WVEMS BOARD OF DIRECTORS
December 13, 2012
Salem Civic Center, Parlor B
2:00 PM

1. Call to Order
2. Introduction of Guests:
3. Secretary's Report - Sept 2012 Board Meeting Minutes - Complete
4. Treasurer's Report
    a. Presentation of Audit - John Hash, Brown Edwards CPAs 2012 Draft Financials
    b. Periodic Financial Report Treasurers Report Nov 2012
5. Reports and Action Items
    a. Executive Committee Sept 2012 Exec Comm Minutes Oct 2012 Exec Comm Minutes
        1. Revisions to Personnel Policies
        2. Benny Summerlin Award of Excellence Benny Summerlin Award of Excellence
        3. Bylaw amendment - Bylaw Amendments_markup Draft Bylaws-Clean Committee Structure_Draft
    b. Medical Direction
        1. Protocol Project Update - Cathy Cockrell
    c. Allied Resources and Pharmacy Committees Allied Resources Dec 2012 Pharmacy Dec 2012
    d. Communications Committee
    e. Performance Improvement Committees (meet same day as Board)
        1. Approval of Updated Stroke Triage Plan (Committees meet same day as Board Meeting)
    f. Near Southwest Preparedness Alliance (NSPA)
    g. State EMS Advisory Board Report Advisory Board Report - Dec012
6. EMS Financial Assistance - RSAF FARC RECOMENDED January 2013 awards **NOTE - RECOMMENDATIONS ONLY. AWARDS NOT APPROVED UNTIL OEMS ADVISES IN JANUARY
7. New Business
    a. Nominating Committee Report - Election of Officers and Directors Nominating Committee Report - Dec 2012
    b. Continuity of Operations Plan COOP_rev 2013_draft

c. Annual Report - Annual Report FY 2012 Draft

d. MCI Committee - Update MCI Plan Draft 3

e. Quarterly Report to OEMS OEMS Qtr Report FY 2013 1st Qtr 4th Q FY 12 Deliverables Review

8. President's Report

9. Staff Reports

10. Adjourn

WESTERN VIRGINIA EMERGENCY MEDICAL SERVICES COUNCIL
BOARD OF DIRECTORS

DRAFT MEETING MINUTES

DATE: December 13, 2012

LOCATION: Salem Civic Center – Parlor C

Directors Present
Billy Altman
John Beach
Bill Brown
Jim Cady, Sr.
Steve Davis
Tim Dick
Steve Eanes
Jason Ferguson
Carey Harveycutter
Daryl Hatcher
Rickey Hodge
Mike Jefferson
Charles Lane
Danielle Lissberger
Rob Logan
Ryan Muterspaugh
Kris Shrader
Lee Simpkins
Joe Trigg
Dale Wagoner
Ford Wirt

Staff Present
Charles Berger
Mary Christian
Gene Dalton

Guests Present
Dallas Taylor
John Hash

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

He introduced guests: Dallas Taylor, soon to become the Emergency Nurses Association representative on our board, and John Hash from Brown Edwards, our accounting firm.

He also introduced our new director representing the Fourth Planning District at large, Mr. Bill Brown.

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

Carey Harveycutter and Mary Christian introduced John Hash of Brown Edwards, our auditors, to present the FY 2012 financial report. John reviewed the financial reports, noting that there were no reportable conditions. He thanked the staff and especially Mary Christian for their cooperation and assistance provided during the audit.

Treasurer Harveycutter called for a motion to approve the financial report. It was moved and seconded that the FY 2012 financial reports be approved as presented. **MOTION CARRIED.**

He then presented the FY 13 year to-date report (August 31). He noted that all accounts were within expectations.

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 will soon consider some technical revisions to the council's employee handbook, based on recommendations of SESCO, our HR consultants.

The Executive Committee has reviewed a proposal from Vice President Steve Eanes to create the "Benny Summerlin Award of Excellence." The proposed award guidelines were included in the agenda packet and are moved for adoption by the committee. **MOTION CARRIED.**

The Executive Committee has reviewed bylaw changes as presented in the agenda packet, and as emailed to the board on November 20. The changes address a revision to the committee structure, and a change to elect the ED physician at large board seat. It was moved and seconded to adopt the amendments as distributed and recommended. **MOTION CARRIED.**

MEDICAL DIRECTION COMMITTEE

Charles Berger reported for the regional medical direction committee on the status of the protocol project. Some basic rollout training programs have been scheduled and many more will follow. The actual protocols are complete and final formatting is underway to go to the printer soon. The protocols have been posted on the WVEMS website. A Frequently Asked Questions section will be periodically updated on the website.

Rob acknowledged the outstanding assistance provided by Paramedic/Nurse Nathan Davis in developing the .pdf version of the manual.

ALLIED RESOURCES and PHARMACY COMMITTEES

Allied Resources and Pharmacy met on November 29. The Allied Resources committee approved drug box and supply item changes necessary to implement the new protocols. The committee also approved a revision to the Restocking Agreement's Appendix 1 relating to restocking of supplies for "Community Assist" and "Helicopter Assist" to require supply exchanges within 48 hours.

The Pharmacy Committee developed a plan to implement the drug box exchanges. Dr. Lane spoke on the processes that were developed to implement changes to support the new protocols.

COMMUNICATIONS COMMITTEE

Rob Logan reported for the committee concerning the Alleghany radio replacement project. We are still awaiting Quiet Zone approval of an antenna that will meet restrictions. FARC approved funding for replacement repeaters and a generator for the two Alleghany sites.

The Tinker Mountain tower inspection recommended re-tensioning of the guy wires, and a quote of $2,670 was received. Tree work to clear brush will be required first. Botetourt County will participate in the cost. Roanoke County has not responded to a similar request. Rob and Gene are meeting a tree contractor next week to obtain a price quote for the work.

PERFORMANCE IMPROVEMENT COMMITTEES

Charles Berger reported for the General and Trauma Performance Improvement Committees. Both met today.

Minor **r**evisions to the Trauma Triage Plan were recommended (copy attached to and made a part of these minutes). The plan will be reformatted to more easily differentiate region-specific content to assist in reporting to the Office of EMS. Upon motion and duly seconded, the proposed revisions to the Trauma Triage Plan were approved and the plan was adopted.

Minor **r**evisions to the Stroke Triage Plan were recommended (copy attached to and made a part of these minutes). The plan will be reformatted to more easily differentiate region-specific content to assist in reporting to the Office of EMS. Upon motion and duly seconded, the proposed revisions to the Stroke Triage Plan were approved and the plan was adopted.

NSPA

Danielle Lissberger reported for NSPA. She informed the board of additional non-hospital coalition funding that had been awarded. Also, NSPA was awarded funds to purchase two med-surge supply trailers and to hire an employee to work on coalition-building and RHCC coordination. She also announced the roll-out of a newly-designed website.

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 advised the board of the importance of completing the EMS Needs Assessment that was recently distributed.

EMS FINANCIAL ASSISTANCE

A report on recommended awards for the December 2012 cycle is included in the agenda packet.

A request was submitted by the Regional Directors Group for a day and a half long Board Leader and Administrator summit, proposed to be held in Roanoke, to share best practices relating to fiscal policies, coalition building, and other matters of common interest. However, based on poor scoring by OEMS staff, it was not funded.

NEW BUSINESS

The report of the nominating committee was presented.

Directors	
(three year terms)	
Emergency Physician at-large	Karen Alldredge, MD
Fourth Planning District at-large	Bill Brown

The floor was opened for additional nominations. Being none, it was moved and seconded to elect the directors as nominated by the committee. **MOTION CARRIED.**

Officers	
(two year terms)	
President	Ford Wirt
Vice President	Steve Eanes
Secretary	Steve Simon
Treasurer	Carey Harveycutter
Fourth Planning District at-large	Joe Trigg
Fifth Planning District at-large	Jim Cady
Twelfth Planning District at-large	Dale Wagoner

The floor was opened for additional nominations. Being none, it was moved and seconded to elect the officers as nominated by the committee. **MOTION CARRIED.**

The Continuity of Operations Plan was included in the agenda packet. Revisions were made only to the sections regarding IT security and contact information. It was moved and seconded to adopt the COOP as revised. **MOTION CARRIED**

The FY 2012 Annual Report was presented. All content is complete, but some formatting changes might be made. It was moved and seconded to accept the report. **MOTION CARRIED.**

PRESIDENT'S REPORT - none

STAFF REPORTS

Rob Logan – Reminded directors to begin review of the WVEMS Strategic Plan to be considered at the next meeting.

Rob called the board's attention to the most recent draft of the regional MCI plan. It is expected to be presented for adoption at the next meeting.

Mary Christian - none

Charles Berger - none

Gene Dalton – none

OTHER BUSINESS
None

HEARING OF THE PUBLIC

Being no further business, the meeting was adjourned at 2:40 PM.

/s Robert Logan, Executive Director

WESTERN VA EMS COUNCIL
UNAUDITED TREASURER'S REPORT
AS OF
NOVEMBER 30, 2012

REVENUES	BUDGET	TOTAL	% YTD
STATE GOVERNMENT (OEMS CONTRACT)	416,190	105,948	25.46%
LOCAL GOVERNMENT	120,000	127,789	106.49%
UNITED WAYS	2,000	1,115	55.77%
CONTRIBUTIONS	2,000		0.00%
NSPA/VHHA REVENUE	220,000	117,512	53.41%
DIRECT PROGRAM INCOME (Tuitions, grants, VDH/OEMS)	165,000	57,330	34.75%
DIRECT MRC INCOME	55,000	28,715	52.21%
CISM REVENUE			
NSPA OFFSET REVENUE (Contract for services)	8,000	7,227	90.33%
RENT INCOME (NSPA)	18,000	6,250	34.72%
INVESTMENT / GAINS/LOSSES	3,000	5,566	185.52%
MISCELLANEOUS/SPECIAL FUNDS		0	
TOTAL REVENUES	1,009,190	457,451	45.33%
EXPENDITURES	**BUDGET**	**TOTAL**	**% YTD**
SALARIES / WAGES (WVEMS)	371,000	173,682	46.81%
PAYROLL TAXES (FICA)	27,203	12,731	46.80%
VEC	450	42	9.34%
403(b) / RETIREMENT	20,250	7,486	36.97%
HOSPITAL / MEDICAL INSURANCE	47,000	20,052	42.66%
LIFE INSURANCE/DISABILITY	10,000	3,888	38.88%
DENTAL INSURANCE	3,400	1,043	30.68%
PROFESSIONAL SERVICES/FEES	8,000	8,240	103.00%
MEDICAL DIRECTION ASSISTANCE	1,000		0.00%
MAINTENANCE / REPAIRS / SERVICE CONTRACTS	2,500		0.00%
OCCUPANCY (Utilities, repairs, NRV rent etc.)	16,000	7,514	46.96%
POSTAL / SHIPPING	2,000	307	15.36%
TELECOMMUNICATIONS	10,500	4,418	42.08%
SUPPLIES (ADMIN)	6,587	1,317	20.00%
EQUIPMENT	5,000	1,490	29.80%
INSURANCE	7,500	3,262	43.49%
DIRECT NSPA/VHHA EXPENSE	195,000	114,576	58.76%
DIRECT PROGRAM EXPENSES	150,000	44,111	29.41%
DIRECT MRC EXPENSES	55,000	23,728	43.14%
PRINTING / PUBLICATIONS	14,000	2,233	15.95%
TRAVEL / LODGING	7,000	617	8.82%
FUEL/VEHICLE MAINTENANCE	10,000	5,270	52.70%
MEETING SUPPORT	1,200	150	12.51%
DUES / MEMBERSHIP FEES	1,200	555	46.25%
STAFF DEVELOPMENT	9,000	3,544	39.37%
CISM PROGRAM COSTS	2,000	436	21.81%
COMMUNICATION SITE RENTAL	8,100	3,375	41.67%
COMMUNICATIONS WIRELINES	7,500	3,269	43.59%
COMMUNICATIONS MAINTENANCE	2,000	1,400	70.00%
COMMUNICATIONS UTILITIES	800	161	20.10%
COMMUNICATIONS INSURANCE	3,000	1,250	41.67%
COMMUNICATIONS EQUIPMENT	5,000		0.00%
TOTAL EXPENDITURES	1,009,190	450,145	44.60%

BOARD APPROVED ITEMS BOUGHT WITH RESERVE:

ID CARD PRINTERS (2) AND SUPPLIES	5,677
PARKING LOT PAVING	1,825

NSPA-VHHA

REVENUES (NSPA ACCOUNTS)	TOTAL
SPECIAL GRANTS / HOSPITAL FOUNDATIONS	49,257
TOTAL REVENUES	49,257
EXPENDITURES (NSPA ACCOUNTS)	**TOTAL**
SALARIES -NSPA	41,981
PAYROLL TAXES (FICA) - NSPA	2,979
BENEFITS - NSPA	4,246
VEC - NSPA	
TOTAL EXPENDITURES	49,206

REVENUES (VHHA ACCOUNTS)	TOTAL
VHHA FUNDING	
TOTAL REVENUES	68,255
EXPENDITURES (VHHA ACCOUNTS)	**TOTAL**
SALARIES - VHHA	51,135
PAYROLL TAXES (FICA) - VHHA	3,888
BENEFITS - VHHA	2,125
MISC. - VHHA	8,222
TOTAL EXPENDITURES	65,369

PROGRAM

REVENUE (PROGRAM ACCOUNTS)	TOTAL
OEMS FUNDS - INTERMEDIATE	6,120
OEMS FUNDS - ENHANCED	
OEMS FUNDS - ADJUNCT	2,880
OEMS FUNDS - CARDIAC	
OEMS FUNDS - CT TRANSITION	
OEMS FUNDS - SHOCK TRANSITION	
OEMS FUNDS - ALS CE	560
PROGRAM SERVICE FEES	1,200
PROTOCOL, ETC. SALES	21
TEXTBOOK SALES	6,000
CONSOLIDATED TESTING	3,010
DRUG BOX ENTRANCE FEES	550
GRANTS & SPECIAL PROJECTS	6,252
SALES - CONSUMER GOODS	
WEB DATABASE	
PROCESSING FEES	
PROGRAM FEES - MONROE HEALTH CENTER	2,193
PROGRAM TUITION - INTERMEDIATE	
PROGRAM TUITION - ENHANCED	
PROGRAM TUITION - ADJUNCT	2,205
PROGRAM TUITION - CARDIC	
PROGRAM TUITION - OTHER	
PROGRAM TUITION - NRVTC	22,308
ID CARD SALES	249
COMMUNITY COLLEGE COURSE REVENUE	3,783
TRAVEL/TOWING CONTRACT REVENUE	
TOTAL REVENUES	57,330

EXPENSES (PROGRAM ACCOUNTS)	TOTAL
CONTRACTS FOR SERVICES (INTERMEDIATE)	
CONTRACTS FOR SERVICES (ENHANCED)	
CONTRACTS FOR SERVICES (ADJUNCT)	1,650
CONTRACTS FOR SERVICES (CARDIAC)	
CONTRACTS FOR SERVICES (SPEC. PROJ.)	
CONTRACTS FOR SERVICES (ALS TEST)	5,813
CONTRACTS FOR SERVICES (CTS)	2,741
CONTRACTS FOR SERVICES (CE WEEKENDS)	
CONTRACTS FOR SERVICES (DRUG TESTING)	960
CONTRACT FOR SERVICES (MONROE HEALTH CENTER)	2,038
PAYROLL TAXES (FICA)	936
VEC	420
POSTAGE (NRVTC)	3
SUPPLIES (Programs)	698
SUPPLIES (CTS)	248
SUPPLIES (ALS TESTING)	318
SUPPLIES (EDUCATION)	
SUPPLIES (NRVTC)	4,095
SUPPLIES (MONROE HEALTH CENTER)	
TEXTBOOKS (ALS)	803
TEXTBOOKS (BLS)	
TEXTBOOKS (ITLS)	1,631
TEXTBOOKS (NRVTC)	8,622
TEXTBOOKS (MONROE HEALTH CENTER)	120
EQUIPMENT (BLS)	167
EQUIPMENT(BLS TESTING)	
EQUIPMENT (ALS TESTING)	
EQUIPMENT (EDUCATION)	
INSURANCE	550
TRAVEL (MONROE HEALTH CENTER)	
PRINTING / PUBLICATIONS (EDUCATION)	252
PRINTING / PUBLICATIONS (NRVTC)	
AMLS CERTIFICATES AND CARDS	135
GRANTS & SPECIAL PROJECTS	5,856
DRUG BOX EXCHANGE	
CREDIT CARD DISCOUNT	1,516
MERCHANDISE FOR RESALE	563
ID CARD PROGRAM	194
RETENTION PROJECT	
COMMUNITY COLLEGE FEES	3,783
TUITION REIMBURSEMENT - ENHANCED	
TUITION REIMBURSEMENT - INTERMEDIATE	
TRAVEL/TOWING CONTRACT EXPENSE	
TOTAL EXPENDITURES	44,111

MRC

REVENUE (MRC ACCOUNTS)	TOTAL
PROGRAM MANAGEMENT - MRC	25,000
COST REIMBURSEMENT - MRC	3,715
TOTAL REVENUES	28,715
EXPENSES (MRC ACCOUNTS)	**TOTAL**
SALARIES AND WAGES - MRC	16,778
FICA EXPENSE - MRC	1,284
VEC - MRC	
HOSPITAL MEDICAL - MRC	1,802
DENTAL INSURANCE - MRC	149
POSTAGE - MRC	
TELECOMMUNICATIONS - MRC	369
SUPPLIES - MRC	39
PROMOTIONAL - MRC	
TRAINING SUPPLIES - MRC	1,430
EQUIP-MRC	
TRAVEL/LODGING - MRC	1,085
DUES & MEMBERSHIPS - MRC	
STAFF DEVELOPMENT	792
MEETING SUPPORT - MRC	
TOTAL EXPENDITURES	23,728

WESTERN VIRGINIA EMS COUNCIL, INC.
Balance Sheet
November 30, 2012

ASSETS

Current Assets			
PETTY CASH	$ 69.59		
FSA CASH	1,024.57		
MUTUAL BOARD DESIGNATED	6,119.95		
SUNTRUST CHECKING	212,941.07		
SUNTRUST PAYROLL	200.00		
VALLEY BANK MONEY MARKET	65,402.12		
PREPAID EXPENSES	8.69		
ACCOUNTS RECEIVABLE	64,801.45		
DUE FROM NSPA	10,703.56		
Total Current Assets			361,271.00
Property and Equipment			
Total Property and Equipment			0.00
Other Assets			
ARC III REIT	26,028.35		
FRANKLIN TEMPLETON	100,280.37		
COMMUNICATIONS EQUIPMENT	51,757.66		
MISCELLANEOUS EQUIPMENT	265,591.74		
OFFICE EQUIPMENT	41,879.86		
BUILDING	175,223.00		
LAND	201,600.00		
BLDG. IMPROVEMENTS	64,232.94		
GENERATOR BUILDING & EQUIPME	11,402.25		
ACCUMULATED DEPRECIATION	(274,598.97)		
Total Other Assets			663,397.20
Total Assets		$	1,024,668.20

LIABILITIES AND CAPITAL

Current Liabilities			
ACCOUNTS PAYABLE	$ 1,156.81		
CLEARING ACCT (UNCASHED CHEC	290.00		
ACCRUED SALARIES	28,590.10		
FLEX SPENDING ACCOUNT-MEDIC	1,427.00		
FLEX SPENDING ACCT-DEPENDENT	706.75		
DEFERRED REVENUE	18,516.20		
Total Current Liabilities			50,686.86
Long-Term Liabilities			
Total Long-Term Liabilities			0.00
Total Liabilities			50,686.86
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	48,343.72		

WESTERN VIRGINIA EMS COUNCIL, INC.
Balance Sheet
November 30, 2012

Total Capital		973,981.34
Total Liabilities & Capital	$	1,024,668.20

Trauma Triage Plan

The Trauma Performance Improvement Committee moves for re-adoption of the 2012 Trauma Triage Plan with the following changes.

- Adopting the 2011 CDC Field Triage Decision Scheme and moving it from within the Plan to an Appendix.
- Updating the helicopter list and moving it to an Appendix.
- Move other reference materials to Appendices to allow their regular updates and fit the plan within the template of the State Plan

Above per a meeting of the Trauma Performance Improvement Committee on 12-13-12

Stroke Triage Plan

The Performance Improvement (General) Committee moves for re-adoption of the 2012 Stroke Triage Plan with the following changes.

- Update the Designated Stroke Centers list to include Lewis-Gale Medical Center and move the list from the plan to an Appendix.
- Change Appendix C to the new 2012 Medical – Stroke/TIA Protocol 49
- Adjust the plan as necessary to fit within the template of the State Plan

Above per a meeting of the Performance Improvement (General) Committee on 12-13-12

AGENCY	ITEM	WVEMS Exec Cmtte Score	FARC Cmtte Score	Amount Requested	Amount Awarded (Suggested)	Comments
Roanoke County Fire & Rescue	Mechanical CPR Device	1	1.50	$7,642.50	$7,413.50	
Botetourt County	Ford 4WD Type 1 Ambulance	3	3.00	$155,798.40	$0.00	Awards stopped at 2.83
	15 - Panasonic Toughbook Computers	3	2.67	$28,755.00	$12,336.00	Funded quantity of 8 at State Maximum
Fincastle Rescue Squad	Ford 4WD Type 1 Ambulance	3	3.50	$97,374.00	$0.00	Awards stopped at 2.83
Mount Hermon Volunteer Fire Dept	Philips Heartstart Marx Monitor	3	3.50	$17,280.76	$0.00	Awards stopped at 2.83
Franklin County	Retention Focused Leadership Training	2	2.17	$22,777.60	$19,168.00	
Brosville Community Volunteer Fire Dept	Hurst High Pressure Air Bags / Stabilization Kit	2	1.83	$6,759.50	$6,759.50	WVEMS had graded together, FARC graded seperately, both 1.83
	Panasonic Toughbook Computer	3	3.17	$1,693.00	$0.00	Awards stopped at 2.83
	Laerdal Compact Suction Unit	5	4.00	$295.00	$0.00	Awards stopped at 2.83 (also less than $500 min)
Craig County - New Castle Vol Fire Dept	Hurst Equipment and Stabilization Kit	1	1.50	$31,008.00	$31,008.00	
	Protective Gear (10 sets)	1	1.67	$4,668.00	$4,668.00	
Falling Springs Rescue Squad	Type 1, 4x4 Ambulance	3	3.17	$146,895.20	$0.00	Awards stopped at 2.83
Christiansburg Rescue Squad	4 - Masimo SpCo / SpO2	2	2.50	$8,188.00	$4,094.00	Funded quantity of 2
	10 - Philips Heartstart MRx Monitor Defib (AED)	2	2.33	$8,001.50	$8,001.50	
	4 - Lucas2 Chest Compression	3	2.50	$24,037.62	$6,509.41	Funded quantity of 1
Town of Vinton	Stryker Power Pro Stretcher	2	2.00	$5,620.29	$5,620.29	
JEB Stuart Rescue Squad	3 - Physio-Control/Lifepak 15 monitor	4	3.67	$70,348.00	$0.00	Awards stopped at 2.83
Patrick Henry Volunteer Fire Dept	12 Lead ECG Monitor with AED	1	1.50	$22,988.76	$22,988.76	
Danville Life Saving & First Aid Crew	International Navistar Trauma H (Type 1 Amb)	2	3.83	$98,415.00	$0.00	Awards stopped at 2.83
Sharon Volunteer Fire Department	3 - Panasonic Toughbook Computers	1	1.67	$6,436.80	$4,291.20	Quantity reduced from 3 to 2
Boiling Springs Vol Fire Dept & Rescue Sqd	Type 1 Ambulance	1	2.67	$131,768.00	$128,000.00	Funded at State Maximum
CCDF Volunteer Fire Department	2012 Ambulance, Type 1	2	2.33	$135,715.20	$128,000.00	Reduced to State Maximum
	2 - Stretchers (Stryker PowerPro XT)	2	2.17	$9,657.60	$4,828.80	Funded 1 at 1/2 of total requested for 2
Cave Spring First Aid & Rescue Squad	2 - Stretchers (Stryker PowerPro XT)	2	1.83	$12,734.70	$12,465.00	Funded at State Maximum
Virginia Tech Rescue Squad	Repeaters and Infrastructure	1	4.50	$60,000.00	$0.00	Awards stopped at 2.83, Also not P25 compliant
Shawsville Volunteer Rescue Squad	2 - E Series Defibrillator	3	2.17	$68,580.00	$16,474.00	Funded 1 at 50/50 at State Maximum
	4 - Zoll Autopulse System	4	3.33	$61,140.00	$0.00	Awards stopped at 2.83
Bassett Volunteer Fire Department	Set of Assorted Rescue Tools	1	2.00	$19,904.00	$19,904.00	
Henry County	4x4 Type 1 ambulance	1	1.50	$135,549.60	$128,000.00	
	Stretcher-Power Lift Style	2	1.83	$10,400.84	$9,972.00	Awarded at State Maximum
Fieldale-Collinsville Volunteer Rescue Squad	Extrication/Quick Response Vehicle	5	4.50	$100,000.00	$0.00	Awards stopped at 2.83
	Pediatric EMS Training Package	4	3.67	$6,499.50	$0.00	Awards stopped at 2.83
Bassett Rescue Squad	4 - Stryker Power Lift Stretchers	2	2.00	$41,039.36	$6,232.50	Funded 1 at 50/50 at State Maximum
Dyers Store Volunteer Fire Department	Extrication Tools	5	3.33	$40,427.99	$0.00	Awards stopped at 2.83
Ridgeway District Volunteer Rescue Squad	2 - Ambulance Stretchers (PowerPro)	2	2.00	$21,410.53	$6,232.50	Funded 1 at 50/50 at State Maximum
Western Virginia EMS Council - CISM	Training Projects	N/A	2.0 - 2.5	$5,696.00	$5,696.00	
Western Virginia EMS Council	2 - Comunications equip (Med Channel repeaters)	N/A	4.17	$10,423.36	$0.00	Awards stopped at 2.83, Also not P25 compliant
				$1,635,929.61	**$598,662.96**	**36.6% - Awarded percentage of Requested**
				18.4%	**13.9%**	
				WVEMS percentage of overall requests	WVEMS percentage of overall awards	

General Notes

Approximately 180 applications with 277 individual line items
Approximately 8.9 million in requests
$4,320,755 to award this cycle

ANNEX XX

Regional Mass Casualty Incident Plan

OF THE

Western Virginia EMS Council
Blue Ridge EMS Council
Near Southwest Preparedness Alliance

Ver 2.0
9/12

APPROVAL & IMPLEMENTATION

Annex XX

Regional Mass Casualty Incident Plan

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

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

RECORD OF CHANGES

Annex XX

Regional MCI Plan

Change #	Date of Change	Entered By	Date Entered

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ANNEX XX

REGIONAL MCI PLAN

I. AUTHORITY

A. Regional

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

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

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

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

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

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

B. Local

1. **Interlocal Agreements and Contracts.**

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

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

    b. Copies of the Regional MCI Plan shall be provided to each locality and hospital either through WVEMS, BREMS or NSPA. A copy of the plan should be maintained within each Hospital and all licensed EMS commander vehicles. The field guide is maintained 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.

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

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

II. PURPOSE and SCOPE

A. Purpose

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

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

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

for next-level support for incidents in scope and significance that surpass the capabilities addressed in a local plan.

B. Scope

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

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

III. EXPLANATION OF TERMS

A. Acronyms

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

B. Definitions

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

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

3. Hazardous Materials. Define here.

4. Inter local agreements. Define here.

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

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

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

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

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

10. START & JumpSTART. Define here.

11. VHASS. Virginia Healthcare Alerting and Status System

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

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

IV. SITUATION & ASSUMPTIONS

A. Situation

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

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

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

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

B. Assumptions

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

2. In most multiple or mass casualty incidents (MCIs), the following ICS functions/positions should be staffed: incident command, staging area, extrication, triage, treatment and transportation. In a small scale incident, one person may assume more than one function, (i.e., triage and treatment may be done by the same person or transportation and staging may be handled by the same person.) In a larger incident, the Incident or Unified Commander may establish a Medical Group or Medical Branch to oversee some or all of the above functions. The RHCC and the hospitals involved will interact with and support the Medical Branch as requested by the Unified Command. In multi area events or widespread disaster situations, the RHCC may serve as the Medical branch if requested by Unified Command.

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

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

5. 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, regional 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.

6. 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.

7. 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.

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

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, as well as EMS transported patients received, 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. The coordinating Emergency room will interact with the RHCC to verify bed availability and transport destinations.

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.

12. 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).

V. CONCEPT OF OPERATIONS

A. Objective

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

B. General

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

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

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

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

5) Managing MCIs can produce significant stressors for responders and the community. CISM Teams comprised of volunteers within the region are available and are encouraged to be used to by agencies for post-incident stress management. These services are free and confidential and free to the emergency services community. Teams for each EMS Council have their own activation

procedures. WVEMS 24/7 Dispatch: 1-888-377-7628; BREMS CISM Team: 434 947 5934 or by email: **Janet Blankenship** [j.blankenship@bedfordcountyva.gov]; **Meg Cosby** [MCosby@depaulfamilyservices.org]-or- [MCosby@depaulcr.org]

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

7) Mass Casualty Incident Management Goals

Manage scarce resources. 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.

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. In large events, some victims are likely to leave the scene and seek shelter and/or treatment at medical facilities nearby the scene. 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 or affected medical facilities (such as urgent cares and physician offices). It is essential that communications be established with the one or two Emergency Departments closest to the incident scene and the RHCC as quickly as possible. Effective scene to hospital and scene to RHCC communications, combined with triage will ensure that patients will be distributed to the appropriate receiving hospital, in the correct order and quantity.

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

and NSPA will support regional training activities and as able, equipment purchases in support of this plan.

9) 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, agencies may suspend select routine functions.

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

1. Levels for MCI Response

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

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.

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 work collaboratively with Emergency Department MedComs to provide patient placement support for this level.

Resources: Plan activation strongly recommended

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

A medical disaster of this magnitude is considered catastrophic and will require broad support from multiple entities.

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

Resources: Plan activation strongly recommended

2. **Initial Response.** Our Emergency Medical Services and Fire Services 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. Through 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. In most MCIs, a MAC is the most common and acceptable type of Incident Command structure, given the number of agencies involved in mitigation.

   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 hospitals proximate to the Scene, and if indicated per section 1 "Levels of MCI Response", the RHCC.

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

   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 10 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 7.
3) Request Regionally controlled assets through the appropriate entity
   a) NSPA RHCC may be used to request assets that are owned or known (regional hospital, and other entities). (Attachment 7)
   b) VDH Medial Reserve Corps can be requested thru the RHCC, or by contacting the VDH Emergency Planner directly for each district (Attachment 1 contact list).
   c) Chempacks locate at regional hospitals may be requested. Attachment 12 details the request process for each chempack.
4) Request State controlled assets through VDEM (1-800-468-8892)
   a) VDEM May be use to request assistance from volunteer groups active in disasters.
5) 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, hospital, or jurisdiction policies and standard operating procedures. State and Federal resources must be requested via your local jurisdiction's Emergency Operations Center (EOC). The request will then be sent to the Virginia State Emergency Operations Center (VaEOC) by calling 1-800-468-8892.

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

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

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

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. *HOW*

5. Activating the Plan

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

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

3. The decision to activate the plan will engage the NSPA RHCC and Regional Healthcare entities, including Hospitals, Long Term Care, Behavioral health, OCME, EMS agencies, etc. Activation of the plan will provide for mutual aid ambulances (and other resources), initiate a bed status update for all 16 NSPA region hospitals, allow for readiness steps to be taken by receiving hospitals, and provide for regional situational awareness.

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

    a. SUGGESTED ACTIVATION GUIDANCE: The plan should be activated (By EMS or by Hospital) and the RHCC should be consulted and assist as the regional guide for patient capacity and placement for EMS when any of the below conditions are met:

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

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

    a. Entity (Locality, Agency, EOC) requesting MCI Plan activation
    b. Call Back Number
    c. Radio channel being utilized (Channel Name)
    d. Tier and if possible, number of Red/Yellow/Green patients
    e. Needs (Such as patient placement or resources)

- Please specify to the Dispatcher whether or not you will need patient placement support and the Emergency Room(s) that have already been contacted

f. Actions you've taken so far (Such as calling a local Emergency Room, Deploying a MCI trailer, or notifying a neighboring Jurisdiction)
g. A brief summary of the incident to include "What happened"

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

D. 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

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

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

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

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

1. For major emergencies and disasters, the on scene Incident Command, Local Emergency Operations Center (EOC), Affected Hospital EOCs, and the RHCC will be activated. When these entities activate, it is essential to establish a division of responsibilities between these groups, as 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 Municipal EOC is generally responsible for:

a. Providing resource support for the incident command operations.
b. Issuing community-wide warning.
c. Sharing information with the RHCC and the Hospital EOC(s) involved and providing for a coordinated response.
d. Issuing instructions and providing information to the general public.
e. Organizing and implementing large-scale evacuation.
f. Organizing and implementing shelter and mass arrangements for evacuees.
g. Coordinating traffic control for large-scale evacuations.
h. 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, the On Scene Incident Command post, and the EOC(s) involved.
b. Communicating information on patient dispositions and transfers for the purposes of family reunification
c. Collaborating with the RHCC, On Scene EMS, and the local EOC to assure equal distribution of resources.
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 members maintain an awareness of current ED capacity to accept patients.
b. Collaborating with the RHCC and On Scene EMS to assure equal distribution of Patients.
c. Collaboration with the municipal EOC and the RHCC on facility status and needs

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 and Email*
    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.

e. Request thru Text Message/Email 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 through the RHCC and a bed count obtained.

f. Collaborating with involved hospitals, On Scene EMS, and the local EOC to assure equal distribution of patients and resources. The RHCC will support involved hospitals and On Scene EMS in the distribution of patients when requested by hospitals involved or On Scene EMS, and specifically when patients will be distributed beyond the "Local" area hospitals. A good point of reference is when **more than two** hospitals are needed to absorb patients from the scene. There is a list of suggested criteria regarding the involvement of the RHCC in patient placement in (Section V, Letter C, Bullitt 5.)

g. 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).

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

i. Support large-scale evacuation and mass healthcare operations

j. Deploy, as available, resources managed by NSPA to competent and approved entities. A list of resources is available in the Resource attachment 7

k. Support the activities of the Office of the Chief Medical Examiner, and the needs of Hospitals with expanded morgue capacity thru the use of Mobile Morgue assets.

l. As Needed, Support interoperable communications thru the creation of radio patches and message relay from response entities thru maintained communications systems

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 HCC will be integrated in the response. The first contacted RHCC will remain the point of contact for escalation and support from other RHCCs and the state HCC.

F. State Assistance

1. State Assistance

   a. If local and regional 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.

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 administrator] 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, such as Drills and full scale exercises. 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.

   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.

VI. ORGANIZATION & ASSIGNMENT REPONSIBILITIES

A. Organization

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

B. Assignment of Responsibilities

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 emergency operations plan. Generally, primary responsibility for an emergency function will be assigned to an individual from the department or agency that has legal responsibility for that function or possesses the most appropriate knowledge and skills. Other officials, departments, and agencies may be assigned support responsibilities for specific emergency functions. Attachment 4 summarizes the general emergency responsibilities of local officials, department and agency heads, and other personnel.

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

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

2. EMS, Hospital, RHCC, Locality Responsibilities

A. EMS Initial Actions and responsibilities:

a. First Arriving Unit Responsibilities: It is the responsibility of the first arriving unit to establish command and to perform the initial scene size-up using what is known as the "5-S's and reporting the information to their dispatcher. The "5-S's" are:

i. 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Hospitals/Healthcare Facilities

a. Initiate assessment of Emergency Room and Inpatient bed capacity and report that capacity to requesting On Scene EMS and to the RHCC via VHASS.
b. Implement internal and/or external disaster plans.
c. Provide for the security of facility and monitor for self-presenting patients
d. Report patient arrivals to incident command or, if activated, to the RHCC
e. Continually re-assess bed capacity and evaluation for ability to continue to accept patients.
    i. Notify the RHCC and On Scene incident command if you are no longer able to accept patients (EMS DIVERSION). If you require diversion declaration assistance, tell the RHCC when notifying.

f. Monitor status and count of critical medical supplies necessary for sustained operations. Consider requesting additional supplies to be deployed as needed (RHCC or local EOC).
g. Consider requesting police / security support thru the local EOC
h. Establish and staff a reception and support center at each hospital for relatives and friends of disaster victims searching for their loved ones.
i. Report names of received victims to the FAC if activated. This may be done thru the RHCC. If a FAC is not activated (or an RHCC not activated) Share this information with local emergency management PIO, the EOC, or Command (depending on accessibility)
j. Coordinate with local emergency responders to isolate and decontaminate incoming patients, if needed, to avoid the spread of chemical or bacterial agents to other patients and staff.
k.

C. Regional healthcare Coordination Center (RHCC) Dispatch Center

a. Receive call for assistance
b. Ask standard questions (Section V, Letter E, Bullitt 5.)
c. Clarify if bed status for upto three closest hospitals is needed
d. Send SMS text alert to RHCC ICT
    i. Monitor for Incident commander call back and initiate a phone tree if no response within 5 minutes
e. Upon IC call back, provide a brief report of known incident, immediate needs, actions taken, and overall status of regional assets.
f. Carry out actions per direction of IC
g. Prepare Main RHCC (physical space) for occupancy if instructed per IC
h. Maintain contact with RHCC ICT thru Radio, phone, or WebEOC

D. Regional healthcare Coordination Center (RHCC) Incident Command team

a. Receive notification of incident (or potential incident)
b. Assess situation based on information available and determine Tier for RHCC Response
c. Alerting Regional Contacts affiliated in the VHASS (VHHA-MCI.org) System. *Generally by SMS Text message and Email*

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. Initiate Tier specific actions per protocol
e. Obtain a Bed count for regional hospitals via SMS Text Message alert sent to regional contacts in VHASS
f. Place follow-up phone calls to facilities who have not posted status.
g. Establish a WebEOC Event and post a SitREP based on known information
h. Monitor radio channels and email for updates from response entities
i. For MCI Level Two and One, transmit a SitRep to the state including known Injured and fatality count.
j. Collaborating with involved hospitals, On Scene EMS, and the local EOC to assure equal distribution of patients and resources. Ensure check-back to hospitals proximate to the Scene to verify status.
k. Escalate incident to additional RHCCs when the incident occurs on or near a geographic boundary. Request specific hospital status updates.

l. Request bed count for specialty centers (Burn, Pediatric, Neuro, Trauma, hyperbaric chamber, etc) when the nature of the incident mechanism can produce patients of a specialty nature.
m. Respond to requests for assistance as the incident matures.
n. Support large-scale evacuation and mass healthcare operations
o. Deploy NSPA Resources as available and as requested
o. Create radio patches to support inter-operable communication as requested.
p. Coordinate efforts of local health and medical organizations activated for an emergency assessing their needs, obtain additional resources, and ensure that necessary services are provided.

E. The Mental Health Authority will:

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

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

F. Law Enforcement will:

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

G. Public Information.

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

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

3. Recovery / Post-Incident

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

2) Emergency tasks to be performed include:

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

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

c. Public health and medical activities as requested by the local EOC
d. Rapid assessments of health and medical needs in collaboration with the RHCC.
e. Support ESAR VHP activities as requested.
f. Monitor situation for public health concerns and communicate identified issues to local EOC
g. Collaborate with the lead PIO on casualties and instructions to the public on dealing with public health problems.
h. The provision of laboratory services required in support of emergency health and medical services.
i. Immunization campaigns or quarantines, if required.
j. As applicable Inspections of foodstuffs, water, drugs, and other consumables that were exposed to the hazard.
k. Implementation of measures to prevent or control disease vectors such as flies, mosquitoes, and rodents.
l. Preventive health services, including the control of communicable diseases such as influenza, particularly in shelters.
m. Food handling and sanitation monitoring in emergency facilities.

5. Mortuary Services, Regional/State/Federal Teams

A. **Mortuary Services**

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

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

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

B. **Medical and Mortuary Assistance**

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

C. **Disaster Medical Assistance Team (DMAT)**

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

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

D. **Disaster Mortuary Operational Response Teams (DMORT)**

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

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

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

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.

VII. DIRECTION & CONTROL

A. General

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

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

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

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

VIII. READINESS LEVELS

Readiness levels have no correlation to MCI Levels or RHCC Tiers. These levels simply provide guidance to localities and regional entities on preparedness steps that can be taken in advance of known events, such as mass gatherings, as well as weather related warnings.

A. Level IV: Normal Conditions

1. Review and update plans and related SOPs.
2. Review assignment of all personnel.
3. Coordinate with local private industries on related activities.
4. Maintain a list of health & medical resources
5. Maintain and periodically test equipment.
6. Conduct appropriate training, drills, and exercises.
7. Develop tentative task assignments and identify potential resource shortfalls.
8. Establish a liaison with all private health & medical facilities.

B. Level III: Increased Readiness:

1. Check readiness of health and medical equipment, supplies, and facilities.
2. Correct any deficiencies in equipment and facilities.
3. Check readiness of equipment, supplies, and facilities.
4. Correct shortages of essential supplies and equipment.
5. Update incident notification and staff recall rosters.
6. Notify key personnel of possible emergency operations.
7. Review procedures for relocating patients and determine the availability of required specialized equipment if evacuation of health & medical facilities may be required.

C. Level II: High Readiness:

1. Alert personnel to the possibility of emergency duty.
2. Place selected personnel and equipment on standby.
3. Identify personnel to staff the EOC and ICP if those facilities are activated.

D. Level I: Maximum Readiness:

1. Mobilize health and medical resources to include personnel and equipment.
2. Dispatch health and medical representative(s) to the EOC when activated.

IX. ADMINISTRATION & SUPPORT

A. Reporting

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

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

B. Maintenance and Preservation of Records

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

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

3. Preservation of Records. Vital health & medical records should be protected from the effects of a disaster to the maximum extent possible. Should records be damaged during an emergency situation, professional assistance for preserving and restoring those records should be obtained as soon as possible.

C. Post Incident Review

For large-scale emergencies and disasters, the locality emergency manager, in cooperation with designees from WVEMS, BREMS, and NSPA shall organize and conduct a review of

emergency operations. The purpose of this review is to identify needed improvements in this annex, procedures, facilities, and equipment. Health and medical services that participated in the emergency operations being reviewed should participate in the post-incident review.

D. Exercises

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

E. Resources

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

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

X. ANNEX DEVELOPMENT & MAINTENANCE

A. Plan Development

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

B. Distribution of Planning Documents

1. The MCIPC shall determine the distribution of this plan and its attachments. In general, copies of plans and attachments 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.

C. Review

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

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

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

XI. REFERENCES

A.

XI. ATTACHMENTS

Attachment 1 ..... Local Health & Medical Facilities contact page

Attachment 2 ..... START and JUMP Start Triage Algorithms

Attachment 3 ..... Field Triage Guide

Attachment 4 ..... Scene setup guide for MCI Incidents

Attachment 5 ..... MCI Tactical Worksheets

Attachment 6 ..... VHHA-MCI.org Guidelines for accounts

Attachment 7 ..... Resource Guide

Attachment 8 ..... Hospital Direction and Information page

Attachment 9 ..... Municipal Information page

Attachment 10 ..... Field Guide for MCIs

Attachment 11 ..... Communications Plan

Attachment 12 ..... Chempack Information Guide

ATTACHMENT 1

LOCAL HEALTH & MEDICAL FACILITIES LISTING

1. Hospitals

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

2. Clinics

3. Nursing Homes

Facility	Phone	Address	City	Zip
Abingdon Place of Danville	(434) 799-1930	149 Executive Court,	Danville	24541
Autumn Care of Altavista	(804) 369-6651	1317 Lola Avenue,	Altavista	24517
Avante at Lynchburg	(434) 846-8437	2081 Langhorne Road	Lynchburg	24501
Avante at Roanoke	(540) 345-8139	324 King George Avenue, Southwest	Roanoke	24016
B&B Adult svc., Inc. DBA Covington Manor I	(540) 962-4967	4401 Midland Trail,	Covington	24426
Bedford County Nursing Home	(540) 586-7658	1229 County Farm Road	Bedford	24523
Bentley Commons at Lynchburg	(434) 316-0207	1604 Graves Mill Road,	Lynchburg	24501
Berkshire Healthcare Center, The	(540) 982-6691	705 Clearview Drive	Vinton	24179
Bethel Ridge, Inc.	(540) 992-6226	10535 Lee Highway, North,	Fincastle	24090
Blue Ridge Manor	(276) 638-8701	400 Blue Ridge Street,	Martinsville	24112
Blue Ridge Nursing Center	(276) 694-7161	105 Landmark Drive, PO 549	Stuart	24171
Blue Ridge Rehab	(276) 638-8701	300 Blue Ridge Street PO4904	Martinsville	24112
Branches of Hope, LLC	(276) 656-2181	337 East Church Street,	Martinsville	24112
Brandon Oaks	(540) 776-2600	3804 Brandon Avenue SW,	Roanoke	24018
Brandon Oaks Nursing and Rehabilitation ct	(540) 776-2616	3837 Brandon Avenue, Southwest	Roanoke	24018
Brian Center Nursing Care/Fincastle	(540) 473-2288	188 Old Fincastle Road	Fincastle	24090
Brian Center Rehabilitation and Nursing	(540) 862-3610	100 Alleghany Regional Hospital Lane	Low Moor	24457
Campbell Rest Home	(540) 586-0825	1350 Longwood Ave.,	Bedford	24523
Cana Adult Home	(276) 755-4981	2004 Wards Gap Road,	Cana	24317
Candis Adult Care, Inc	(540) 343-8640	1619 Hanover Ave,	Roanoke	24017
Carriage Hill	(540) 586-5982	1203 Roundtree Drive,	Bedford	24523
Carrington Place at Botetourt Commons	(540) 966-0056	290 Commons Parkway	Daleville	24083
Carrington, The	(434) 846-3200	2406 Atherholt Road	Lynchburg	24501
Cave Creek ALF	5409924599	8088 Lee Highway,	Troutville	24175
Central Va. Training Center (MR)	(434) 947-6000	521 Colony Road	Lynchburg	24572
Central Va. Training Center (SNF/NF)	(434) 947-6960	521 Colony Road	Lynchburg	24505
Eastwood Assisted Living, Inc.	(540) 265-2244	320 Hershberger Road,	Roanoke	24012
Elkridge ALF (Central VA CSB)	(434) 213-2471	109 Elkridge Drive,	Forest	24551
Elks National Home	(540) 586-8232	931 Ashland Avenue,	Bedford	24523
Emeritus at Cave Spring	(540) 772-7181	3585 Brambleton Avenue,	Roanoke	24018
Emeritus at Danville	(434) 791-3180	432 Hermitage Drive,	Danville	24541
Emeritus at Ridgewood Gardens	(540) 387-4945	2001 Ridgewood Drive,	Salem	24153
Emeritus at Roanoke	(540) 343-4900	1127 Persinger Road, S.W.	Roanoke	24015
English Meadows Senior Living Facility	540-3824919	1140 West Main Street	Christiansburg	24073
Fairmont Crossing	(434) 946-2850	173 Brockman Park Drive	Amherst	24521
Fairview Home	(540) 674-5260	5140 Hatcher Road,	Dublin	24084
Fairview Home Assisted Living Facility	540-674-5260	5140 Hatcher Road	Dublin	24084
Forest Hill ICF/MR	(434) 386-4449	3018 Forest Hill Circle	Lynchburg	24501
Fork Mountain Adult Home	(540) 483-8800	2925 Fork Mountain Road,	Rocky Mount	24151
Franklin Healthcare Center	(540) 489-3467	720 Orchard Avenue	Rocky Mount	24151
Friendship Health and Rehab Center	(540) 265-2100	327 Hershberger Road, Northwest	Roanoke	24012
Glebe, The	(540) 591-2100	250 Glebe Road	Daleville	24083
Golden LivingCenter - Allegheny	(540) 862-5791	1725 Main Street	Clifton Forge	24422
Golden LivingCenter - Martinsville	(276) 632-7146	1607 Spruce Street Extension	Martinsville	24112
Grace Lodge	(434) 528-0969	1503 Grace Street,	Lynchburg	24504
Guggenheimer Nursing Home	(434) 947-5100	1902 Grace Street	Lynchburg	24504
Hairston Home for Adults	(276) 638-5121	601 Armstead Ave,	Martinsville	24112
Hamilton Haven of Roanoke	(540) 366-5355	2720 Cove Road NW,	Roanoke	24017
Harmony Hall Assisted Living Facility	(276) 629-3533	PO Box 1614,	Bassett	24055
Heritage Green Daybreak	(434) 385-5102	200 Lillian Lane,	Lynchburg	24502
Heritage Hall	540-951-7000	3610 South Main Street	Blacksburg	24060
Heritage Hall - Brookneal	(434) 376-3717	633 Cook Avenue	Brookneal	24528
Highland House	(540) 862-4271	3501 Longdale Furnace Road,	Clifton Forge	24422
Highland Ridge Rehab Center	540-674-4193	5872 Hanks Ave	Dublin	24084
Hollins Manor	(540) 563-1212	7610 Williamson Road,	Roanoke	24019
Jeanne's Elderly Care	(540) 563-1262	1682 Monterey Road,	Roanoke	24019
Johnson's Senior Center, Inc.	(434) 964-2770	108 & 112 Senior Street,	Amherst	24521
Joseph C. Thomas Center	(540) 380-6527	3939 Daugherty Road,	Salem	24153
Kings Grant Retirement Community	(276) 634-1000	350 Kings Way Rd.,	Martinsville	24112-6631
Kroontjie Health Care Center	540-953-3200	1000 Litton Lane	Blacksburg	24060
Lea's Home For Adults	(434) 792-5865	157 Broad Street,	Danville	24541
Lynchburg Health & Rehabilitation Center	434 239-2657	5615 Seminole Avenue	Lynchburg	24502
Magnolia Ridge ALF	5403428861	1007 Amherst Street, SW,	Roanoke	24015

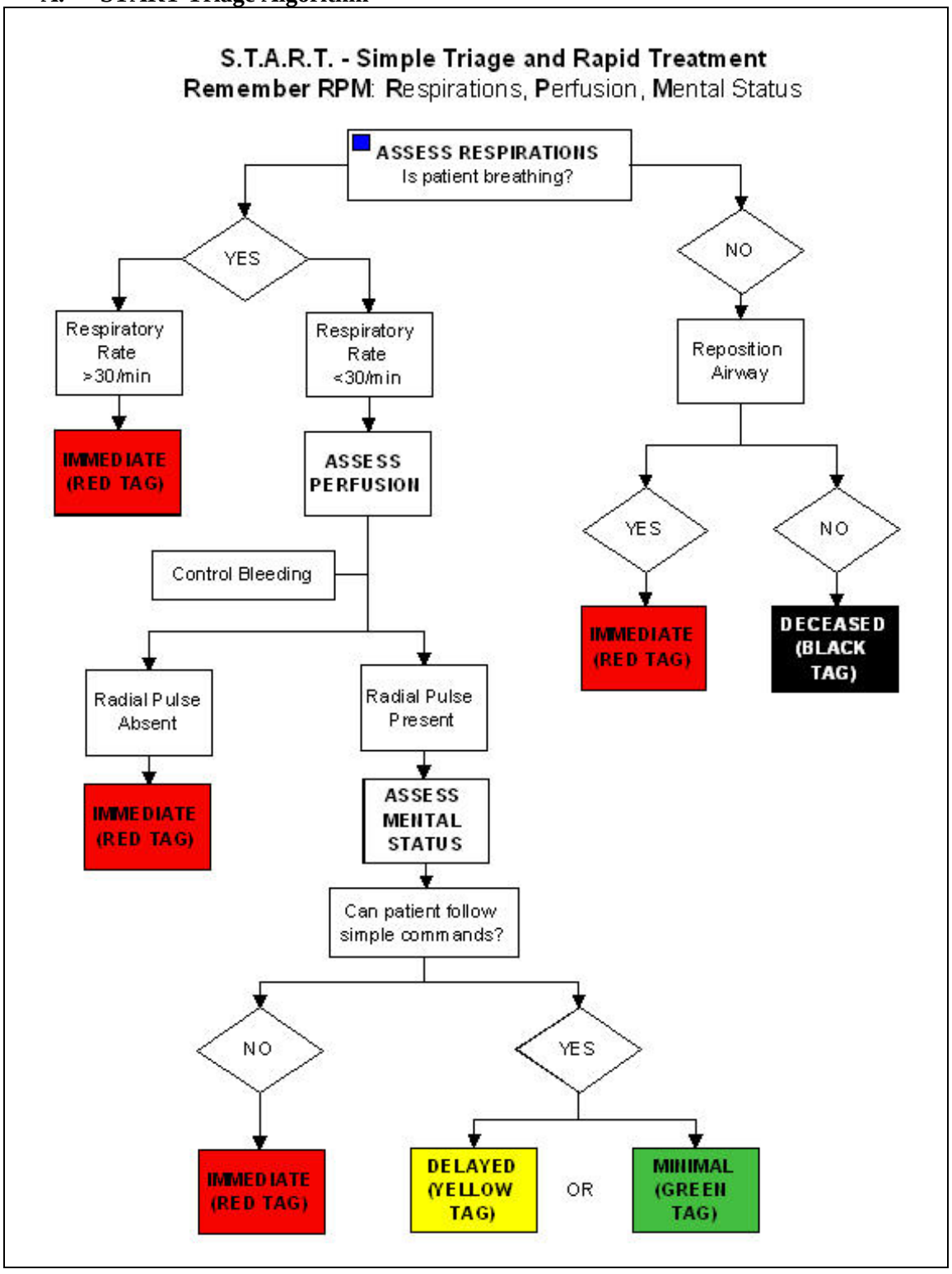
Facility	Phone	Address	City	Zip
Medical Care Center	804 740-2900	2200 Landover Place	Lynchburg	24501
Milam's Home for Adults	(434) 799-9482	1111 N Main St,	Danville	24540
North Roanoke Assisted Living Facility	(540) 265-2173	6910 Williamson Road,	Roanoke	24019
Oak Grove Lodge Residential Care	(434) 432-0513	220 Oak Grove Lane,	Chatham	24531
Oaks of Lynchburg	4348466611	2249 Murrell Road,	Lynchburg	24501
Oakwood Manor (Bedford Mem Hosp LTC)	(540) 586-2441	1613 Oakwood Street	Bedford	24523
Odd Fellows Home of Virginia	(434) 845-1261	600 Elmwood Avenue,	Lynchburg	24503
Our Lady of the Valley	(540) 345-5111	650 N. Jefferson St,	Roanoke	24016
Pheasant Ridge Nursing and Rehab Ctr	540 725-8210	4355 Pheasant Ridge Road	Roanoke	24014
Pheasant Ridge Senior Living	(540) 725-1120	4435 Pheasant Ridge Road SW,	Roanoke	24014
Pinecrest Adult Home	(434) 685-1620	709 River Ridge Road,	Danville	24541
Pineview Estate	(434) 352-8282	4471 Salem Road,	Spout Spring	24593
Pulaski Health and Rehab	540-980-3111	2401 Lee Highway	Pulaski	24301
Pulaski Retirement Community	(540) 980-8535	2421 Lee Highway,	Pulaski	24301
Radford Health and Rehab	540-633-6533	700 Randolph Street	Radford	24141
Raleigh Court Health and Rehab Center	540 342-9525	1527 Grandin Road	Roanoke	24015
Red Oak Manor	(540) 482-0982	18360 Virgil Goode Highway,	Rocky Mount	24151
Restin South	(540) 774-9255	6347 Crowell Gap Road,	Roanoke	24014
Richfield Recovery and Care Center	540 380-4500	3615 West Main Street	Salem	24153
Riverview Nursing Home	540-726-2328	120 Old Virginia Ave. PO Box 327	Rich Creek	24147
Roanoke United Methodist Home	(540) 344-6248	1009 Old Country Club Road, N.W.,	Roanoke	24017
Runk & Pratt of Forest Inc.	(434) 385-6678	208 Gristmill Drive,	Forest	24551
Runk & Pratt Residential Adult Care	4342377809	20212 Leesville Road,	Lynchburg	24502
Salem Health and Rehabilitation Center	540 345-3894	1945 Roanoke Boulevard	Salem	24153
Salem Terrace at Harrogate	5404440343	1851 Harrogate Drive,	Salem	24153
Showalter Center	(540) 443-3427	1060 Showalter Drive,	Blacksburg	24060
Skyline Nursing and Rehab	540-745-2016	2378 Franklin Pike Road	Floyd	24091
Slagle Home	(434) 845-1636	3209 Memorial Avenue,	Lynchburg	24501
Smith Mountain Lake Retirement Village	5407191300	115 Retirement Drive,	Hardy	24101
Smith's Adult Care Facility	(434) 685-1778	16069 Martinsville Highway,	Axton	24054
Snyder Nursing Home	540 389-0160	11 North Broad Street	Salem	24153
South Roanoke Nursing Home	540 344-4325	3823 Franklin Road, Southwest	Roanoke	24014
Springtree Health & Rehabilitation Center	540 981-2790	3433 Springtree Drive	Roanoke	24012
Stanleytown Healthcare Center	276 629-1772	240 Riverside Drive PO538	Stanleytown	24055
Stratford House	(434)799-2266	1111 Main Street,	Danville	24541
Summit Assisted Living	(434) 845-6045	1320 Enterprise Drive,	Lynchburg	24502
Summit Health & Rehabilitation Center	434 845-6045	1300 Enterprise Drive	Lynchburg	24502
The Brian Center	(540) 862-3610	100 ARH Lane, Robert (Bob) McClintic	Low Moor	24457
The Fields of Heritage Green	(434) 385-5102	201 Lillian Lane,	Lynchburg	24502
The Glebe	(540) 591-2100	200 Glebe Boulevard,	Daleville	24083
The Landmark Center	(276) 694-3050	227 Landmark Drive,	Stuart	24171
The Oaks at Richfield	(540) 380-4500	3706 Knollridge Rd,	Salem	24153
The Park-Oak Grove Retirement Community	(540) 989-9501	4920 Woodmar Drive, SW,	Roanoke	24018
The Village on Pheasant Ridge	(540) 400-6482	4428 Pheasant Ridge Road,	Roanoke	24014
The Wybe & Marietje Kroontje Health Care	(540) 953-3200	1000 Litton Lane,	Blacksburg	24060
Timothy and Bethany House	(804) 239-0722	3011 Roundelay Road	Lynchburg	24502
TLC Adult Home	(276) 629-4884	880 Lillian Naff Drive,	Henry	24102
Trinity Mission Health & Rehab of Rocky	540 483-9261	300 Hatcher Street	Rocky Mount	24151
Valley Retirement Home	(540) 563-9153	1418 10TH Street NW,	Roanoke	24012
Valley View Retirement Community	(434) 237-3009	1213 Long Meadows Drive,	Lynchburg	24502
Virginia Baptist Hospital LTC	(434) 947-4000	3300 Rivermont Avenue	Lynchburg	24503
Virginia Veterans Care Center	(540) 982-2860	4550 Shenandoah Ave.,	Roanoke	24017
Virginia Veterans Care Center	540/982 2860	4550 Shenandoah Avenue, Northwest	Roanoke	24017
Virginia's Assisted Living Facility	(540) 343-3330	1205 Moorman Rd. NW,	Roanoke	24017
Westminster Canterbury of Lynchburg	(434) 386-3500	501 Ves Road,	Lynchburg	24503
Wheatland Hills-Christiansburg	(540) 382-5200	201 Wheatland Court,	Christiansburg	24073
Wheatland Hills-Radford	(540) 639-2411	7486 Lee Highway,	Radford	24141
Williams Home Incorporated	4343848282	1201 Langhorne Road,	Lynchburg	24503
Woodhaven Nursing Home	540/947-2207	13055 West Lynchburg/Salem Turnpike	Montvale	24122-0168
Woodlands Health & Rehab Ctr, The	540/863-4096	1000 Fairview Avenue	Clifton Forge	24422

4. EMS Agencies

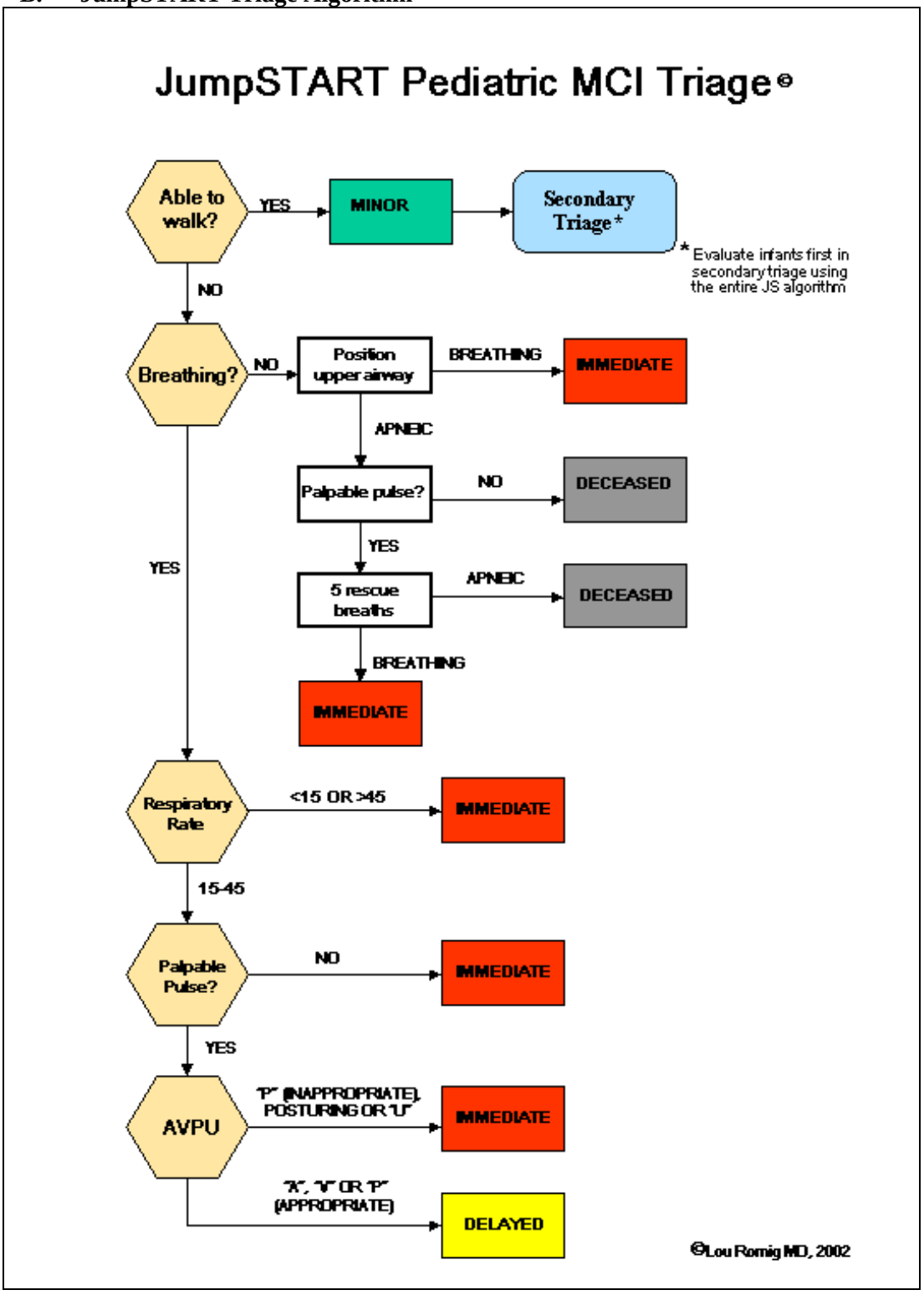
5. Health Districts and Emergency Planners

ATTACHMENT 2
Start and JumpStart Triage Algorithm

A. START Triage Algorithm



B. JumpSTART Triage Algorithm

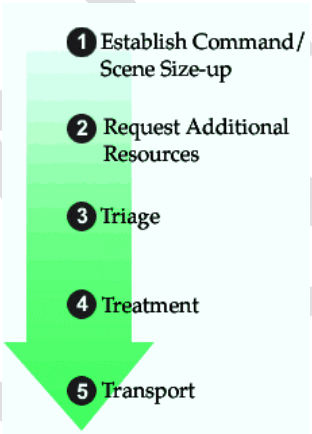


ATTACHMENT 3
Standard Trauma Triage Methods

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



Provisions must be made for the following:

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

The initial triaging of victims must begin right where the patients 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. For all remaining patients, triage personnel must quickly triage each patient and apply the appropriate color-coded triage ribbons (surveyor's tape).

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

Secondary Triage

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

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

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

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

Triage and Mass Patient Care

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 4
Scene Setup and Patient Management

First Arriving Unit Actions

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

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.

Continual Evaluation

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

Designating and Marking the Treatment Area

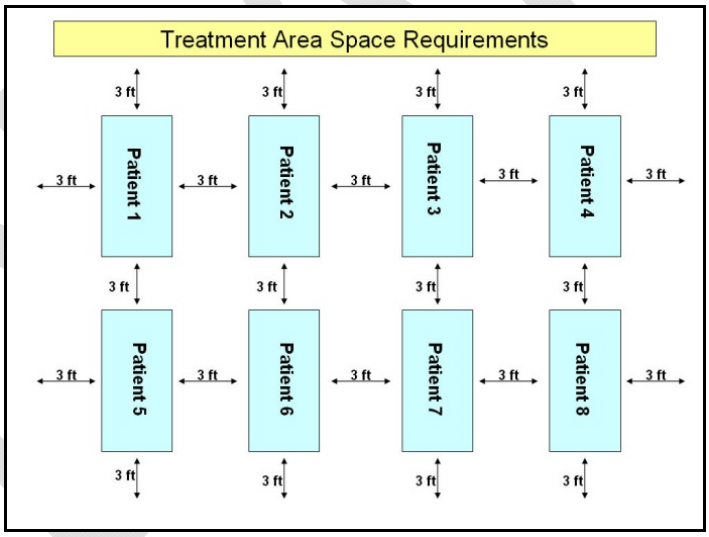
Patients are placed in the Treatment Area and emergency medical care is provided on the basis of the triage priority. The Treatment Area is usually divided into separate areas for the care of Red Tagged/Immediate, Yellow Tagged/Delayed, Yellow Prime/Catastrophically Injured, and Green Tagged/Minimal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

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

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

Treatment Area Space Requirements

It is important to provide enough space between patients to allow providers room to place, treat, and move safely between patients. 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 Transport Group Supervisor/Unit Leader or Medical Communications Coordinator must be in contact with the Emergency Departments initially contacted, as well as the RHCC when activated. The distribution of patients is dependent on these entities..

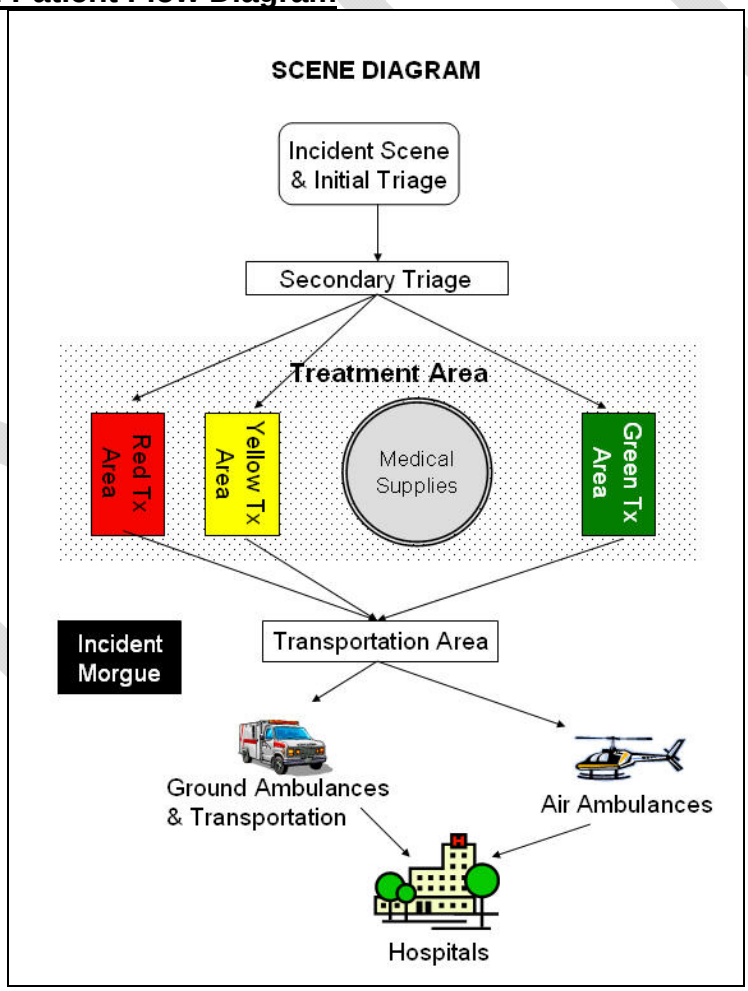
Transportation resources are assigned based on triage priority. Patients are moved to the Transportation Area, and then loaded into the appropriate vehicle by Porters/Transport Loaders.

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



HAZ MAT 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".

I. 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.

II. 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.*

III. Cold Zone

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

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

IV. 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.

V. 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.

A properly packaged radiologically contaminated patient.

- Wrap one sheet around patient, then the other.
- Perform radiological monitoring of the ambulance cot/stretcher and wheels to reduce the spread of contamination.

VI. Transportation Considerations

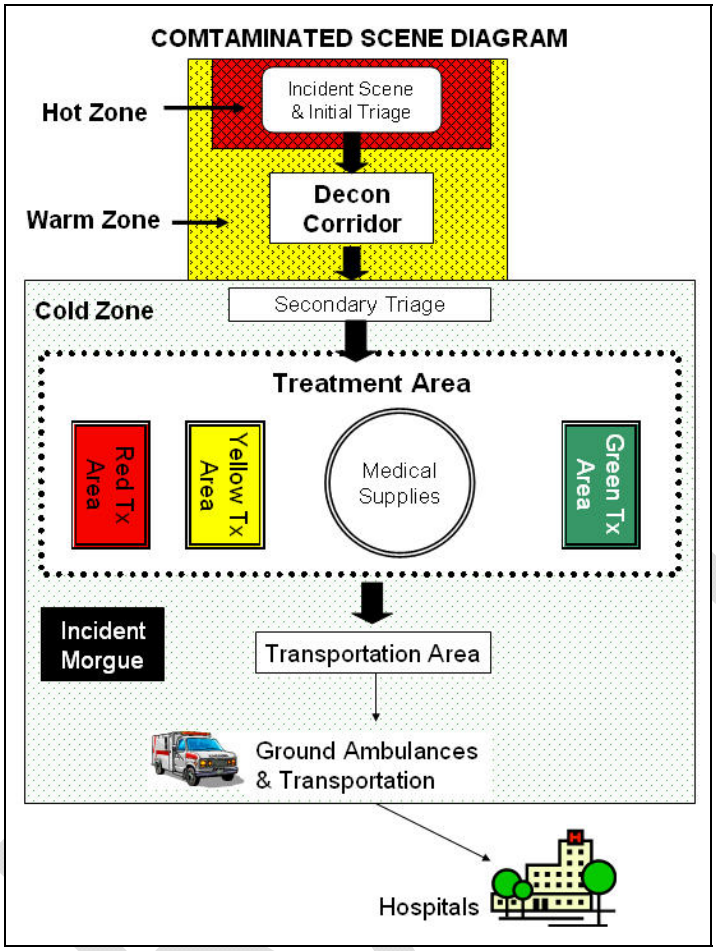
Clinically unstable, radiologically contaminated patients must be transported via ground ambulance to an Emergency Department. These patients should be packaged as outlined above and the receiving Emergency Department must be notified that they will be receiving a contaminated patient.

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.

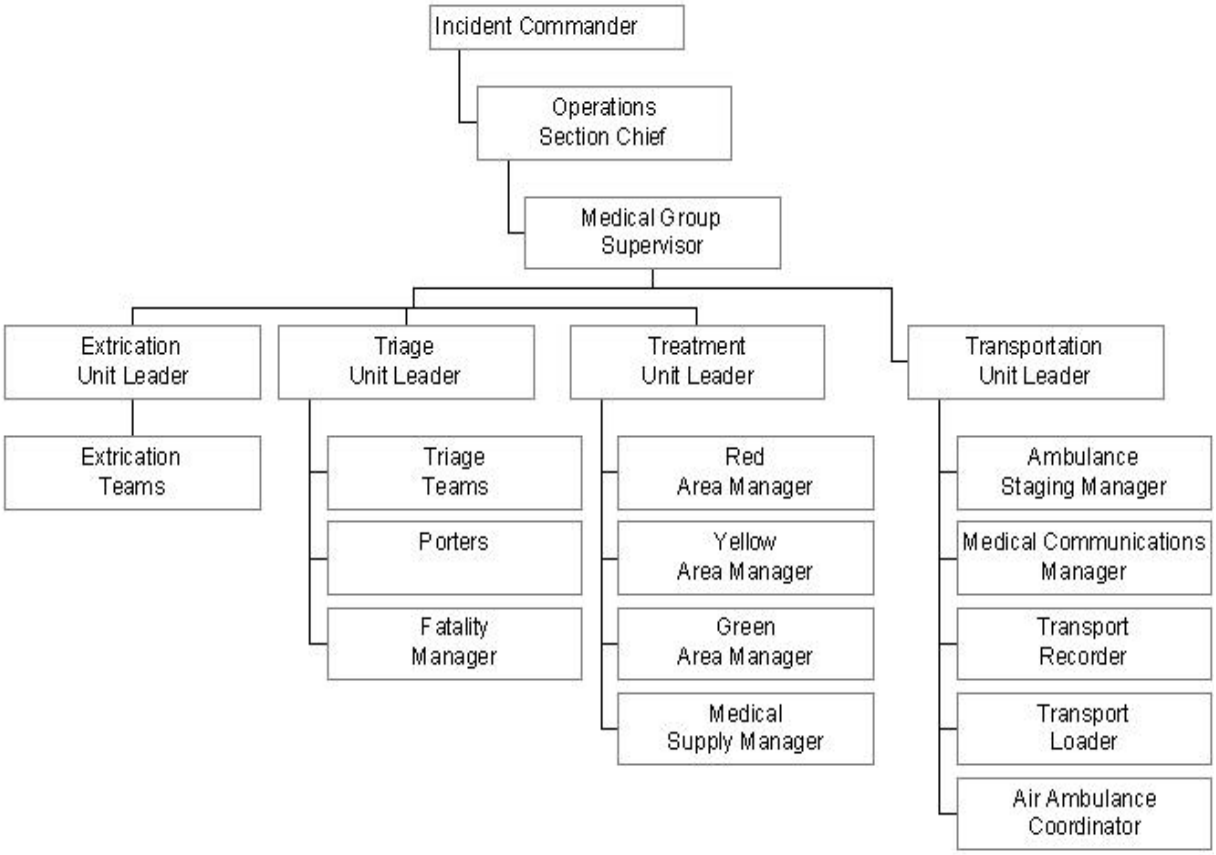
VII. Scene Layout

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.

VIII. Contaminated Patient Flow Diagram


COMTAMINATED SCENE DIAGRAM
Hot Zone
Incident Scene & Initial Triage
Warm Zone
Decon Corridor
Cold Zone
Secondary Triage
Treatment Area
Red Tx Area
Yellow Tx Area
Medical Supplies
Green Tx Area
Incident Morgue
Transportation Area
Ground Ambulances & Transportation
Hospitals

Attachment 5: MCI Tactical Worksheets and Response Guide



MASS CASUALTY PATIENT FLOW

1. INCIDENT SCENE

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

2. TREATMENT AREA

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

3. TRANSPORTATION AREA

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

IX. FIRST EMERGENCY MEDICAL UNIT ON SCENE

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

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

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

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

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

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

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

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

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

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

SECOND EMERGENCY MEDICAL UNIT ON SCENE

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

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

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

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

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

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

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

INCIDENT COMMAND
(COMMAND)

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

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

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

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

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

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

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

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

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

MEDICAL GROUP SUPERVISOR
(MEDICAL GROUP)

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

_____ 1. Put on the MEDICAL GROUP vest.

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

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

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

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

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

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

_____ 8. Monitor work and progress toward incident objectives.

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

_____ 10. Account for all assigned personnel.

_____ 11. Keep OPERATIONS Section Chief or COMMAND informed.

TRIAGE UNIT LEADER
(TRIAGE)

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

_____ 1. Put on TRIAGE vest.

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

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

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

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

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

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

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

_____ 9. Account for all personnel assigned.

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

FATALITY MANAGER
(FATALITY MANAGER)

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

_____ 1. Put on FATALITY MANAGER vest.

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

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

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

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

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

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

_____ 8. Keep TRIAGE and TREATMENT informed.

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

TREATMENT UNIT LEADER
(TREATMENT)

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

_____ 1. Put on TREATMENT vest.

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

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

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

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

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

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

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

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

_____ 10. Isolate emotionally disturbed patients if possible.

_____ 11. Determine patient transport order and best means.

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

_____ 13. Account for all assigned personnel.

_____ 14. Keep MEDICAL GROUP and TRANSPORTATION informed.

MEDICAL SUPPLY MANAGER
(SUPPLY)

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

_____ 1. Put on MEDICAL SUPPLY vest.

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

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

Backboards and rescue baskets and straps
Splints
Oxygen and airway kits
IV sets
Bleeding control supplies
Prepacked disaster kits

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

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

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

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

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

TRANSPORTATION UNIT LEADER
(TRANSPORTATION)

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

_____ 1. Put on TRANSPORTATION vest.

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

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

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

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

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

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

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

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

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

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

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

_____ 13. Keep MEDICAL GROUP and TREATMENT informed.

AMBULANCE STAGING MANAGER
(STAGING)

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

_____ 1. Put on STAGING vest.

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

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

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

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

_____ 6. Update TRANSPORTATION on available vehicles and personnel.

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

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

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

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

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

MEDICAL COMMUNICATIONS MANAGER (COMMUNICATIONS)

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

_____ 1. Put on COMMUNICATIONS vest.

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

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

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

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

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

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

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

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

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

TRANSPORT RECORDER (RECORDER)

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

_____ 1. Put on TRANSPORT RECORDER vest.

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

_____ 3. Record patient movement information on tactical worksheet.

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

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

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

TRANSPORTATION LOADER
(LOADER)

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

_____ 1. Put on TRANSPORTATION LOADER vest.

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

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

_____ 4. Make sure patients selected for ground transportation by TRANSPORTATION are:

a. Ready for movement.

b. Loaded on the correct ambulance - cross check numbers with RECORDER.

_____ 5. Provide instructions to vehicle drivers:

a. Directions to the designated hospital.

b. Actions to take (Return to Staging or Return to Home) after delivering patients.

_____ 6. Keep TRANSPORTATION and RECORDER informed.

AIR AMBULANCE COORDINATOR
(AIR)

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

_____ 1. Put on AIR AMBULANCE COORDINATOR vest.

_____ 2. Select Landing Zone site.

a. Select area large enough for safe operations:

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

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

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

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

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

_____ 6. Coordinate patient loading and movement with TRANSPORTATION.

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

_____ 8. Keep TRANSPORTATION and HELICOPTER CREWS informed.

STAFFING CHART - TREATMENT AND PORTERS

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

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

BASIC STAFFING RATIOS:

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

TACTICAL WORKSHEET BOOK

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

Incident	Date	Time

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

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

CASUALTIES					
Time	RD	YE	GN	BK	Trans
Totals					

HOSPITAL CAPABILITIES					
Facility	RD	YE		GN	Trans

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

Incident	Date	Time

For Operational Period From: To:

INCIDENT COMMANDER GOALS:			
INCIDENT COMMANDER STRATEGY:			

Scene Sketch

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

HAZARDS AND LIMFACS:	

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

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

Incident	Date	Time

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

Accountability Worksheet	Commonwealth of Virginia Mass Casualty Incident Management	MCI 12

Incident	Date	Time

Unit	Assignment	Released	Accountability Checks					
			1	2	3	4	5	6

Action Taken:

Ver 2.0
9/12

EXTRICATION WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 2

Incident	Date	Time

Scene Sketch:

No.	Patients	Problem	Unit	Start	Complete

Notes:

Special Resources	

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

TRIAGE WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 3

Incident	Date	Time

Scene Sketch:

TRIAGE TEAM REPORTS

Team	RED	YELLOW	GREEN	BLACK	Total	Notes
TOTALS						

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

FATALITY WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 31

Incident	Date	Time

Scene Sketch:

Number	Sex	Description	Condition

Individual Completing:	Agency:

TREATMENT WORKSHEET	Commonwealth of Virginia Mass Casualty Incident Management	MCI 4

Incident	Date	Time

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

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

TREATMENT LOG	Commonwealth of Virginia Mass Casualty Incident Management	MCI 41

Incident	Date	Time
Unit (Optional Use):		

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

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

Incident	Date	Time

Hospital (Optional Use):

Patient	Status	Hospital	Unit	Time
Name				
Name				
Name				
Name				

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

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

Time	Station Calling	Freq	Message

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

Incident	Date	Time

LZ Sketch

AIRCREW BRIEFING

LZ Lat:

LZ Lon:

Landmark:

Approach From:

Size:

Hazards:

Lighting:

Aircraft	Type	Patients	Operational

Winds:

Visibility:

Precip:

Other:

AIRSPACE RESTRICTION

Time From:

Time To:

By:

Contact:

Altitudes:

Area:

HOSPITALS RECEIVING PATIENTS BY AIR

Facility	From Scene:

Notes:

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

Incident	Date	Time

In	Agency / Unit	Crew	Class	Assignment	Out

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

Attachment 6: Registration on VHHA-MCI.org

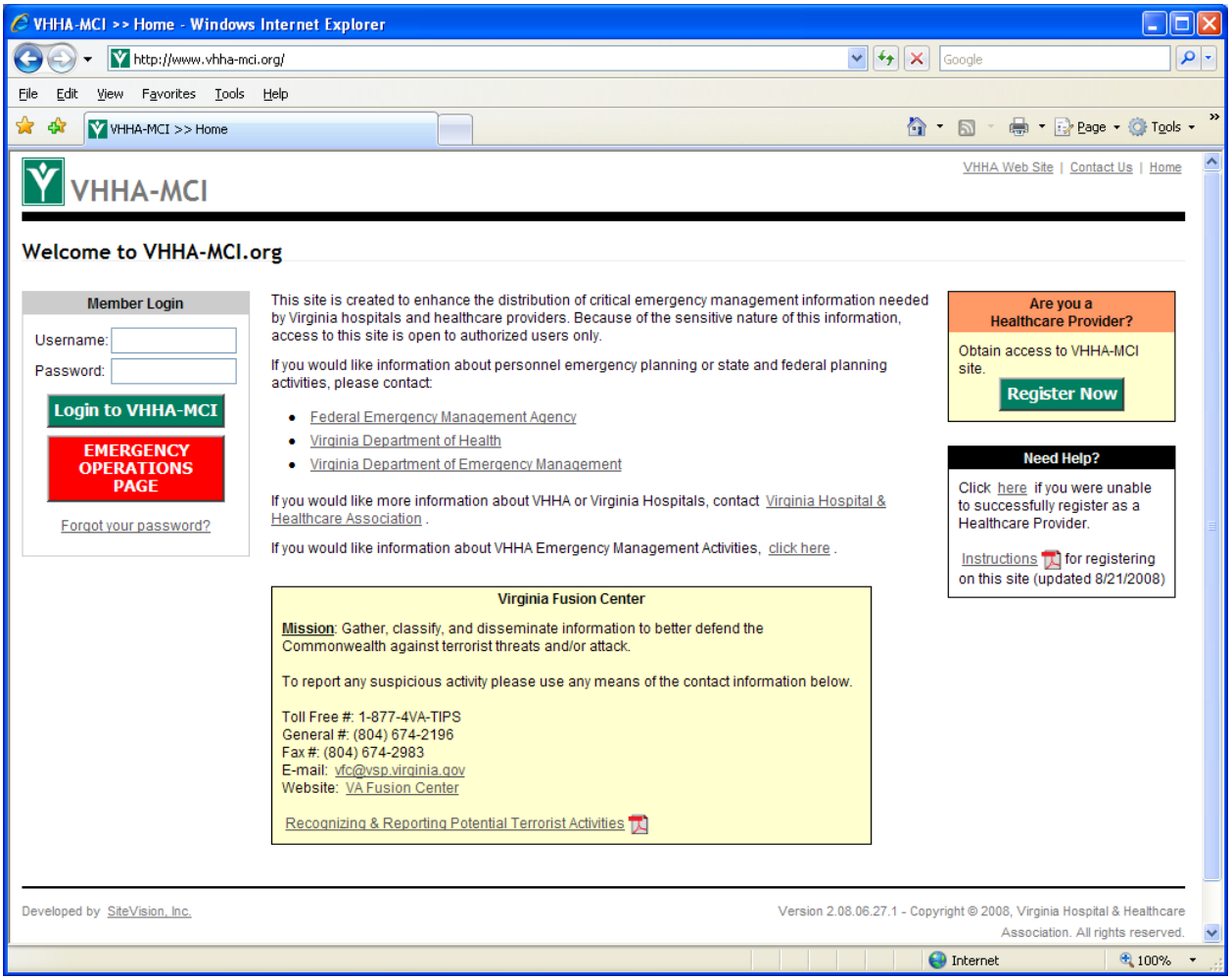
How do I register a user account?

Register Now

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

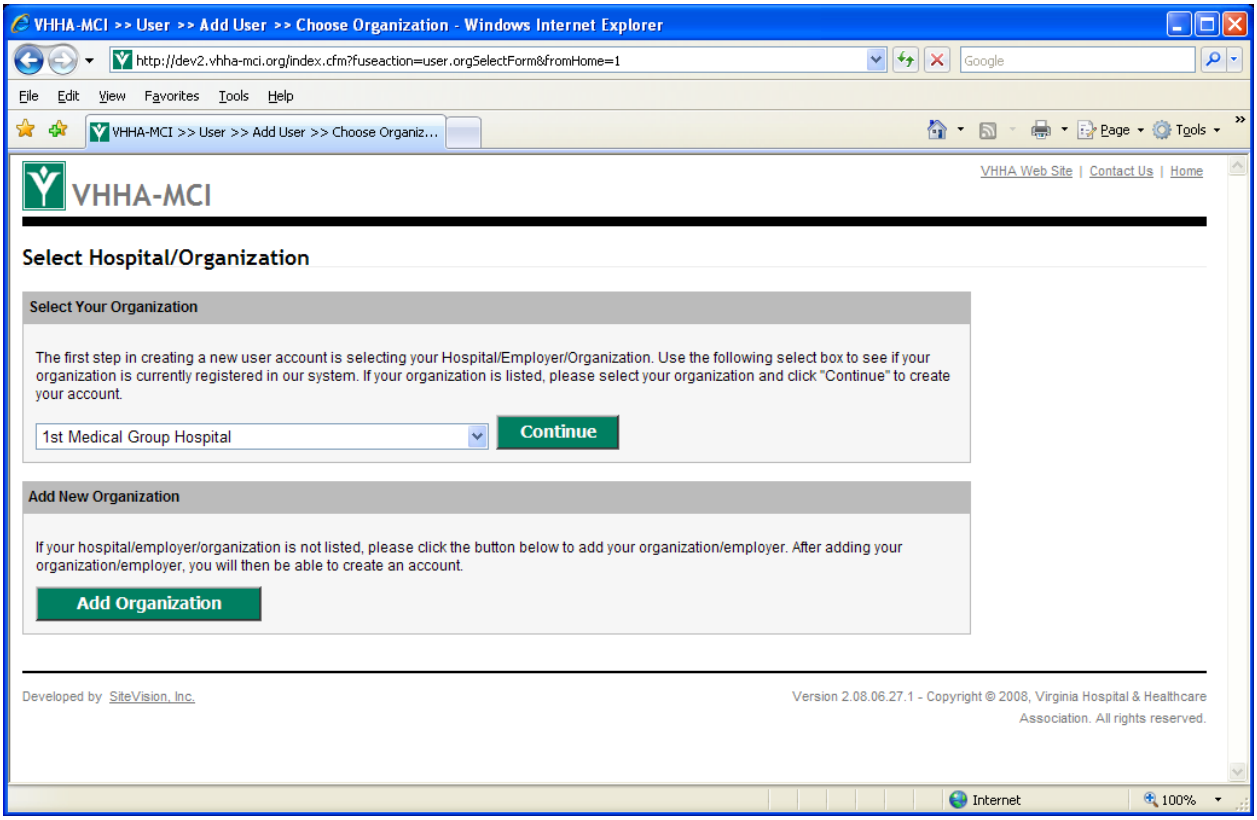
- *NOTE: You may not logon to VHHA-MCI until your account has been approved by either a VHHA-MCI Administrator or your organization's designated Organization Contact or Alternate Organization Contact.*
- *NOTE: You may want to create a bookmark of the homepage to quickly access the logon screen. Hold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

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



Select Hospital/Organization

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



Account Information

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

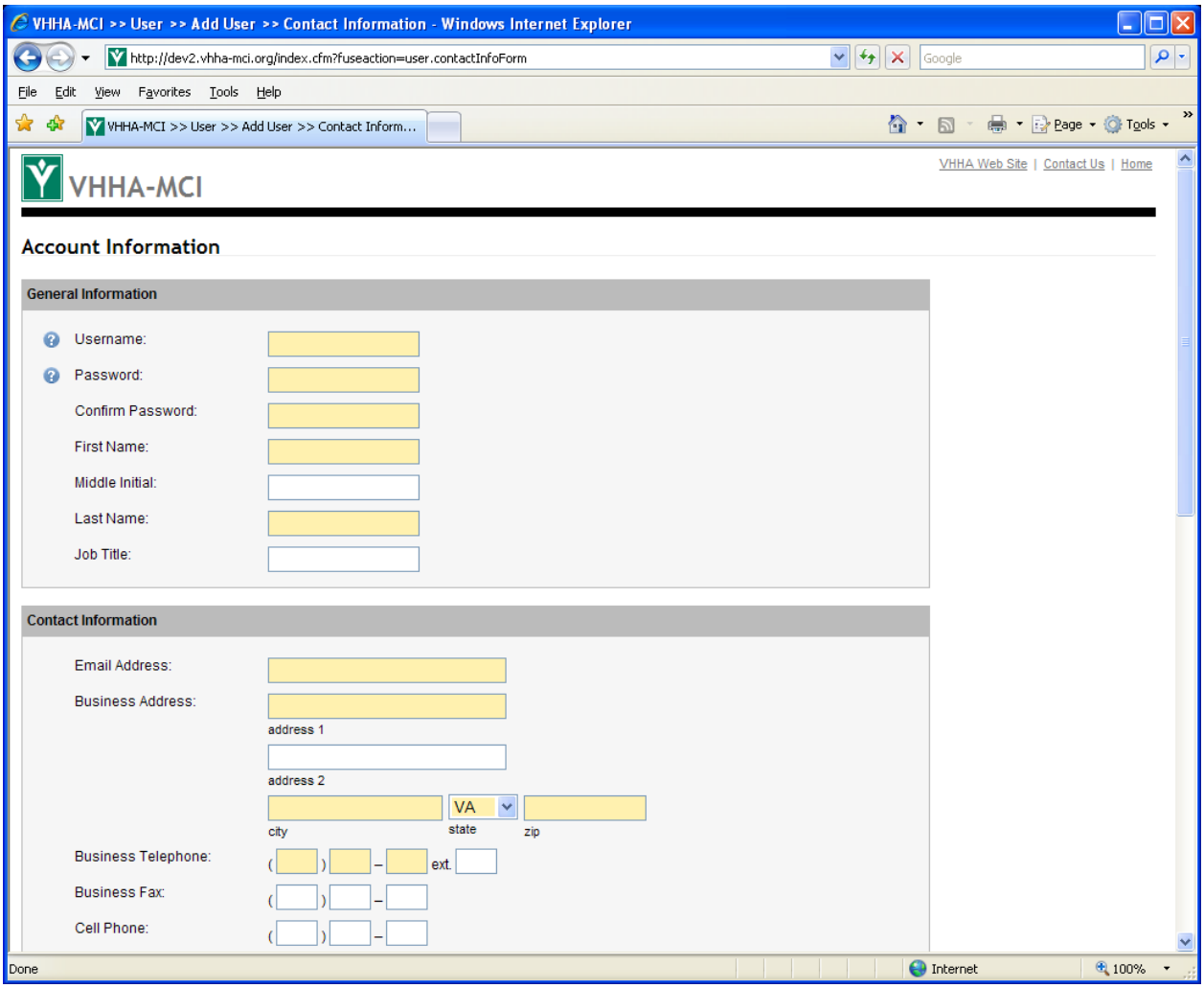
- o Username
- o Password (and Confirm Password)
- o First Name
- o Last Name
- o Email Address
- o Business Address
- o Business Telephone

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

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

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

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



Registration Complete

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

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

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

REPORT OF THE NOMINATING COMMITTEE

December 13, 2012

The Nominating Committee is pleased to offer the following nominees for officers and elected directors:

Directors
(three year terms)

Emergency Physician at-large	Karen Alldredge, MD
Fourth Planning District at-large	Bill Brown

Dr. Alldredge's nomination is contingent upon passage of bylaw amendment to define the former VACEP seat to an at-large (elected) emergency physician seat.

Officers
(two year terms)

President	Ford Wirt
Vice President	Steve Eanes
Secretary	Steve Simon
Treasurer	Carey Harveycutter
Fourth Planning District at-large	Joe Trigg
Fifth Planning District at-large	Jim Cady
Twelfth Planning District at-large	Dale Wagoner

Respectfully submitted:

Carey Harveycutter, Chair
Ford Wirt
Steve Eanes
Steve Simon
Dale Wagoner

Continuity of Operations Plan (COOP)

Guide for Disaster Avoidance, Preparation and Recovery

Revision 11-12
To be considered by WVEMS Board of Directors December 13, 2012

Mission

The mission of the Western Virginia EMS Council is to reduce morbidity and mortality by facilitating regional cooperation, planning and implementation of an integrated emergency medical services delivery system.

Introduction

The primary purpose of the continuity of operations plan (COOP) is to enable the council to recover from a disaster as soon as possible so that it can continue its operations to fulfill its mission. In times of disaster, that mission might additionally include support and assistance to the various EMS agencies, localities, hospitals, and other public safety organizations and personnel, and the general public, to help them recover from disaster. The exact form of assistance may be variable depending on the disaster, but this plan does identify certain essential steps the council will take to support the EMS community and others who will depend on that support.

Contents

Section 1. Leadership Team

Who is in charge during a crisis? The WVEMS Leadership Team, appointed by the WVEMS executive director, consisting of:

- WVEMS Executive Director
- Regional Education Program Director
- WVEMS Business Manager
- NSPA Executive Director

Duties of Leadership Team members in times of crisis:

- Admin/Management – facilitates communications among team members and oversees plan and plan tests. Locate temporary office space and coordinate activity around setup. Coordinate activity between and among staff regarding client, customer, vendor and other party communications to ensure continuation of operations and continued provision of essential functions. (See Appendix B)
- Systems/telecommunications recovery – Conduct all activities around IT and telecom recovery as well as data preservation, security and recovery. Provide staff briefings on internal emergency preparedness supplies, equipment, security and procedures.
- General additional team duties: Conduct an initial business preparedness and impact analysis and continue to reassess preparedness needs based on board, staff, experiential and best practices feedback. Develop and periodically revise the COOP.

Section 2. Essential Functions

Listing of significant, identified essential functions that must be continued in case of a major disruption. This list is not intended to be all-inclusive, but represents examples of functions that must be given priority to restore and maintain.

1. Payroll and benefits administration to support adequate competent staffing
2. Payable/Receivable processing to ensure that vendors are paid and payments to WVEMS are deposited
3. Off-site educational program support to ensure that ongoing programs may continue
4. Off-site consolidated testing to ensure that scheduled CTS sites are conducted as announced
5. Technical support to agencies and providers to ensure that means of communication are maintained to allow those we normally serve to contact WVEMS for assistance

6. Maintain WVEMS and NSPA fleet to ensure use of vehicles and support trailers. Particular attention to be given to the NSPA Mobile RHCC which offers satellite Internet, etc.
7. Maintain EMS communications systems
8. Maintain VHAAS status boards and Web-EOC, and staffing for RHCCs as needed
9. Maintain administrative and programmatic support for the Medical Reserve Corps in areas contracted by the Virginia Department of Health

Section 3. Order of Executive Succession

Key Position	Successor 1	Successor 2	Successor 3	Successor 4
Executive Director	Regional Education Pgm. Director	Business Manager	Senior Field Coordinator	President, Board of Directors
Regional Education Program Director	Senior Field Coordinator	Field Coordinators	WVEMS Executive Director	President, Board of Directors
Business Manager	Executive Director	Office Manager or Admin Asst	Treasurer, Board of Directors	President, Board of Directors
NSPA Executive Director	NSPA Chairman	WVEMS Executive Director	VHHA HPP Technical Advisor	VHHA Vice President

Section 4. Delegation of Authority for Essential Functions

Authority	Position Holding Authority	Triggering Conditions	Procedures
Authorize Alternate Work Location(s)	Executive Director (Follow order of succession above if necessary)	Disruption of infrastructure at regular site(s)	Work from home or establish alternate longer-term location
Implement Other Emergency Procedures	Executive Director (Follow order of succession above if necessary)	Failure or disruption of essential support services	Work from home, activate alternate sites, implement backup communications systems

Section 5. Staff and Visitor Preparedness

- All staff will receive training in emergency preparedness. At a minimum:
    - All staff will review this COOP as part of initial employment briefing.
    - All staff will be trained in the equivalent of the American Heart Association's Heartsaver CPR, AED and First Aid within six months of employment. (Prior training at the EMT-B level or above will suffice for the first aid training)
    - All staff will initially and periodically receive orientation on the location and use of the council's AEDs, first aid kits, fire extinguishers, emergency lighting, evacuation routes and assembly points.
    - All staff will periodically discuss office security, locking procedures and other personal security techniques.
- Floor plan drawings representing the council office, evacuation routes and placement of fire extinguishers, first aid kits and AEDs will be posted in conspicuous locations.
- Any persons or groups using the council office for meetings, courses and events will receive written or electronic information for attendees. The information will highlight general housekeeping announcements (restrooms, vending, coffee, etc) and include life safety information regarding facility evacuation routes and location of fire extinguishers, first aid kits and AEDs.
- In case notification needs to be made of office closing or meeting/course/event postponement or cancellation, the registration process for events should include reliable email addresses and 24/7 telephone contact information for attendees. In the event of outside groups, the group planner/event coordinator should be advised to maintain up-to-date attendee contact information for this same reason, and staff should have reliable 24/7 contact information for that group planner or coordinator.

Section 6. Maintaining Contact with Employees

- The team will initially utilize email, utilizing computers and handheld communications device (Smart phone or whatever similar device is in use at the time of crisis) to contact all employees. Contact information for all employees will be provided to all employees in hard-copy form and for inclusion in Outlook contacts which can be accessed from any location via the Internet, using the Outlook web interface. The WVEMS Office Manager (or Administrative Assistant) will keep employee information up-to-date. Additional backup employee contact information will be maintained in the council's password-protected electronic bookkeeping system and in locked personnel files (the backup information accessible to the Office Manager/Administrative Assistant, the Executive Director and the Business Manager).
- During emergencies or any situation which closes the office during regular office hours (examples include prolonged loss of power, localized flooding, etc), the team will utilize the methods described above to notify all staff members of the situation

and anticipated resumption of operations. These methods may also be used to notify staff of any other serious office situation or security issue.

- The team will utilize staff members' vaems.org email (and any existing secondary email addresses) to supplement and augment emergency notification information.
- All staff members will use the Microsoft Outlook program to maintain personal work calendars, and shall "share" their calendars with other staff members. The Council's management team will regularly review staff calendars and will be generally cognizant of the current location of each staff member. Staff members in the Roanoke office should also verbally notify the Office Manager/Administrative Assistant when coming and going from the office.

Section 7. Emergency Assembly Location

- In the event of emergency evacuation of the council's main office, staff members and visitors will assemble across Norwood Street in the Duncan Automotive parking lot near the door to the pre-owned car showroom. The assembly point for evacuation from other Council offices will be as described in the evacuation plan for the facilities in which those offices are located. Situations such as a fire alarm or known fire, security situation or any other emergency deemed to render the office unsafe shall prompt emergency evaluation.
- A team member or other responsible party will provide an "all clear" to those evacuated to return to the office, or to depart and return as indicated based on the circumstances causing the emergency evacuation.

Section 8. Data Protection, Redundancy and Recovery (Also see Appendix 2)

General Policies

- Council policies require all staff to save all work-related electronic files on the network server ("S" drive).
- The WVEMS network server will be configured with the capability to make off-site backups which will be uploaded automatically to server networks maintained by a subscription-based service. Other backups on-site may also be maintained.
- The WVEMS network server will be configured such that backup copies may be restored at any time. Each backup site maintains incremental daily backups for a minimum of 14 days.
- All desktop computers, servers and other essential electronic equipment will be protected by Uninterruptible Power Supplies. All laptop computers will be protected by surge suppressors.
- All council users will be assigned network passwords. Server enforced policy will automatically log off a user after 30 minutes of inactivity.
- The main network server, related equipment and onsite backup drives will be maintained in a locked area accessible to the team and IT support technicians.

- All council computers will have up-to-date antivirus software, firewalls and other processes to avoid malicious attacks as recommended by IT support.
- A listing of computer network hardware, software, telephone equipment, IT vendors, network mapping and settings are included in Appendix 1 (IT/Telecom Vendor List).
- Copies of board and standing committee minutes and council program reports will be posted to the OEMS Lotus Notes system (when required by contract) as well as to the council's website providing multiple, redundant copies of these records.
- The council's website and email service will be provided and maintained on off-site servers protected with UPS, physical site security, resistance to high winds, nightly backups, and redundant Internet connectivity. The current vaems.org host and council IT support is Coralogic Corporation.
- Related "Computer Usage and Email Policies" are found in the Council's Employee Policies (hard copy provided to each employee and accessible on-line at www.wvems.org/pp2006).

Document Preservation

In addition to electronic files addressed in the previous section, the council will identify and take precautions to preserve critical paper documents.

- The council's records retention policy requires maintenance and disposal of certain documents at 3 and 7 year intervals, and maintenance of certain documents on a permanent basis. See related Records Management Policy (hard copy maintained by Office Manager or Administrative Assistant) and computer network Public folder.
- Storage for permanent and 7-year paper records will be provided in marked file boxes in a closed storage room which may be on-site or off-site.
- Critical records (including the IRS non-profit determination letter, articles of incorporation, bylaws, current asset lists, etc) will be scanned to electronic format and retained in the computer network Admin folder which will also cause offsite backup of these files.
- Copies of critical documents, including vehicle titles will be stored in the Council's on-site safe with a minimum 2-hour fire rating.

Section 9. Insurance and Liability, Human Resources Protection

- The council will maintain general business insurance coverage (includes fire, theft and general liability) for all assets, staff and visitors. The level of fire and theft coverage will be revised and adjusted annually if needed based on replacement costs of furnishings and equipment assets.
- The council will maintain required automotive insurance for council-owned vehicles and trailers.
- The council will maintain a general risk management policy (umbrella liability coverage) available through the Commonwealth of Virginia (VA Risk2) to provide staff, board and volunteer coverage.
- The council will maintain employee theft insurance.
- The council will indemnify the board of directors.

- Staff will monitor general conditions of furnishings, carpets, and other aspects of the council office and correct or report to the team and/or building management any situation which might cause a hazard.
- The Council will maintain workers' compensation insurance for all employees to ensure the most effective "return-to-work" environment.
- The Leadership team will continually assess the Council's policies, procedures and benefits structure to prevent excessive absenteeism and to promote prompt return-to-work in the event of a major disruptive event. Emphasis will be placed on policies and benefits to maintain and improve the health of employees and their families.

Section 10. Disaster Preparations and Response

Predesignated assembly location for office evacuation
See Section 1.

Mass illness
The primary objective related to mass illness such as the pandemic flu will be to help prevent the spread of the disease among employees and their families, to maintain essential office operations as much as possible and to take action to help restore normal office operations as soon as possible.

To help prepare for mass illness, staff members are generally paired with other staff members (wherever possible) in understanding and performing work functions; that is, at least one other staff member can assume a staff member's duties. An administrative duties pairing is established for all administrative support staff (see Appendix 3). All program staff within each program should frequently work with other staff members to ensure sharing of information, project lists, contract deliverables, contacts, etc. All committee members and contact information is maintained in the main WVEMS database. Such individual contact lists may also be maintained in individual staff member's Outlook. Staff members with responsibility for a committee or program are responsible for the accuracy of the main server database information for committees, students, instructors and others within their area of responsibility.

To help minimize disease spread, staff members and their families are advised to take personal actions such as frequent hand washing, distancing from others with disease, and other actions consistent with recommendations provided by public health directors. To assist with recommendations related to social distancing, the council will support electronic meetings, teleconferencing, etc. of committee meetings and other networking necessary to continue council activities.

Unanticipated disasters
Localized versus regional (weather events, fire, other office damage) – In general, this plan helps ensure that regardless of the disaster, the council is prepared to restart operations by restoring data, short or long term relocation, or other actions to get back in business as soon as possible. An unanticipated disaster such as a fire might prompt

immediate evacuation, then a return after an “all clear”. Significant fire damage might prompt temporary or permanent office relocation depending on the severity of damage. A tornado may not prompt an immediate evacuation, but resulting damage might cause the need for office relocation. In all cases of unannounced disaster, the most immediate plan calls for life safety—taking action to ensure the safety of staff and visitors to the office. Following the disaster, the team will access the need for follow up actions and advise remaining staff.

Event cancellation or postponements
Since office closure due to an impending weather emergency or unanticipated disaster can disrupt planned meetings, courses or other activities involving visitors to the office, the plan includes notification of such facility issues to expected visitors. Anticipated attendee information should be collected in advance of meetings, courses or other activities in the office (see previous section). Program support staff should be prepared to rapidly communicate closing or other event change information to anticipated attendees by email and/or by telephone as time and abilities allow. Appropriate signs should also be prepared and posted on council office/classroom doors related to cancellations and closings by program support staff. In addition, staff should use the council’s website, listserv, committee email lists and any other means of communications to notify committee members and others of event cancellations, changes or office closings.

Section 11. Recovery

Planning for predesignated short term office relocation
The council has develop memorandums of understanding with two potential alternate short term office locations. The first is a MOU with NSPA to use the Mobile RHCC/Communications Trailer as an emergency office. This trailer is configured with satellite communications, Internet, radios, telephone, and workstations. It also has kitchen and restroom facilities. The second MOU was developed with the Salem Civic Center to provide a temporary fixed office facility. These MOUs are on file with NSPA and the Salem Civic Center, and stored in a public folder on the WVEMS document server.

Current vendor contact information, computer network information, telephone information and re-use of existing undamaged equipment will be used by the Leadership Team to recreate a reliable office infrastructure. (See Appendix 1)

Telephone and email contingency for off-site work
The Council’s email system is hosted on a secure Exchange Server located in an off-site data center. Email may be accessed and used anywhere that an Internet connection is available. The Council’s telephone service is Voice-Over-Internet-Protocol (VOIP) based. WVEMS maintains an off-site cache of VOIP telephones that will take over the WVEMS phone system automatically when plugged into any high-speed Internet connection.

Work from home alternatives
The council's network and telephone system will support remote/offsite work locations. Depending on the anticipated need and duration for office relocation, a temporary "work from home" alternative will be considered. VOIP telephones and remote access to files and email make this a viable alternative.

E-meeting alternatives
Temporary relocation, mass illness or other factors may prompt the need to conduct council business of committee meetings or other networking by electronic means. The council maintains a conference calling capability with a third party vendor which supports audio and web conferencing. The web conferencing is available as document sharing for large groups or web-based videoconferencing for small groups.

Reestablish/purchase office equipment, Internet service, Telephone service
A comprehensive documentation of current vendors, service providers, IP assignments, office equipment, etc will be maintained to assist in reestablishment or purchase or replacement office electronics and other equipment. (See Appendix 1)

Reestablish mail delivery
The team will notify the USPS, FedEx, DHL and UPS of any changes in short or long term office relocation.

Reestablish financial management
A priority in reestablishing office operations, and supporting others, will be continuation of accounts payable, payroll and accounts receivable. The council utilizes Peachtree Accounting software for bookkeeping. The program saves its data to the council's server, and is backed up daily. In the event of office disruption, the data can be restored on any other computer with the Peachtree Accounting program, and also by a number of accountants throughout the region. The Business Manager and Office Manager (or Administrative Assistant) will remain proficient in the use of the accounting software. Any program manager can issue purchase orders. Payroll is handled via direct deposit to staff member's banks. The Business Manager has primary responsibility for bookkeeping and the Leadership Team has responsibility for restoring the Office Manager/Administrative Assistant's and Business Manager's computer, Peachtree software and council financial data.

Support to NSPA and MRC
Replacement of medications and supplies - Mass illness, WMD attack or other disaster might require use of NSPA-provided supplies of preventative medications, antidotes or other bulk supplies. The Council will support replenishment of medications or other related supplies as required utilizing available NSPA/ASPR sustainment funding. Medication and supply caches are maintained at the WVEMS office in Roanoke, and at other external locations. WVEMS staff members will assist NSPA staff in distributing this cache upon request.

Support for the contracted MRCs will continue, and perhaps be increased during a disaster or major disruptive event.

Support to EMS community
Emergency protocols: Mass illness or other disaster might require short or long term changes to EMS medical protocol related to triage, treatment and/or transportation of patients. The council will support committee meetings and other networking necessary to facilitate such decision-making. This facilitation may need to accommodate social distancing.

Support to the Virginia Office of EMS
The VAOEMS continuity of operations plan calls for restoration of documents such as regional EMS contracts with assistance from the EMS councils. The council will support the VAOEMS with document recovery and with any other reasonable request to help assess and restore the statewide EMS system.

Planning long term office relocation
Consideration for the potential for long term or permanent office relocation would be driven by catastrophic damage to the existing structure and resulting decisions by the board of directors and insurance providers to rebuild or not. The Executive Director or designee would explore these issues with the board and insurers and would identify suitable office space for long term or permanent relocation if necessary.

Section 12. Devolution

Section 12VAC5-31-2320 of the EMS Rules and Regulations requires that any organization or person establishing, operating, maintaining, advertising or representing itself or any services as a designated regional EMS council must have a valid designation issued by the Board of Health. Section § 32.1-111.11 of the Code of Virginia grants unilateral power to designate regional EMS councils to the Board of Health. Pursuant to these regulations, the Council does not have the authority to transfer operations or authority to any other agency. Should total disruption of services lasting more than 72 hours occur due to catastrophic damage or disaster, the Executive Director or successor will notify the Office of Emergency Medical Services system planner. A determination to temporarily relocate services or to designate another entity will be the responsibility of the Board of Health pursuant to the regulations cited above.

Section 13. Training on, and Exercising the COOP

As addressed in Section 5 above, all office-based employees are provided with the COOP as part of their initial orientation. Annually, a COOP update is provided as part of the council's ongoing staff development program. Once each year, elements of the COOP are exercised. An actual disruptive event such as an emergency weather-related office closure may substitute for a drill.

Appendix 1 - Vendor List

Information Technology/Computer Support- Email, website, web store Coralogic Corporation	Jim Huffman www.coralogic.com 3700 Commerce Blvd Suite 107W Kissimmee, FL 34741-4656 407.520.5135 888.267.2564 (888.CORALOG) Support ticket requests: Email to support@coralogic.com or visit www.coralogicsupport.com
Telephone System Support: All offices Coralogic Corporation	Jim Huffman www.coralogic.com 3700 Commerce Blvd Suite 107W Kissimmee, FL 34741-4656 407.520.5135 888.267.2564 (888.CORALOG) Support ticket requests: Email to support@coralogic.com
Mobile Phone/Smart Phone Support Verizon Coralogic Corporation	Melody Hodges Customer Service 540-798-8248 Blackberry Enterprise Server and Smart Phone integration Justin Ebaugh Coralogic (See IT Support above)
Security System/Card Access System: Roanoke Office Diversified Security Resources	Don Gordon PO Box 505 335 Sontag Road Rocky Mount VA 24151 540.484.1634 Mobile 540.400.3173 divscrty@aol.com

Accountants/Auditors Brown Edwards Certified Public Accountants	John C. Hash, II, CPA http://www.becpas.com 319 McClanahan St. SW Roanoke VA 24014 540.345.0936 jhash@becpas.com
Vehicle Maintenance-Fuel: Roanoke Roanoke County General Services – Fleet Service Center	Director of Fleet Service Center Roanoke County 5235 Hollins Road Roanoke, VA 24019 540.387.6555
Attorney/Registered Agent	Robert H. Logan 2222 York Road Roanoke, VA 24015 540.982.6624 540.400.1243 Fax 206.339.2585 logan@vaems.org
Audio/Video/Smartboards Lee Hartman and Sons, Inc.	John Cosgrove www.leehartman.com 3236 Cove Road, NW Roanoke, VA 24017 540.366.3493 800.344.1832 Fax 540.362.4659

Communications Trailer Satellite Internet Service Skycasters	1520 S. Arlington St., 1st Floor Akron, OH 44306 330.785.2100 800.268.8594
EMS Radio Systems Pro Comm, Inc. Two Way Radio, Inc. Mountain Electronics	Tinker Mountain System Pro Comm, Inc. 3805 South Main Street. Blacksburg, VA 24060 http://www.vawireless.com/ 800 277-1777 Peaks Knob System Two-Way Radio Inc. 1300 West Ridge Street Wytheville, VA 24382 www.twowayradioinc.com sales@twowayradioinc.com 888.228.2791 Fax 276.228.5053 Alleghany Sites (Horse Mountain and Bald Knob) Mountain Electronics 701 S. Highland Ave. Box 328 Covington, VA 24426 www.mountainelectronics.com info@mountainelectronics.com 540 962-3346 Fax 540 962-7869

Appendix 2 – Computer Network Documentation

Council documents and other electronic records are stored on an in-house server or other network storage device to ensure regular backups and security of sensitive documents. All employees have been trained in storage of critical documents on network shares and to redirect “My Documents” folders to the server. Transparent to user operations, this process guarantees both a local and network synchronized copy of user documents and settings providing a redundant copy of documents on the server as well as functional documents in the event of a server and/or network outage.

Local servers have automated nightly backups that contain both a full restore as well as archived incremental backups of modified files. While archive periods vary based on amount of changed data and size of files, current backup media will maintain at least a 30 day archive.

Local servers also provide DHCP assignment of IP addresses and other network configuration settings. Printers and other devices requiring “static” IP assignment are also provided IP information via DHCP with address reservations. Every attempt has been made to limit manual configuration of equipment on the network. Static IP addresses for routers are provided by the ISP providing Internet connectivity. Any configuration information needed to restore services in the event of a failure will be provided upon equipment replacement.

Uninterruptable power supplies are installed to maintain network and Internet connectivity during brief power outages as well as to allow a controlled shutdown of servers to prevent data corruption. UPS units are not designed to maintain long term power but as a protective measure against power fluctuations that may cause hardware damage, file corruption or momentary disruptions in network connectivity.

Council websites are hosted by Coralogic and are located on servers in a secured 24/7 staffed facility at the Kissimmee, Florida data center. Uninterruptable power supplies provide an uninterrupted power source until diesel generators restore power to the data center. Fuel to cover a 14 day span is onsite and the data center is 3rd on the local list of critical operations to receive replacement fuel. Equipment is protected by an Inergen fire suppression system and housed in a facility rated to withstand CAT5 strength winds.

Internet connectivity is provided by multiple Tier 1 backbone providers on a redundant fiber ring. Redundant firewalls and routers are also onsite to provide load balancing between providers as well as fault tolerance in connections. Backups are performed nightly and retained on a nightly, weekly and monthly basis. Those backups are readily available to users through the CPanel interface. Backups are also duplicated to a data center backup repository to retain data in the event of total server failure.

Hosted PBX services are provided by equipment housed in the same data center. In addition, an alternate server in an adjoining administrative building receives nightly

updates of all configuration changes, voicemail messages, call logs, etc. Accounts can be activated on the alternate server within moments to retain services in the event of a failure of any PBX equipment in the data center. Due to the hosted nature of PBX services, council offices are not dependant on local telco facilities or on premise equipment. Restoration of telephone service can be rapidly deployed using offsite IP telephones and or computer based softphones. There is also the ability to redirect incoming DID (direct inward dial) numbers to alternate landline numbers as a failover.

All council email (vaems.org accounts) are maintained on equipment owned by the Alliance for Emergency Medical Education and Research, and controlled by the Council, in the Kissimmee data center. This server holds the AEMER event registration system, Exchange mailboxes and the regional EMS council Blackberry Enterprise Server.

In the event of hardware failure, standby servers are available for lease from the data center until such time the defective equipment can be rebuilt or replaced. There is no cost to maintain the availability of standby servers until these servers are actually placed into operation and are then billed on a month-to-month lease basis. Rack space in the data center is also available to the council offices for other dedicated services and would be provided the same protection as other equipment in the facility.

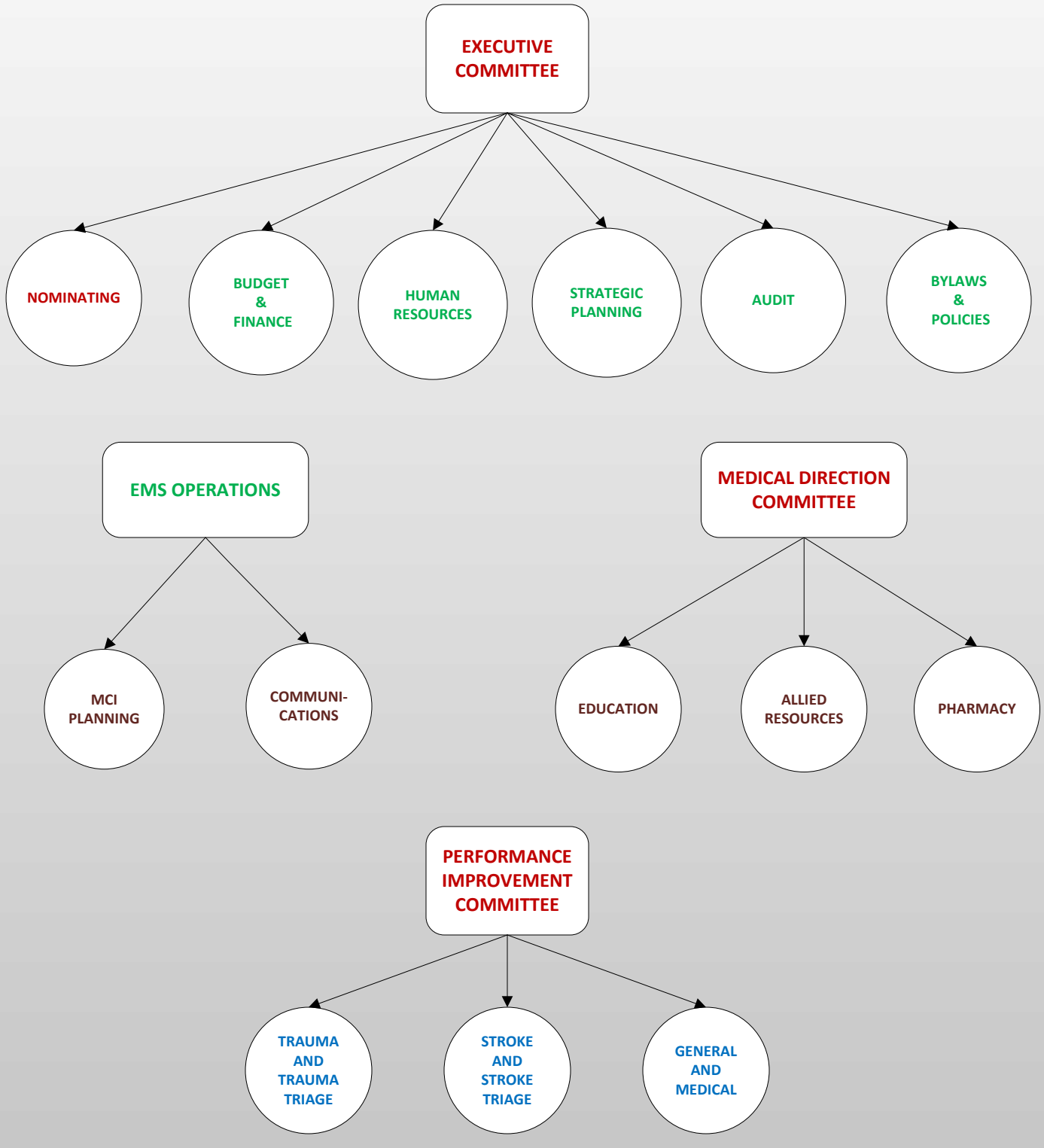
Offsite hosting of council email accounts will provide increased communications reliability. Users will have complete access to all email messages, contacts, calendars, tasks, etc. from remote computers using Outlook, the Outlook Web Access web interface, as well as wireless handheld devices. Email communications is not dependent on Internet connectivity and/or power at the council office.

Appendix 3 – Administrative Duties Pairing

WVEMS Executive Director is paired with Education Program Director
Business \Manager is paired with Office Manager (or Administrative Assistant)
Senior Field Coordinator is paired with Field Coordinators
NSPA Executive Director is paired with WVEMS Executive Director

PROPOSED WVEMS COMMITTEE STRUCTURE

September 13, 2012



WESTERN VIRGINIA EMERGENCY MEDICAL SERVICES COUNCIL, INC.

As amended February 4, 2010

BYLAWS

ARTICLE I - NAME

The name of this Corporation shall be the Western Virginia Emergency Medical Services Council, Inc.

ARTICLE II - PURPOSES

The purposes of this Corporation shall be those set forth in the Articles of Incorporation.

ARTICLE III - AREA TO BE SERVED

The Corporation shall serve the areas consisting of the following political subdivisions of the State of Virginia:

City of Roanoke	Alleghany County*	Patrick County*
City of Salem	Roanoke County*	Floyd County*
City of Covington	Botetourt County*	Pulaski County*
City of Radford	Giles County*	Craig County*
City of Danville	Montgomery County*	Pittsylvania County*
City of Martinsville	Franklin County*	Henry County*

(* Including incorporated towns therein)

The corporation may serve additional political subdivisions as may be authorized upon a majority vote of the Board of Directors.

ARTICLE IV - LOCATION OF OFFICE

The principal office of the Corporation shall be located in the City of Roanoke, Virginia. The Corporation may have such additional offices at other places and such times as may, from time to time, be designated by the Board of Directors.

ARTICLE V - BOARD OF DIRECTORS

Section 1 - MEMBERSHIP

Directors of the Corporation, hereinafter referred to as the Council Board, shall be elected or appointed in accordance with the Articles of Incorporation and the following provisions:

Section 3 - ELECTIONS, TERM OF OFFICES AND VACANCIES

The Council Board shall be comprised of twenty-seven (27) members allocated as follows:

A. Among Political Jurisdictions (18)

At least one director from each of the following political jurisdictions:

City of Roanoke	Alleghany County
City of Salem	Roanoke County
City of Radford	Botetourt County
City of Covington	Craig County
Pulaski County	Montgomery County
Floyd County	Giles County
City of Danville	Franklin County
City of Martinsville	Henry County
Pittsylvania County	Patrick County

Directors allocated to political jurisdictions shall include residents of the area served and representatives of organizations, including rescue squads and medical societies, engaged in the emergency medical services system as prescribed in Article V, Section 1. Directors representing localities shall be appointed by the locality represented.

B. At Large Professional (~~5~~4)

~~Virginia Chapter - American College of Emergency Physicians~~	~~1~~
Emergency Nurses Association	1
Virginia Association of Volunteer Rescue Squads	1
Near Southwest Preparedness Alliance	1
Regional Medical Director	1

One at-large from each of the above professional organizations shall be elected from among names of persons submitted by each organization to the Council Board. In the case of the Regional Medical Director, nominations shall be provided by the nominating committee.

C. At-Large Other (~~3~~4)

Three directors, one from Fourth Planning District, one from the Fifth Planning District, and one from the Twelfth Planning District, shall be chosen with out regard to professional organization affiliation or political jurisdiction, and shall be elected by the board. One board-certified emergency physician affiliated with a hospital-based emergency department in the region shall be chosen, and shall be elected by the board.

D. The Council's Executive Director, who shall serve without vote.

Of the foregoing twenty-seven directors, not less than ten percent (10%) shall be persons whose vocational or professional activities do not directly involve them as emergency health care providers.

E. Directors, (with the exception of the Executive Director and Regional Medical Director) shall serve a term of three (3) years in office, measured beginning the first day of the month following the annual meeting of the Council Board. The Executive Director's term shall coincide with his/her employment. The Regional Medical Director's term shall coincide with his/her appointment.

All directors elected or appointed annually shall take office on the first day of the month following their election or appointment.

F. Vacancies on the Council Board shall be filled for the unexpired portion of the term by the Council Board or the appointing authority at any regular meeting or at a Special meeting called for that purpose.

G. A director shall serve until the expiration of the term to which elected or until replaced by the appointing authority, and until a successor has been appointed or qualified, or until the prior resignation, death or removal of such director.

H. An elected director who shall be absent from three (3) consecutive Board Meetings shall be considered to have resigned from the Board, subject to acceptance of the resignation by the Board of Directors.

I. Removal of a director for cause, other than absence, shall require a vote of two-thirds (2/3) of the members of the Board present and voting. Notice of a meeting to consider a removal shall be mailed to each director at least seven (7) days prior to the date of such proposed meeting, stating the purpose of such meeting.

Vacancies resulting from the above shall be filled according to the membership and election and appointment requirements of the Bylaws.

ARTICLE VI

Section 1 - OFFICERS

The officers shall be elected by and from the directorship of the Council Board except as hereinafter stated, and shall consist of the following:

A. President, who shall serve as the Chairman of the Board of Directors.
B. Vice President
C. Secretary
D. Treasurer
E. Executive Director

Officers, except the Executive Director, shall be elected for two-year terms of office at the annual meeting of the Council Board of the odd-numbered years. The Executive Director shall serve a term consistent with his/her employment. Officers shall serve until their successors are elected to and take office. An officer shall be eligible to serve consecutive terms.

Assistant treasurers and secretaries may from time to time be elected, as desired by the Council Board.

A person shall hold no more than one office in the Corporation.

Section 2 - PRESIDENT

There shall be the President, who shall be the Chairman of the Board of Directors and will preside at all of its meetings and shall be the Chairman of the Executive Committee. The President shall appoint the members of all committees of the Council with the approval of the Council Board. The President shall be an ex-officio member of all committees and task forces of the Board.

Section 3 - VICE PRESIDENT

In the absence of the President, or in the event of his/her inability to act, or if that office is temporarily vacant, the Vice President shall exercise all the powers and perform all the duties of the President.

Section 4 - SECRETARY

The Secretary shall keep the minutes of all meetings of the Council. He/she shall be responsible for the giving and serving of all notices of meetings of the Council and, in general, shall perform all duties incident to the office of Secretary and shall have such other powers and duties as may be assigned to him by the Council Board.

Section 5 - TREASURER

The Treasurer shall have general supervision over the care and custody of the funds and securities of the Council and shall be Treasurer of the Council. he/she shall deposit the same or cause the same to be deposited in the name of the Council in such banks or other depositories as the Council Board may direct. he/she shall cause the funds of the Council to be disbursed by checks or drafts upon the authorized depositories of the Council and shall cause to be taken and preserved proper vouchers for all funds disbursed. he/she shall keep or cause to be kept full and accurate accounts of all receipts and disbursements of the Council and shall present to the Council Board, whenever requested, a complete report of receipts and disbursements and of financial conditions. He/she shall perform such other duties as may be assigned to him from time to time by the Council Board.

Section 6 - EXECUTIVE DIRECTOR

The Executive Director shall be the Chief Professional Officer of the Corporation. The Executive Director shall have the power to make and execute contracts in the ordinary business of the Corporation in the sum of up to $5,000 or binding the Corporation for up to twelve months and for and in the name of the Corporation to execute other legal instruments as authorized by the Council Board. The Executive Director shall be employed by contract approved by the Board. Upon any matter concerning his/her employment, the Executive Director shall have no vote.

The Executive Director shall have such powers and duties as from time to time may be assigned to him/her by the Council Board.

Section 7 - VACANCIES

A vacancy in any office, except of the Executive Director, shall be filled for the unexpired portion of the term by the Council Board at any regular meeting, or at a special meeting called for that purpose.

ARTICLE VII - COMMITTEES

Section 1 - EXECUTIVE COMMITTEE

It shall be the purpose of the Executive Committee to conduct the necessary and routine business of the Council Board between meetings of the Board of Directors.

The Executive Committee shall consist of the following members of the Council Board:

A. The President, who shall serve as the Chairman of the Executive Committee.

B. The Vice President

C. The Secretary

D. The Treasurer

E. The Executive Director, who shall not vote.

F. Three (3) members from the Council Board, one from the Fourth Planning District, one from the Fifth Planning District, and one from the Twelfth Planning District.

The at-large members elected from the Council Board shall serve for a term of two (2) years and are eligible to serve consecutive terms. A vacancy occurring on the Executive Committee shall be filled at any regular meeting of the Council Board or at any special meeting called for that purpose.

Functions of the Executive Committee shall include, but not be limited to the following:

A. Budget and Finance

B. Human Resources

C. Strategic Planning

D. Audit

E. Bylaws and Policies

Section 2 – STANDING AND SPECIAL COMMITTEES, TASK FORCES AND WORK GROUPS

Committees have broad responsibility to address ongoing issues affecting the provision and coordination of EMS within the region. Committees shall be chaired by a WVEMS board member. Recommendations of committees typically require board action for adoption and implementation.

Subcommittees exist under the auspices of a committee, and address a specific subset of the committee's charge. Recommendations of subcommittees require adoption by the parent committee prior to board action.

Work Groups are perpetual and function independently, although they may be organized by a committee. They are established to address issues related to specific elements of the EMS system such as MCI planning, communications and hospital relations. Recommendations of work groups may require committee and/or board action.

Task forces are established for a limited duration and for a specific purpose or to complete a specific task. They cease to exist upon fulfillment of the purpose or completion of the task.

~~Non-Board members may serve on Standing or Special Committees and Task Forces of the Board. The Chairman of each committee shall be a member of the Council Board.~~Committee and Work Group members are appointed by the president with concurrence of the board. Subcommittee members are appointed by the parent committee. Task force members are appointed by the president with concurrence of the executive committee.

A. The Nominating Committee shall be appointed by the President with the concurrence of the Council Board. The Nominating Committee shall be composed of not more than one director of the Council Board from any of the participating political jurisdictions and shall have no fewer than ~~five~~ three members. Prior to the annual meeting at which officers and directors will be elected, the Nomination Committee shall fulfill the following charges:

i. ~~a.~~ Prepare a slate for the election of directors for each elected position. ~~to which a political jurisdiction is entitled and for at-large positions. The slate for the election of directors shall be constituted of persons who are engaged in the emergency medical services system as well as residents of the area served who have no professional training or financial interest in provision of health care.~~

ii. ~~b.~~ Prepare a slate nominating directors to serve as officers of the Council Board.

iii. ~~c.~~ Prepare a slate nominating directors to serve as at-large members of the Executive Committee.

iv. ~~d.~~ Ensure that such slates are submitted in writing to each director of the Council at least ten (10) days in advance of such election.

v. ~~e.~~ Perform such other duties as may be appropriately delegated by President or the Council Board.

~~B.~~ ~~The Finance Committee shall be appointed by the President with the concurrence of the Council Board. The Finance Committee shall be composed of the Treasurer, who shall serve as Chairman, and not more than one director of the Council Board from any of the participating political jurisdictions and shall have no fewer than five (5) members.~~

~~C.~~B. There shall be an established Medical ~~Directorate~~ Direction Committee, comprised of all active Operational Medical Directors of Emergency Medical Services Agencies within the WVEMS region. The committee will also include at least two career and two volunteer ALS-certified EMS providers. The Regional Medical Director shall be the chair.

~~comprised of representatives of each emergency room of each hospital served within the Planning Districts of the Council, which representative shall be a licensed physician. The Directorate shall appoint three Medical Directors of the Council. One shall be from the Fourth Planning District, one shall be from the Fifth Planning District and one shall be from the Twelfth Planning District. Each appointment shall be subject to the consent and pleasure of the Board of the Western Virginia Emergency Medical Services Council.~~

~~There shall be established a Medical Advisory Committee, comprised of all individuals who are in positions of Operational Medical Director of an Emergency Medical Services Agency within the Fourth, Fifth and Twelfth Planning Districts of Virginia.~~
The Medical Direction Committee is responsible for oversight of the following three work groups:

i. Education which shall consist of no less than 7 members broadly representing EMS education in the region.

ii. Pharmacy which shall consist of the Pharmacist in Charge of each hospital pharmacy in the region(s) included (or their designees). In the event that the Blue Ridge EMS Council's pharmacy group is established jointly with the WVEMS pharmacy group, their will be co-chairs, one from each region. The pharmacy group will include at least two pre-hospital EMS providers who shall serve without vote.

1. Allied Resources which shall consist of one representative from the administration of each hospital within the WVEMS region, and at least four pre-hospital EMS providers. This work group may be established jointly with the Blue Ridge EMS Council, in which case it will include similar representation from hospitals in the Blue Ridge EMS region.

D. There shall be established ~~an E.M.S. Personnel and Training Committee which will develop the means to effect and assure the availability of an adequate number of health professionals, including ambulance personnel, to staff the E.M.S. system; ensuring that such personnel, including appropriate public safety personnel, receive commensurate training and are provided an opportunity for, and encouraged to participate in, coordinated continuing education programs; and to emphasize the recruitment of veterans of the Armed Forces with training and experience in the health care field.~~Performance Improvement Committee which

shall consist of members broadly representing hospitals, trauma centers, stroke centers, volunteer and career prehospital EMS agencies, and others. The committee shall establish subcommittees including, but not limited to the following:

i. Trauma and Trauma Triage

ii. Stroke and Stroke Triage

iii. General and Medical

E. There shall be established a Communications ~~and Transportation Committee~~ Work Group which will ~~develop and implement a central~~ provide guidance and advice on interoperable communications system~~s to join the personnel, facilities and equipment of the E.M.S. System; developing and implementing a transportation system that provides an adequate number of air, land and sea vehicles which meet the appropriate standards relating to location, design, performance, equipment and patient needs, including transfer of patients to facilities and program offering specialized critical care follow-up care and rehabilitation.~~and on operation, licensure and maintenance of any EMS radio systems owned and/or operated by WVEMS.

F. There shall be established ~~a Public Education and Information Committee which will develop and implement programs for visitors as well as residents which provide information as to: The means of obtaining emergency medical services; appropriate methods of medical self-help and first-aid; and the availability of related first-aid training and programs~~an Mass Casualty Incident Planning Work Group which shall consist of emergency management officials from each locality in the WVEMS region, hospital emergency managers, pre-hospital EMS providers and others with expertice in emergency management and MCI planning. This Work Group may operate jointly with the Blue Ridge EMS Council, in which event it shall include similar representation from the Blue Ridge EMS region

~~G. There shall be established an Allied Resources Committee which will provide the means to effectively utilize various resources within the region, to include:~~

~~Utilization of the appropriate personnel, facilities and equipment of each public service agency, hospital and other medical facilities;~~

~~Development of plans to assure that the system will be capable of providing emergency medical services during normal operations and mass casualties, natural disasters, or national emergencies;~~

~~Provision for the establishment and annual review of appropriate arrangements and written agreements between the Council, hospitals and EMS agencies, and with emergency medical services systems in neighboring areas for the provision of emergency medical services within the region and on a reciprocal basis as appropriate;~~

~~Development of the means to assure the availability of an adequate number of~~

~~easily accessible emergency medical services facilities which are collectively capable of providing services on a continuous basis, which have appropriate non-duplicative and categorized capabilities, which meet appropriate standards relating to capacity, location, personnel record keeping, equipment and supplies, and which are coordinated with other health care facilities of the system, and which provide access to specialized critical medical care units.~~

~~H. There shall be established a Long Range Planning Committee which will review goals and assess needs for the effective development of the emergency medical services system.~~

~~Section 3 - SPECIAL COMMITTEES AND TASK FORCES~~

~~A. Special committees and task forces shall be established to serve in a resource capacity to the Council Board in matters concerned with the emergency medical services system and shall serve at the pleasure of the Board.~~

~~B.~~ The President, with the concurrence of ~~a majority of~~ the Council Board ~~and task forces, shall appoint or authorize the appointment of all committees.~~may establish other work groups and task forces as deemed necessary and appropriate.

ARTICLE VIII - MEETINGS

Section 1 - SCHEDULING AND CALL OF MEETINGS

The Annual Meeting of the Council Board shall be held in January of each year. The date, place and exact time of such meetings shall be set by the Council Board. The Council Board shall have the power to set the date, times and places of regular meetings of the Council Board. Special meetings of the Council Board shall be called by the President or by the Secretary on the written request of any five (5) directors of the Council.

Section 2 - NOTICE OF MEETINGS

Notice of the time, place and purpose of annual and special meetings of the Council Board shall be served as provided by law, but in no case shall such notice be less than five (5) days unless agreed upon by all directors of the Council Board. Attendance at such meetings shall constitute waiver of notice, unless such attendance is for the sole purpose of objecting to the notice provisions therefore.

ARTICLE IX - QUORUM

To constitute a quorum at all meetings of the Council and its Executive Committee, one-third of each body shall constitute a quorum for the transaction of business, but less than a quorum may adjourn any meeting without further notice until a quorum may be present. On matters of personnel employment, the Executive Director shall not vote, but his/her presence shall be included in the quorum.

ARTICLE X - VOTE

Each director of the Council Board shall be entitled to one vote, with the exception of the Executive Director, who serves without vote. All actions taken by the Council Board shall require a majority vote of those directors present and voting at any meeting. The same procedure shall apply to all meetings of the Council. ~~On matters concerning his/her employment, the Executive Director shall not vote.~~

ARTICLE XI - ANNUAL AND OTHER REPORTS

The President, Secretary, Treasurer and Executive Director shall present to the Council Board at its Annual Meeting a report, verified by them, showing the whole amount of real and personal property owned by the Corporation, where located, and where and how invested, the amount and nature of the property acquired during the year immediately preceding the date of the report and the manner of its application, appropriations and expenditures have been made; and the names and addresses of the directors of the Council Board and officers of the Corporation, which report shall be filed with the records of the Corporation and an abstract thereof entered in the minutes of the proceedings of the Annual Meeting of the Council.

The Council shall also publish at least annually a report or reports adequately summarizing the activities of the Corporation and shall make such reports and the financial report specified above available to each director of the Council Board, the participating political sub-divisions, and shall otherwise cause these reports to be given wide distribution in the member communities.

ARTICLE XII - EXECUTIVE DIRECTOR

The Council Board shall be empowered to employ an Executive Director for the carrying out of the purposes of this Corporation at such salary as may be set by the Council Board. The Executive Director shall be the Chief Professional Officer.

ARTICLE XIII

Section 1 - EXECUTION OF INSTRUMENTS

All checks, bills of exchange, notes or other obligations or orders for payment of money shall be signed in the name of the Corporation by the Treasurer or such other officer or officers as the Council Board may, from time to time, designate by resolution.

All persons authorized to execute the instruments set forth in the Articles or to otherwise deal with the receipts and payments of funds of this Corporation shall be bonded by the corporate surety bond in an amount not less than the annual budget for this Corporation.

ARTICLE XIV

Section 1 - FISCAL YEAR

The fiscal year of the Corporation shall be from the first day of July to thirtieth day of June, inclusive, or such other twelve-month period as the Council Board may designate by resolution.

Section 2 - BUDGET

Prior to the close of each fiscal year, the council board shall adopt a budget of income and expense to control the finances of the Corporation during the next ensuing fiscal year. The adopted budget for any year may be revised from time to time at any meeting of the Council Board in light of changing conditions.

ARTICLE XV - SEAL

The seal of the Corporation shall be circular in form with the name of the Corporation and figures, "1975", an impression of which the Secretary shall impress upon the margin of these Bylaws.

ARTICLE XVI - AMENDMENTS

These Bylaws may be amended or repealed at any meeting of the Council Board by an affirmative vote of two-thirds of those directors present provided notice of all proposed amendments shall have been mailed to the directors of the Council Board at least fifteen (15) days prior to such meetings.

ARTICLE XVII - INDEMNIFICATION

Section 1 - CLAIMS OF THIRD PARTIES

The Corporation shall indemnify an officer or director who was, or is a party, or is threatened to be made, a party to any threatened, pending or completed action, suit or proceedings, whether civil, criminal, administrative, arbitrative or investigative (other than an action by or in the right of the Corporation) by the reason of the fact that he/she is, or was, a director, officer, employee or agent of the Corporation, or is, or was serving at the request of the Corporation, partnership, joint venture, trust or other enterprise, against expenses (including attorneys' fees), judgments, fines and amount paid in settlement actually and reasonably incurred by him in connection with such action, suit or proceedings if he/she acted in good faith and in a manner he/she reasonably incurred by him in connection with such action, suit or proceedings if he/she acted in good faith and in a manner he/she reasonably believed to be in or not opposed to the best interests of the Corporation, and, with respect to any criminal action or proceeding, he/she had no reasonable cause to believe that his/her conduct was unlawful. The termination of any action, suit or proceeding by judgment, order, settlement, conviction or upon a plea of nolo conterdere or its equivalent, shall not of itself create a presumption that the person did not act in good faith and in a manner which he/she reasonable believed to be in or not opposed to the best interests of the Corporation, and, with respect to any criminal action or proceeding, he/she had no reasonable cause to believe that his/her conduct was unlawful.

Section 2 - CLAIMS OF CORPORATION

The Corporation shall indemnify any officer or director who was, or is a party, or is threatened to be made a party to any threatened, pending or competed action or suit by or in the right of the

Corporation to procure a judgment in its favor by reason of he/she fact that he/she is, or was, a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee, or agent of another Corporation, partnership, joint venture, trust or other enterprise, against expenses (including attorneys' fees), actually and reasonably incurred by him or her in connection with defense or settlement of such action or suit if he/she acted in good faith and in a manner he/she reasonably believed to be in or not opposed to the best interests of the Corporation and except that no indemnification shall be made in respect to any claim, issue or matter as to which such personal shall have been determined to be liable for gross negligence or willful misconduct in the performance of his/her duty to the Corporation, unless and only to the extent that the court in which such action or suit was brought shall determine upon application that, despite the adjudication of liability but in view of all circumstances of the case, such person is fairly and reasonably entitled to indemnity for such expenses which such court shall deem proper.

Section 3 - INDEMNIFICATION UPON SUCCESSFUL DEFENSE

To the extent that any such person has been successful on the merits or otherwise in defense of any action, suit or proceeding referred to in Sections 1 and 2, or in defense of any claim, issue or matter therein, he/she shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by him in connection therewith.

Section 4 -DETERMINATION OF RIGHT TO INDEMNIFICATION

Any indemnification under Sections 1 and 2 (unless ordered by a court) shall be made by the Corporation only as authorized in the specific case upon a determination that indemnification is proper in the circumstances because he/she has net the applicable standard of conduct. Such determination shall be made (i) by the Board of Directors by a majority vote of a quorum consisting of directors who are not parties to such action, suit or proceeding, or (ii) if such a quorum is not obtainable, or, even if obtainable a legal counsel in a written opinion, or (iii) by a majority vote of the shareholders. Each such indemnity may continue as to a person who has ceased to have the capacity referred to above and may inure to the benefits of the heirs, executors and administrators of such a person.

Section 5 - ADVANCE PAYMENTS

Expenses (including attorneys' fees) incurred in defending an action, suit or proceeding, whether civil, criminal, administrative, arbitrative or investigative, may be paid by the Corporation in advance of the final disposition of such action, suit or proceeding as authorized in the manner provided in Section 4, upon receipt of an undertaking by or on behalf of such person to repay such amount unless it shall ultimately be determined that he/she or she is entitled to by indemnified by the Corporation as authorized in this Article.

Section 6 - INSURANCE

The Corporation shall have power pursuant to resolution of the Board of Directors, to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another Corporation, partnership, joint venture, trust or other enterprise, against any liability asserted against him or incurred in any such capacity or arising out of his/her status as such, whether or not the Corporation would have the power to indemnify him against such liability under the provisions of this Article.

Section 7 - DEFINITION OF "CORPORATION"

For the purposes of this Article, references to "Corporation" include all constituent Corporations absorbed in a consolidation or merger as well as the resulting or surviving Corporation so that any person who is, or was, an officer or director of such a constituent Corporation or is, or was, serving at the request of such constituent Corporation as director, officer, employee or agent of another Corporation, partnership, joint venture, trust or other enterprise shall stand in the same position under the provisions of this Article with respect to the resulting or surviving Corporation as he/she would if he/she had served the resulting or surviving Corporation in the same capacity.

Article XVIII - DISTRIBUTION OF ASSETS UPON DISSOLUTION OF THE CORPORATION

Upon the dissolution of the corporation, assets shall be distributed for one or more exempt purposes within the meaning of section 501(c)(3) of the Internal Revenue Code, or the corresponding section of any future federal tax code, or shall be distributed to the federal government, or to a state or local government, or another 501(c)(3) organization, for a public purpose. Such distribution shall be made in accordance with all applicable provisions of the laws of the Commonwealth of Virginia.

_____

PRESIDENT, COUNCIL BOARD

_____

SECRETARY, COUNCIL BOARD

Benny Summerlin Award of Excellence in Local Government

The Summerlin Award of Excellence is awarded by the Western Virginia EMS Council Executive Committee to recognize outstanding contributions to local government by current or former EMS providers.

Benny Summerlin dedicated his life to serving citizens in the community where he lived. As a young teenager in 1973, he began serving as a volunteer junior member of Martinsville – Henry County Rescue Squad and he continued serving his community until his passing at age 53.

Some of his major contributions or positions to the community are:

- Henry County Deputy Sheriff – 1981
- Captain - Martinsville – Henry County Rescue
- World Champion EMT – 3 years
- Director of Public Safety – Henry County – 1985
- President and founding member- Axton Life Saving Crew
- Director of Operations – Henry County - 1992
- Deputy County Administrator – Henry County - 1996
- County Administrator – Henry County – 2002

In 2002, Summerlin received a master's degree in public administration and policy from Virginia Tech. He was a member of the International City/County Management Association (ICMA), Virginia Local Government Management Association (VLGMA) and American Society of Public Administration (ASPA). Previously, Summerlin had served many positions with the Virginia Association of Volunteer Rescue Squads (VAVRS), Virginia Emergency Management Association (VEMA), Western Virginia EMS Council (WVEMS), Virginia EMS Advisory Board, and many other local and State committees.

In 2009, Summerlin received the Fred Herring Award from the Chamber's Partnership for Economic Growth (CPEG). The award recognizes a "person who has given unselfishly to the community through their volunteerism and dedication to the economic growth of Martinsville-Henry County,"

Benny Summerlin’s dedication and service to EMS alone is an exemplary standard for one to strive to reach. This award seeks to honor those EMS providers that lead the community in which they live through excellent service in other areas of local government. The recipient of this award must have met the following minimum standards of service.

- 25 years of service to the community (volunteer and/or career).
- Must have been an EMS provider in good standing and served with an EMS agency within the WVEMS region.
- Must have served as a leader in another division (other than EMS) of local government.
- Must set the example of ethical and professional service to a local community.

This award will be considered during the annual awards process for WVEMS Council. The selection of the recipient will be done by the Executive Committee of the WVEMS Board from nominations received.

The purpose of this award of excellence is to recognize achievements and service to communities beyond the field of EMS. This award emphasizes the value EMS provides communities through its development of community leaders. The life of Benny Summerlin is a testament of the role EMS has in preparing the leaders of our communities.

www.wvems.org

Western Virginia Emergency Medical Services Council, Inc.

Annual Report

July 1, 2011 - June 30, 2012

Western Virginia
Emergency Medical Services Council, Inc.

and

Near Southwest Preparedness Alliance

Table of Contents

Staff Directory *(as of 11-1-2012)*

- Executive Director: Robert H. Logan, Ph.D. (logan@vaems.org)
- Education Program Director: Cathy Cockrell, CICP, CCEMT-P, NREMT-P (ccockrell@vaems.org)
- Business Manager: Mary H. Christian (mchristian@vaems.org)
- Administrative Assistant: Sandra D. Short - (sshort@vaems.org)
- Senior Field Coordinator: Charles W. Berger, NREMT-P (cberger@vaems.org)
- Field Coordinator: Michael L. Garnett, NREMT-P (mgarnett@vaems.org)
- Field Coordinator: William E. (Gene) Dalton (gdalton@vaems.org)
- NSPA Executive Director: Danielle Lissberger, MHA (dlissberger@vaems.org)
- NSPA RHCC Coordinator: Jeffrey M. Echternach (jmechternach@carilionclinic.org)
- NSPA Mobile RHCC Coordinator: Phillip Belcher (pbelcher@vaems.org)
- Medical Reserve Corps Coordinator: Tanya Ferraro (tferraro@vaems.org)
- Regional Medical Director: Charles J. Lane, MD, FACEP (clane@vaems.org)

Office Information

- Main office: 1944 Peters Creek Road, Roanoke VA 24017
- New River Valley office: 6580 Valley Center Drive, Radford VA 24141
  (located in the New River Competitiveness Center)
- Piedmont Office: 1024 DuPont Road, Martinsville VA 24115
  (located in the Henry County Public Safety Training Center)

*Additional Contact information is found on page 12, and on our website: **www.wvems.org***

Mission

The mission of the Western Virginia EMS Council is to facilitate regional cooperation, planning and implementation of an integrated emergency medical services delivery system.

Regional EMS Councils in the Code of Virginia § 32.1-111.11

Regional emergency medical services councils

The Board [of Health] shall designate regional emergency medical services councils which shall be authorized to receive and disburse public funds. Each council shall be charged with the development and implementation of an efficient and effective regional emergency medical services delivery system.

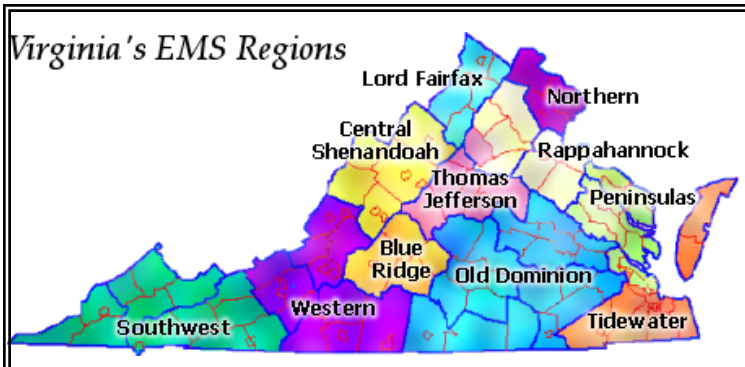
The Board shall review those agencies that were the designated regional emergency medical services councils. The Board shall, in accordance with the standards established in its regulations, review and may renew or deny applications for such designations every three years. In its discretion, the Board may establish conditions for renewal of such designations or may solicit applications for designation as a regional emergency medical services council.

Each council shall include, if available, representatives of the participating local governments, fire protection agencies, law-enforcement agencies, emergency medical services agencies, hospitals, licensed practicing physicians, emergency care nurses, mental health professionals, emergency medical technicians and other appropriate allied health professionals.

Each council shall adopt and revise as necessary a regional emergency medical services plan in cooperation with the Board.

The designated councils shall be required to match state funds with local funds obtained from private or public sources in the proportion specified in the regulations of the Board. Moneys received directly or indirectly from the Commonwealth shall not be used as matching funds. A local governing body may choose to appropriate funds for the purpose of providing matching grant funds for any council. However, this section shall not be construed to place any obligation on any local governing body to appropriate funds to any council.

The Board shall promulgate, in cooperation with the State Emergency Medical Services Advisory Board, regulations to implement this section, which shall include, but not be limited to, requirements to ensure accountability for public funds, criteria for matching funds, and performance standards.



WVEMS is one of 11 regional EMS councils in Virginia. It serves the fourth, fifth and twelfth planning districts of Virginia, encompassing the following localities: Alleghany County, Botetourt County, Craig County, Floyd County, Giles County, Franklin County, Henry County, Montgomery County, Patrick County, Pittsylvania County, Pulaski County, Roanoke County, City of Covington, City of Danville, City of Martinsville, City of Radford, City of Roanoke, City of Salem

Leadership and Oversight

Board of Directors	*Representing*
Ford S. Wirt, President*	Floyd County
Steven D. Eanes, Vice President*	Henry County
Stephen G. Simon., Secretary*	Roanoke County
R. Carey Harveycutter, Treasurer*	5th Planning District At-Large
Steve Allen	Patrick County
William O. Altman	City of Roanoke
Karen Alldredge, MD	Virginia ACEP
John E. Beach	City of Salem
James L. Cady, Sr.*	Craig County
Tim Duffer	Pittsylvania County
Dallas Taylor, RN	Emergency Nurses Association
W. Steven Davis	Giles County
Timothy Dick	City of Covington
Jason Ferguson	Botetourt County
Joe Coyle	Montgomery County
Daryl Hatcher	Franklin County
Rickey Hodge	Va. Assoc. of Vol. Rescue Squads
Michael Jefferson	City of Danville
Charles J. Lane, M.D., FACEP	Regional Medical Director
Robert H. Logan, Ph.D.* (non-voting)	Executive Director
Ryan Muterspaugh	Alleghany County
Danielle Lissberger	Hospital System Representative
Kristopher Shrader	City of Martinsville
Lee Simpkins	City of Radford
L. Joseph Trigg*	Pulaski County
J. Dale Wagoner*	12th Planning District At-Large
Bill Brown	4th Planning District At-Large

**Executive committee*

Committee and Program Leaders

Executive Committee - Ford Wirt, Chair
Medical Direction Committee - Charles Lane, M.D., Regional Medical Director/Chair
General Performance Improvement Committee - Charles Lane, M.D., Chair
Trauma Performance Improvement Committee - Charles Lane, M.D., Chair
Personnel and Training Committee - Steve Simon, Chair
Near Southwest Preparedness Alliance (NSPA) - Carol M. Gilbert, M.D., Chair
Critical Incident Stress Management Team (CISM) -Mary Jones, Team Administrator
Allied Resources Committee - Steve Simon, Interim Chair
Communications Committee - Jim Cady, Sr., Chair
Pharmacy Committee - Joe Ciezkowski, R.Ph., Co-chair; Nadine Gilmore, R. Ph., Co-chair

Significant Accomplishments

Provider Services and Recognition

- ✓ Provided volunteer and career referrals and training course information in response to daily telephone and electronic inquiries.
- ✓ Conducted an annual EMS awards program at the Salem Civic Center. Recognized providers and agencies in ten categories of regional EMS awards. Submitted regional award recipients as statewide EMS award nominees. Two winners went on to win Governor's awards.
- ✓ Coordinated and provided a point of contact for an accredited (VOEMS) regional critical incident stress management (CISM) Team consisting of some 50 volunteer mental health and peer public safety debriefers. Quarterly team meetings were conducted, along with several special events including a certification CISM training program.
- ✓ Responded to nine requests for CISM team interventions, and provided numerous educational sessions.
- ✓ Maintained statewide "Virginia EMS Jobs" web database for the Virginia Office of EMS.
- ✓ Managed multi-regional Consolidated Test Site registration system. (WVEMS staff coordinated development of this system.)
- ✓ Served as EMS infrastructure point of contact for all EMS agencies, providers, hospitals, and local governments in the region and beyond.

EMS Education and Advocacy

- ✓ Provided standardized testing of enhanced and intermediate students exiting from initial certification courses.
- ✓ Coordinated 29 OEMS consolidated test sites throughout the region, registering 806 students for testing.
- ✓ Conducted five Regional EMS Instructor Network meetings, including ALS coordinators, emergency operations instructors and EMT instructors.
- ✓ Provided a loaner library of EMS educational videos and training equipment.
- ✓ Participated in program planning for the annual statewide EMS symposium held November 2011 in Norfolk attended by some 1500 EMS providers, nurses and physicians.
- ✓ Offered four EMT-Enhanced courses, enrolling 37 students.
- ✓ Offered one EMT-Intermediate course enrolling 29 students.
- ✓ Partnered agency in accredited EMT-Intermediate programs at the Roanoke Valley Regional Fire-EMS Training Center, New River Valley Training Center, and the Franklin County Department of Public Safety.
- ✓ Partnered with community colleges across the region to offer college credits for EMS educational programs at no additional cost to students.
- ✓ Offered 380 hours of ALS and BLS continuing education, including the following:
- ✓ 342 hours through certification programs; 24 hours BLS category 1 CE; four AMLS courses, two PEPP courses
- ✓ Offered four International Trauma Life Support (ITLS) courses.
- ✓ Actively participated in numerous State-level committees and work groups.
- ✓ Served on advisory boards for local college and university programs.
- ✓ Participated in pre-hospital care committees for hospitals in the region.
- ✓ Conducted six peer review committee meetings
- ✓ Promoted and co-sponsored numerous educational events across the region.
- ✓ Participated in disaster exercises in six localities, including multi-jurisdictional drills.
- ✓ Served as site evaluator for other planned EMT-Intermediate programs.
- ✓ Participated in statewide committee reviewing BLS testing procedures and scenarios.
- ✓ Participated in statewide committee charged with writing guidelines for VA EMS providers.
- ✓ Staff members attended national EMS conferences.
- ✓ Maintained professional liability insurance on all students enrolled in council-sponsored ALS training programs, saving students some $15,000.
- ✓ Field training staff maintained certification as instructors in PEPP, AMLS and ITLS.
- ✓ Maintained regional web-based training calendar
- ✓ Staff served as state affiliate faculty for ITLS.

EMS Education and Advocacy, cont'd.

- ✓ Membership on advisory boards pursuing accreditation for Intermediate education in Botetourt and Alleghany.
- ✓ Active participation in regional Heart Alert committees.
- ✓ Assumed staff responsibility of BLS test site coordination to ensure uniformity and provide better customer service at BLS test sites.

Medical Direction and Performance Improvement

- ✓ Updated the regional ambulance diversion policy.
- ✓ Maintained a regional ambulance supply exchange and drug restocking policy.
- ✓ Continued projects for regional EMS performance improvement.
- ✓ Planned for and developed new Regional Operational Guidelines, set for implementation in March 2012.
- ✓ Provided suggested guidelines for quality improvement programs in agencies.
- ✓ Endorsed 12 ALS Coordinators for recertification. according to regional guidelines.
- ✓ Reestablished and established new clinical education agreements at 13 hospitals in the region.
- ✓ Expanded clinical education to other healthcare entities beyond hospitals.
- ✓ Endorsed 8 new Operational Medical Directors and/or Physician Course Directors for the WVEMS region.
- ✓ Worked with two Operational Medical Directors in obtaining re-endorsement of their OMD status.
- ✓ Continued and expanded the role of regional Performance Improvement Committees.
- ✓ Developed and adopted a Regional Stroke Triage Plan.

Communications, Facilities

- ✓ Coordinated a region-wide system of drug and IV box exchange, incident reporting and follow-up, and provision of inventory control.
- ✓ Maintained a regional waiver exempting EMS agencies from registration for testing of blood with portable glucometry equipment, saving EMS agencies some $17,500 every two years.
- ✓ Maintained a regional Controlled Substances Registration Permit to allow EMS agencies to carry IV fluids and other controlled substances as "restock items" saving individual agencies some $11,500 every year.
- ✓ Provided continuing liaison between EMS agencies, medical directors and emergency department nurse managers related to the exchange of supplies and equipment.
- ✓ Provided technical assistance and regional administration for VHASS and Web-EOC, web-based ambulance diversion and mass casualty incident management software.
- ✓ Supported statewide "WeatherSafe" program for sharing air medical turn-down information.
- ✓ Continued ownership and operation of various regional EMS communication systems.
- ✓ Completed narrowbanding for all FCC licenses held by WVEMS

Public Information and Referral

- ✓ Maintained an electronic mailing list with over 2,000 subscribers to provide frequent notices of training events and other timely EMS news.
- ✓ Served as a clearinghouse for regional and state EMS pamphlets, posters, displays and other public relation and recruitment materials.
- ✓ Regularly updated the council's Internet web site www.wvems.org with current EMS news and events, education, recruitment, CISM information, committee minutes and council reports, trauma triage information, mass casualty information, General Assembly information and relevant EMS links.
- ✓ Maintained and used large floor-standing display unit that is available for use throughout the region.
- ✓ Published various flyers, for courses, service offerings, etc. throughout the year.
- ✓ Conducted various surveys and published results.

Mass Casualty and NSPA

WVEMS partnered with the Near Southwest Preparedness Alliance (NSPA) to continue building regional medical surge capability through systematic planning, procurement of needed supplies and equipment, and training and exercise efforts. These activities were based on the regional Hazard Vulnerability Analysis, which ranked anticipated risks in the following order:

SPECIFIC RESPONSE AND PREPAREDNESS ACTIVITIES INCLUDED:

- ✓ Assisted regional hospitals and healthcare facilities during response to the Derecho weather event
- ✓ Coordinated with Hospitals, EMS, and Public Health during the Fungal Meningitis outbreak
- ✓ NSPA's Regional Healthcare Coordination Center was activated multiple times for emergency response assistance to hospitals and health/medical agencies
- ✓ Purchased water storage tanks for emergency use
- ✓ Planned for at-risk populations in conjunction with regional partners annual NSPA Regional Collaborative Workshop.
- ✓ Established Long Term Care Workgroup to prepare Nursing Facilities for disaster response
- ✓ Worked with WVEMS/BREMS, EMS, and Hospital agencies to create a regional MCI plan
- ✓ Continued power and water resiliency projects for regional hospitals
- ✓ Supported MRC and related projects in three health districts. MRC Coordinator is housed within the WVEMS/NSPA offices in Roanoke.

TRAINING AND EDUCATIONAL ACTIVITIES INCLUDED:

- ✓ Basic & Advanced Disaster Life Support; Communications (RIOS and BGAN) training;
- ✓ Hazmat training; Mobile medical asset (including STIP) training
- ✓ VDH epidemiology conference
- ✓ Best practice visits to Knoxville, TN and Pittsburgh, PA
- ✓ NDMS integrated summit
- ✓ Regional Collaborative Workshop
- ✓ State Hospital Emergency Preparedness Forum
- ✓ Annual VDEM conference
- ✓ VDH integrated summit

Other Planning and Coordinating Activities

- ✓ Published periodic financial reports, quarterly program reports, an annual report, frequent committee minutes and other training and event announcements.
- ✓ Provided a consistent point of contact for EMS providers, agencies and local governments.
- ✓ Provided representation on a number of local, regional and statewide committees and boards.
- ✓ Provided technical assistance to applicants for Virginia EMS Financial Assistance (RSAF) grants and provided standardized grading for all EMS grants submitted to OEMS from agencies within the WVEMS region.
- ✓ Gained approval for $1,616,181 in RSAF grant awards to agencies within the region.
- ✓ Revised regional EMS strategic plan and other regional planning documents.
- ✓ Provided fiscal and administrative support for the Alliance for Emergency Medical Education and Research, co-sponsor of the Virginia EMS Symposium and other events.
- ✓ Provided fiscal and administrative support to the Near Southwest Preparedness Alliance (NSPA) to manage some $1 million in federal hospital preparedness program (HPP) funds.
- ✓ Continued coordination of the Medical Reserve Corps (MRC) in two health districts within the region for the Virginia Department of Health (VDH), and added coordination for the Blue Ridge MRC.

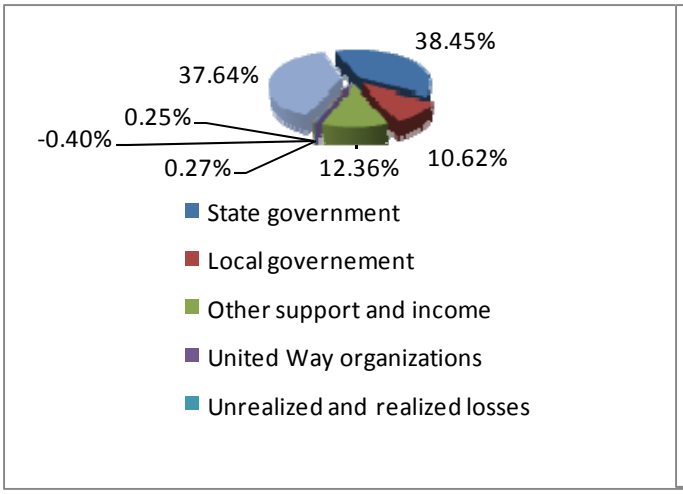
FINANCIAL POSITION

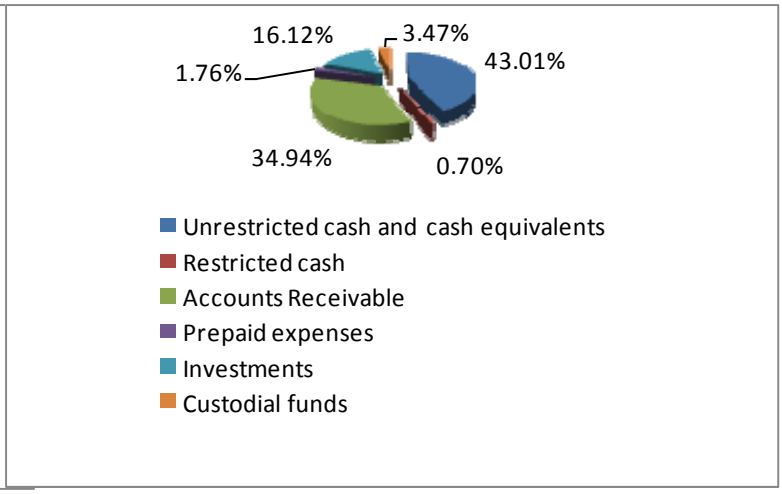
June 30,	2012	2011
Assets		
Current Assets		
Unrestricted cash and cash equivalents	322,925	358,256
Restricted cash	5,236	2,041
Accounts Receivable	262,366	171,940
Prepaid expenses	13,252	7,780
Investments	121,033	
Custodial funds	26,086	27,775
Total current assets	750,898	567,792
Property and equipment - net	423,648	443,099
	1,174,546	1,010,891
Liabilities and Net Assets		
Current Liabilities		
Accounts Payable	41,095	36,083
Accrued expenses	165,357	32,480
Custodial funds liability	26,086	27,775
Other liabilities	2,705	
Total liabilities	235,243	96,338
Net Assets		
Unrestricted	933,036	906,885
Unrestricted - designated	6,001	5,627
Total unrestricted	939,037	912,512
Temporarily restricted	266	2041
Total net assets	939,303	914,553
	1,174,546	1,010,891

The Western Virginia EMS Council, Inc. was chartered in 1975 under the laws of the Commonwealth of Virginia.
The council is a private, not-for-profit, tax exempt organization as described in section 501 (c)(3) of the Federal IRS Code.
Donations to the council are tax deductible.
Federal Employer Identification Number (EIN): 54-1010118
DUNS Number: 011866139
Guidestar: Search EIN above or "Western Virginia Emergency Medical Services"

STATEMENT OF ACTIVITIES

June 30,	2012	2011
Unrestricted revenues and support		
State government	482,746	475,390
Local governement	133,332	132,652
Other support and income	155,212	224,431
United Way organizations	3,365	4,041
Unrealized and realized losses	(5,067)	
Investment income	3,089	7,150
Net assets released	472,579	362,547
	1,245,256	1,206,211
Expenses		
Program services	976,358	949,197
Management and general	242,373	225,912
	1,218,731	1,175,109
Change in unrestricted net assets	26,525	31,102
Temporarily restricted net assets		
Federal grant revenue	470,804	344,214
Net assets released from restrictions and reclassiifications	(472,579)	(362,547)
Change in temporarily restricted net assets	(1,775)	(18,333)
Change in net assets	24,749	12,769
Net assets - beginning of year	914,553	901,784
Net assets - end of year	939,302	914,553





$4.25-for-Life Funding to Localities

In 2006, the full funding generated by the "$4-for-Life" vehicle registration add-on was allocated in its entirety to EMS. For several years, a portion of this fund has been diverted to other areas, but beginning July 1, 2006, the full amount came back to EMS. Of this amount, 26% is returned directly to the localities. The allocation is based on DMV collections, determined by the number of eligible vehicles registered in each jurisdiction. In the 2009-2010 session, this program was increased to $6.25, but the additional revenue does not go to benefit EMS at this time.

JURISDICTION	FY-04 Payment	FY-05 Payment	FY-06 Payment	FY-07 Payment	FY 08 Payment	FY 09 Payment	FY 10 Payment	FY 11 Payment	FY 12 Payment
ALLEGHANY COUNTY	8,080.50	8,013.00	13,593	13,911	15,379	17,412	16,236	17,524	21,882
BOTETOURT COUNTY	15,843.50	15,883.00	26,738	28,225	30,767	36,120	33,726	36,851	35,078
COVINGTON	2,755.50	2,726.00	4,363	4,596	5,088	5,569	5,232	5,464	5,338
CRAIG COUNTY	2,694.50	2,655.50	4,321	4,541	5,090	5,631	5,337	5,785	5,524
DANVILLE	17,991.00	17,871.00	29,018	29,599	31,550	34,753	32,313	34,816	33,625
FLOYD COUNTY	7,271.50	7,301.50	12,271	12,605	13,938	16,208	15,279	16,823	16,099
FRANKLIN COUNTY	25,055.50	24,923.00	42,407	44,175	49,228	56,097	52,532	57,215	54,567
GILES COUNTY	7,836.63	7,870.50	13,282	13,664	15,125	17,040	16,002	16,923	16,503
HENRY COUNTY	26,352.00	26,240.00	43,571	45,029	54,812	54,517	50,131	54,334	51,995
MARTINSVILLE	5,811.50	5,766.50	9,535	9,765	10,777	11,686	11,127	12,028	11,590
MONTGOMERY COUNTY	31,116.50	30,686.50	51,493	53,092	58,653	67,460	63,440	69,536	66,801
PATRICK COUNTY	9,333.50	9,296.00	15,334	16,036	17,569	19,566	18,306	19,847	18,980
PITTSYLVANIA COUNTY	29,777.00	29,726.50	49,589	51,360	56,854	64,605	59,870	65,057	63,412
PULASKI COUNTY	15,495.00	15,531.50	25,705	26,368	28,670	32,960	30,444	32,967	32,054
RADFORD	4,555.00	4,508.00	7,365	7,574	8,435	9,494	8,794	9,329	9,039
ROANOKE CITY	39,259.50	38,622.23	63,889	65,410	71,737	81,145	75,208	81,241	77,886
ROANOKE COUNTY	43,007.63	42,979.50	71,631	75,042	81,765	93,703	87,909	95,237	91,778
SALEM	11,127.50	10,983.50	18,365	18,744	21,143	23,345	21,676	23,201	22,396
WVEMS Region	**303,363.76**	**301,583.73**	**502,470**	**519,736**	**576,580**	**647,311**	603,562	654,178	634,547

2012 Regional EMS Award Winners

Excellence in EMS – John "Dale" Wagoner
Deputy County Administrator—Henry County,
(former Director of Henry County Public Safety)

Outstanding Administrator – Jason Ferguson
Battalion Chief, Botetourt County Emergency Services

Outstanding EMS Agency — Christiansburg Rescue Squad

Outstanding EMS Physician – Karen Alldredge, MD
OMD, Salem Fire-EMS, PCD National Business College

Outstanding EMS Educator – James Doran
EMS Training Specialist, Roanoke County Fire & Rescue Department

Outstanding Contribution to EMS by a Nurse— Dallas Taylor, RN
Carilion Clinic Roanoke Memorial, Trauma Services

Outstanding EMS Provider – Nathan J Davis
Regional Emergency Medical Services, Inc

Outstanding Contribution to EMS for Children — Brain Clingenpeel
Roanoke County Fire & Rescue Department

Outstanding Contribution to EMS by a Telecommunication Officer – Cindi Bowles
City of Roanoke E-911 Center

Scholarship for Outstanding Contribution to EMS by a High School Senior – Joanna Mason
Red Valley Rescue Squad

SUPPORTERS

Commonwealth of Virginia
Alleghany County
Botetourt County
Craig County
Floyd County
Giles County
Franklin County
Henry County
Montgomery County
Patrick County
Pittsylvania County
Pulaski County
Roanoke County
City of Covington
City of Danville
City of Martinsville
City of Radford
City of Roanoke
City of Salem
Virginia Rescue Squad Assistance Fund
US Office of the Assistant Secretary for Preparedness and Response (ASPR), DHHS
Greater Alleghany United Fund (partner)
United Fund of Giles County (partner)
United Way of Roanoke Valley (eligible)
United Way of Montgomery, Radford & Floyd (eligible)
Carilion Clinic:
Carilion Roanoke Memorial Hospital
Carilion New River Valley Medical Center
Carilion Giles Memorial Hospital
Carilion Franklin Memorial Hospital
Carilion Clinic Patient Transportation
LewisGale Medical Center—Salem
LewisGale Alleghany
LewisGale Pulaski
LewisGale Montgomery
Danville Regional Medical Center
Memorial Hospital of Martinsville and Henry County
Pioneer Community Hospital
VA Medical Center—Salem

John "Dale" Wagoner

Two WVEMS regional award winners went on to receive Governor's Awards in November 2012. Deputy County Administrator of Henry County (former Henry County Director of Public Safety) **Dale Wagoner** received the capstone "Excellence in EMS" for 2012. Dale was recognized for his outstanding service as a volunteer and career EMS provider, educator, administrator and leader. **Brian Clingenpeel** of Roanoke County Fire & Rescue Department received the "Governor's award for Outstanding Contribution to EMS for Children". Brian was recognized for his many outreach programs for the children of Roanoke County.

Brian Clingenpeel

Our Vision

The EMS system in the Western Virginia region will . . .

- provide access for victims for injury and sudden illness via a **universally available enhanced 9-1-1** emergency telephone system.
- provide for **dispatcher-provided telephone assistance** (pre-arrival instructions) to callers with life-threatening emergencies.
- provide for **timely response** of first responder and transportation, personnel and vehicles through a system of predetermined minimum response intervals, monitoring and quality assurance-performance improvement.
- provide for **high-quality, prehospital treatment** of patients as a result of standardized basic life support training programs, accredited advanced life support educational and mentoring programs, standardized testing programs, frequent and timely continuing education programs, and quality assurance-performance improvement programs.
- provide **triage and transport**, and transfer if necessary, of patients to the most appropriate facility based on predetermined universally accepted transport guidelines and protocols.
- provide **timely emergency department care** with emergency physicians, emergency nurses and other support personnel and **trauma care**, when necessary, with personnel and resources associated with a designated trauma center.
- provide **communications system** capabilities that enable EMS personnel to communicate with all other EMS personnel throughout the region, their dispatchers, all hospital emergency departments and other public safety personnel.
- provide resources and capabilities in order to appropriately respond to and manage large disasters and **mass casualty** situations.
- ensure EMS system **viability and excellence** through the effective use of state, local and private funding

Contact Information

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Facsimile 540.562.3488
E-mail western@vaems.org
Web www.wvems.org

WVEMS New River Field Office

6580 Valley Center Drive, Radford VA 24141
Facsimile: 206.202.1190

WVEMS Piedmont Field Office

1024 DuPont Road, Martinsville VA 24115
Facsimile: 206.984.3120

WVEMS Allied Resources Committee
November 29, 2012 9:30 am

Agenda
WVEMS Roanoke Office

1. Announce Interim Chairperson
2. Review status of Protocol Rollout
3. Set time limit for *Helicopter Assist/Community* Assist in Appendix 1, Policy Element 1
4. Approve changes to WVEMS Drug Boxes for new Protocols
    a. Increase quantity of 1 medication
    b. Reduce quantity of 2 medications
    c. Add 5 new medications
    d. Eliminate 3 medications, including Epi-Pens (as supported by BOD)
    e. Add 1 new medication delivery device for intranasal administration
    f. Approximately $300.00 reduction in drug box cost
    g. Change in Drug box seals

MINUTES

Attendance

WVEMS Executive Board Member, Interim Chairperson	Steve Simon
Regional Medical Director,	Charles Lane, MD
Carilion Franklin Memorial	Lori McClure, Lisa Dillon (p)
Carilion New River Valley Medical Center	Joyce Yearout (p)
Carilion Roanoke Memorial	Kris Peters (p)
Danville Regional Medical Center	Anne Mills, Sherri Francisco, Virginia Hylton (p)
Lewis Gale Medical Center	Joe Ciezkowski
Lewis Gale – Montgomery	Adam Berger (p)
Memorial Hospital of Martinsville & Henry County	Michael Pitman, Marcus Stone (p)
Veterans Administration	Kim Slaughter
Blue Ridge EMS Council	Connie Purvis (p)
Pulaski County	Shawn Hite (p)
Roanoke County	Billy Duff
City of Roanoke	David Bishop
WVEMS Board of Directors	Dale Wagoner PD-12 (p)
Near Southwest Preparedness Alliance	Danielle Lissberger
WVEMS Staff	Rob Logan, Cathy Cockrell, Charles Berger
	Mike Garnett, William Dalton

Hospitals Absent
Bedford Memorial
Carilion Giles Community
Lewis Gale – Alleghany
Lewis Gale – Pulaski
Pioneer Community

Called to Order 9:33

Steve Simon, Interim Chairperson, called the meeting to order at 9:33 am. He introduced himself and then had all present and on conference call, introduce themselves with representation.

Cathy Cockrell reviewed the status of the Protocols and their implementation and rollout. Protocol Committee meeting December 3rd to hopefully finalize rollout training so that Train the Trainers can take place. January 1, 2013 is implementation date.

Rob Logan brought up concern of some facilities regarding Community/Helicopter assist supply exchange creating a time limit. Discussion was held and a motion and second were made for amending Appendix 1, Policy Element to state their will be a 48 hour time limit, motion passed unanimously.

Charles Berger explained in detail the changes proposed to the drug boxes. Lori McClure questioned the cost savings presented stating that the Epi-Pens were approximately $60. Totaling $180, she questioned were the balance of the savings were. It was explained that the list was sent to a hospital to price, and the numbers were based upon that 1 hospital's pricing. A motion was made and seconded to approve the changes, motion passed unanimously.

Gene Dalton presented the need for changing the current blue padlock style drug box seal due to it get inadvertently broken in handling of drug boxes during vehicle check-offs. Discussion was held and WVEMS Council staff will advise this committee of any price change due to trying to go to a more durable seal. It was also discussed the new re-seal at the hospital procedure, and that those seals would be purchased from the Council in the future.

Dr. Lane expressed his concern state-wide on the lack of importance that is being given to drug diversions. He felt that there needed to be some scare put into agencies for when this happens. Some of it may have just been retaliatory to an agency or individual, but whether a narcotic or not it still should be taken seriously and handled as such. He also spoke of how glucagon will be taken down to the EMT level and administered intra-nasal with the MAD.

Being no further business, Chairperson Simon thanked everyone for their participation and the meeting was adjourned at 10:21am.

Called to Order: 14:20

Dr. Charles Lane welcomed those present in person and by telephone conference and requested approval of the minutes from the September 30, 2009 meeting. One change was requested and that was to show that James Powers DO was in attendance. No other changes and minutes were approved

Dr Lane welcomed and introduced Charles Berger as the new WVEMS Staff Liaison replacing Debbie Akers.

Current General PI Projects;

Three (3) agencies returned data for Respiratory Distress calls and data from a 4th agency was received at this meeting. We reviewed the data that was received. It was noted that there appeared to be low usage of Solu-Medrol and CPAP. It was asked how many agencies were using CPAP and response was 1 agency and 3 counties. Discussion was about possibility of region wide grant after better support from hospital than on King Airway. No need for change from current seen at this time.

Future General PI Projects

1. Cardiac Arrest and how the following relates
    a. Bystander CPR
    b. Bystander AED
    c. R.O.S.C.

    Charles to distribute a spreadsheet for data collection

System-wide PI Project

1. Re-survey 12 lead capability and again ALS vs BLS acquisition and what then done with data. It was agreed that Life-Guard training seemed to do good at making BLS providers confident based upon Botetourt County results

Furture System-wide PI Project

1. Survey of Bariatric capabilities in region and how being handled of getting equipment to scene if not permanent on a unit. Charles to gather this data

There was a question of status of new Protocols it was out to OMDs and Dr Lane to convene meetings in regions to get input from OMDs.

MIR Referrals: There have been no general referrals, only 1 Trauma that was handled by facility, agency and OMD

No further business. Next meeting is set for 3/10/10 at 14:00

Adjourned 15:40

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

The most recent meeting was held in conjunction with the 33rd Virginia EMS Symposium on November 7, 2012 in Norfolk, Virginia.

The EMS Needs Assessment survey will be sent by email to EMS agency contacts and respondents are requested to submit their results prior to the end of this year. Only one survey per agency will be allowed.

The Virginia Office of EMS Strategic and Operational Plan is mandated to be reviewed and revised every three years. Each committee of the State EMS Advisory Board has been tasked with evaluating the current plan and proposing additions and/or deletions as it pertains to their particular subject area.

The new 2012 EMS regulations are now effective. Efforts are ongoing to assure all forms and applications are updated to reflect the new regulations. The new regulations may be downloaded from http://tinyurl.com/vaRulesRegs

Congratulations to Matthew Tatum, Deputy Director/EMS Coordinator of Henry County Public Safety for being selected as President of Virginia Association of Governmental EMS Administrators (VAGEMSA).

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