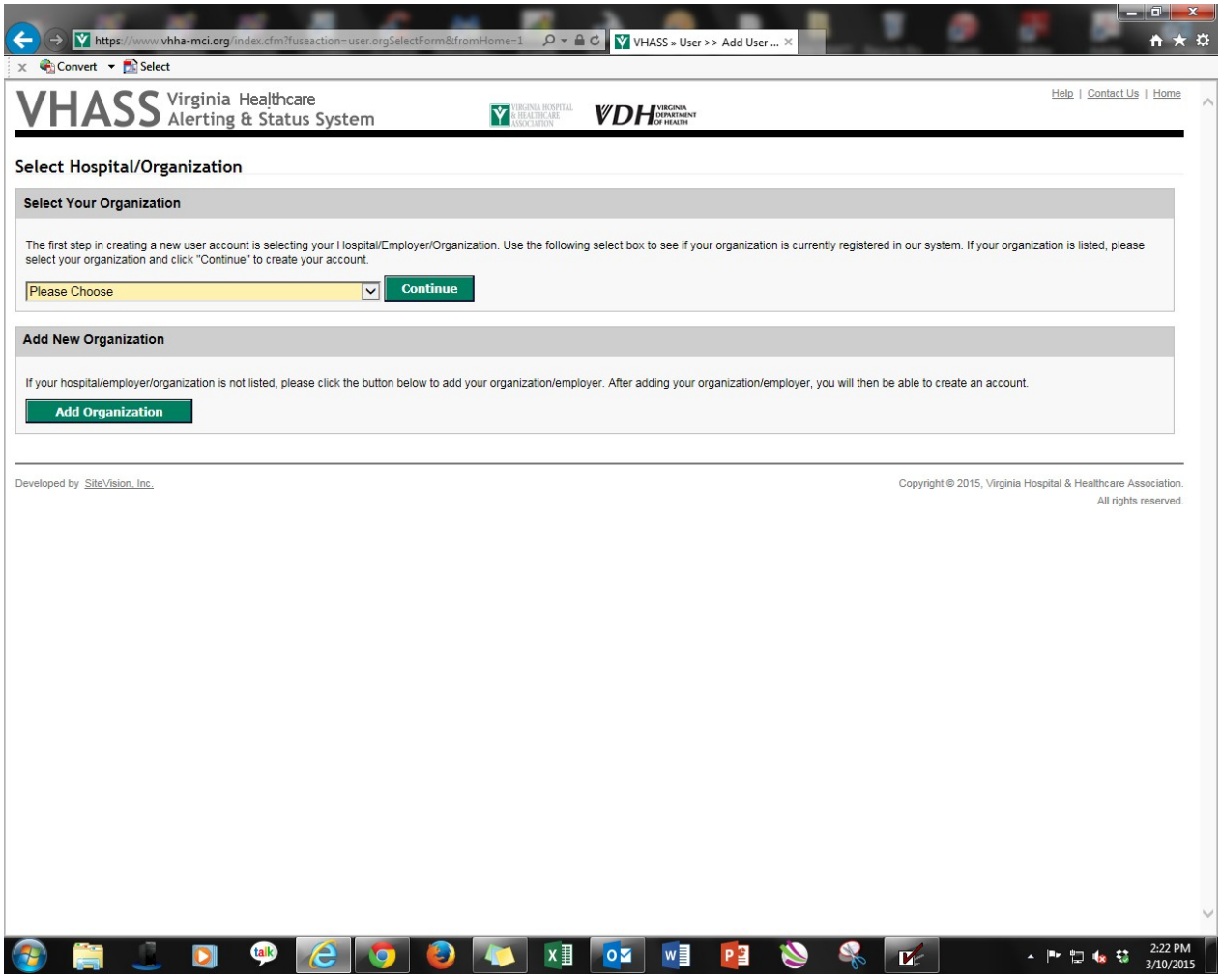
- *NOTE: You may not logon to VHASS until your account has been approved by either a VHASS Administrator or your organization's designated Organization Contact or Alternate Organization Contact.*
- *NOTE: You may want to create a bookmark of the homepage to quickly access the logon screen. Hold down the CTRL key and press the D Key (CTRL+D) to create a bookmark.*

The VHASS Homepage will be displayed as shown below: Under the "Are you a Healthcare Provider" heading, click the green "Register Now" button



Select Hospital/Organization

Select your organization from the dropdown menu and click the “Continue” button under “Select Your Organization”



Account Information

Fill in the information on this page. The required fields are:

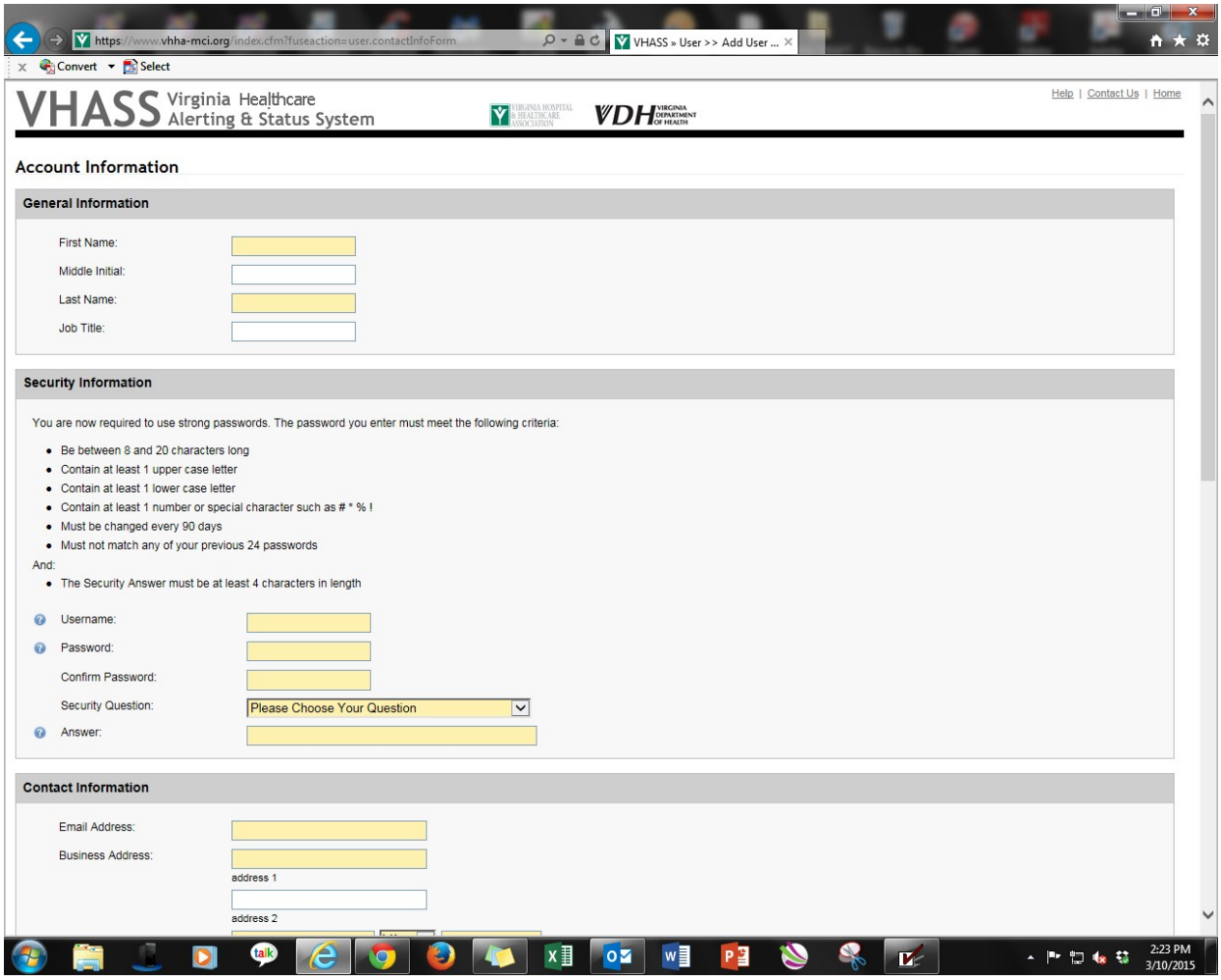
- o Username
- o Password (and Confirm Password)
- o First Name
- o Last Name
- o Email Address
- o Business Address
- o Business Telephone

NOTE: The username and password must contain a minimum of 4 letters, numbers, or a combination of both.

You can select a job category from the dropdown menu and click the check boxes beside any professional groups you are a member of.

You will be able to communicate with members of your professional groups and committees thought the state using the post office.

Click the “Continue” button at the bottom of the page.
Review the information on the confirmation page and click the “Continue” button to submit your information and complete the registration process.



Registration Complete

Upon completing the registration process, you will be sent a confirmation email notifying you that your information has been received.

Your user account will now be sent to your organization’s designated organization contact.

Once your account has been approved, you may then login to VHHA-MCI and begin using the system.

Attachment 7: Incident Command System

Incident Command System (ICS)

1. We should utilize ICS, an integral part of the NIMS, in managing emergencies. ICS is both a strategy and a set of organizational arrangements for directing and controlling field operations

2. The incident commander is responsible for carrying out the ICS function of command -- managing the incident. The four other major management activities that form the basis of ICS are operations, planning, logistics, and finance/administration. For small-scale incidents, the incident commander and one or two individuals may perform all of these functions. For larger incidents, a number of individuals from different departments or agencies may be assigned to separate staff sections charged with those functions.

3. An incident commander using response resources from one or two departments or agencies can handle the majority of emergency situations. Departments or agencies participating in this type of incident response will normally obtain support through their own department or agency.

4. In emergency situations where other jurisdictions or the region, state or federal government are providing significant response resources or technical assistance, it is generally desirable to transition from the normal ICS structure to a MAC model or Area Command structure. This arrangement helps to ensure that all participating agencies are involved in developing objectives and strategies to deal with the emergency.

Attachment 8: ORGANIZATION & ASSIGNMENT REPONSIBILITIES

A. Organization

1. Most departments and agencies of local government have emergency functions in addition to their normal day-to-day duties. During emergency situations, our normal organizational arrangements are modified to facilitate emergency operations

B. Assignment of Responsibilities

2. General

For most emergency functions, successful operations require a coordinated effort from a number of departments, agencies, and groups. The municipality where the MCI takes place will be the lead responder and incident command entity. To facilitate a coordinated effort the municipality will provide clear guidelines regarding emergency authority on MCI incidents. Usually, this authority is clearly outlined in the Municipalities emergency operations plan. Generally, primary responsibility for an emergency function will be assigned to an individual from the department or agency that has legal responsibility for that function or possesses the most appropriate knowledge and skills. Other officials, departments, and agencies may be assigned support responsibilities for specific emergency functions. Attachment 4 summarizes the general emergency responsibilities of local officials, department and agency heads, and other personnel.

All agencies/organizations assigned to provide health and medical services support are responsible for the following:

a. Designating and training representatives of their agency, to include NIMS and ICS training.
b. Ensuring that appropriate SOPs are developed and maintained.
c. Maintaining current notification procedures to insure trained personnel are available for extended emergency duty in the EOC and in the field.

3. EMS, Hospital, RHCC, Locality Responsibilities

A. EMS Initial Actions and responsibilities:

a. First Arriving Unit Responsibilities: It is the responsibility of the first arriving unit to establish command and to perform the initial scene size-up using what is known as the "5-S's and reporting the information to their dispatcher. The "5-S's" are:
   i. <u>SAFETY assessment</u>: Assess the scene for safety by looking for:
      - ✓ Electrical hazards.
      - ✓ Flammable liquids.
      - ✓ Hazardous Materials

- ✓ Other life threatening situations.
- ✓ The potential for secondary explosive devices or other security threats.

ii. SIZE UP the scene: How big and how bad is it? Survey the incident scene for:
- ✓ Type and/or cause of incident.
- ✓ Approximate number of patients.
- ✓ Severity level of injuries (either Major or Minor).
- ✓ Area involved, including problems with scene access.

iii. SEND information:
- ✓ Contact dispatch with your size-up information.
- ✓ Request additional resources.
- ✓ Notify the closest hospital.

iv. . SETUP the scene for management of the casualties:
- ✓ Establish the staging area.
- ✓ Identify access and egress routes.
- ✓ Identify adequate work areas for Triage, Treatment, and Transportation.

v. START Triage: Triage all patients using Simple Triage and Rapid Treatment (START) and Jump START triage methods as appropriate. (The triage algorithms may be found in Chapter 4 of this document.)
- ✓ Begin where you are standing.
- ✓ Ask anyone who can walk to move to a designated area.
- ✓ Use surveyor's tape to mark patients.
- ✓ Move quickly from patient to patient.
- ✓ Maintain patient count including a record of casualties and transport destinations
- ✓ Provide only minimal treatment.
- ✓ Keep moving!

b. The First Unit On-Scene size-up position check list is located in attachment x of this document.

c. All ambulances and emergency rescue vehicles serving in our region will be equipped with Virginia Field Triage Tags and shall contain at all times, those essential items as specified by the VDH/WVEMS/BREMS Councils.

d. Emergency Department/Hospital and RHCC Notification. It is vital that the First Arriving contact the closest one or two Emergency Departments and inform the facility that there is a MCI in progress. The EDs contacted will report Capacity utilizing the START Triage Categories "Red, Yellow, and Green". EMS or the Hospital will then notify the RHCC if it is necessary.

i. Each of these notifications should include the nature or apparent cause of the event, the estimated number of victims, and whether or not the victims may be contaminated.

e. Establishing Incident Command. The senior crewmember on the first arriving unit becomes the Incident Commander and reports that they established command to their dispatcher. This person will remain in charge until command is transferred to a higher authority.

f. Once capacity numbers have been obtained for the closest one or two Emergency Departments, EMS can start making transports to said hospitals.

g. When activated, the RHCC will update EMS on additional facilities bed capacity and make transport recommendations when more than two EDs are needed to absorb the patients generated from the MCI

h. Upon the establishment of a Triage / Transport Officer, all ambulance service personnel will place themselves at his/her disposal and will follow their directions in regard to casualty movement.

i. The Triage / Transport Officer, during the course of the disaster, will provide the ambulance personnel with information relative to situation and/or existing capabilities at the various medical treatment facilities.

j. Request Additional Resources. If the emergency situation warrants, the Operations Chief (or another appropriate designee) will request, through the Incident Commander, additional ambulances. The Incident Commander's request for additional resources should be accompanied by the identification of the incident Staging Area(s).

B. Hospitals/Healthcare Facilities

a. Initiate assessment of Emergency Room and Inpatient bed capacity and report that capacity to requesting On Scene EMS and to the RHCC via VHASS.
b. Implement internal and/or external disaster plans.
c. Provide for the security of facility and monitor for self-presenting patients
d. Report patient arrivals to incident command or, if activated, to the RHCC
e. Continually re-assess bed capacity and evaluation for ability to continue to accept patients.
    i. Notify the RHCC and On Scene incident command if you are no longer able to accept patients (EMS DIVERSION). If you require diversion declaration assistance, tell the RHCC when notifying.
f. Monitor status and count of critical medical supplies necessary for sustained operations. Consider requesting additional supplies to be deployed as needed (RHCC or local EOC).
g. Consider requesting police / security support thru the local EOC
h. Establish and staff a reception and support center at each hospital for relatives and friends of disaster victims searching for their loved ones.
i. Report names of received victims to the FAC if activated. This may be done thru the RHCC. If a FAC is not activated (or an RHCC not activated) Share this information with local emergency management PIO, the EOC, or Command (depending on accessibility)

j. Coordinate with local emergency responders to isolate and decontaminate incoming patients, if needed, to avoid the spread of chemical or bacterial agents to other patients and staff.

C. Regional healthcare Coordination Center (RHCC)

Regional Healthcare Coordination Center (RHCC)

1. RHCC Call Center (866) 679-7422 is staffed 24 hours a day.
2. When seeking the assistance or involvement of the RHCC, contact the Call Center and be prepared to provide the following information:
    a. Entity
    b. Point of Contact Name
    c. Point of Contact Phone Number
    d. Type of Incident (Patient Surge or Evacuation)
    e. Any Known Resources Requested
3. The RHCC Call Center will notify the On-Call RHCC Duty Officer of the activation.
4. The RHCC Duty Officer will contact the Point of Contact to establish communication and confirm requests. The following will routinely be included in the initial steps.
    a. Confirm lead entity
    b. Confirm Point of Contact
    c. Confirm Telephone Number
    d. Identify Radio Channel being utilized (Channel Name)
    e. MCI Tier
    f. Number of Red/Yellow/Green Patients (if known)
    g. Special circumstances of patients (special medical needs, pediatrics, elderly, etc)
    h. Any identified needs
    i. Actions taken so far by on-scene personnel
    j. Any summary of the incident, in terms of “What happened?”

5. Based on information received, the RHCC Duty Officer will perform the following tasks:
    k. Notify other RHCC personnel and request assistance as needed.
    l. Issue a regional ALERT using the VHASS Text Alerting Platform and the Regional ALERTING process. Such actions may include notifications of Hospital, EMS, Public Health, OCME, Long Term Care, and Emergency Management of a developing situation.
    m. Request a CLINICAL STATUS BOARD update within VHASS by all seventeen (17) hospitals and one (1) free standing Emergency Department.
    n. Create an EVENT within the VHASS Event Module. This platform

can be used by VHASS Account Holders to post information about the incident response, organization operations, and organizational capacity.

o. Provide follow-up, as warranted, for any facilities that have not responded to the ALERT, as appropriate.
p. Provide appropriate information back to the Point of Contact as the situation warrants or as was requested.
q. Monitor communication platforms for updates from response entities.
r. Transmit Situation Reports through the VHASS Events Module relating to known injuries, fatality counts, and other pertinent information.
s. Ensure that available hospital capacities are relayed to the Point of Contact to allow for the best opportunity to appropriately distribute patients.
t. ALERT adjacent RHCCs when warranted by magnitude, geographic location, or patient demographic, etc.
u. Request VHASS CLINICAL STATUS BOARD update for specialty centers (burn, pediatric, neurology, trauma, hyperbaric chamber, etc) when the nature of the incident mechanism can produce patients of a specialty nature.
v. Respond to requests for assistance as the incident matures.
w. Support large-scale evacuation and mass healthcare operations.
x. Deploy NSPA resources as available and as requested.
y. Create radio patches (via RIOS) to support interoperable communication as requested.
z. Coordinate efforts of local health and medical organizations activated for an emergency assessing their needs, obtain additional resources, and ensure that necessary services are provided.
aa. Initiate planning process with a focus on secondary and tertiary impacts from the event.

D. The Mental Health Authority will:

Ensure appropriate mental health services are available for disaster victims, survivors, bystanders, responders and their families, and other community caregivers during response and recovery operations. The request to deploy Mental Health servies will come from the:

Local EOC
Hospital(s) involved
RHCC (on behalf of an aforementioned entity)

E. Law Enforcement will:

a. Upon request, provide security for medical facilities.
b. Conduct investigations of deaths not due to natural causes.
c. Locate and notify next of kin

F. Public Information.

a. Primary responsibility for this function is assigned to the locality leading the response. A common message is essential, and Annex I (Public Information) provides guidance on the collaboration between PIOs.
b. Emergency tasks to be performed include:

(1) Establish a Joint Information Center (JIC) when indicated by the scope of the incident.
(2) Pursuant to the Joint Information System (JIS), compile and release information and instructions for the public during emergency situations and respond to questions relating to emergency operations.
(3) Utilize WebEOC or Email distribution groups to share and collaborate on common message between PIOs involved in the incident.
(4) Provide information to the media and the public during emergency situations.
(5) Arrange for media briefings.
(6) Compiles print and photo documentation of emergency situations.

3. Recovery / Post-Incident

1) Primary responsibility for this function is assigned to the Locality leading the response.

2) Emergency tasks to be performed include:

a) Evaluate the need for Counseling and bereavement coordination.
b) Enact a Family Assistance Center
c) Assess and compile information on damage to public and private property and needs of disaster victims.

4. The Health Regional District of the Virginia Department of Health will coordinate:

1. Public health and medical activities as requested by the local EOC
2. Rapid assessments of health and medical needs in collaboration with the RHCC.
3. Support ESAR VHP activities as requested.
4. Monitor situation for public health concerns and communicate identified issues to local EOC
5. Collaborate with the lead PIO on casualties and instructions to the public on dealing with public health problems.
6. The provision of laboratory services required in support of emergency health and medical services.
7. Immunization campaigns or quarantines, if required.
8. As applicable Inspections of foodstuffs, water, drugs, and other consumables that were exposed to the hazard.
9. Implementation of measures to prevent or control disease vectors such as flies, mosquitoes, and rodents.
10. Preventive health services, including the control of communicable diseases such as influenza, particularly in shelters.
11. Food handling and sanitation monitoring in emergency facilities.

5. Mortuary Services, Regional/State/Federal Teams

A. Mortuary Services

1) Law enforcement is responsible for investigating deaths that are not due to natural causes or that do not occur in the presence of an attending physician. The office of the chief medical examiner and the local Medical Examiner are responsible for determining cause of death, authorization of autopsies to determine the cause of death, forensic investigations to identify unidentified bodies, and removal of bodies from incident sites.

2) When it appears an incident involves fatalities, the Incident Commander shall request the Emergency communications Center make notifications to the Medical Examiner and law enforcement requesting a response to the scene.

3) Law enforcement or and the Medical Examiner shall arrange for the transportation of bodies requiring autopsy or identification to morgues or suitable examination facilities. When mass fatalities have occurred, it may be necessary to establish a temporary morgue and holding facilities. Additional mortuary service assistance may be required.

B. Medical and Mortuary Assistance

1) Virginia Department of Health (VDH). When requested by local officials, the VDH can provide health and medical advice and assistance during emergency situations from its various regional offices.

C. Disaster Medical Assistance Team (DMAT)

DMAT is a group of professional and Para-professional medical personnel (supported by a cadre of logistical and administrative staff) designed to provide medical care during a disaster or other event. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site. To supplement the standard DMATs, there are highly specialized DMATs that deal with specific medical conditions such as crush injury, burn, and mental health emergencies.

In mass casualty incidents, their responsibilities may include triaging patients, providing high-quality medical care despite the adverse and austere environment often found at a disaster site, and preparing patients for evacuation. DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved.

D. Disaster Mortuary Operational Response Teams (DMORT)

DMORTs provide victim identification and mortuary services. These responsibilities include: temporary morgue facilities; victim identification, forensic dental pathology, forensic anthropology methods, processing preparation, and disposition of remains.

DMORTs are composed of funeral directors, medical examiners, coroners, pathologists, forensic anthropologists, medical records technicians and scribes; finger print specialists, forensic odonatologists, dental assistants, x-ray technicians, mental health specialists, computer professionals, administrative support staff, and security and investigative personnel.

The DMORT provides mortuary and victim identification services following major or catastrophic disasters. The team is comprised of volunteer professionals from the mortuary and funeral industries.

6. Volunteer and Other Services

This group includes organized volunteer groups and businesses that have agreed to provide certain support for emergency operations. *The Medical Reserve corps is considered a state supported agency and is listed in Section 4.

COMMUNICATIONS ANNEX

_____

Jurisdiction

COMMUNICATIONS

I. AUTHORITY

See Basic Plan, Section I.

II. PURPOSE

This annex provides information about our communications equipment and capabilities available during MCI Operations. Our entire communications system is discussed and procedures for its use are outlined.

III. EXPLANATION OF TERMS

A. **Acronyms**

EOC	Emergency Operations Center
FEMA	Federal Emergency Management Agency
IC	Incident Commander
JIC	Joint Information Center
SOP	Standard Operating Procedures
STARS	Statewide Telecommunications and Radio System
RHCC	Regional Healthcare Coordinating Center
PSAP	Public Safety Answering Point
NSPA	Near Southwest Preparedness Alliance
VHASS	Virginia Hospital Status and Alerting System
VDH ECC	Virginia Dept. of Health Emergency Coordination Ctr.
VaEOC	Virginia Emergency Operations Center
ICS	Incident Command Systems
RIOS	Radio Interoperable System
WPS	Wireless Priority Service

IV. SITUATION AND ASSUMPTIONS

A. Situation

1. As noted in the general situation statement in the basic plan, it is nearly almost impossible to predict and prevent Mass Casualty Incidents. Maintaining systems and preparing for the event is the best method to remain vigilant. A reliable and interoperable communications system is essential to obtain the most complete information on emergency situations and to direct and control our resources responding to those situations.

2. Each participating municipality maintains a Dispatch/Communications Center. Its location is listed in this plan. It is staffed on a 24-hour basis by emergency dispatchers. Equipment is available to provide communications necessary for emergency operations.

B. Assumptions

1. Adequate communications are available for effective and efficient warning, response and recovery operations.

2. Any number of natural or manmade hazards may neutralize or severely reduce the effectiveness of communications currently in place for emergency operations.

3. Additional communications equipment required for emergency operations will be made available from NSPA, citizens, businesses, volunteer organizations, and/or other governmental agencies.

V. CONCEPT OF OPERATIONS

A. General

1. A common operating picture within our jurisdiction and across other jurisdictions provides the framework of our communications capabilities. This framework is made possible by interoperable systems. Extensive communications networks and facilities are in existence throughout our region to provide coordinated capabilities for the most effective and efficient response and recovery activities.

2. Our existing communications network consisting of telephone (Landline, Cellular, Satellite), computer (Via Internet thru T1, Cellular, Broadband, Satellite), and radio (LMR system) and will serve to perform the initial and basic communications effort for emergency operations.

3. During emergency operations, all departments will maintain their existing equipment and procedures for communicating with their field operations units. They will keep the EOC informed of their operations and status at all times.

4. To meet the increased communications needs created by an emergency, various state and regional agencies will be asked to supplement communications capabilities. These resource capabilities will be requested through local, regional and state mutual-aid agreements.

5. Inter-operability is achieved through the maintenance of common regional radio channels. These channels are listed in this Annex. Further inter-operability can be achieved through the radio patching capabilities maintained at local EOCs, the RHCC, and the Montgomery County Radio Cache. These capabilities are detailed later in the Annex.

6. Plain English will be used at all times for communications throughout the region. During MCI events units will identify themselves using the Agency's name as a prefix, followed by their unit's number. (i.e. Roanoke County Medic 71)

7. When an order has been received, briefly restate the order received to allow confirmation that the receiver actually received and understood the order, and is proceeding with correct action.

8. The Transport Group Supervisor/ Unit Leader or designee (i.e., Medical Communications Officer) will establish and maintain communications with the Coordinating Emergency Department or RHCC.

9. The responding EMS agency will contact the closest Emergency Department as indicated, immediately after a multiple or mass casualty incident has been identified. The responding EMS agency must advise that hospital incident location, approximate number of patients, possible types of injuries involved, and the presence or absence of chemical, biological or radiological contamination.

10. Early Emergency Department notification by EMS is paramount as it allows the facility time to contact the RHCC if needed, to work on bed availability for patients arriving from the MCI scene. It also gives the Emergency Department time to begin calling in additional staffing resources as needed.

11. Hospitals will communicate with each other, with EMS, and with the RHCC. The message boards as part of the Event Module within the VHASS platform will be a method of communication among hospitals and the RHCC.

12. The RHCC will be the point of contact for healthcare/hospital escalation of needs to the VDH ECC / ESF-8 desk with VaEOC ,that are unmet with regional support.

13. The RHCC will provide coordination assistance for multi-regional or cross-regional /interstate Mass Casualty Incidents.

B. Communication activities by EMS :

1. Response

   a. Select communications personnel required for emergency operations according to the incident.

   b. Incident communications will follow ICS standards and will be managed by the IC using a common communications plan and an incident-based communications center.

   c. All incident management entities will make use of common language during emergency communications. This will reduce confusion when multiple agencies or entities are involved in an incident.

   d. The region has a mix of VHF to UHF to 800MHz primary radio systems. Mutual Aid channels exist in each VHF, UHF, and 800MHz spectrum and are identified in this annex. However, in a large-scale incident, resources may be called from outside their normal response area. Statewide frequencies are designed to provide a standard communications mechanism throughout Virginia.

1. Use of the following VHF frequencies may be employed in a region-wide event:

1.1 155.205 MHz- Statewide Mutual Aid: Used for communications between incoming units and staging officer.

1.2 155.340 MHz - HEAR Radio: Used for communications between ambulances and hospitals.(Note: Some hospitals do not have a HEAR radio in the Emergency Department. Ambulances should use their normal methods for conducting ambulance to hospital communications unless otherwise directed by the Incident Communications Plan.)

1.3 These channels should be utilized in the event of an MCI where multiple jurisdictions are involved. To meet the increased communications needs created by an emergency, various state and regional agencies will be asked to supplement communications capabilities. These resource capabilities will be requested through local, regional and statewide mutual-aid.

2. Use of the following UHF frequencies may be employed in a region-wide event:

Med 9 or Med 10

VI. ORGANIZATION AND ASSIGNMENT RESPONSIBILITIES

A. General

1. Many emergency communications system are operated by the Sheriff's Office/Police Department or municipalities and includes a variety of government-owned and operated equipment as well as equipment owned and operated by certain volunteer groups. The departments, agencies, and groups that are part of our communications system are listed in this document.

B. Task Assignments (POSITION ASSIGNMENTS ARE ALSO OUTLINED IN TACTICAL WORKSHEETS)

1. The Incident Commander will:

a. Be responsible for all activities enumerated in this annex in Section V.B, Activities by Phases of Emergency Management.

b. Supervise the activities of the Transport group Supervisor/Unit Leader

c. Supervise the activities of the on Site communications Leader if staffed

2. The Transport Group Supervisor/Unit Leader will

    a. Use the Emergency Department capacity and bed status data received from the Coordinating Emergency Department or RHCC (Based on tier and needs), to determine the destination for each patient. He/she will consult with the Coordinating Emergency Department to determine the best distribution of unique cases (i.e. multiple burn victims in excess of the capacity of the nearest Burn Center).

    b. The Transport Group Supervisor/Unit Leader or designee will notify coordinating emergency department when ambulances depart the scene and provide them with the following information for each transport:

        - EMS Agency and Ambulance Number with the destination hospital
        - Patient Triage Tag Number(s)
        - Triage Color of each patient.
        - Age and Gender of each patient
        - Nature of each patient's injuries
        - Estimated time of arrival
        - If contacted by EMS, the exact support needed from the RHCC

    c. The distribution of patients should only start after consultation with Coordinating/receiving Emergency department OR the RHCC. Under most circumstances this communication should be conducted on the facilities med-channel. Backup med-channels made need to be utilized during large scale events.

3. EMS Units (Transport)
    a. During an MCI, routine ambulance-to-Emergency Department communications are suspended unless emergent information is needed. The Transport Group Supervisor/Unit Leader or Medical Communication Coordinator will relay the information to the receiving Emergency Departments.

    b. Transport Group Supervisor/Unit Leader or Medical Communication Coordinator will work with the Coordinating Emergency Department via the most reliable communication methods and channels. Contact options are as follows

        - Radio
        - Telephone

** If the dedicated local channel is utilized, the Incident Commander should request that the dispatcher restrict usage of the channel to this incident only. Ambulances working calls elsewhere in the community will need to utilize alternate means of communications.*

4. COM-L or Communications Unit Leader will be:

    On site communications lead will be responsible for supporting radio channel assignment and tactical communications. Verify that units responding are aware of interoperable channels and address issues or connections as they arise.

5. RHCC will be:

The RHCC will communicate with Hospitals and healthcare entities. Using the VHASS Event Module, an EVENT will be established. SMS text messages and regional e-mail ALERTS will be distributed to regional recipients as the situation warrants. Radio patches will be established to meet the communication needs of the hospitals and as requested by Incident Command. As needed, the RHCC will establish a messaging channel for the Regional PIO group to share needed information between entity PIOs.

VII. REGIONAL ASSETS FOR COMMUNICATION

A. General

1. Other Networks

   a. STARS is a statewide telecommunications network connecting the State Police and other governmental agencies, with approximate city, county, state, and federal participants in Virginia.

   b. Joint Information Center (JIC), Joint Operations Center (JOC).

   c. Virginia COMLINC, supported thru the Radio Interoperable System (RIOS) connects local PSAP. Radio assets with a broader statewide system. This Annex provides tested connections based on each locality.

   d. The Montgomery County Radio Cache, a State supported radio asset offers portable and mobile radios in each bandwidth. This asset additionally offers local radio patching capability within and across VHF, UHF, and 800MHz bands.

   e. *NSPA maintains a number of linked voice repeaters on an Amateur Radio platform known as the Hospital Emergency Amateur Radio System (HEARS). This resource is available for use during emergency incidents*

VIII. SUPPORT

A. Communications Protection

1. Telephone (Common Carrier) – Potential Problems

   a. Overloaded Circuits

   b. Overloaded Cellular Circuits

      To maintain access to cell phone circuits, Emergency responders are encouraged to apply WPS priority to critical cellular telephone devices utilized during major emergencies.

B. Support

If requirements exceed the capability of local communications resources, the municipality m request support from nearby jurisdictions or state resources.

IX. Standard Messaging Guide

1. Notice to Home Agency: To be completed based on existing departmental policy
   1.1. Agency notifies leadership via pre-established methods of potential or confirmed incident.

2. Notice to Hospital: To be completed by an EMS Agency on scene of or enroute to a confirmed or possible Mass Casualty incident.
   2.1. Agency notifies the hospital closest to the incident and provides brief report of situation. The Agencies dispatch center may perform this task.
   2.2. Coordinating Hospital/RHCC provides agency with bed count and capabilities to receive patients

3. Notice to RHCC: To be completed by Coordinating Emergency Department OR EMS Agency on scene of to a confirmed or possible Mass Casualty incident.
   3.1. Facility/Agency notifies the RHCC via Emergency Number. If EMS activation, the agency's dispatch center may perform this task.
   3.2. RHCC obtains vital information and initiates a Bed Poll of local Emergency Department capacity and notifies Incident coordination team
   3.3. RHCC Incident coordination team sends Region wide SMS Text alert notifying regional entities of potential incident.
   3.4. RHCC initiates WebEOC incident and posts Situation Report
   3.5. RHCC establishes contact with Coordinating facility/Scene via Radio when applicable.

4. Notice to Mutual Aid: To be completed by the EMS Agencies Communications center or by the Emergency manager, or a designee codified in departmental policy
   4.1. Mutual Aid Entities responding will be provided:
      4.1.1. Channel for operations (Which should be inter operable)*see Interoperable guide
      4.1.2. Point of contact and Staging area directions / instructions
   4.2. Transport Sector Liaison officer or other designee will document staff names and affiliated EMS Unit / Agency for documentation and tracking purposes

5. Notice to OCME: To be completed by the RHCC
   5.1 The OCME will be notified by the RHCC via SMS Text message and Telephone

Emergency Dispatch Centers for BREMS and WVEMS Councils

Municipality/Jurisdiction	Contact Number for PSAP	Frequencies
Alleghany County	540/965-1770	TX: 800 MHz (Tr) 39.5 MHz
Amherst County	434/946-9300	800 MHz Trunked
Appomattox County	434/352-8241	TX: 469.700 RX: 464.700
Bedford County/City	540/586-7827	800 MHz (Tr) 462.975 MHz
Botetourt County	540/473-8631	Tx: 453.6375Mhz Rx: 453.6375Mhz
Campbell County	434/332-9574	Tx: 155.900 Rx: 155.060 Tx: 155.205 Rx: 155.205
Christiansburg (Town of)	540/382-3131	Tx: 456.625 Rx: 451.625 Tx: 457.250 Rx: 452.250
Clifton Forge (City of)	540/863-2513	Tx: 39.50 Rx: 39.50
Covington (City of)	540/965-6333	Tx: 46.0600 Rx: 46.0600 Tx: 45.9200 Rx: 45.9200
Craig County	540/864-5127	Tx: 39.50 Rx: 39.50
Danville (City of)	434/799-5111	Tx: 154.325 Rx: 155.295 Tx: 155.205 Rx: 155.205
Floyd County	540/745-9334	Tx: 453.562 Rx: 458.562
Franklin County	540/483-3000	Tx and Rx: 39.90 Tx and Rx: 155.49 Tx and Rx: 39.50
Giles County	540/921-3842	Tx and Rx: 45.32 Tx and Rx: 45.36
Lynchburg (City of)	434/847-1602	Tx and Rx: 800 MHz Trunked
Martinsville (City of) Henry Co.	276/638-8751	Tx and Rx: 155.085 Tx and Rx: 155.235 Tx: 153.785 Rx: 154.250
Montgomery County	540/382-6900	Tx: 150.775 Rx: 156.165 Tx and Rx: 156.165
Patrick County	540/694-3161	Tx: 158.925 Rx: 155.835
Pittsylvania County	434/432-7931	Tx: 159.185 Rx: 156.135
Pulaski County	540/980-7800	Tx: 453.025 Rx: 458.025 Tx: 45.32 Rx: 45.28
Radford (City of)	540/731-3624	Tx: 460.550 Rx: 460.275
Roanoke County	540/562-3265	Tx and Rx: 800 MHz Trunked
Roanoke (City of)	540/853-2411	Tx and Rx: 800 MHz Trunked
Salem (City of)	540/375-3078	Tx and Rx: 458.475 Tx: 453.225 Rx: 453.600

Virginia State Police Dispatch Centers

Jurisdiction	Primary Telephone Number for PSAP
Virginia State Police	800-542-8716

Regional Healthcare Coordination Center (RHCC)

(866)-679-7422

State Emergency Operations Center (statewide resource requests)

(800) 468-8892