WVEMS BOARD OF DIRECTORS
Thursday, September 13, 2012

Salem Civic Center

Executive Committee - 1:30 PM
Full Board - 2:00 PM

1. Call to Order

2. Introduction of Guests:

3. Secretary's Report - June 2012 Board Minutes

4. Treasurer's Report

    a. Year End FY 2012 Report Treas Report - FY 2012 Year End

    b. Periodic Financial Report Treasurer's Report FY 13 YTD

5. Standing Committees

    a. Executive Committee

        1. Investment Policy Draft Investment Policy

        2. Bylaw amendment - Committee Structure (For action at December meeting)

        3. Committee Appointments Committee Assignments - 2013

    b. Medical Direction

        1. Protocol Project Update - Cathy Cockrell

    c. Allied Resources

    d. Communications

        1. Replacement Radios - Alleghany - update

        2. Narrowbanding

e. Performance Improvement

    1. Approval of Updated Performance Improvement Plans (Committees meet same day as Board Meeting)

f. Near Southwest Preparedness Alliance (NSPA)

g. State EMS Advisory Board AB Report - Aug 2012 Meeting

6. EMS Financial Assistance -

7. New Business

    a. MCI Committee - Update MCI Plan - Draft MCI Plan Draft Comm Annex

    b. Quarterly Report to OEMS

8. President's Report

9. Staff Reports

10. Adjourn

WESTERN VIRGINIA EMERGENCY MEDICAL SERVICES COUNCIL
BOARD OF DIRECTORS

DRAFT MEETING MINUTES

DATE: September 13, 2012

LOCATION: Salem Civic Center – Parlor A

Directors Present
Steve Allen
Joe Coyle
Steve Davis
Steven Eanes
Jason Ferguson
Carey Harveycutter
Daryl Hatcher
Danielle Lissberger
Robert Logan
Stephen Simon
Lee Simpkins
Joe Trigg
Dale Wagoner
Ford Wirt

Staff Present
Charles Berger
Mary Christian
Cathy Cockrell
Gene Dalton
Mike Garnett

Guests Present
Jeff Echternach, RHCC Coordinator

TO ORDER
President Ford Wirt called this regular meeting of the Board of Directors to order at 2:00 PM.

He called for a moment of silence in remembrance of our friend and former president, Benny Summerlin.

Ford congratulated Dale Wagoner on his recent appointment as Deputy County Administrator for Henry County.

He introduced guests: Jeff Echternach, RHCC coordinator and Carilion Clinic

SECRETARY'S REPORT
Ford presented minutes of the last meeting as distributed. He called for any corrections or additions.

Motion was made and duly seconded to approve. **Motion CARRIED.**

TREASURER'S REPORT
Treasurer Carey Harveycutter presented the unaudited treasurer's report for the end of the FY 2012 fiscal year. He noted that we ended the year with an approximate $50,000 surplus revenue over expenditures.

He then presented the FY 13 year to-date report (August 31). He noted that all accounts were within expectations, and explained variances on some accounts that were over budget.

Because state revenue is on a full reimbursement basis, no revenue has been received. The first quarter payment will be billed in October.

The Executive Director explained the grant funds that had been received for the simplation equipment for the WVEMS New River Training Center. The equipment had not been received in total, so the funds have not yet been expended. Business Manager Mary Christian explained the salary figure that appears high due to a month in the reporting period with three pay periods.

Motion was made and duly seconded to accept the reports. **Motion CARRIED.**

EXECUTIVE COMMITTEE
The Executive Committee met prior to this meeting to review and discuss the agenda items.

The committee reviewed a draft investment policy, based on our current investments. This was requested by our auditors.

Motion was made and duly seconded to accept the policy as recommended by the Executive Committee. **Motion CARRIED.**

The Executive Committee will continue work on a restructuring of our committees and will have bylaw amendments ready for action in January.

The Executive Committee reviewed committee assignments (based on current committee structure) and recommends the appointments that were distributed with the agenda.

Motion was made and duly seconded to accept the recommended appointments. **Motion CARRIED.**

MEDICAL DIRECTION COMMITTEE
Cathy Cockrell reported for the regional medical direction committee on the status of the protocol project. She presented a rollout plan (attached to and made a part of these minutes).

By consensus, the board went on record supporting protocol testing for all providers, and instructed the staff to pass this recommendation to the Regional Medical Director.

ALLIED RESOURCES
Allied Resources has not met since the last board meeting, but will meet in October to discuss and approve changes to restocking necessitated by the new protocols.

Discussion took place on the subject of eliminating the epinephrine auto-injectors from our regional drug boxes. It was noted that these injectors may now be carried by EMS providers outside of the drug boxes, and that they present a great cost to the hospitals to stock. Most are replenished only due to product expiration.

Motion was made and duly seconded to recommend to the Medical Direction Committee and Allied Resources Committee that the epinephrine auto-injectors be removed from the regional drug boxes. **Motion CARRIED.**

COMMUNICATIONS COMMITTEE
Rob Logan reported for the committee concerning the Alleghany radio replacement project. He noted that the license modifications have been approved by the Radio Quiet Zone officials, and that funding for replacement repeaters and a generator would be requested in the June 2013 grant cycle.

Rob also reported that work would soon be required on the Tinker Mountain communications building. Funds had been approved last year for this purpose, but since this is a new fiscal year, he requested up to $7000 in reserve funding to perform necessary repairs. Motion was made and duly seconded to approve the expenditure of up to $7000 for repairs to the Tinker Mountain communications building. **Motion CARRIED.**

He further reported that the tower on Tinker Mountain was recently inspected by Shenandoah Tower. We are awaiting results of the inspection.

We are still awaiting FCC approval of the modified license for Alleghany.

PERFORMANCE IMPROVEMENT COMMITTEES
Charles Berger reported for the General and Trauma Performance Improvement Committees. Both met today. The committees reviewed the General Performance Improvement Plan (PI Plan) and the Trauma Performance Improvement Plan (TPI Plan) and recommended re-affirmation without change.

The committees jointly moved to reaffirm PI and TPI Plans. **Motion CARRIED.**

NSPA
Danielle Lissberger reported for NSPA. She informed the board of a pilot “Triage Tuesdays” program that will soon begin in Bedford. She also spoke on a new emphasis on coalition-building, which will bring new partners such as long term care facilities, EMS, etc. into the healthcare preparedness program.

EMS ADVISORY BOARD
Dale Wagoner provided a written report for the Advisory Board. The next meeting is set for November 7, 2012 in Norfolk in conjunction with the EMS Symposium. He also reported that the Governor has signed the new EMS regulations.

EMS FINANCIAL ASSISTANCE
Monday, September 17 is the deadline for current cycle submission. Assistance has been provided to some 10 agencies making requests in the current cycle. WVEMS is requesting defibrillators and rhythm generators for the NRV training center, and replacement repeaters for the Alleghany UHF radio system. The regional grant review meeting will be held on Thursday, October 17 at the Franklin County Government Complex in Rocky Mount.

NEW BUSINESS
Joy Coyle and Jeff Echternach reported on progress of the bi-regional MCI planning committee.

The quarterly report to OEMS will be developed and submitted in October. The last report is posted on the board’s agenda website.

PRESIDENT’S REPORT

President Wirt reported 55 percent of the board members in attendance for the current meeting.

STAFF REPORTS
Rob Logan reported that he had solicited Montgomery County supervisor Bill Brown to serve as the at-large director from the fourth planning district. Mr. Brown has agreed to serve.
It was moved and duly seconded to elect Mr. Bill brown to fill the unexpired term as WVEMS director at-large from the fourth planning district. **Motion CARRIED.**

Rob advised the board that work was underway toward applying for re-designation from the Virginia Board of Health.

Cathy Cockrell – no report

Charles Berger – no report

Mike Garnett reported that a new EMT-Intermediate program is underway at the WVEMS New River Valley Training Center.

Gene Dalton reported on the new "Simbulance" developed by the Blue Ridge Volunteer Rescue Squad in conjunction with Botetourt County Emergency Services. WVEMS has partnered with these agencies to offer this new resource, and Gene will be receiving training on the simulation equipment in Florida in October.

Mary Christian – No report

OTHER BUSINESS - none

HEARING OF THE PUBLIC - none

Being no further business, the meeting was adjourned at 2:50 PM.

/s Robert Logan, Executive Director

WESTERN VA EMS COUNCIL
UNAUDITED TREASURER'S REPORT
THROUGH 6/30/12

REVENUES	BUDGET	PROJECTION	UNAUDITED ACTUAL
STATE GOVERNMENT (OEMS CONTRACT)	416,190	416,190	423,790
LOCAL GOVERNMENT	104,500	133,332	133,332
UNITED WAYS	2,000	3,129	3,365
CONTRIBUTIONS	2,000		
SPECIAL GRANTS / HOSPITAL FOUNDATIONS	122,000	174,890	185,576
DIRECT PROGRAM INCOME (Tuitions, grants, VDH/OEMS)	235,000	239,310	150,611
DIRECT MRC INCOME		47,479	55,833
CISM REVENUE		830	830
NSPA OFFSET REVENUE (Contract for services)	7,000	26,584	28,884
RENT INCOME (NSPA)	18,000	18,000	18,000
INTEREST	4,000	1,580	1,616
INVESTMENT / GAINS/LOSSES		(2,746)	(3,594)
MISCELLANEOUS/SPECIAL FUNDS			1,775
TOTAL REVENUES	910,690	1,058,578	1,000,017
REVENUES	**BUDGET**	**PROJECTION**	**UNAUDITED ACTUAL**
SALARIES / WAGES (WVEMS)	342,330	373,902	380,192
PAYROLL TAXES (FICA)	33,914	27,953	28,392
VEC	550	1,446	1,836
403(b) / RETIREMENT	30,810	18,011	18,224
HOSPITAL / MEDICAL INSURANCE	46,000	45,470	42,188
LIFE INSURANCE/DISABILITY	10,600	10,009	9,990
DENTAL INSURANCE	3,400	1,345	2,426
PROFESSIONAL SERVICES/FEES	12,000	13,355	13,335
MEDICAL DIRECTION ASSISTANCE	1,000		
MAINTENANCE / REPAIRS / SERVICE CONTRACTS	2,500	167	167
OCCUPANCY (Utilities, repairs, NRV rent etc.)	16,000	18,000	17,849
POSTAL / SHIPPING	3,500	1,700	2,057
TELECOMMUNICATIONS	10,500	10,500	11,541
SUPPLIES (ADMIN)	6,286	6,850	7,626
EQUIPMENT	5,200	3,430	3,929
INSURANCE	7,500	7,500	6,664
DIRECT NSPA EXPENSE	101,000	163,075	169,892
DIRECT PROGRAM EXPENSES	220,000	197,538	130,093
DIRECT MRC EXPENSES		42,841	51,944
PRINTING / PUBLICATIONS	4,000	3,068	3,175
TRAVEL / LODGING	7,500	5,000	7,579
FUEL/VEHICLE MAINTENANCE	12,000	10,750	7,469
MEETING SUPPORT	2,000	2,000	2,301
DUES / MEMBERSHIP FEES	1,200	1,090	1,135
STAFF DEVELOPMENT	9,000	6,082	7,591
CISM PROGRAM COSTS	2,000	1,946	1,946
COMMUNICATION SITE RENTAL	8,100	8,100	8,100
COMMUNICATIONS WIRELINES	6,000	7,400	7,783
COMMUNICATIONS MAINTENANCE	2,000	800	835
COMMUNICATIONS UTILITIES	800	550	487
COMMUNICATIONS INSURANCE	3,000	3,000	3,000
COMMUNICATIONS EQUIPMENT			
TOTAL EXPENDITURES	910,690	992,878	949,747
NET TOTAL REVENUE MINUS TOTAL EXPENSE	**-**	**65,700**	**50,270**

WESTERN VA EMS COUNCIL
UNAUDITED TREASURER'S REPORT
AS OF 8/31/2012

REVENUES	BUDGET	TOTAL	% YTD
STATE GOVERNMENT (OEMS CONTRACT)	416,190		0.00%
LOCAL GOVERNMENT	120,000	8,036	6.70%
UNITED WAYS	2,000	440	22.00%
CONTRIBUTIONS	2,000		0.00%
SPECIAL GRANTS / HOSPITAL FOUNDATIONS	220,000	23,031	10.47%
DIRECT PROGRAM INCOME (Tuitions, grants, VDH/OEMS)	165,000	18,439	11.18%
DIRECT MRC INCOME	55,000	10,394	18.90%
CISM REVENUE			
NSPA OFFSET REVENUE (Contract for services)	8,000		0.00%
RENT INCOME (NSPA)	18,000	2,500	13.89%
INVESTMENT / GAINS/LOSSES	3,000	1,685	
MISCELLANEOUS/SPECIAL FUNDS			
TOTAL REVENUES	1,009,190	64,525	6.39%
EXPENDITURES	**BUDGET**	**TOTAL**	**% YTD**
SALARIES / WAGES (WVEMS)	371,000	75,862	20.45%
PAYROLL TAXES (FICA)	27,203	5,579	20.51%
VEC	450		0.00%
403(b) / RETIREMENT	20,250	3,366	16.62%
HOSPITAL / MEDICAL INSURANCE	47,000	10,349	22.02%
LIFE INSURANCE/DISABILITY	10,000	1,642	16.42%
DENTAL INSURANCE	3,400	648	19.06%
PROFESSIONAL SERVICES/FEES	8,000	120	1.50%
MEDICAL DIRECTION ASSISTANCE	1,000		0.00%
MAINTENANCE / REPAIRS / SERVICE CONTRACTS	2,500		0.00%
OCCUPANCY (Utilities, repairs, NRV rent etc.)	16,000	2,826	17.66%
POSTAL / SHIPPING	2,000	157	7.85%
TELECOMMUNICATIONS	10,500	1,631	15.53%
SUPPLIES (ADMIN)	6,587	399	6.06%
EQUIPMENT	5,000	312	6.24%
INSURANCE	7,500	1,079	14.39%
DIRECT NSPA EXPENSE	195,000	20,761	10.65%
DIRECT PROGRAM EXPENSES	150,000	27,193	18.13%
DIRECT MRC EXPENSES	55,000	9,594	17.44%
PRINTING / PUBLICATIONS	14,000	1,671	11.93%
TRAVEL / LODGING	7,000	260	23.87%
FUEL/VEHICLE MAINTENANCE	10,000	509	5.09%
MEETING SUPPORT	1,200		0.00%
DUES / MEMBERSHIP FEES	1,200	500	41.67%
STAFF DEVELOPMENT	9,000	1,278	14.19%
CISM PROGRAM COSTS	2,000		0.00%
COMMUNICATION SITE RENTAL	8,100	1,350	16.67%
COMMUNICATIONS WIRELINES	7,500	1,304	17.38%
COMMUNICATIONS MAINTENANCE	2,000		0.00%
COMMUNICATIONS UTILITIES	800	78	9.70%
COMMUNICATIONS INSURANCE	3,000	500	16.67%
COMMUNICATIONS EQUIPMENT	5,000		0.00%
TOTAL EXPENDITURES	1,009,190	168,966	16.74%

NSPA-VHHA

REVENUES (NSPA ACCOUNTS)	TOTAL
SPECIAL GRANTS / HOSPITAL FOUNDATIONS	
TOTAL REVENUES	9,767
EXPENDITURES (NSPA ACCOUNTS)	**TOTAL**
SALARIES -NSPA	7,643
PAYROLL TAXES (FICA) - NSPA	542
BENEFITS - NSPA	1,329
VEC - NSPA	
TOTAL EXPENDITURES	9,514

REVENUES (VHHA ACCOUNTS)	TOTAL
VHHA FUNDING	13,264
TOTAL REVENUES	13,264
EXPENDITURES (VHHA ACCOUNTS)	**TOTAL**
SALARIES - VHHA	9,115
PAYROLL TAXES (FICA) - VHHA	693
BENEFITS - VHHA	402
MISC. - VHHA	1,036
TOTAL EXPENDITURES	11,247

PROGRAM

REVENUE (PROGRAM ACCOUNTS)	TOTAL
OEMS FUNDS - INTERMEDIATE	
OEMS FUNDS - ENHANCED	
OEMS FUNDS - ADJUNCT	2,160
OEMS FUNDS - CARDIAC	
OEMS FUNDS - CT TRANSITION	
OEMS FUNDS - SHOCK TRANSITION	
OEMS FUNDS - ALS CE	560
PROGRAM SERVICE FEES	
PROTOCOL, ETC. SALES	21
TEXTBOOK SALES	
CONSOLIDATED TESTING	2,860
DRUG BOX ENTRANCE FEES	120
GRANTS & SPECIAL PROJECTS	5,841
SALES - CONSUMER GOODS	
WEB DATABASE	
PROCESSING FEES	
PROGRAM FEES - MONROE HEALTH CENTER	1,225
PROGRAM TUITION - INTERMEDIATE	
PROGRAM TUITION - ENHANCED	
PROGRAM TUITION - ADJUNCT	1,105
PROGRAM TUITION - CARDIC	
PROGRAM TUITION - OTHER	
PROGRAM TUITION - NRVTC	4,488
ID CARD SALES	60
TUITION CREDIT REIMBURSEMENT	
OMD PROJECT	
COMMUNITY COLLEGE COURSE REVENUE	
TRAVEL/TOWING CONTRACT REVENUE	
TOTAL REVENUES	18,439

EXPENSES (PROGRAM ACCOUNTS)	TOTAL
CONTRACTS FOR SERVICES (INTERMEDIATE)	
CONTRACTS FOR SERVICES (ENHANCED)	
CONTRACTS FOR SERVICES (ADJUNCT)	1,317
CONTRACTS FOR SERVICES (CARDIAC)	
CONTRACTS FOR SERVICES (SPEC. PROJ.)	
CONTRACTS FOR SERVICES (ALS TEST)	5,813
CONTRACTS FOR SERVICES (CTS)	2,373
CONTRACTS FOR SERVICES (CE WEEKENDS)	
CONTRACTS FOR SERVICES (DRUG TESTING)	
PAYROLL TAXES (FICA)	1,664
VEC	
POSTAGE (NRVTC)	
SUPPLIES (Programs)	
SUPPLIES (CTS)	29
SUPPLIES (ALS TESTING)	
SUPPLIES (EDUCATION)	
SUPPLIES (NRVTC)	801
TEXTBOOKS (ALS)	162
TEXTBOOKS (BLS)	
TEXTBOOKS (ITLS)	1,631
TEXTBOOKS (NRVTC)	6,885
EQUIPMENT (BLS)	
EQUIPMENT(BLS TESTING)	
EQUIPMENT (ALS TESTING)	
EQUIPMENT (EDUCATION)	
INSURANCE	550
PRINTING / PUBLICATIONS (EDUCATION)	
PRINTING / PUBLICATIONS (NRVTC)	
GRANTS & SPECIAL PROJECTS	4,787
DRUG BOX EXCHANGE	
CREDIT CARD DISCOUNT	620
MERCHANDISE FOR RESALE	563
ID CARD PROGRAM	
RETENTION PROJECT	
COMMUNITY COLLEGE FEES	
TUITION REIMBURSEMENT - ENHANCED	
TUITION REIMBURSEMENT - INTERMEDIATE	
TRAVEL/TOWING CONTRACT EXPENSE	
OMD PROJECT	
SWVEMS CONTRACT	
TOTAL EXPENDITURES	27,193

MRC

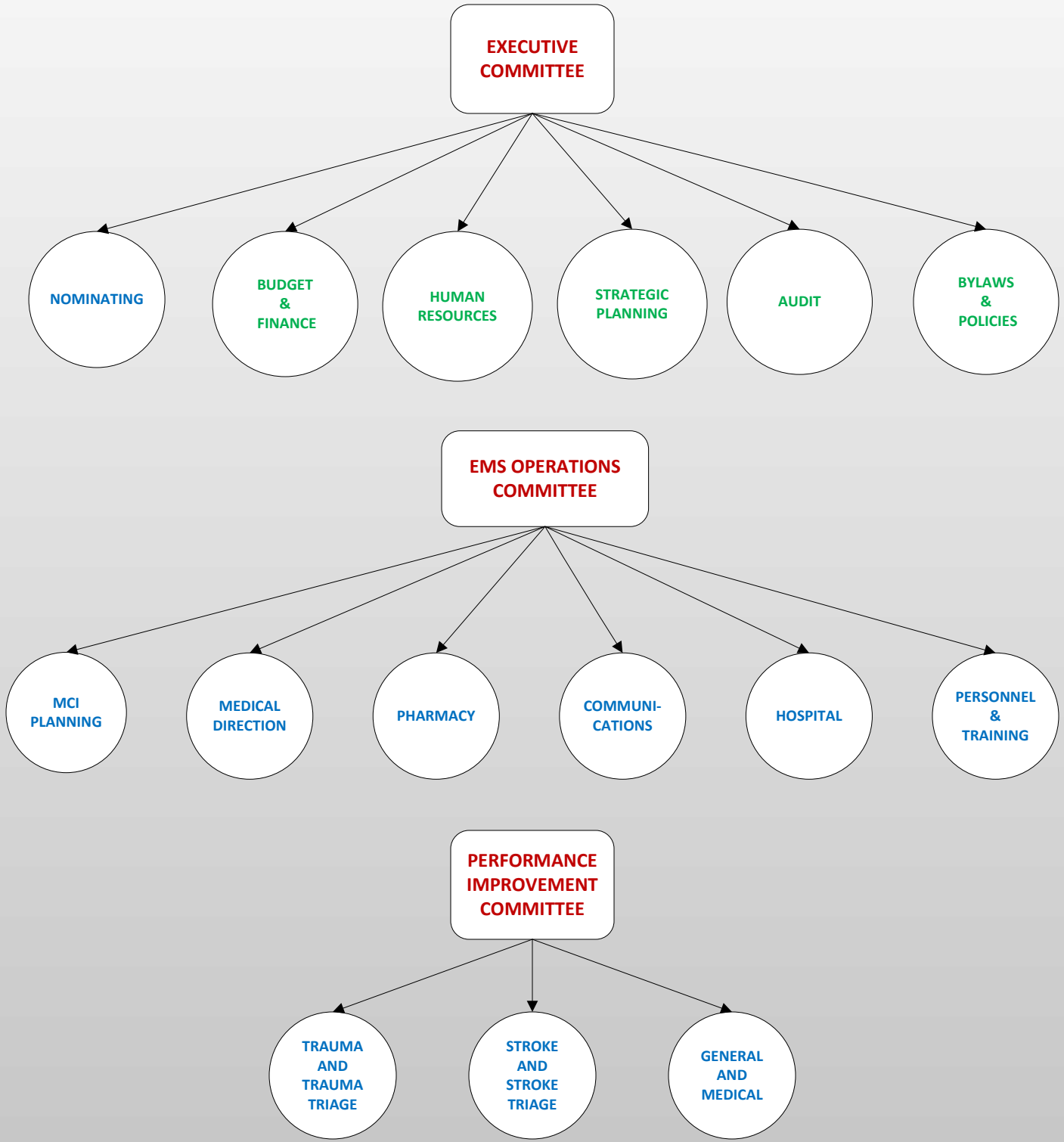
REVENUE (MRC ACCOUNTS)	TOTAL
PROGRAM MANAGEMENT - MRC	10,000
COST REIMBURSEMENT - MRC	394
TOTAL REVENUES	10,394
EXPENSES (MRC ACCOUNTS)	**TOTAL**
SALARIES AND WAGES - MRC	7,626
FICA EXPENSE - MRC	583
VEC - MRC	
HOSPITAL MEDICAL - MRC	901
DENTAL INSURANCE - MRC	90
POSTAGE - MRC	
TELECOMMUNICATIONS - MRC	92
SUPPLIES - MRC	
PROMOTIONAL - MRC	
TRAINING SUPPLIES - MRC	
EQUIP-MRC	
TRAVEL/LODGING - MRC	302
DUES & MEMBERSHIPS - MRC	
MEETING SUPPORT - MRC	
TOTAL EXPENDITURES	9,594

WESTERN VIRGINIA EMS COUNCIL, INC.
Balance Sheet
August 31, 2012

ASSETS			
Current Assets			
PETTY CASH	$	69.59	
FSA CASH		3,729.53	
MUTUAL BOARD DESIGNATED		6,071.92	
SUNTRUST CHECKING		151,113.46	
SUNTRUST PAYROLL		200.00	
VALLEY BANK MONEY MARKET		65,347.74	
PREPAID EXPENSES		8.69	
ACCOUNTS RECEIVABLE		24,444.90	
Total Current Assets			250,985.83
Other Assets			
ARC III REIT		25,579.14	
FRANKLIN TEMPLETON		97,003.98	
COMMUNICATIONS EQUIPMENT		51,757.66	
MISCELLANEOUS EQUIPMENT		162,781.70	
OFFICE EQUIPMENT		41,879.86	
BUILDING		175,223.00	
LAND		201,600.00	
BLDG. IMPROVEMENTS		64,232.94	
GENERATOR BUILDING & EQUIPMENT		11,402.25	
ACCUMULATED DEPRECIATION		(274,598.97)	
Total Other Assets			556,861.56
Total Assets			$ 807,847.39
LIABILITIES AND CAPITAL			
Current Liabilities			
ACCOUNTS PAYABLE	$	39.67	
CLEARING ACCT (UNCASHED CHECK)		290.00	
ACCRUED SALARIES		28,590.10	
SALES TAX PAYABLE		0.90	
FLEX SPENDING ACCOUNT-MEDICAL		1,940.64	
FLEX SPENDING ACCT-DEPENDENT		1,058.85	
DEFERRED REVENUE		20,482.28	
Total Current Liabilities			52,402.44
Total Liabilities			52,402.44
Capital			
FUND BAL. UNRESTRICTED		707,162.00	
FUND BAL. UNRESTRICTED DES.		55,036.00	
RETAINED EARNINGS		143,065.62	
FUND BALANCE TEMP. RESTR.		20,374.00	
Net Income		(170,192.67)	
Total Capital			755,444.95
Total Liabilities & Capital			$ 807,847.39

PROPOSED WVEMS COMMITTEE STRUCTURE

September 13, 2012



FUNCTION

TASK FORCE
or
SUBCOMMITTEE

Tentative Protocol Rollout Procedure

The video of WVEMS Protocols is complete (August 28, 2012). We hope to have the completed copy of the DVD within the next week (September 17 – 21, 2012)

The council, along with the Protocols Committee will provide training to a selected group to be "trainers" for the Western Virginia Regions.

Training will consist of:

- Protocol
- Policy
- Procedure

The WVEMS staff is creating an ALS and BLS test of 25 questions per test

- BLS Test (Due by September 17)
- ALS Test (Due by September 17)
- Procedure checklist of new skills will be created for competency testing (Due by September 17)
- Train the Trainers by October 15, 2012
- Provide OMD's with a copy of the written competency evaluation by October 22, 2012
- November 1 – December 31, 2012 – trainers will provide training to each PD region
- January 1, 2013 – anticipated "go live" date for Protocols to be implemented

The WVEMS Council, along with Dr. Lane, recommends that each provider take the competency validation test that the Council will provide. However, it will be at the discretion of each individual agency OMD to decide if the agency will opt in/out of testing.

We will have protocols available to view on our website as well as smart phone and smart pad applications that will be free to download. We will also make sure that each agency has a copy of the DVD that is being created to facilitate the rollout.

Western Virginia EMS Council
Report from the State's EMS Advisory Board

The most recent meeting was held August 10, 2012 in Richmond, Virginia.

Since the last report, I have attended the Financial Assistance Review Committee, Rules and Regulations Committee, Legislative & Planning Committee, and Regional Directors' meeting.

During the Financial Assistance Review Committee (FARC) meeting, I was able to discuss the letter from WVEMS dealing with the P25 requirement for communications grant requests. Following discussion with the communications committee, FARC changed its P25 requirement to only require equipment to be P25 compatible. I am grateful for Billy Altman's work on FARC and the committee for taking time to consider this issue.

At the last meeting, I mentioned that there was an effort to complete an EMS needs survey. Since that time, OEMS and the Legislative and Planning Committee decided not to make that survey part of the Fire Programs survey. The Legislative and Planning Committee is currently developing the survey and working with OEMS staff to produce a web-based EMS needs survey.

Governor Robert McDonnell has signed the EMS regulations. They will be published in the Virginia Register on September 10, 2012, which begins the 30 day comment period, thus ending on October 10, 2012. The Regulation and Policy Committee has scheduled a meeting for October 25th to review the public comments, etc.

Other action items of the Board included:

- Reviewed and approved the 2010 and 2011 financial reports of the Virginia Association Volunteer Rescue Squads per Code of Virginia requirements.
- Endorsed the requirement that providers trained outside Virginia submit a report from the National Practitioner Data Bank to gain EMS certification in Virginia.
- Endorsed the Transition Plan from the EMT Enhanced certification program to the Advanced EMT certification program to meet the National Scope of Practice.
- Endorsed White Paper regarding the use of EMD at Public Safety Answering Points in Virginia.
- Endorsed the Virginia Version 3 Minimum Data Set (VAv3)

Thank you for your confidence in me to represent the Council on the Advisory Board. Should you have any questions, comments or concerns, please do not hesitate to contact me.

Respectfully submitted,
Dale Wagoner

Proposed Committee Assignments for Calendar Year 2013

Executive (Lead Staff – Rob Logan)
Meets quarterly.
(This committee consists of the officers of the board of directors, the executive director who serves without vote, and three at-large members, one from each planning district. Subject to change after December 2012 elections.)
Ford Wirt, Chair
Steve Eanes
Steve Simon
Carey Harveycutter
Dale Wagoner
Jim Cady
Joe Trigg
Rob Logan

Personnel & Training (Lead Staff – Cathy Cockrell)
Meets as needed.
Stephen Simon, Chair, Roanoke County
Karen Alldredge, MD, OMD
Jason Ferguson, Botetourt County
Mike Hopson, Danville
Jane Lindsay, Salem
Mac Snead, Roanoke (Carilion Clinic Patient Transport)
Neal Turner, Montgomery County
Suzie Helbert, Henry County

Performance Improvement – General (Lead Staff – Charles Berger)
Meets quarterly.
(The organizations and localities to be represented on this committee are dictated by OEMS in our annual contract.)
Charles Lane, MD, Chair (Franklin Co)
David Bishop (City of Roanoke) Governmental Fire-EMS Agency
Bill Duff (Roanoke County) Governmental Fire-EMS Agency
Jane Lindsay (City of Salem) Volunteer EMS Provider
Tim Dick (City of Covington) Volunteer EMS Provider
John Steely (Floyd County) Governmental EMS Agency
Andy Seabolt (Alleghany County) Volunteer EMS Provider
Jason Gifford (City of Radford) Career EMS Agency
Mike Jefferson (City of Danville) Governmental Fire-EMS Agency
Kris Shrader (City of Martinsville) Governmental Fire-EMS Agency
Jason Ferguson (Botetourt County) Career EMS Agency
Scott Davis (Giles County) Volunteer and Career EMS Provider
Steve Allen (Patrick County) Governmental Emergency Services, Volunteer EMS Provider
Shawn Hite (Pulaski County) Career EMS Agency
Jim Cady (Craig County) Governmental Emergency Services, Volunteer EMS Provider
Tim Duffer (Pittsylvania County), Volunteer EMS Provider, Career EMS Agency
Matt Tatum (Henry County) Governmental Public Safety, Volunteer EMS Provider
James Powers, MD (Montgomery County) Hospital representative
Bobby Baker (City of Salem) Hospital representative, Governmental Fire-EMS Agency

Performance Improvement – Trauma (Lead Staff – Charles Berger) (Also serves as Trauma Triage Committee)
Meets quarterly.
(The organizations and localities to be represented on this committee are dictated by OEMS in our annual contract.)
Charles Lane, MD, Chair
Dallas Taylor, RN, Level 1 TC, Carilion Clinic - CMC
Emory Altizer, RN, Level 3 TC, Montgomery Regional
Jane Gilley, Level 3 TC, CNRVMC
John Dallara, MD, Non-designated Hospital, Danville Regional
Bobby Baker, Non-designated Hospital, Lewis-Gale
Susan Smith, Air Medical, Carilion Clinic Transport-Life Guard
Kris Shrader, Fire-based Agency, Martinsville FD
Shawn Hite, Career EMS Agency, REMSI (Pulaski County)
Jane Lindsay, Volunteer EMS Provider
Dan Freeman, RN, Trauma Outreach Coordinator, Carilion Clinic-CMC, Level 1 TC

Communications and Transportation (Lead Staff – Rob Logan)
Meets as needed.
Jim Cady, Sr., Chair
Bob Bruch (Botetourt County)
John Hudson (City of Covington)
Jeff Echternach (NSPA)
Andy Seabolt (Alleghany County)
Chris Akers (Pulaski County)
Jim Davis (Pittsylvania County)
President may appoint other members in consultation with Chair.

Allied Resources – Hospital (Lead Staff – Rob Logan and Cathy Cockrell)
Meets as needed.
Joyce Yearout, RN, (Carilion Clinic New River Valley Med Center) Chair
Membership consists of an administrative-level representative from each hospital within the region. Normally this will be a nurse manager, pharmacist, materials manager, physician, or administrator. Appointed by the hospitals. Additional members are:
Stephen Simon, PD 5 EMS provider
Shawn Hite, PD 4 EMS provider
Dale Wagoner, PD12 EMS provider
Charles Lane, MD, Regional Medical Director
Connie Purvis, BREMS
President may appoint other members in consultation with Chair.

Long-Range Planning and Finance (Lead Staff – Rob Logan)
These two committees are called for in the by-laws, but historically the Executive Committee has served in place of these committees as needed.

Stroke Triage Planning Committee (Lead Staff – Charles Berger)
This committee has been designated a work group under the General Performance Committee, adding stroke system representatives from the hospitals within the region.

Medical Direction (Lead Staff – Cathy Cockrell and Rob Logan)
Meets as needed.

Charles Lane, MD, Regional Medical Director, Chair
All EMS Physicians (operational and course medical directors) in the region.

Ad Hoc Committees

Pharmacy Committee (Lead Staff – Cathy Cockrell and Rob Logan)
Meets as needed.
Joe Ciezkowski, (LewisGale Medical Center Pharmacy Director) and Nadine Gilmore (Centra Lynchburg General Pharmacy Director) Co-Chairs. Members: Pharmacist from each hospital in the WVEMS and BREMS regions, plus two EMS providers.

MCI Planning Workgroup (Lead Staff – Mike Garnett and Jeff Echternach)
Meets as needed.
Joe Coyle, Chair. This workgroup consists of staff and volunteers familiar with MCI planning and exists to offer assistance to localities and Local Emergency Planning Committees in the region, and to participate in the MCI planning process across the region. This committee operates jointly with WVEMS and BREMS, and has representation from each locality (appointed by the localities), hospitals, VDH, VDEM, NSPA, WVEMS and BREMS.

NOTE: Bylaw amendments to revise the committee structure will be considered at the board's December 2012 meeting. This roster will be revised and resubmitted as the new structure takes effect.

Western Virginia Council, Inc.

Reserve and Investment Policy
(DRAFT)

Purpose of the council's reserve funds:

- Maintain adequate cash flow and cash reserves to guard against market forces, disasters or unexpected expenses.
- Allow for continued operations when income falls unexpectedly.
- Permit adjustments to seasonal variances in expenses and income.
- Allow the organization to seize unprecedented opportunity such as financing a new venture, making an advantageous capital purchase or expanding a program at an opportune moment.

Certain Unique Characteristics: The council is not a typical fund-raising organization. Historically, we have effectively managed existing and contract funds over time for EMS and related purposes. The council is also a custodian of funds for the Western 14 EMS Task Force, the Near Southwest Region HPP Program, the MRC unit in several health districts, and possibly other special programs. Current and carryover funds for those programs should be effectively managed for maximum benefit of those programs and the Council.

Assumptions: Continued and generally unchanged annual state EMS, locality and HPP program funding.

Operating Funds: Maintain an average of three months operating expenses in an interest checking account. All remaining funds to one or more Reserve Funds.

Investment strategy for the Reserve Fund: General preservation of capital and conservative risk with a mix of investments that moderately increase risk for a portion of funds with the expectation of higher return as follows:

- **80% Mix of easily liquidated low risk mutual funds**
- **20% Moderate risk longer term investments such as Real Estate Investment Trusts with potential for higher yield**

The Treasurer or any officer, designated by resolution as a signatory for financial transactions, or the Executive Director, subject to approval by any officer, may invest reserve funds subject to the above allocation. The investment portfolio will be reviewed quarterly by the Executive Committee or more frequently as market conditions suggest.

REGIONAL MASS CASUALTY INCIDENT PLAN

WESTERN VIRGINIA EMS COUNCIL, BLUE RIDGE EMS COUNCIL AND THE NEAR SOUTHWEST PREPAREDNESS ALLIANCE COMPRISING THE FOLLOWING PARTICIPATING JURISDICTIONS:

CITY OF BEDFORD
CITY OF COVINGTON
CITY OF DANVILLE
CITY OF LYNCHBURG
CITY OF MARTINSVILLE
CITY OF RADFORD
CITY OF ROANOKE
CITY OF SALEM
ALLEGHANY COUNTY
ALLEGHANY COUNTY
AMHERST COUNTY
APPOMATTOX COUNTY
BEDFORD COUNTY
BOTETOURT COUNTY
CAMPBELL COUNTY
CRAIG COUNTY
FLOYD COUNTY
FRANKLIN COUNTY
GILES COUNTY
MONTGOMERY COUNTY
PATRICK COUNTY
PATRICK COUNTY
PULASKI COUNTY
ROANOKE COUNTY

APPROVAL & IMPLEMENTATION

The [City of___/___County]

Mass Casualty Plan

This Mass Casualty plan is hereby approved. This plan is effective immediately and supercedes all previous editions.

WVEMS Executive Director	Date
BREMS Executive Director	Date
NSPS Executive Director	Date
WVEMS Board Chair	Date
BREMS Board Chair	Date
NSPS Board Chair	Date
Regional MCI Committee Chairperson	Date
Regional MCI Committee Coordinator	Date
Regional MCI Committee Coordinator	Date

RECORD OF CHANGES

Basic Plan

Change #	Date of Change	Change Entered By	Date Entered

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BASIC PLAN

ATTACHMENTS

ANNEXES (distributed under separate cover)

MASS CASUALTY INCIDENT PLAN

I. AUTHORITY

A. Federal

1. Robert T. Stafford Disaster Relief & Emergency Assistance Act, (as amended), 42 U.S.C. 5121
2. Emergency Planning and Community Right-to-Know Act, 42 USC Chapter 116
3. Emergency Management and Assistance, 44 CFR
4. Hazardous Waste Operations & Emergency Response, 29 CFR 1910.120
5. Homeland Security Act of 2002
6. Homeland Security Presidential Directive. *HSPD-5,* Management of Domestic Incidents
7. Homeland Security Presidential Directive, *HSPD-3,* Homeland Security Advisory System
8. National Incident Management System
9. National Response Plan
10. National Strategy for Homeland Security, July 2002
11. Nuclear/Radiological Incident Annex of the National Response Plan

B. Regional Authority

The Western Virginia and Blue Ridge EMS Councils represent two of eleven Regional EMS Councils established within the Code of Virginia, § 32.1-111.11. Created in 1975 and 1976 respectively, WVEMS and BREMS is 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 regional healthcare preparedness group comprising both WVEMS and BREMS regions, the three agencies have joined to realize this plans region wide implementation and ongoing maintenance.

The Board of Directors of these three agencies have assigned the body of work to make 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 MCI Plan.

C. Local

1. Inter-local Agreements & Contracts. See the summary in Attachments 6 and 8.
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 MCIPC Memorandum of Understanding, as most recently revised.*

b. *Copies of the Memorandum of Understanding and this Mutual Aid Response Guide shall be provided to each locality and hospital by WVEMS and BREMS. A copy of the plan should be maintained within each Emergency Department and all licensed EMS commander vehicles. The Field Guide is maintained and reproduced 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.*

c. *WVEMS and BREMS shall be responsible for providing the signatory agencies with copies of the most recent updated Memorandum and Mutual Aid Response Guide, and not more than 60 days following any revision(s).*

d. *Copies of the Memorandum and one copy of the Mutual Aid Response Guide shall be filed by WVEMS and BREMS with the Virginia Office of Emergency Medical Services.*

e. *In the case of a hospital, a resolution of adoption shall include an appendix 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

This Basic Plan outlines our approach to Mass Casualty Incident Management, and is applicable to the participating cities and counties within the WVEMS and BREMS Region. It provides general guidance for MCI Management activities and an overview of our methods of mitigation, preparedness, response, and recovery.

SCOPE: The Blue Ridge and Western Virginia MCI Plan will address the regional response to a mass or multi casualty incident within the Blue Ridge EMS Council, Western Virginia EMS Council, and Near Southwest Preparedness alliance 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 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.

PURPOSE: 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 and Western Virginia EMS Councils and the Near Southwest preparedness alliance, this plan will provide guidance for regional EMS 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 involved in a regional mutual aid EMS 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 municipal plan.

III. EXPLANATION OF TERMS

A. Acronyms

AAR	After Action Report
ARC	American Red Cross
BREMS	Blue Ridge EMS Council
CFR	Code of Federal Regulations
DDC	Disaster District Committee
DHS	Department of Homeland Security
EMS	EMERGENCY MEDICAL SERVICES
EOC	Emergency Operations or Operating Center
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency, an element of the U.S. Department of Homeland Security
Hazmat	Hazardous Material
HSPD-5	Homeland Security Presidential Directive 5
ICP	Incident Command Post
ICS	Incident Command System
IP	Improvement Plan
JFO	Joint Field Office
JIC	Joint Information Center
MCI	Mass Casualty Incident
NIMS	National Incident Management System
NRP	National Response Plan
NSPA	Near Southwest Preparedness Alliance
OCME	Office of the Chief Medical Examiner
OSHA	Occupational Safety & Health Administration
PIO	Public Information Officer
SOPs	Standard Operating Procedures
SOC	State Operations Center
VDEM	Virginia Department of Emergency Management
VDH	Virginia Department of Health
VHHA	Virginia Hospital and Healthcare Association
WVEMS	Western Virginia EMS Council

B. Definitions

800 MHz Radio	A robust 2-way radio system; used by most local jurisdictions for public safety communication; a repeated radio system capable of extended transmission distances.
AAR	After Action Report
ARTCC	The Federal Aviation Administration's Washington Air Route Traffic Control Center

Area Command (Unified Area Command).	An organization established (1) to oversee the management of multiple incidents that are each being managed by an ICS organization or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Sets overall strategy and priorities, allocates critical resources according to priorities, ensures that incidents are properly managed, and ensures that objectives are met and strategies followed. Area Command becomes Unified Area Command when incidents are multijurisdictional.
Branch	The organizational level having functional or geographical responsibility for major aspects of incident operations. A Branch is organizationally situated between the Section Chief and the Division or Group in the Operations Section, and between the Section and Units in the Logistics Section. Branches are identified by the use of Roman numerals or by functional area.
C-SALTT	The critical components of a resource request: Capability (as in, the capabilities needed), Size of the resource, Amount of the resource required, Location where the resource is needed; the Type of resource required, and the Time the resource is needed.
Catastrophic Incident	For the purposes of the NRP, this term is used to describe any natural or manmade occurrence that results in extraordinary levels of mass casualties, property damage, or disruptions that severely affect the population, infrastructure, environment, economy, national morale, and/or government functions. An occurrence of this magnitude would result in sustained national impacts over prolonged periods of time, and would immediately overwhelm local and state capabilities. All catastrophic incidents are Incidents of National Significance.
CBRNE	Chemical, Biological, Radiological, Nuclear & Explosive
Chief	The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section).
CISM	Critical Incident Stress Management
Cold Zone	The control zone for a hazardous materials incident; contains the Incident Command Post and other incident support facilities. Also referred to as the clean zone or support zone.
Command	The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority.
Command Staff	(Officer) In an incident management organization, the Command Staff consists of the Incident Command and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.
Communications Unit	An organizational unit in the Logistics Section responsible for providing communication services at an incident or an EOC. A Communications Unit may also be a facility (e.g., a trailer or mobile van) used to support an Incident Communications Center.

Critical Care Transport	An ambulance transport of a patient from a scene or a clinical setting whose condition warrants care commensurate with the scope of practice of a physician, registered nurse, or Critical Care Paramedic (e.g., capable of providing advanced hemodynamic support and monitoring, use of ventilators, infusion pumps, advanced skills, therapies, and techniques).
Deputy	A fully qualified individual who, in the absence of a superior, can be delegated the authority to manage a functional operation or perform a specific task. In some cases, a deputy can act as relief for a superior and, therefore, must be fully qualified in the position. Deputies can be assigned to the Incident Commander, General Staff, and Branch Directors.
Division	(Supervisor) The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section.
DoD	Department of Defense; includes the U.S. Army, U.S. Navy, U.S. Marine Corps and the U.S. Air Force
ECC	Emergency Communications Center
EEG	Exercise Evaluation Guide
Engine Company	A Fire apparatus consisting of a minimum of three (3) firefighters one of which is assumed to be qualified as a company level officer. Additional manpower is encouraged. In an MCI event the Engine Company can expect to be used both as manpower and to perform patient care to their level of training. There should be an expectation that they will be broken up into Individual Resources at the discretion of Command.
EOC	Emergency Operations Center, Specially equipped facilities from which government officials exercise direction and control and coordinate necessary resources in an emergency situation.
ERG	Emergency Response Guide
ETA	Estimated Time of Arrival
FAA	Federal Aviation Administration
FCC	Federal Communications Commission
Function	Function refers to the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved, e.g., the planning function. A sixth function, Intelligence, may be established, if required, to meet incident management needs.
General Staff	A group of incident management personnel organized according to function and reporting to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.
Group	Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to

	perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section. (See Division.)
Hazardous Materials	A substance in a quantity or form posing an unreasonable risk to health, safety, and/or property when manufactured, stored, or transported. The substance, by its nature, containment, and reactivity, has the capability for inflicting harm during an accidental occurrence. Is toxic, corrosive, flammable, reactive, an irritant, or a strong sensitizer, and poses a threat to health and the environment when improperly managed. Includes toxic substances, certain infectious agents, radiological materials, and other related materials such as oil, used oil, petroleum products, and industrial solid waste substances.
Hazard Analysis	A document, published separately from this plan, that identifies the local hazards that have caused or possess the potential to adversely affect public health and safety, public or private property, or the environment.
HEAR	Hospital Emergency Administrator Radio; a VHF, open channel radio system where everyone is on the same frequency
Helibase	A location at where helicopters may be parked, maintained, fueled, and equipped.
Helispot	A temporary location where helicopters can land and load and off load personnel and mission equipment.
Hot Zone	The area that immediately surrounds a hazardous materials incident; normally extends out in a 360 degree radius around the incident scene and far enough to prevent adverse effects from hazardous materials releases to personnel outside the zone. Also referred to as the exclusion zone or restricted zone in other documents.
HSEEP	Homeland Security Exercise and Evaluation Program
Incident Action Plan (IAP)	An oral or written plan containing general objectives reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and important information for management of the incident during one or more operational periods.
Incident Command Post (ICP)	The field location at which the primary tactical-level, on-scene incident command functions are performed. The ICP may be collocated with the incident base or other incident facilities and is normally identified by a green rotating or flashing light.
Incident Command System (ICS)	A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.

Incident Commander (IC)	The individual responsible for all incident activities to include the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.
Incident of National Significance	An actual or potential high-impact event that requires a coordinated and effective response by and appropriate combination of federal, state, local, tribal, nongovernmental, and/or private sector entities in order to save lives and minimize damage, and provide the basis for long-term communication recovery and mitigation activities.
IMT	Incident Management Team
Inter-local agreements	Arrangements between governments or organizations, either public or private, for reciprocal aid and assistance during emergency situations where the resources of a single jurisdiction or organization are insufficient or inappropriate for the tasks that must be performed to control the situation. Commonly referred to as mutual aid agreements.
IP	Improvement Plan
ISO	Incident Safety Officer
JIC	Joint Information Center
JumpSTART	Jump Simple Triage and Rapid Treatment; A pediatric triage method adopted for use in the Commonwealth of Virginia.
LG-Montgomery	Lewis Gale Montgomery Regional Hospital
Liaison Officer	A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.
Logistics	Providing resources and other services to support incident management.
Logistics Section	The section responsible for providing facilities, services, and material support for the incident.
MAA	Mutual Aid Agreement
MHz	Megahertz
Multiple Casualty Incident	An incident 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.
NDMS	National Disaster Management System
NFA	National Fire Academy, Emmitsburg, Maryland
NIMS	National Incident Management System

NFPA	National Fire Protection Association; serves as the world's leading advocate of fire prevention and is an authoritative source on public safety.
OEMS	The Virginia Office of Emergency Medical Services
OCME	The Office of the Chief Medical Examiner; responsible for determining the cause and manner of deaths that occur under certain circumstances in Virginia.
Operations Section	The section responsible for all tactical incident operations. In the Incident Command System this section will normally includes subordinate branches, divisions, and/or groups.
Personnel Accountability	The ability to account for the location and welfare of incident personnel. It is accomplished when supervisors ensure that ICS principles and processes are functional and that personnel are working within established incident management guidelines.
Planning Section	Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the IAP. This section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.
Public Information Officer (PIO)	A member of the Command Staff responsible for interfacing with the public and media or with other agencies with incident-related information requirements.
Public Information	Information that is disseminated to the public via the news media before, during, and/or after an emergency or disaster.
RHCC	Regional Healthcare Coordinating Center; there are two RHCC's in the Near southwest region. The RHCCs are Located in Roanoke Virginia. The Primary is located at 431 McClanahan st. The second is a Mobile Trailer based in Roanoke.
Safety Officer	A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and for developing measures for ensuring personnel safety.
Section	(Chief) The organizational level having responsibility for a major functional area of incident management, e.g., Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established). The section is organizationally situated between the branch and the Incident Command.
Span of Control	The number of individuals a supervisor is responsible for, usually expressed as the ratio of supervisors to individuals. (Under the NIMS, an appropriate span of control is between 1:3 and 1:7.)
Stafford Act	The Robert T. Stafford Disaster Relief and Emergency Assistance Act authorizes federal agencies to undertake special measures designed to assist the efforts of states in expediting the rendering of aid, assistance, emergency services, and reconstruction and rehabilitation of areas devastated by disaster
Staging Area	Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.
Standard Operating Procedures	Approved methods for accomplishing a task or set of tasks. SOPs are typically prepared at the department or agency level. May also be

	referred to as Standard Operating Guidelines (SOGs).
START	Simple Triage and Rapid Treatment; An adult triage method adopted for use in the Commonwealth of Virginia
Strike Team	A set number of resources of the same kind and type that have an established minimum number of personnel.
Task Force	Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.
Transport Unit	An ambulance capable of transporting patients from the scene. Minimum staffing will be at least two Virginia EMT-B's one of which is released as an Attendant In Charge.
Trauma Center	A specialized hospital facility distinguished by the immediate availability of specialized surgeons, physician specialists, anesthesiologists, nurses, and resuscitation and life support equipment on a 24-hour basis to care for severely injured patients or those at risk for severe injury. In Virginia, trauma centers are designated by the Virginia Department of Health as Level I, II or III.
Unified Command (UC)	An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single IAP.
Unit	(Unit Leader) The organizational element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.
USCG	United States Coast Guard
USFA	United States Fire Administration
VDEM	Virginia Department of Emergency Management, VDEM Districts are regional state emergency management division created byvdem relating to Emergency Management whose boundaries parallel those of Highway Patrol Districts and Sub-Districts of the Virginia State Police.
VDOT	Virginia Department of Transportation
VEOC	Virginia Emergency Operations Center located in Richmond, Virginia.
VHASS	Virginia Helathcare Alerting and Status System. A web based tool that allows for sharing of bed status, WebEOC Communication, GIS Mapping and integration, Alerting, and Patient Tracking.
VHF	Very-high frequency, A radio band commonly used.
Warm Zone	Area where personnel and equipment decontamination and hot zone support takes place; includes control points for access corridor. Also referred to as the decontamination, contamination reduction, or limited access zone.
WebEOC	A real-time internet based emergency management information system, designed to deliver real-time emergency information to any size Emergency Operations Center or exchange information between

	multiple centers, hospitals and the field.
WMD	Weapons of Mass Destruction

1. Emergency Situations. As used in this plan, this term is intended to describe a *range* of occurrences, from a minor incident to a catastrophic disaster. It includes the following:

   f. Incident. An incident is a situation that is limited in scope and potential effects. Characteristics of an incident include:

      1) Involves a limited area and/or limited population.
      2) Evacuation or in-place sheltering is typically limited to the immediate area of the incident.
      3) Warning and public instructions are provided in the immediate area, not community-wide.
      4) One or two local response agencies or departments acting under an incident commander normally handle incidents. Requests for resource support are normally handled through agency and/or departmental channels.
      5) May require limited external assistance from other local response agencies or contractors.
      6) For the purposes of the NRP, incidents include the full range of occurrences that require an emergency response to protect life or property.

   b. Emergency. An emergency is a situation that is larger in scope and more severe in terms of actual or potential effects than an incident. Characteristics include:

      1) Involves a large area, significant population, or important facilities.
      2) May require implementation of large-scale evacuation or in-place sheltering and implementation of temporary shelter and mass care operations.
      3) May require community-wide warning and public instructions.
      4) Requires a sizable multi-agency response operating under an incident commander.
      5) May require some external assistance from other local response agencies, contractors, and limited assistance from state or federal agencies.
      6) The EOC will be activated to provide general guidance and direction, coordinate external support, and provide resource support for the incident.
      7) For the purposes of the NRP, an emergency (as defined by the Stafford Act) is "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of catastrophe in any part of the United States."

   c. Disaster. A disaster involves the occurrence or threat of significant casualties and/or widespread property damage that is beyond the capability of the local government to handle with its organic resources. Characteristics include:

      1) Involves a large area, a sizable population, and/or important facilities.
      2) May require implementation of large-scale evacuation or in-place sheltering and implementation of temporary shelter and mass care operations.

3) Requires community-wide warning and public instructions.
4) Requires a response by all local response agencies operating under one or more incident commanders.
5) Requires significant external assistance from other local response agencies, contractors, and extensive state or federal assistance.
6) The EOC will be activated to provide general guidance and direction, provide emergency information to the public, coordinate state and federal support, and coordinate resource support for emergency operations.
7) For the purposes of the NRP, a *major disaster* (as defined by the Stafford Act) is any catastrophe, regardless of the cause, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster federal assistance.

IV. SITUATION AND ASSUMPTIONS

A. Situation

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. As a stipulation of the MOU outlining the working relationship between Healthcare entities and NSPA, it is required that each signing agency adopt this plan. The combination of these efforts will produce a better prepared Healthcare system.

EMS efforts in a multiple or mass casualty incident will begin with the first arriving unit and expand to meet the needs of the incident. The first arriving unit should establish Incident Command. After establishing Incident Command, the unit is responsible for assessing scene safety, conducting a scene size-up and sending that information to the Emergency Communications/911 Center, establishing the triage and treatment areas, and beginning to triage victims.

The three priorities of incident management are:
- Life Safety
- Incident Stabilization
- Property Conservation/Incident Mitigation

The MCI Plan will be reviewed each year by the MCIPC, referencing the MCI Plan Memorandum of Understanding. Updated copies will be provided by the respective entities.

B. Assumptions

1. All agencies and other identities 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 and BREMS 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 will interact or may serve as the Medical Branch as requested by the Unified Command.
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. Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district(s) and related jurisdictions which comprise the region.
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. When considering their responses to activation of the MCI Plan, member localities and/or EMS agencies will be expected to maintain their own emergency medical response capabilities to meet local needs.
8. Hospital and pre-hospital components in the region should participate in annual training exercises of the MCI Plan.
9. Some incidents may be so large, or the sense of danger so pervasive (such as a terrorist incident), that victims may not wish to remain on the scene and will self-refer to known medical facilities. During such incidents, EMS triage and treatment resources may have to be co-located at hospitals, assembled at multiple locations, and/or situated a great distance away from the initial scene location to ensure the safety of first responders and victims. When the RHCC is activated, Hospitals affected will report self referring patients to the RHCC in an effort to create and maintain situational awareness. The Affected hospitals bed capacity should be updated on VHASS as self referrals are received.
10. 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.

11. Predetermined EMS mutual aid responses will be employed by hospital and pre-hospital members when any of the signatory health care facilities must be evacuated under the MCI Plan. Facility evacuations will be coordinated between the jurisdiction having the authority's Emergency Operations Center, the RHCC, and the affected facility. There are specific considerations that should be accounted for when evacuating a healthcare facility. These considerations are addressed in the Appendix on Healthcare Facility Evacuations.

V. CONCEPT OF OPERATIONS

A. Objectives

The objectives of our mass casualty incident plan are to provide resources to the MCI response that will support life safety, incident stabilization, and incident mitigation while doing the best for the most 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 affect 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 <u>any</u> emergency 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: XXX-XXX-XXXX

6. The U.S. Fire Administration defines the difference between a multiple casualty and a mass casualty event as follows:
   a. 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.

b. Mass Casualty Incidents: 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.
c. The *WVEMS/BREMS MCI Response Guide* can be applied to both multiple and mass casualty incidents.

7. Multiple Simultaneous Incidents: 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.

8. Management of Catastrophic MCIs: A catastrophic MCI will require assistance from the state and federal government. This level of MCI will also force responders to establish casualty collection points and may also require the establishment of intermediate care facilities. Additional resources may also be needed to assist with patient care at air heads established by the National Disaster Medical System (NDMS).

9. 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.

10. Mass Casualty Incident Management Goals

    a. <u>DO THE GREATEST GOOD FOR THE GREATEST NUMBER.</u> The primary concern is to save as many lives as possible with the resources available, while protecting the first responders and bystanders

    b. <u>MANAGE SCARCE RESOURCES.</u> In a resource limited environment heroic resuscitative efforts are not appropriate. These heroic efforts take too much time, require too many people to perform, and require the use of supplies and equipment that should be used for salvageable patients. In normal day-to-day circumstances four or more providers may work on a single patient. In mass casualty incidents this provider to patient ratio is reversed. Scarce resources

management recognizes that you do not have enough providers, equipment, vehicles, or time to provide the normal level of prehospital care. Providers must focus their efforts on salvaging as many patients as possible while waiting for the arrival of additional resources.

c. DO NOT RELOCATE THE DISASTER. Do not relocate the incident by transporting all of the patients to one hospital. Providers must use triage to determine patient prioritization for treatment and transport. The first arriving EMS units may never transport a single patient, often it is better to conduct triage, establish the treatment area and wait for more units to arrive and provide patient transportation. Many victims are likely to leave the scene and seek shelter and/or treatment at the closest emergency department or hospital. This is likely to occur before first responders are able to complete the triage process and establish control of the scene. The unexpected patient influx may overwhelm the closest emergency department. This is of particular concern when an incident occurs in close proximity to an emergency department or hospital. It is essential that communications be established with the Emergency Department closest to the incident scene as quickly as possible. (The closest Emergency Department is by default the Coordinating Emergency Department.)First Responders need to verify the bed availability at that emergency department prior to the initial transport of patients. Effective scene to hospital communications, combined with triage will ensure that patients will be distributed to the appropriate receiving hospital, in the correct order and quantity.

11. 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.

12. This plan is based upon the concept that the emergency functions that must be performed by many departments or agencies generally parallel some of their normal day-to-day functions. To the extent possible, the same personnel and material resources used for day-to-day activities will be employed during emergency situations. Because personnel and equipment resources are limited, some routine functions that do not contribute directly to the emergency may be suspended for the duration of an emergency. The personnel, equipment, and supplies that would normally be required for those functions will be redirected to accomplish emergency tasks.

13. We have adopted the National Incident Management System (NIMS) in accordance with the President's Homeland Security Directive (HSPD)-5.

C. Operational Guidance

There will be Four Tiers that classify Mass or Multiple casualty incidents within the WVEMS and BREMS regions. Utilizing the NIMS typing matrix to move from the Most significant and demanding of resources of events “a ONE” to the least significant, “a FOUR”.

1. Tiers for MCI Response

   MCI Level 4 (up to 15 Ill/Injured Victims) (4-10 HazMat Patients requiring Gross Decon)
   Larger agencies may be capable of handling incidents with less than 15 ill or injured patients without implementing the MCI Plan or requesting mutual aid resources. The decision to declare an MCI Level I is left to the Incident Commander.
   The RHCC should be considered if Patients cannot be accommodated by local hospital.

   Resources:

   MCI Level 3 (16-30 Ill/Injured Victims) (11-20 HazMat Patients requiring Gross Decon)
   An incident producing this number of patients may require additional resources beyond what traditional mutual aid agreements can provide. Additionally, patients in these numbers will tax the healthcare system receiving these patients.
   The RHCC should be considered if Patients cannot be accommodated by local hospital.

   Resources:

   MCI Level 2 (31-100 Ill/Injured Victims) (21-40 HazMat Patients requiring Gross Decon)
   A medical disaster of this magnitude will frequently require the activation of one or more regional and/or state specialty teams. The addition of these teams may require the establishment of a Unified Command and the expansion of the Incident Management Structure to include the Planning, Logistics, and/or Finance and Administration Sections.

   The RHCC will be contacted and provide patient placement support for this level

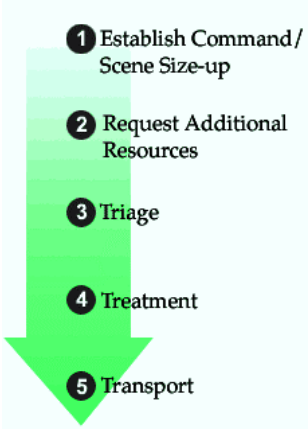
   Resources:

   MCI Level 1 (101 or more Ill/Injured Victims) (40 or more HazMat Patients requiring Gross Decon)
   The RHCC will be contacted and provide patient placement support for this level

   Resources:

2. Initial Response. Our Emergency Medical Services workers and Fire Fighters are likely to be the first on the scene of a mass casualty situation. These EMS and Fire officials will initiate Incident command per local protocol. Thru a locally defined incident command structure, they will normally take charge and remain in charge of the incident until it is resolved or others who have legal authority to do so assume responsibility.

They will seek guidance and direction from our local and regional officials and seek technical assistance from state and federal agencies and industry where appropriate.



3. 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. The incident commander will establish an incident command post (ICP) and provide an assessment of the situation to local officials, identify response resources required, and direct the on-scene response from the ICP.
   d. 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 regional hospitals, and if indicated per section XXX, the RHCC.
   e. Requesting resources and communicating an assessment of the scene will be done thru a scripted communications plan. The Communications Plan can be found in annex XXX

   f. 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.

4. 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. Purchasing supplies and equipment, if necessary, and/or request

assistance if the lead agencies resources are insufficient or inappropriate will be requested as follows:

1) Summon those resources available to us pursuant to inter-local agreements. See Attachment 6 to this plan, which summarizes the inter-local agreements and identifies the officials authorized to request those resources.
2) Summon emergency service resources that we have contracted for. See Attachment 6.
3) Request State controlled assets thru VDEM (PROVIDE NUMBER)
   a) VDEM May be use to request assistance from volunteer groups active in disasters.
4) Request assistance from industry or individuals who have resources needed to deal with the emergency situation.

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 (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 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

g. If the victims of the mass casualty incident are contaminated, or potentially contaminated with a chemical, biological or radiological agents or materials consider the activation of the Regional Hazardous Materials (HAZMAT) Team and the Hampton Roads Metropolitan Medical Response Strike Team (HRMMST). Refer to ANNEX Xxx: Emergency Management of Contaminated Patients for additional information.

D. Activating The Plan

1. Ems will contact the closest, most appropriate hospital(s) for patient capacity. Capacity will be reported utilizing the START Triage Categories “Red, Yellow, and Green”. EMS will make transports to said hospitals.

2. The RHCC will be consulted and will serve as the guide for patient capacity and placement for EMS…

- When the number of patients requiring transport and definitive medical care exceeds the capabilities or the scope of the contacted hospitals
- When more than two Hospitals must be involved
- When patients will be taken to hospitals out of the state
- For Any Tier 2 or Tier 1 (highest acuity) MCI
- When a large portion of the patients exceed the capabilities of the hospital proximate to the scene (such as complex Trauma, Pediatrics, etc).
- When the Scene requires RHCC assistance with resources

3. The locality designated Incident Commander will activate the MCI Plan using their Emergency Communications Center. Activation of the plan should be accompanied with your assessed tier (Page X) and what you need. The Regional MCI Plan should be activated by calling the Near Southwest RHCC at 1-866-679-7422, regardless of the need for patient placement support. When Calling, You will be asked the following questions:

- Locality requesting MCI Plan activation
- Call Back Number
- Radio channel being utilized (Channel Name)
- Tier and if possible, number of Red/Yellow/Green patients
- Needs (Such as patient placement or resources)
    - Please specify to the Dispatcher whether or not you will need patient placement support.
- Actions you’ve taken so far (Such as calling a local Emergency Room, Deploying a MCI trailer, or notifying a neighboring Jurisdiction)
- A brief summary of the incident to include “What happened”

4. When activating the plan, it’s important to be specific about what your needs are. The Duties and actions of the RHCC are detailed in Section XXX
5. We intend to employ 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

E. Incident Command System (ICS)

1. We intend to employ 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. It is designed to effectively integrate resources from different agencies into a temporary emergency organization at an incident site that can expand and contract with the magnitude of the incident and resources on hand. A summary of ICS is provided in Attachment 7.

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 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 Unified 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 7 provides additional information on Unified and Area Commands.

F. ICS – EOC - Hospital(s) - RHCC Interface

1. For major emergencies and disasters, the Emergency Operations Center (EOC) will be activated. When the EOC is activated, it is essential to establish a division of responsibilities between the incident command post and the EOC. A general division of responsibilities is outlined below. It is essential that a precise division of responsibilities be determined for specific emergency operations.

2. The incident commander is generally responsible for field operations, including:

    a. Isolating the scene.
    b. Directing and controlling the on-scene response to the emergency situation and managing the emergency resources committed there.
    c. Warning the population in the area of the incident and providing emergency instructions to them.
    d. Determining and implementing protective measures (evacuation or in-place sheltering) for the population in the immediate area of the incident and for emergency responders at the scene.
    e. Implementing traffic control arrangements in and around the incident scene.
    f. Requesting additional resources from the EOC.

3. The EOC is generally responsible for:

    a. Providing resource support for the incident command operations.
    b. Issuing community-wide warning.
    c. Issuing instructions and providing information to the general public.
    d. Organizing and implementing large-scale evacuation.
    e. Organizing and implementing shelter and mass arrangements for evacuees.
    f. Coordinating traffic control for large-scale evacuations.
    g. Requesting assistance from the State and other external sources.

4. The Hospital(s) involved in a MCI is generally responsible for:

    a. Providing a coordinated response and sharing information with the RHCC and the EOC.
    b. Communicating information on patient dispositions and transfers for the purposes of family reunification
    c. Collaborating with the RHCC and the local EOC to assure equal distribution of resources and not displacing the scene of the disaster to the closest hospital.

    d. Posting and/or making available Inpatient and ED Bed capacity in a timely manner
        1) The Goal is for hospitals to post within 15 minutes of a request
        2) The ED may be called by phone in the initial phases of a MCI and it is requested that staff are identified to speak to the RHCC and that these staff members maintain an awareness of current ED capacity to accept patients.

5. The RHCC is generally responsible for:

    a. Serving as the Regional ESF-8 entity for activated EOCs within the NSPA Region.

    b. Serving as the regional monitor for ESF-8 activities and a conduit for reporting needs and current activities to the State.

    c. Alerting Regional Contacts affiliated in the VHASS (VHHA-MCI.org) System. *Generally by SMS Text message*
        1) Regional Contacts include key individuals with Emergency management at each of the 16 regional Hospitals, Municipal EMS and Emergency Management, Long Term Care facilities, and other affiliated agencies.

    d. *AS REQUESTED* Obtain Bed count (***Immediately***) for the three closest Emergency Rooms proximate to the MCI Scene and best fitting Patient needs / acuity. This is done by phone calling the Med Com desk and is completed by the Dispatcher answering the RHCC Line

    e. Request thru Text Message to Primary Hospital Emergency Management contacts that a status of ED and Inpatient beds be updated for all 16 hospitals in the region.
        1) If the incident falls at or near a regional boundary, Adjacent region hospitals will be alerted thru the RHCC and a bed count obtained.

    f. If the incident produces large populations of patients with unique or special needs, such as Pediatric, or Burn patients, The RHCC will obtain specialty bed counts for medical centers outside the region and in other states (as needed).

    g. Respond to requests for assistance as the incident matures.

    h. Support large-scale evacuation and mass care operations

    i. Deploy, as available, resources managed by NSPA to competent and approved entities. A list of resources is available in the Resource section (XXX)

6. In some large-scale emergencies or disasters, emergency operations with different objectives may be conducted at geographically separated scenes. In such situations, more than one incident command operation may be established. If this situation occurs, a transition to an Area Command or a Unified Area Command is desirable, and the allocation of resources to specific field operations will be coordinated through the EOC. The RHCC will be the Area commands point of contact for Health and Medical incidents until such time as more than two RHCCs have been involved in the incident. At that time, the State ESF-8 Desk and State RHCC will be integrated in the response.

F. State, Federal & Other Assistance

1. State & Federal Assistance

   a. If local and regiona resources are inadequate to deal with an emergency situation, the municipality leading the response will request assistance from the State. State assistance furnished to local governments is intended to supplement local resources and not substitute for such resources, including mutual aid resources, equipment purchases or leases, or resources covered by emergency service contracts.

2. Other Assistance

   a. If resources required to control an emergency situation are not available within the State, the Governor may request assistance from other states pursuant to a number of interstate compacts or from the federal government through the Federal Emergency Management Agency (FEMA).

   b. For major emergencies and disasters for which a Presidential declaration has been issued, federal agencies may be mobilized to provide assistance to states and local governments. The *National Response Plan (NRP)* describes the policies, planning assumptions, concept of operations, and responsibilities of designated federal agencies for various response and recovery functions. The *Nuclear/Radiological Incident Annex of the NRP* addresses the federal response to major incidents involving radioactive materials.

   c. FEMA has the primary responsibility for coordinating federal disaster assistance. No direct federal disaster assistance is authorized prior to a Presidential emergency or disaster declaration, but FEMA has limited authority to stage initial response resources near the disaster site and activate command and control structures prior to a declaration and the Department of Defense has the authority to commit its resources to save lives prior to an emergency or disaster declaration. See Annex J, Recovery, for additional information on the assistance that may be available during disaster recovery.

   d. The NRP applies to Stafford and non-Stafford Act incidents and is designed to accommodate not only actual incidents, but also the threat of incidents. Therefore, NRP implementation is possible under a greater range of incidents.

G. Emergency Authorities

1. Key federal, state, and local legal authorities pertaining to emergency management are listed in Section I of this plan.

2. Virginia statutes and the Executive Order of the Governor Relating to Emergency Management provide local government, principally the chief elected official, with a number of powers to control emergency situations. If necessary, the locality involved shall use these powers during emergency situations. These powers include:

   a. Disaster Declaration. When an emergency situation has caused severe damage, injury, or loss of life or it appears likely to do so, the [County Judge/Mayor] may by executive order or proclamation declare a local state of disaster.

H. Actions by Phases of Emergency Management

1. This plan addresses emergency actions that are conducted during all four phases of emergency management.

   a. Mitigation

      While it is virtually impossible to identify and mitigate all of the causes of MCI events, participants will participate in training activities described in Annex P-Mitigation, of this plan. Training is an integral part in a successful MCI response. Mitigation should be a pre-disaster activity, although mitigation may also occur in the aftermath of an emergency situation with the intent of avoiding repetition of the situation. Our mitigation program is outlined in Annex P, Mitigation.

   b. Preparedness

      We will conduct preparedness activities to develop the response capabilities needed in the event an emergency. Among the preparedness activities included in our emergency management program are:

      1) Providing emergency equipment and facilities.
      2) Emergency planning, including maintaining this plan, its annexes, and appropriate SOPs.
      3) Conducting or arranging appropriate training for emergency responders, emergency management personnel, other local officials, and volunteer groups who assist us during emergencies.
      4) Conducting periodic drills and exercises to test our plans and training.

   c. Response

      We will respond to emergency situations effectively and efficiently. The focus of most of this plan and its annexes is on planning for the response to emergencies. Response operations are intended to resolve an emergency situation while minimizing casualties. Response activities specific to MCIs *can* include the following: warning, emergency medical services, firefighting, law enforcement operations, evacuation, shelter and mass care, emergency public information, search and rescue, as well as other associated functions.

d. Recovery

If a disaster occurs, we will carry out a recovery program that involves both short-term and long-term efforts. Short-term operations seek to restore vital services to the community and provide for the basic needs of the public, like ensuring the restoration of EMS capability to respond to calls. Long-term recovery focuses on restoring the community to its normal state. Our recovery program is outlined in Annex J, Recovery.

VI. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

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. Our governmental organization for emergencies includes an executive group, emergency services, and support services. Attachment 3 depicts our emergency organization. Each Jurisdiction shall develop and implement, as part of their state-mandated Emergency Operations Plan, as Outlined in 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.

2. Executive Group

   The respective Executive Groups of WVEMS, BREMS, and NSPA provides guidance and direction for emergency management programs and for emergency response and recovery operations. The Executive Groups include the board of directors / executive committee of each of these three groups. These three groups have created and support the MCIPC, comprised of EMS and EM representatives from each municipality within the NSPA Region, and functioning under the auspices of this plan.

3. Emergency Services

Emergency Services include the designated Locality or Facility Emergency Manager or a designee. Additional representation will come from the designated Emergency Medical Services Leader (Chief / Captain) or a designee.

4. Emergency Medical Services

   Emergency Medical Services include the designated Locality or Agency Emergency Medical Services Commander (Chief / Captain) or a designee.

5. Regional Entities (Including Sub-divisions of state agencies)

   This group includes the Health District Emergency Planners for the Virginia Department of Health, the Region Emergency Manager for VDEM, RHCC Manager, Coordinator and the NSPA Executive Director from NSPA, Medical Reserve Corps Coordinators, and other regional agencies that support and sustain emergency responders, have a responsibility in emergencies, and/or support a regional emergency response.

6. Emergency Support Services

   This group includes departments and agencies that support and sustain emergency responders and also coordinate emergency assistance provided by organized volunteer organizations, business and industry, and other sources.

5. 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.*

B. Assignment of Responsibilities

1. 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 EM 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.

2. Emergency Services Responsibilities

   EMS Initial Actions:

- ***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:

  1. SAFETY ASSESSMENT: 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.

  2. 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.

  3. SEND INFORMATION:
     - ✓ CONTACT DISPATCH WITH YOUR SIZE-UP INFORMATION.
     - ✓ REQUEST ADDITIONAL RESOURCES.
     - ✓ NOTIFY THE CLOSEST HOSPITAL.

  4. 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.

  5. 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.
     - ✓ PROVIDE ONLY MINIMAL TREATMENT.
     - ✓ KEEP MOVING!

The First Unit On-Scene size-up position check list is located in Annex C of this document.

- ***Emergency Department/Hospital Notification.*** **It is vital that the First Arriving Unit tell the Dispatcher to contact the closet Emergency Department, or contact the closest Emergency Department directly, and inform the facility that there is a MCI in progress.** This notification should include the nature or apparent cause of the event, the estimated number of victims, and whether or not the victims may be contaminated. The Emergency Department(s) will not be prepared to receive the influx of patients from the MCI unless they are immediately notified of the multiple or mass casualty incident.

- ***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. It is the responsibility of the Incident Commander to perform the initial scene size-up using the "5-S's" and report their findings to the dispatcher.

Request Additional Resources. Once the initial scene size-up has been completed the Incident Commander must request additional resources based on his/her assessment of the incident. The Incident Commander's request for additional resources should be accompanied by the identification of the incident Staging Area(s).

a. Public Information.

1) 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.

2) Emergency tasks to be performed include:

a) Establish a Joint Information Center (JIC) when indicated by the scope of the incident.
b) 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.
c) Utilize WebEOC or Email distribution groups to share and collaborate on common message between PIOs involved in the incident.
d) Provide information to the media and the public during emergency situations.
e) Arrange for media briefings.
f) Compiles print and photo documentation of emergency situations.

b. Recovery / Post-Incident

1) Primary responsibility for this function is assigned to the Locality leading the response. See Annex J (Recovery / Post-Incident) for additional instructions or recommendations

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.

c. Utilities.

1) Primary responsibility for this function is retained by the individual Utility operators. Annex L (Energy and Utilities) describes additional resources and communication with utility operators. ESF-3 staffed at the Local or State level will participate in carrying out the Emergency Tasks.

2) Emergency tasks to be performed include:

a) Prioritize restoration of utility service to vital facilities and other facilities.
b) Arrange for the provision of emergency power sources where required.
c) Identify requirements for emergency drinking water and portable toilets to the department or agency responsible for mass care.
d) Assess damage to, repair, and restore public utilities.
e) Monitor recovery activities of privately owned utilities.

3. Volunteer & Other Services

a. Volunteer Groups. The following are local volunteer agencies that can provide disaster relief services and traditionally have coordinated their efforts with our local government:

1) _____ Chapter, American Red Cross.

Provides shelter management, feeding at fixed facilities and through mobile units, first aid, replacement of eyeglasses and medications, provision of basic clothing, and limited financial assistance to those affected by emergency situations. The Red Cross also provides feeding for emergency workers.

2) The Salvation Army.

Provides emergency assistance to include mass and mobile feeding, temporary shelter, counseling, missing person services, medical assistance, and the warehousing and distribution of donated good including food clothing, and household items. It also provides referrals to government and private agencies for special services.

3) RACES.

The Radio Amateur Civil Emergency Service provides amateur radio support for emergency operations, including communications support in the EOC.

b. Business Support.

The following businesses have agreed to provide support for emergency operations as indicated:

1)
2)

VII. DIRECTION AND CONTROL

A. General

1. The [County Judge/Mayor] is responsible for establishing objectives and policies for emergency management and providing general guidance for disaster response and recovery operations, all in compliance with the NIMS. During disasters, [he/she] may carry out those responsibilities from the EOC.

8.

VIII. READINESS

A. Many emergencies follow some recognizable build-up period during which actions can be taken to achieve a gradually increasing state of readiness. There are broad threat categories and planned incidents that are referenced below to create broad awareness. Often times, local Emerency Management is the first to become aware of these events. The following described methods should be used to notify other regional stakeholders. We the following systems; Regional Email Distribution, SMS Text message. General actions to be taken for these events and are outlined in the annexes to this plan; more specific actions will be detailed in departmental or agency SOPs and can be taken based on the incident.

B. The following Readiness Levels will be used as a means of increasing our alert posture. Needed???

1. Increased Readiness

   a. Increased Readiness refers to situations that presents a greater potential

      1) Tropical Weather Threat. A tropical weather system has developed that has the potential to impact the local area. Readiness actions may include regular situation monitoring, a review of plans and resource status, determining staff availability and placing personnel on-call.

      2) Tornado Watch indicates possibility of tornado development. Readiness actions may include increased situation monitoring and placing selected staff on alert.

      3) Flash Flood Watch indicates flash flooding is possible due to heavy rains occurring or expected to occur. Readiness actions may include increased situation-monitoring, reconnaissance of known trouble spots, deploying warning signs.

      4) Wildfire Threat. During periods of extreme wildfire threat, readiness actions may include deploying additional resources to areas most at risk, arranging for standby commercial water tanker support, conducting daily aerial reconnaissance, or initiating burn bans.

5) Mass Gathering. For mass gatherings with previous history of problems, readiness actions may include reviewing security, traffic control, fire protection, and first aid planning with organizers and determining additional requirements.

IX. ADMINISTRATION AND SUPPORT

A. Agreements and Contracts

1. Should our local resources prove to be inadequate during an emergency, requests will be made for assistance from other local jurisdictions, other agencies, and industry in accordance with existing mutual-aid agreements and contracts and those agreements and contracts concluded during the emergency. Such assistance may include equipment, supplies, or personnel. All agreements will be entered into by authorized officials at the local, regional, or state level and should be in writing whenever possible. Agreements and contracts should identify the officials authorized to request assistance pursuant to those documents.

2. The agreements and contracts pertinent to emergency management that we are a party to are summarized in Attachment 6.

B. Reports

1. Initial Emergency Report. This short report should be prepared and transmitted by the EOC when an on-going emergency incident appears likely to worsen and we may need assistance from other local governments or the State. See Annex N, Direction and Control for the format and instructions for this report.

2. Situation Report. A daily situation report should be prepared and distributed by the EOC during major emergencies or disasters. See Annex N, Direction and Control, for the format of and instructions for this report.

3. Other Reports. Several other reports covering specific functions are described in the annexes to this plan.

C. Records

1. Record Keeping for Emergency Operations

   Each Municipality is responsible for establishing the administrative controls necessary to manage the expenditure of funds and to provide reasonable accountability and justification for expenditures made to support emergency operations. The following are recommended documents to maintain during the response and recovery period for an MCI.

   a. Activity Logs. The Incident Command Post and the EOC shall maintain accurate logs recording key response activities, including:

      1) Activation or deactivation of emergency facilities.
      2) Emergency notifications to other local governments

3) Significant changes in the emergency situation.
4) Patient Allocation/Distribution of patients and records of destinations
5) Number of deceased
6) Major commitments of resources or requests for additional resources from external sources.
7) Issuance of protective action recommendations to the public.
8) Evacuations.
9) Containment or termination of the incident.

b. Incident Costs. All department and agencies shall maintain records summarizing the use of personnel, equipment, and supplies during the response to day-to-day incidents to obtain a estimate of annual emergency response costs that can be used as in preparing future department or agency budgets.

c. Emergency or Disaster Costs. For major emergencies or disasters, all departments and agencies participating in the emergency response shall maintain detailed of costs for emergency operations to include:

1) Personnel costs, especially overtime costs
2) Equipment operations costs
3) Costs for leased or rented equipment
4) Costs for contract services to support emergency operations
5) Costs of specialized supplies expended for emergency operations

These records may be used to recover costs from the responsible party or insurers or as a basis for requesting financial assistance for certain allowable response and recovery costs from the state and/or federal government.

D. Training

It will be the responsibility of each agency director to ensure that agency personnel, in accordance with the NIMS, possess the level of training, experience, credentialing, or capability for any positions they are tasked to fill.

E. Post-Incident and Exercise Review

For Local exercises, the Locality designated Emergency Manager or EMC is responsible for organizing and conducting a critique following the conclusion of a significant emergency event/incident or exercise. For Regionally sponsored exercises, such as those put on by NSPA or by the State of Virginia where elements of this plan are employed, the Regional point of contact designated in the planning process will be responsible for the Critique and after action. The After Action Report (AAR) will entail both written and verbal input from all appropriate participants. An Improvement Plan will be developed based on the deficiencies identified, and an individual, department, or agency will be assigned responsibility for correcting the deficiency and a due date shall be established for that action.

X. PLAN DEVELOPMENT AND MAINTENANCE

A. Plan Development

The WVEMS, BREMS, and NSPA is responsible for approving and promulgating this plan.

B. Distribution of Planning Documents

1. The MCIPC shall determine the distribution of this plan and its annexes. In general, copies of plans and annexes should be distributed to those individuals, departments, agencies, and organizations tasked in this document. Copies should also be set-aside for the EOC and other emergency facilities.

2. The Basic Plan should include a distribution list (See Attachment 1 to this plan) that indicates who receives copies of the basic plan and the various annexes to it. In general, individuals who receive annexes to the basic plan should also receive a copy of this plan, because the Basic Plan describes our emergency management organization and basic operational concepts.

C. Review

The Basic Plan and its annexes 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

D. Update

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

2. The Basic Plan and its annexes must be revised or updated by a formal change at least once **every year**. Responsibility for revising or updating the Basic Plan 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 annex.

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

ATTACHMENTS:

1. Distribution List
2. References
3. Organization for Emergencies
4. Functional Responsibility Matrix
5. Annex Assignments
6. Summary of Agreements & Contracts
7. National Incident Management System
8. Start and JumpStart Triage
9. Sample MOU
10. Trauma Triage
11. Scene Setup and Patient considerations

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ATTACHMENT 1
DISTRIBUTION LIST

Jurisdiction/Agency Plan	Basic Plan	Annexes
Western Virginia EMS Council (WVEMS)	Online	All
Blue Ridge EMS Counncil (BREMS)	Online	All
Near Southwest Preapredness Alliance (NSPA)	Online	All
Each Jurisdiction EOC	1	All
Each Jurisdiction EMC	1	All
Each Jurisdiction EMS Chief/Captain(s)	1	All
Each Jurisdiction County Sheriff	1	All
Each Jurisdiction Police Chief	1	All
Each Fire Chief or Public Safety Administrator	1	All
Each of 16 Hospital ERs	1	All
Each of 16 Hospital Ems	1	All
Each of 16 Hospital EOCs	1	All
Each of 5 Health District Directors	1	All
Each of 5 Health District EPs	1	All
Each of 5 MRC Units leaders	1	All
Each Local Chapter of the ARC with Disaster responsibility	1	All
Each Community Service Board	1	All
Western Region Office of Chief Medical Examiner	1	All
RACES Officer	1	All
Radiological Specialists affiliated with Healthcare	1	All
Each Long Term Care facility	1	All
Each Emergency Management Contact with Higher Education	1	All
Near Southwest (NSPA) RHCC	1	All
State Office of EMS	1	All
State Hospital Preparedness Coordinator	1	All
VDEM Region 4, Region 6 Coordinator	1	All
VHHA Technical Advisor	1	All
Regional HazMat Teams Leader	1	All
	1	All

ATTACHMENT 2
REFERENCES

1. FEMA, Independent Study Course, IS-288: *The Role of Voluntary Organizations in Emergency Management*

2. FEMA, *State and Local Guide (SLG) 101: Guide for All-Hazard Emergency Operations Planning*

3. U. S. Department of Homeland Security, *National Response Plan*

ATTACHMENT 3
ORGANIZATION FOR EMERGENCY MANAGEMENT

See the sample organization charts in the Planning Notes for the Basic Plan

ATTACHMENT 4
EMERGENCY MANAGEMENT FUNCTIONAL RESPONSIBILITIES

	Warning	Communications	Shelter & Mass Care	Radiological Protection	Evacuation	Firefighting	Law Enforcement	Health & Medical	Public Information	Recovery	Public Works & Engineering	Utilities	Resource Management	Direction & Control	Human Services	Hazard Mitigation	Hazmat & Oil Spill Response	Search & Rescue	Transportation	Donations Management	Legal	Terrorist Incident Response
County Judge/Mayor	S	S	S	S	S	S	S	S	S	S	S	S	S	P	S	S	S	S	S	S	S	S
Asst. to Judge/City Manager									P	S			S							S		
EMC	S	C	C	C	S	C	C	C	C	C	C	C	S	C	C	S	C	C	C	S	C	C
Law Enforcement	P	P	S	S	P	S	P						S	S	S		S	S		S		P
Fire Service	S	S	S	P	S	P							S	S		S	P	S		S		S
Public Works		S	S	S	S		S			S	P	S	S	S		P	S	S				S
Utilities		S								S		P	S	S		S	S			S		S
Health & Medical Services			S	S	S			P					S	S	S		S	S	S	S		S
Human Services			S		S								S		P	S				S		S
Community Services			P	S	S								S	S	S					P		S
Human Resources													P							S		
Tax Assessor/Finance Dir.										P			S			S				S		
Transportation/ISD			S		S								S		S		S		P			S
City/County Attorney's Office					S								S			S				S	P	S
Search & Rescue					S									S				P				S

P – INDICATES PRIMARY RESPONSIBILITY
S – INDICATES SUPPORT RESPONSIBILITY
C – INDICATES COORDINATION RESPONSIBILITY

ATTACHMENT 5
ANNEX ASSIGNMENTS

ANNEX	ASSIGNED TO:
Annex A: Warning	Police Chief/County Sheriff
Annex B: Communications	Police Chief/County Sheriff
Annex C: Shelter & Mass Care	Community Services Director
Annex D: Radiological Protection	Fire Chief/Fire Marshal
Annex E: Evacuation	Police Chief/County Sheriff
Annex F: Firefighting	Fire Chief/Fire Marshal
Annex G: Law Enforcement	Police Chief/County Sheriff
Annex H: Health and Medical Services	City/County Health Officer
Annex I: Public Information	City Secretary/Asst. to the Judge
Annex J: Recovery	Finance Director/Tax Assessor
Annex K: Public Works & Engineering	Public Works Director
Annex L: Utilities	Public Utilities Director
Annex M: Resource Management	Human Resources Director
Annex N: Direction & Control	City Manager/Asst. to the Judge
Annex O: Human Services	Human Services Director
Annex P: Hazard Mitigation	Public Works Director
Annex Q: Hazardous Materials & Oil Spill Response	Fire Chief/Fire Marshal
Annex R: Search & Rescue	Fire Chief/Fire Marshal/Rescue Officer
Annex S: Transportation	City/County or ISD Transportation Director
Annex T: Donations Management	Community Services Director
Annex U: Legal	City/County Attorney
Annex V: Terrorist Incident Response	Police Chief/County Sheriff

ATTACHMENT 6
SUMMARY OF AGREEMENTS & CONTRACTS

Agreements

Description:
Summary of Provisions:
Officials Authorized to Implement:
Costs:
*Copies Held By***:**

Description:
Summary of Provisions:
Officials Authorized to Implement:
Costs:
*Copies Held By***:**

Description:
Summary of Provisions:
Officials Authorized to Implement:
Costs:
Copies Held By:

Contracts

Description:
Summary of Provisions:
Officials Authorized to Implement:
Costs:
Copies Held By:

Description:
Summary of Provisions:
Officials Authorized to Implement:
Costs:
Copies Held By:

ATTACHMENT 7
NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) SUMMARY

A. BACKGROUND

1. NIMS is a comprehensive, national approach to incident management that is applicable to all jurisdictional levels and across functional disciplines. This system is suitable across a wide range of incidents and hazard scenarios, regardless of size or complexity. It provides a flexible framework for all phases of incident management, as well as requirements for processes, procedures, and systems designed to improve interoperability.

2. NIMS is a multifaceted system that provides a national framework for preparing for, preventing, responding to, and recovering from domestic incidents.

B. COMPONENTS

1. Command and Management. The incident management structures employed by NIMS can be used to manage emergency incidents or non-emergency events such as celebrations. The system works equally well for small incidents and large-scale emergency situations. The system has built-in flexibility to grow or shrink depending on current needs. It is a standardized system, so personnel from a variety of agencies and geographic locations can be rapidly incorporated into a common management structure.

   a. Incident Management System. A system that can be used to manage emergency incidents or non-emergency events such as celebrations.

      1) FEATURES OF ICS

         ICS has a number of features that work together to make it a real management system. Among the primary attributes of ICS are:

         a) Common Terminology. ICS requires the use of common terminology, such as the use of standard titles for facilities and positions within an organization, to ensure efficient and clear communications.

         b) Organizational Resources. All resources including personnel, facilities, major equipment, and supply items used to support incident management activities must be “typed” with respect to capability. This typing will minimize confusion and enhance interoperability.

         c) Manageable Span of Control. Span of control should ideally vary from three to seven. Anything less or more requires expansion or consolidation of the organization.

         d) Organizational Facilities. Common terminology is used to define incident facilities, the activities conducted at these facilities, and the organizational positions that can be found working there.

e) Use of Position Titles. All ICS positions have distinct titles.

f) Reliance on an Incident Action Plan. The incident action plan, which may be verbal or written, is intended to provide supervisory personnel a common understanding of the situation and direction for future action. The plan includes a statement of objectives, organizational description, assignments, and support material such as maps. Written plans are desirable when two or more jurisdictions are involved, when state and/or federal agencies are assisting local response personnel, or there has been significant turnover in the incident staff.

g) Integrated Communications. Integrated communications includes interfacing disparate communications as effectively as possible, planning for the use of all available systems and frequencies, and requiring the use of clear text in communications.

h) Accountability. ICS is based on an orderly chain of command, check-in for all responders, and only one supervisor for each responder.

2) UNIFIED COMMAND

a) Unified Command is a variant of ICS used when there is more than one agency or jurisdiction with responsibility for the incident or when personnel and equipment from a number of different agencies or jurisdictions are responding to it. This might occur when the incident site crosses jurisdictional boundaries or when an emergency situation involves matters for which state and/or federal agencies have regulatory responsibility or legal requirements.

b) ICS Unified Command is intended to integrate the efforts of multiple agencies and jurisdictions. The major change from a normal ICS structure is at the top. In a Unified command, senior representatives of each agency or jurisdiction responding to the incident collectively agree on objectives, priorities, and an overall strategy or strategies to accomplish objectives; approve a coordinated Incident Action Plan; and designate an Operations Section Chief. The Operations Section Chief is responsible for managing available resources to achieve objectives. Agency and jurisdictional resources remain under the administrative control of their agencies or jurisdictions, but respond to mission assignments and direction provided by the Operations Section Chief based on the requirements of the Incident Action Plan.

3) AREA COMMAND

a) An Area Command is intended for situations where there are multiple incidents that are each being managed by an ICS organization or to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned. Area Command becomes Unified Area Command when incidents are multijurisdictional.

b) The organization of an Area Command is different from a Unified Command in that there is no operations section, since all operations are conducted on-scene, at the separate ICPs.

b. Multiagency Coordination Systems. Multiagency coordination systems may be required for incidents that require higher level resource management or information management. The components of multiagency coordination systems include facilities, equipment, EOCs, specific multiagency coordination entities, personnel, procedures, and communications; all of which are integrated into a common framework for coordinating and supporting incident management.

c. Public Information. The NIMS system fully integrates the ICS Joint Information System (JIS) and the Joint Information Center (JIC). The JIC is a physical location where public information staff involved in incident management activities can collocate to perform critical emergency information, crisis communications, and public affairs functions. More information on JICs can be obtained in the DHS *National Incident Management System* Plan, dated March 2004.

2. Preparedness. Preparedness activities include planning, training, and exercises as well as certification of response personnel, and equipment acquisition and certification. Activities would also include the creation of mutual aid agreements and Emergency Management Assistance Compacts. Any public information activities such as publication management would also be preparedness activities.

3. Resource Management. All resources, such as equipment and personnel, must be identified and typed. Systems for describing, inventorying, requesting, and tracking resources must also be established.

4. Communications and Information Management. Adherence to NIMS specified standards by all agencies ensures interoperability and compatibility in communications and information management.

5. Supporting Technologies. This would include any technologies that enhance the capabilities essential to implementing the NIMS. For instance, voice and data communication systems, resource tracking systems, or data display systems.

6. Ongoing Management and Maintenance. The NIMS Integration Center provides strategic direction and oversight in support of routine review and continual refinement of both the system and its components over the long term.

ATTACHMENT 8
SAMPLE MEMORANDUM OF UNDERSTANDING FOR PLAN PARTICIPATION

Western Virginia and Blue Ridge EMS Mass Casualty Incident Plan
Memorandum of Understanding

1. MISSION STATEMENT

The goal of the WVEMS and BREMS Mass Casualty Incident Plan is to prepare on a regional basis for a unified, coordinated and immediate emergency medical services (EMS) mutual aid response to any type of Mass Casualty Incident (MCI) or Health Care Facility Evacuation in the 9,000-square-mile WVEMS and BREMS regions. This regional response by member hospitals and pre-hospital EMS agencies includes the effective emergency medical management of the victims of an MCI, or of patients who are involved in the emergency evacuation of any health care facility in the region, and/or of any health care facility hat has signed this Memorandum.

The WVEMS-BREMS MCI Plan (hereafter referred to as the MCI Plan) also is designed to provide safe and rapid access to sites of definitive care for victims of an MCI, or for patients involved in an emergency evacuation of a health care facility in the region. The MCI Plan, through its EMS Mutual Aid Response Guide (hereafter referred to as the Response Guide) as most recently amended, is the reference and basis for this Memorandum of Understanding. It will provide guidelines for hospital and out-of-hospital EMS mutual aid to any incident, including acts f terrorism, in which the regional MCI Plan is activated.

Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in Planning Districts 13, 14, 15 and 19 which comprise WVEMS and BREMS as provided in the Code of Virginia, Section 32.1-111.11.

2. DEFINITIONS

2.1 For the purposes of this Memorandum, the following definitions will apply:

2.1.1 **MASS CASUALTY INCIDENT (MCI)** -- Sometimes called a Multiple- Casualty Incident, is an event resulting from man-made or natural causes which results in illness and/or injuries which exceed the EMS capabilities of a hospital, locality, jurisdiction and/or region.

2.1.2 **HEALTH CARE FACILITY EVACUATION (Evacuation)** -- An event resulting in the need to evacuate any number of patients from a health care facility on a temporary basis when the movement of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.

3. GENERAL AGREEMENT.

3.1 The signers of this Memorandum of Understanding agree to the following:

3.1.1. Predetermined guidelines and 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.

3.1.2. Localities and/or individual pre-hospital EMS agencies will respond 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 and will not reduce any locality's own EMS response capabilities below established, predetermined levels.

3.1.3. When considering their responses to activation of the MCI Plan, member localities and/or EMS agencies will be expected to maintain their own emergency medical response capabilities to meet local needs.

3.1.4. Predetermined mutual aid responses will be employed by hospital and pre-hospital members when any of the signatory health care facilities must be evacuated under the MCI Plan.

3.1.5. All participating out-of-hospital EMS agencies and/or localities will use a standard Incident Management System (IMS) as endorsed by MCIPC and taught within the WVEMS and BREMS regions.

3.1.6. Transportation of patients during an MCI or Evacuation will be done by licensed pre-hospital EMS agencies within the WVEMS and BREMS regions and from neighboring regions as detailed in the Response Guide. Response to an incident scene by individual providers is strongly discouraged. Instead, they should report to their respective agencies.

3.1.7. Both hospital and pre-hospital components in the region will participate when possible in annual training exercises of the MCI Plan in various locations. These exercises will be coordinated by the MCIPC through its Operations Group and the WVEMS and BREMS staff.

3.1.8. All participating pre-hospital and hospital agencies, along with local, state or federal governments and non-transport and/or related support components will be entitled to representation on the MCIPC, a standing Committee of WVEMS and BREMS. An agency may join the Committee following a written request to WVEMS and BREMS.

3.1.9. The Committee's exact makeup, duties and responsibilities will be included in its Policies and Procedures, to be reviewed annually.

4. ACTIVATING THE M.C.I. PLAN.

4.1. The MCI Plan will be activated according to the procedure in the Central Virginia MCI Plan EMS Mutual Aid Response Guide.

4.2. The Incident Manager at the scene of an MCI can activate the MCI Plan; or the EMS or Emergency Services Coordinator of a political subdivision who has authority for the management of the incident or that person's representative; or the Chief Executive Officer of a health care facility that must evacuate or otherwise relocate patients, or that person's representative.

4.3. Any health care facility in the ODEMSA region may activate the MCI Plan when additional resources are inadequate for appropriate hospital and/or pre-hospital patient care in an emergency situation or other crisis.

4.4. It is strongly recommended that activation of the MCI Plan be done through the local emergency communications center.

5. M.C.I. MEDICAL CONTROL

5.1. By mutual agreement among participating hospitals, Medical College of Virginia Hospitals (MCVH) will serve as primary MCI Medical Control for the ODEMSA region in any incident involving the MCI Plan.

5.2. MCVH may designate another acute care medical facility to act as primary MCI Medical Control based on the procedure in the Response Guide.

5.3. MCI Medical Control will activate or alert the appropriate acute medical and other health care facilities in those numbers and in those locations that best can accommodate the scope of the MCI and/or Evacuation, and which are in the best interest of patient care.

5.4. MCI Medical Control will assign patients to the appropriate health care facilities closest to the site of the MCI and/or Evacuation as may be in the best interest of patient care and as agreed to in tables prepared by participating hospitals.

5.5. The numbers and types of patients which member hospitals will be prepared to receive during an MCI or Evacuation are based on the pre-determined Patient Acuity Capability and Mutual Aid Capability tables, as adjusted and reported to MCI Medical Control by participating hospitals during activation of the MCI Plan.

6. MEDICAL DIRECTION AND FIELD TRIAGE

6.1. Field triage of patients in an MCI will conform to the guidelines described in the Commonwealth of Virginia Disaster Response Plan. This involves the START Triage System as outlined in the Response Guide. In the absence of on-line medical direction, out-of-hospital adult and pediatric care will be rendered in accordance with ODEMSA's Pre-hospital Patient Care Protocols as most recently revised.

7. DEACTIVATING THE PLAN

7.1. The Medical Incident Manager will be responsible for notifying MCI Medical Control that all patients have been assigned to transport units and that all on-scene patient care activities at an MCI or Evacuation have been completed.

7.2. MCI Medical Control will deactivate the MCI Plan among activated hospitals when so-notified by the on-scene Medical Incident Manager in accordance with procedures designated in Section 30 of the Response Guide.

8. MASS FATALITIES

8.1. Mass fatality incidents involving the ODEMSA region will be handled in cooperation with the Office of the Chief Medical Examiner and the Virginia Department of Emergency Services which state agencies, along with the Virginia Office of EMS of the Virginia Department of Health, will have representation on the Central Virginia MCI Committee.

9. STANDARD PRECAUTIONS

9.1. All EMS personnel involved in a regional response to an MCI or Evacuation will be expected to observe Standard Precautions and other infection control Body Substance Isolation practices as specified by the Centers for Disease Control, Occupational Safety and Health Administration (OSHA) and the National Fire Protection Association (NFPA) Infection Control Standard 1581, and other applicable state and local infection control regulations.

10. HAZARDOUS MATERIALS

10.1. All hospitals posess the capabilities to render secondary decontamination. Based on available staff, hospitals may place a patient CAP on their decon capabilities. In Mass Decon situations, the RHCC will coordinate Decon capabilities with patient placement and EMS Transports.

10.2. Decontamination and treatment of hazmat patients will be in accordance with established national guidelines and state, local and regional emergency response plans including the regional Hazmat Plan that is an annex to the Response Guide.

11. REVISIONS OF THE M.C.I. PLAN

11.1. The MCIPC is responsible for each year reviewing and revising the MCI Plan to maintain its effectiveness, for reviewing and evaluating any activation of the MCI Plan, and for planning annual MCI training exercises. The WVEMS and BREMS MCI Plan govern regional EMS mutual aid response to a Mass Casualty Incident or to a Health Care Facility Evacuation within the WVEMS and BREMS regions and neighboring regions. The signing of this Memorandum of Understanding by an authorized official testifies that the WVEMS-BREMS Regional MCI Plan has been approved and adopted by the participating locality, health care facility or agency named below.

Agency / Entity name if not a County or City

County / CITY of_____, Virginia

(Fill out if a Municipality)

_____ _____

Signature of Authorized Official Signature of Authorized Official Title of Authorized Official

_____ **Executive Director**

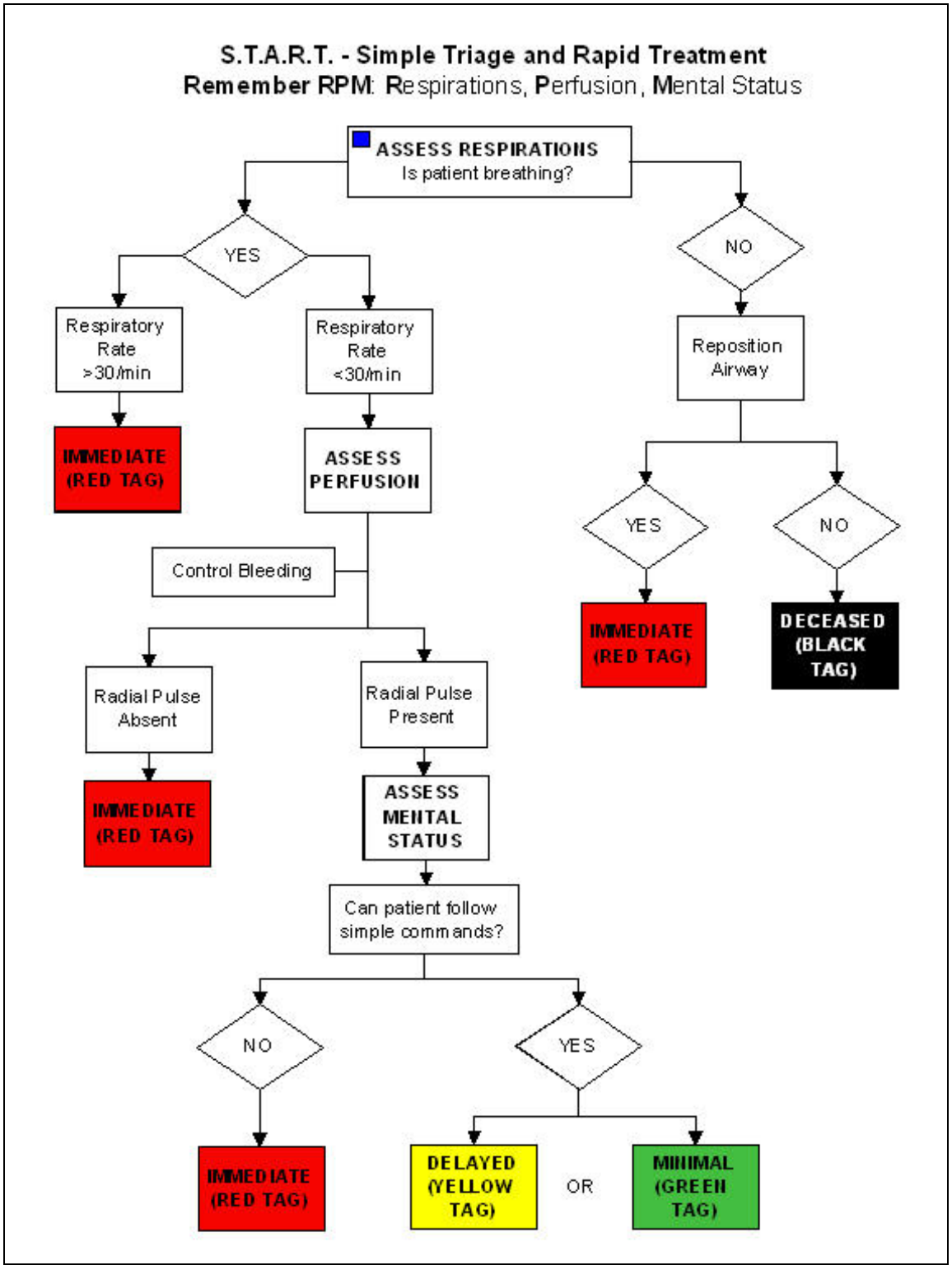
(WVEMS, BREMS, or NSPA)

_____ _____

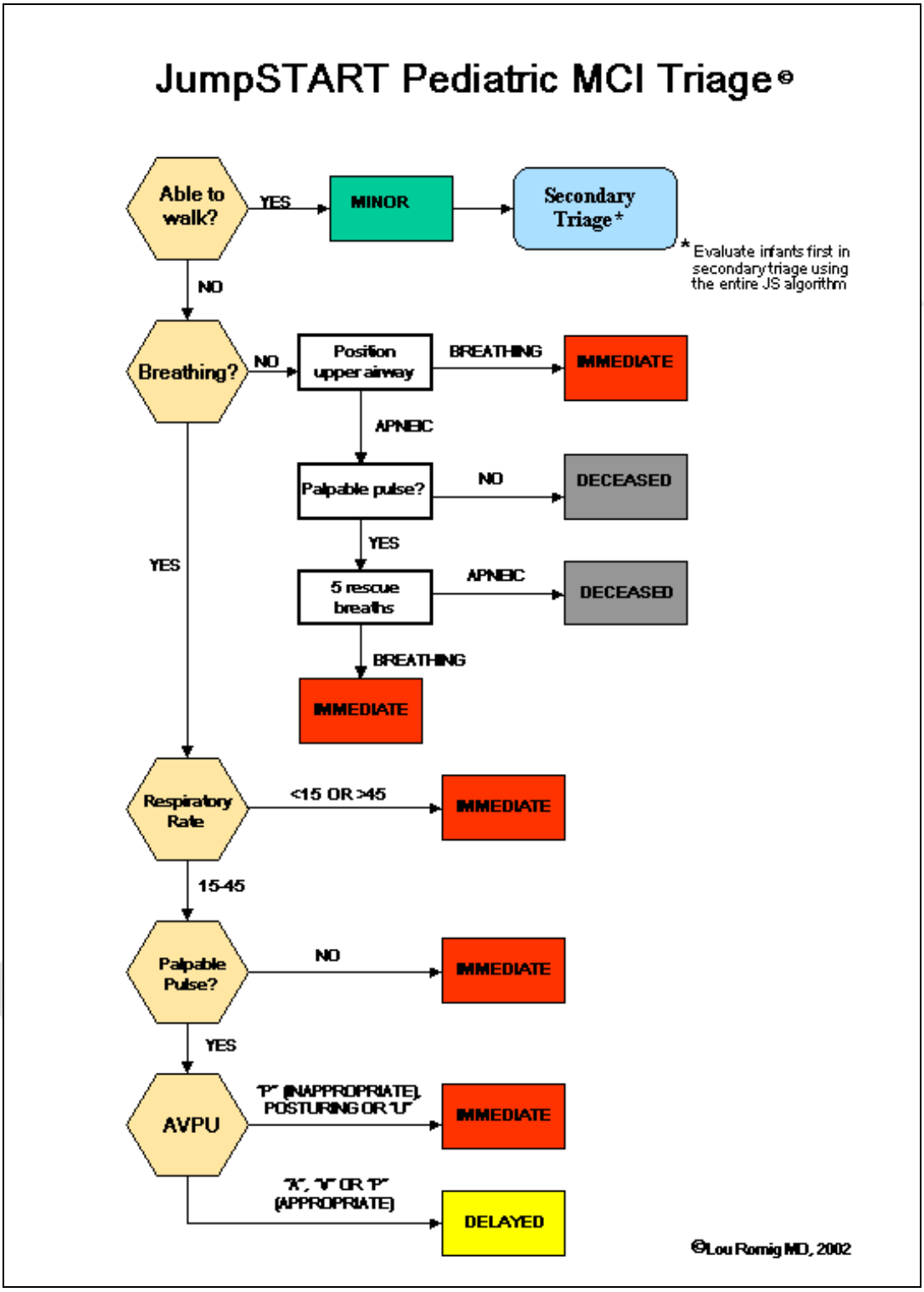
Signature of Executive Director

ATTACHMENT 9
START AND JUMPSTART TRIAGE ALGORITHM

START TRIAGE ALGORITHM



JUMPSTART TRIAGE ALGORITHM



ATTACHMENT 10
STANDARD TRAUMA TRIAGE METHODS

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. The START and Jump START algorithms are found on pages 4-2 and 4-3.

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

The initial triaging of victims must begin right where the patients lay. 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. It is appropriate to provide these patients with self-care kits, if available, so that they may begin treating themselves while awaiting the arrival of EMS providers. 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 apart of the patient assessment until the patient arrives at an Emergency Department/hospital.

Triage and Mass Patient Care

Today's EMS 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.

Massive region wide infrastructure damage may result from these types of incidents and may also result in the loss of hospitals, physicians offices, dialysis centers, other healthcare facilities and home healthcare services. Patients who live with controlled chronic illnesses and conditions may suddenly find themselves separated from their existing family members/care givers, and/or their normal healthcare system. Many of these patients may be unable to obtain needed medications, oxygen, dialysis, cancer treatments, etc. due to the destruction or disruption in the healthcare system. This situation will exacerbate their medical conditions forcing many of these patients to turn to the EMS system for care. The principles of triage still apply during these incidents and serve to assist providers by prioritizing patient care and transportation.

ATTACHMENT 11
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.

The Emergency Department closest to the scene MUST be notified immediately that an MCI has been declared. Ask the hospital if they want to retain the role of Coordinating Emergency Department or hand it off to another facility.

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.

SECONDARY TRIAGE

A more in-depth assessment method, known as secondary triage, must be conducted on all patients arriving at the treatment area from the incident scene. Each patient will have a Virginia Triage Tag applied upon their entry into the treatment area.

CONTINUAL EVALUATION

Patients in the treatment area must be continuously reevaluated (re-triaged) throughout their stay in the treatment area. Annex C: Pre-hospital MCI Job Checklists provides tactical worksheets to assist Treatment and Transportation Area personnel in carrying out their assigned duties (e.g. patient tracking, transportation of patients, etc.)

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

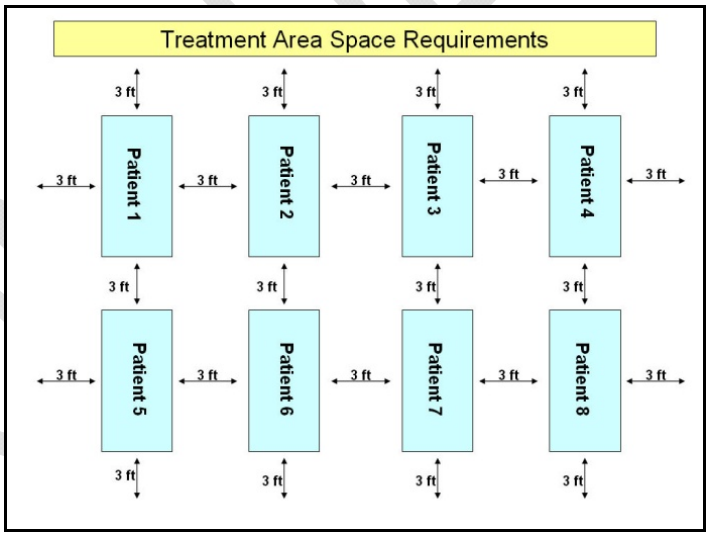
Green Tagged/Minimal patients. Personnel, equipment and supplies are allocated to patients based on their triage priority.

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. Each patient should have three feet of open space on all four sides of the patient as shown in the following figure. Many agencies stock colored tarps for use in designating treatment areas. Be aware that the treatment area required will easily exceed the size of the tarps. Responders must expand and/or relocate the treatment area during an incident to accommodate increasing space requirements.



THE TRANSPORTATION AREA

The Emergency Departments closest to the incident and RHCC **MUST** be contacted as soon as an MCI has been identified. Patient Placement coordination is detailed in the concept of operations, section XXX, XXX

The Transport Group Supervisor/Unit Leader or Medical Communications Coordinator must contact the Coordinating entity (Emergency Department or RHCC) to obtain bed availability

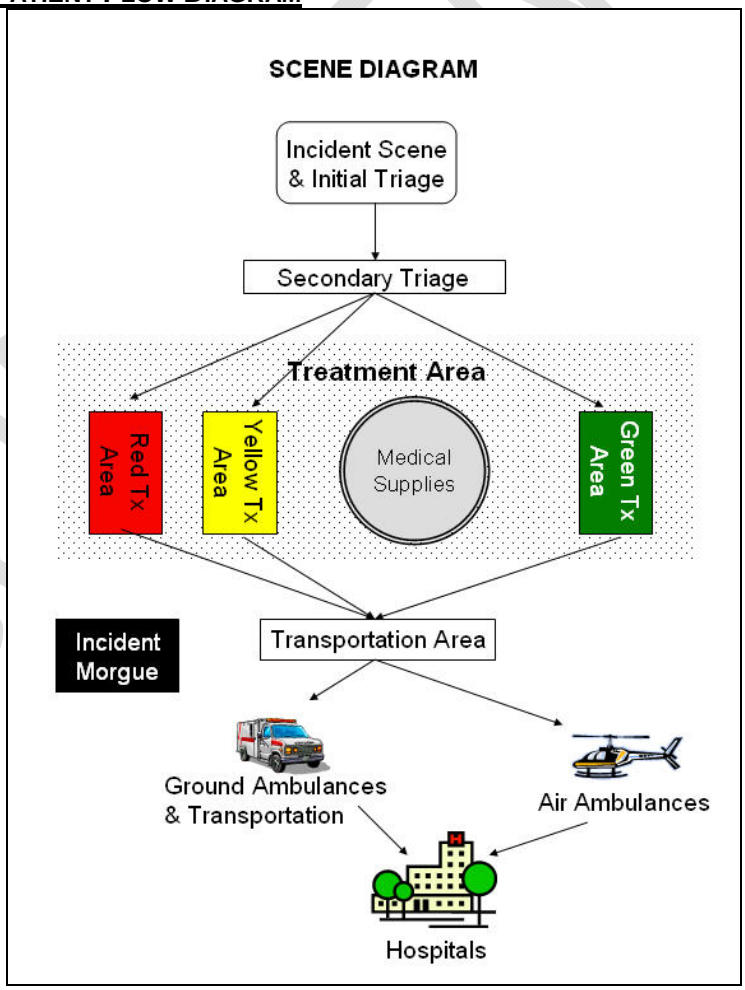
information to assist with the appropriate distribution of patients to various Emergency Departments, hospitals, and/or other medical facilities.

Transportation resources are assigned based on triage priority. Patients are moved to the Transportation Area, and then loaded into the appropriate vehicle by Porters/Transport Loaders. Patients are transported to the appropriate medical facility by the most appropriate means available. Emergency medical care is continued en route to the hospital. At a minimum all medical care must be documented on the Virginia Triage Tag. Patient transports to receiving Emergency Departments are documented on the Virginia Triage Tag and the MCI Patient Tracking Form located in Annex B of 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 uncontaminated patient flow diagram shown below provides a sample diagram of just one way to organize the scene. Ultimately 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



SPECIAL CONSIDERATIONS FOR HAZMAT PATIENTS

FIRST ARRIVING UNIT ACTIONS

The first arriving unit on a potential HAZMAT or CBRNE incident must restrain themselves from rushing into the scene and remain uphill and upwind of the incident. The successful initial management of a HAZMAT or CBRNE incident is based upon the first arriving unit using the "5-S's" to properly assess the hazard and report the information to their dispatch center. This step is vital to the safety of all first responders, victims, and the community alike.

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. For more information on the Strategic National Stockpile and CHEMPACKS refer to Annex J of this document.

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".

HOT ZONE

The hot zone is the area that immediately surrounds a hazardous materials incident. The hot zone normally extends out in a 360 degree radius around the incident scene. The hot zone is also referred to as the exclusion zone, or restricted zone, in other documents. Patients may receive antidotes and other life saving treatments in the hot zone.

WARM ZONE

The warm zone is the area where personnel and equipment decontamination and hot zone support takes place. The designation of access control points reduces the spread of contamination. This is also referred to as the decontamination, contamination reduction, or limited access zone in other documents. The warm zone is the first place that patients will be decontaminated. Patients may receive antidotes and other life saving treatments in the warm zone. Once patients have been decontaminated, they will be transferred into the care of EMS Providers in the cold zone.

Note: *The administration of life saving treatments takes precedence over decontamination for radiologically contaminated patients and the safety of the responder is within a reasonable level of risk.*

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.

PACKAGING RADIOLOGICALLY CONTAMINATED PATIENTS FOR TRANSPORT

Do not withhold lifesaving treatment from a patient solely because they are contaminated with radioactive material. 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.

TRANSPORTATION CONSIDERATIONS

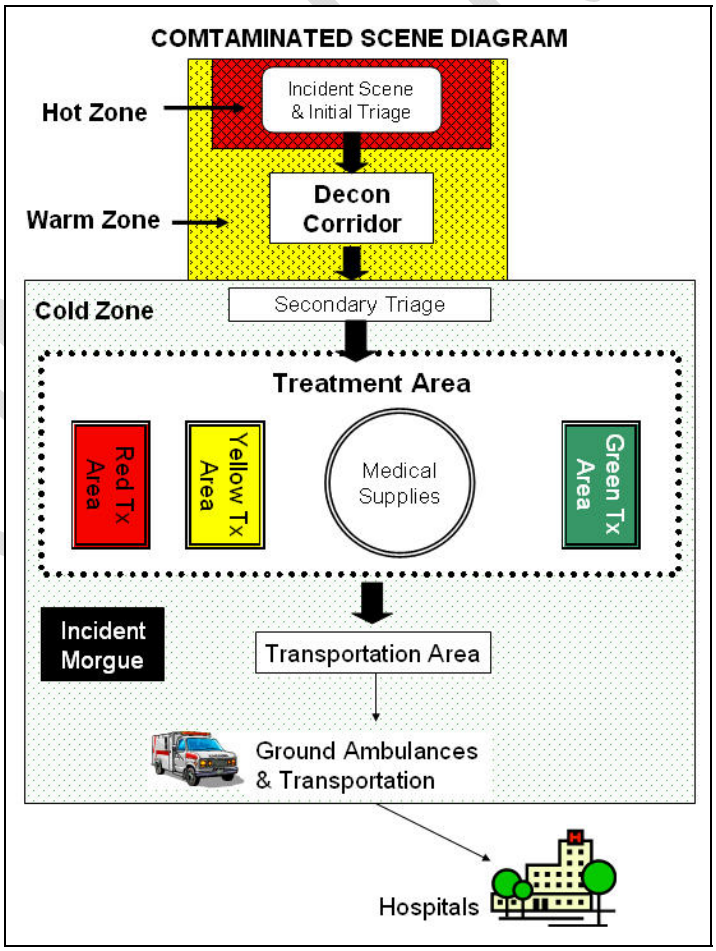
Clinically unstable, radiologically contaminated patients must be transported via ground ambulance to an Emergency Department. These patients should be packaged as outlined above and the receiving Emergency Department must be notified that they will be receiving a contaminated patient.

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.

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. The contaminated patient flow diagram shown below provides a sample diagram of just one way to organize the scene. 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.

CONTAMINATED PATIENT FLOW DIAGRAM



ANNEX B

COMMUNICATIONS

_____

Jurisdiction

Template Color Legend (Text Only)

Red – New NIMS related material for inclusion in plan

Blue – New material for review to consider including in plan

APPROVAL & IMPLEMENTATION

Annex B

Communications

Signature _____ Date _____

Signature _____ Date _____

NOTE: The signature(s) will be based upon local administrative practices. Typically, the individual having primary responsibility for this emergency function signs the annex in the first block and the second signature block is used by the Emergency Management Coordinator, Mayor, or County Judge. Alternatively, each department head assigned tasks within the annex may sign the annex.

RECORD OF CHANGES

Annex B

Communications

Change #	Date of Change	Entered By	Date Entered

ANNEX B

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

CATV	Cable TV
EAS	Emergency Alert System
EMP	Electromagnetic Pulse
EOC	Emergency Operations Center
FEMA	Federal Emergency Management Agency
IC	Incident Commander
JIC	Joint Information Center
SOP	Standard Operating Procedures
RACES	Radio Amateur Civil Emergency Service
STARS	Statewide Telecommunications and radio System
TRCIP	Texas Radio Communications Interoperability Plan

B. Definitions

Definition	Answer

IV. SITUATION AND ASSUMPTIONS

A. Situation

1. As noted in the general situation statement in the basic plan, it is virtually impossible to predict and prevent Mass Casualty Incidents. Maintaining systems and preparing for the event is the best method to remain prepared. 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 citizens, business, 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 [County/City] to provide coordinated capabilities for the most effective and efficient response and recovery activities. A diagram of the communications network is in Appendix 1.

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. Landline circuits, when available, will serve as the primary means of communication with other communication systems as back up.

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 and regional mutual-aid agreements.

5. Inter-operability is achieved thru the maintenance of common regional radio channels. These channels are listed in this Annex. Further inter-operability can be achieved thru 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 will establish and maintain communications with the Coordinating Emergency Department or RHCC.

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

10.

B. Activities by Phases of Emergency Management

1. Prevention

   a. Maintain a current technology based, reliable, interoperable, and sustainable communications system.

   b. Ensure warning communications systems meet regional needs.

   c. Ensure intelligence and other vital information networks are operational.

   d. Ensure integrated communications procedures are in place to meet the needs and requirements of the region

2. Preparedness

   a. Review and update this communications annex.

   b. Develop communications procedures that are documented and implemented through communications operating instructions (include connectivity with private-sector and nongovernmental organizations).

   c. Thoroughly and continually review the system for improvement including the implementation and institutionalized use of information management technologies.

   d. Ensure communications requirements for Emergency Operations Center and potential Joint Information Center (JIC) are regularly reviewed.

   e. Review After Action Reports of actual occurrences and exercises and other sources of information for lessons learned.

f. Acquire, test, and maintain communications equipment.

g. Train personnel on appropriate equipment and communication procedures as necessary.

h. Conduct periodic communications drills and make communications a major element during all exercises.

i. Review emergency notification list of key officials and department heads.

3. 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. Initiate warning procedures as outlined in Annex A, Warning, if required.

e. 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.)

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

2.1 4xx.xxx MHz or Med 9 - Describe

2.2 4xx.xxx MHz or Med 10 – Describe

4. Recovery

All activities in the emergency phase will continue until such time as emergency communications are no longer required.

VI. ORGANIZATION AND ASSIGNMENT RESPONSIBILITIES

A. General

1. Our emergency communications system is operated by the [Sheriff's Office/Police Department] 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 Section VII.C.

2. The [Sheriff/Police Chief] will ensure that warning information received at our warning point, the Dispatch/Communications Center, is disseminated to [county/city] officials and, where appropriate, to the public. The responsibility of ensuring the communications system is operational and incorporates all available resources rests with the [Sheriff/Police Chief], who may appoint a Communications Coordinator to carry out this task.

B. Task Assignments

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 COM-L or 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 destination emergency departments 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

c. The distribution of patients should only start after consultation with the receiving ED and/or the RHCC or Coordinating Emergency department

3. Ambulance Operators:
   a. During an MCI, routine ambulance-to-Emergency Department communications are suspended. 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. Public Information Officer will be:

   Responsible for monitoring commercial radio and telephone broadcasts for accuracy of public information. The PIO will network with affected businesses and other entities in the collaboration of a common message.

5. 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.

6. Each Municipalities Communications coordinator will:

   a. Coordinate common communications procedures.

   b. Develop and maintain a communications resource inventory (See Annex M, Resource Management).

   c. Ensure a communications capability exists between the Dispatch/Communications Center of the [Sheriff's Office/Police Department] and the Emergency Operations Center to include coordination with the telephone company for installation of dedicated telephone lines into the Dispatch/Communications Center and/or EOC.

   d. Ensure communication restoration procedures are developed.

   e. Ensure that the local telephone company is forwarded a list of circuit restoration priorities.

f. Ensure procedures are in place for dissemination of message traffic.

g. Coordinate the inclusion of business/industry and amateur radio operators into the communications network.

h. Develop and maintain SOPs to include message-handling procedures and recall rosters for essential personnel.

i. Switchboard Operators will be:

Responsible for proper screening and routing of all incoming telephone calls. Maintaining awareness of emergency response entities and appropriately triaging incoming calls and routing to the appropriate person.

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 approximately ### city, county, state, and federal, in Virginia.

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

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.

VIII. ADMINISTRATION AND SUPPORT

A. Facilities and Equipment

A complete listing of equipment is included in Appendix 1 of Annex M.

B. Preservation of Records

Vital records should be protected from the effects of disaster to the maximum extent feasible. Should records be damaged during an emergency situation, professional assistance in preserving and restoring those records should be obtained as soon as possible.

C. Communications Protection

1. Telephone (Common Carrier)

   a. Overloaded Circuits

      To maintain access to phone circuits, Emergency responders are encouraged to secure adequate numbers of GETS cards

   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.

D. Support

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

IX. ANNEX DEVELOPMENT AND MAINTENANCE

A. The MCIRC Communications Workgroup will be responsible for maintaining this annex.

B. This annex will be updated in accordance with the schedule outlined in Section X of the Basic Plan.

X. REFERENCES

A. Federal Emergency Management Agency (FEMA), 1996. Guide For All-Hazard Emergency Operations Planning. (SLG-101)

B. Division Of Emergency Management *Local Emergency Management Planning Guide.* (DEM-10)

APPENDICES

Appendix 1 ..... Communications Diagram & Table

Appendix 2 ..... Standard Messaging Guide

Appendix 3 ..... INTEROPERABILITY: Tac Channel Designation

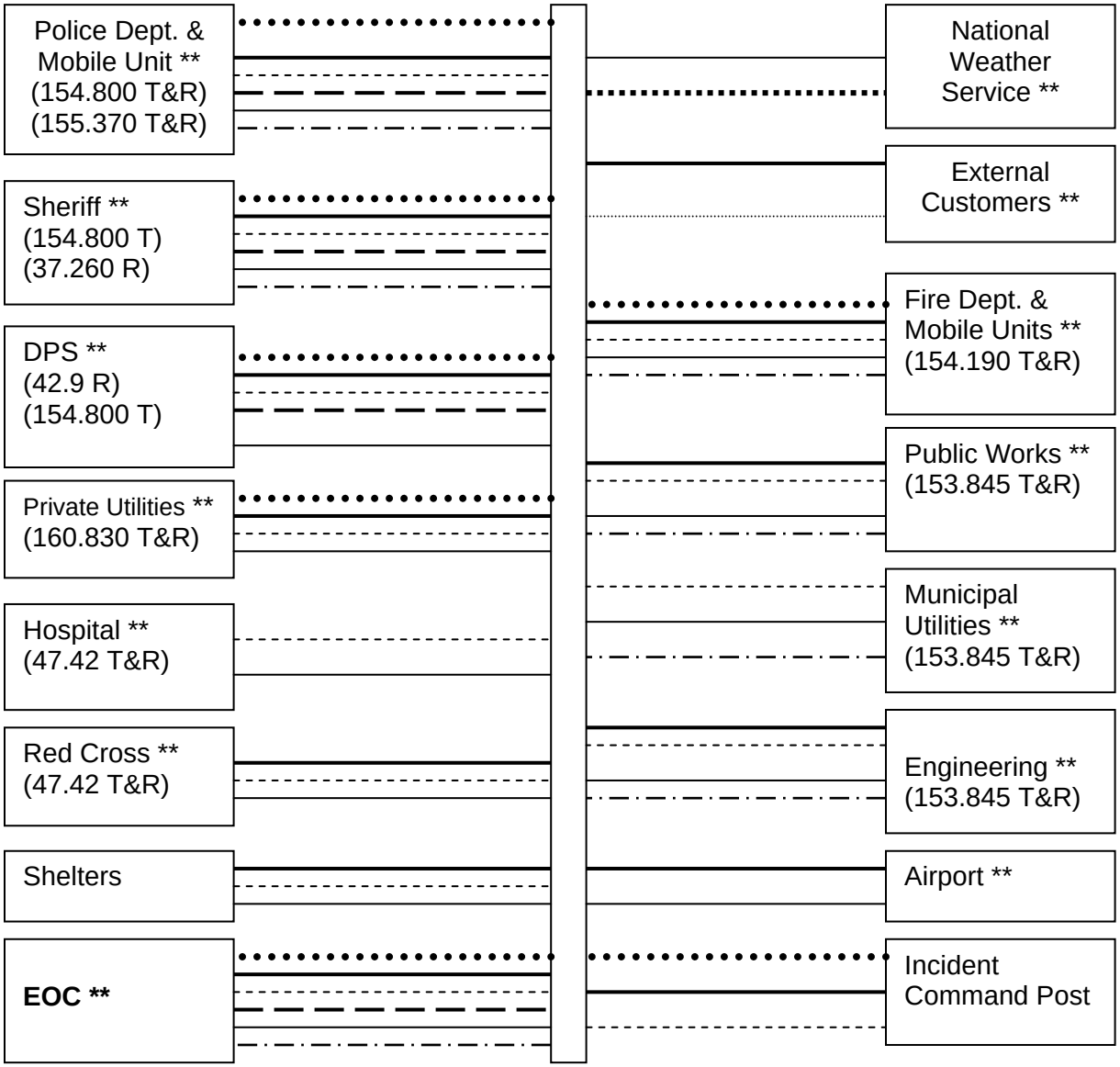
SUPPORTING DOCUMENTS

1. Common Communications SOP

2. Communications Restoration Guide

3.

COMMUNICATIONS DIAGRAM



LEGEND:

----------	Radio	•••••••••	Satellite Phones
.....	CATV or Satellite	———	Cell Phones
———	Telephone and/or Fax	R	Receive Only
— — —	STARS	T	Transmit Only
.....	RACES	T&R	Transmit and Receive
-·—·—·—	Local Computer Network	**	Internet Access & E-mail

XI. COMMUNICATIONS GUIDE

FACILITY	COMMUNICATIONS									
	RIOS	Phone/ Fax	STARS	RADIO 800MHz	RADIO VHF	RADIO UHF	Cell Phones	Satellite Phones	VHASS WEB EOC	Internet E-mail
Roanoke Airport		X					X			X
Roanoke County EMS / EOC	X	X		X			X	X	X	X
Franklin County EMS/EOC	X	X			X		X	X	X	X
EOC	X	X	X	X	X	X	X	X	X	X
External Customers (Citizens, Private Industry)		X		X	X	X	X			X
Fire Department & Mobile Units		X			X		X	X	X	X
Hospital		X			X					X
Municipal Utilities		X			X				X	X
National Weather Service	X	X	X							X
Police Department & Mobile Units	X	X	X		X		X	X	X	X
Private Utilities		X			X		X	X		X
Public Works		X			X		X		X	X
Red Cross		X			X		X			X
Shelters		X			X					
Sheriff's Office	X	X	X		X		X	X	X	X

XII. 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. Hospital provides agency with bed count and capabilities to receive patients

3. Notice to RHCC: To be completed by an EMS Agency on scene of or enroute to a confirmed or possible Mass Casualty incident
3.1. Agency notifies the RHCC via Emergency Number. The Agencies dispatch center may perform this task.
3.2. RHCC obtains vial 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 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 Liason officer or other designee will document staff names and affiliated EMS Unit / Agency for documentation and tracking purposes

5. Notice to the Regional PIO Team: To be completed by the leade response agencies PIO
5.1. Sit rep will be transmitted thru the XXX means
5.2. Collaboration will be faciliatated thru VHASS WebEOC
5.3. Telephone Numbers for the JIC will be provided via XXX means

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

7.

8. This annex will be updated in accordance with the schedule outlined in Section X of the Basic Plan.

XIII. INTEROPERABILITY: Tactical Channels designation

This guide will outline Tactical Channels and Interoperable plans for communication by Municipality. Each municipality listed will be responsible for updating the MCIRC Communications workgroup should channels or radio assets change. In many cases, Connections must be made in order to create links between VHF, UHF and 800MHz systems. The responsible party for making these connections is listed in each Municipality Description.

Roanoke County

Primary System: 800MHz Digital Trunked Motorola
Contact: Rodney Thompson, Communications Coordinator

First MCI Medical Channel for Operations: Tac XX (856.9…)
Second MCI Medical Channel for Transport Sector: Tac XX (859.4675)

UHF First Patch frequency and channel name: Roanoke Med 9 (469.9999)
Frequency is Repeated from Tinker Mountain. Frequency is monitored by Roanoke City Dispatch, RHCC Dispatch Center (CCPT), and Carilion Roanoke Memorial Hospital MedCom.

UHF Second patch frequency and channel name: U TAC 91 (466.9999)
Frequency is Repeated from XXXX

VHF First Patch Frequency: V TAC 91 (155.1111)
Frequency is Repeated from XXXX ?

Entity responsible for creating Radio patch:
Roanoke County Dispatch Center

First Alternate for creating Radio Patch:
Roanoke City Dispatch center

Second Alternate for creating Radio Patch:
RHCC Dispatch Center

Instructions:
Patch the X radio channel with X…