HAMPTON ROADS MASS CASUALTY INCIDENT RESPONSE GUIDE

HRMCIRG

August 2024

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RECORD OF CHANGES

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APPROVALS

The Hampton Roads Mass Casualty Incident Response Guide (HRMCIRG) was developed by the Hampton Roads Metropolitan Medical Response System in partnership with the Peninsulas Emergency Medical Services (PEMS) Council and the Tidewater Emergency Medical Services (TEMS) Council to develop and maintain a viable multiple/mass casualty incident response capability. The HRMCIRG complies with applicable state EMS regulations. This document was approved by the All-Hazards Advisory Committee of the Hampton Roads Planning District Commission on [insert date] and the Board of Directors of both the PEMS Council and the TEMS Council on [insert date].

AUTHORITIES

The following policies, statutes, bylaws, regulations, executive orders, or directives pertain to powers, authorities, or requirements that affect or relate to emergency planning and disaster response in the Hampton Roads Region.

FEDERAL

OSAC 2022-N-0020 Standard for Mass Fatality Incident Management

Robert T. Stafford Disaster Relief and Emergency Assistance Act and Amendments

Homeland Security Presidential Directives #5, Management of Domestic Incidents

Homeland Security Presidential Directive #8, National Preparedness

Title 44 of the Code of Federal Regulations

United States Department of Homeland Security (DHS)

National Incident Management System (NIMS)

National Response Framework (NRF)

Emergency Management and Assistance, 44 Code of Federal Regulations (CFR)

Hazardous Waste Operations and Emergency Response, 29 CFR 1910.120

Federal Radiological Emergency Response Plan

National Oil and Hazardous Substances Pollution Contingency Plan

Target Capabilities List (TCL) 2.0

Universal Task List (UTL) 2.0

COMMONWEALTH OF VIRGINIA

Commonwealth of Virginia Emergency Services and Disaster Law of 2000, as amended, Title 44, Chapter 3.2 Code of Virginia, §44-146.19 through §44-146.28, as amended.

Commonwealth of Virginia Emergency Operations Plan, Virginia Department of Emergency Management, October 2021.

REFERENCES

ICS and NIMS Guidance from Federal Emergency Management Agency (FEMA)

Homeland Security Exercise and Evaluation Program (HSEEP)

PREFACE

The title of this document is Hampton Roads Mass Casualty Incident Response Guide (HRMCIRG). This guide is published by the Peninsulas Emergency Medical Services Council, Tidewater Emergency Medical Services Council, and the Hampton Roads Metropolitan Medical Response System in cooperation with emergency medical services agencies and hospitals within the Tidewater EMS Council's and the Peninsulas EMS Council's regions.

The Hampton Roads Mass Casualty Incident Response Guide is intended as the primary reference and guideline for training and assisting emergency medical services personnel, first responders, and emergency department personnel in the management of multiple or mass casualty incidents. This guide is supported by six incident-specific response playbooks that provide additional EMS response-based information and guidance. It is recommended that copies of this document be kept in every EMS Supervisor, Battalion Chief, Quick Response, and other Command vehicle; at each EMS agency's headquarters and stations; in each jurisdiction's Emergency Communications/911 Center and Emergency Operations Center; adjacent to the radio consoles in Hospitals/Emergency Departments; and in the Regional Healthcare Coordinating Center (RHCC).

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SCOPE AND PURPOSE

The HRMCIRG was developed as an all-hazards guide addressing field operations techniques that are to be employed during multiple or mass casualty incidents occurring within the PEMS Council and TEMS Council regions. The procedures outlined in this Guide can be modified based upon the number of patients, the cause or severity of injuries, and special circumstances involved in the incident.

The HRMCIRG is also intended to be the primary reference and resource for training and assisting EMS personnel, first responders, and emergency department personnel in the management of multiple or mass casualty incidents. This document and its corresponding incident-specific playbooks may also serve as the basis for routine operations, pre-planning of mass gathering events, and other EMS special operations.

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CHAPTER 1: MULTIPLE AND MASS CASUALTY INCIDENT MANAGEMENT

INTRODUCTION

The Hampton Roads Mass Casualty Incident Response Guide addresses techniques in EMS field operations that are to be employed when the number of patients exceeds immediately available resources. The HRMCIRG is intended as the primary reference for use in developing agency standard operating procedures, training, guidance and assistance for first responders, dispatchers, and medical control personnel in the management of multiple and mass casualty incidents.

Mass Casualty Incidents, such as the Pulse Night Club Shooting or the Las Vegas Harvest Festival, are fast-moving incidents that demonstrate the need for today's mass casualty incident (MCI) response plans to be both flexible and scalable, incidents involving active threat cannot and should not be managed in the same way an incident involving over 100+ patients are managed. The HRMCIRG can be applied to both multiple and mass casualty incidents.

MULTIPLE CASUALTY VS. MASS CASUALTY INCIDENT

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

MULTIPLE CASUALTY INCIDENTS (MCI LEVEL 4 AND 5)

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.

MASS CASUALTY INCIDENTS (MCI LEVEL 1, 2, AND 3)

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.

MAJOR MEDICAL EMERGENCY

The Code of Virginia 12VAC5-31-10 defines a Major Medical Emergency as the following:

> "Major medical emergency" means an emergency that cannot be managed using locally available emergency medical resources and that requires implementation of special procedures to ensure the best outcome for the greatest number of patients as determined by the EMS provider in charge or incident commander on the scene. This incident includes local emergencies declared by the locality's government and states of emergency declared by the Governor.

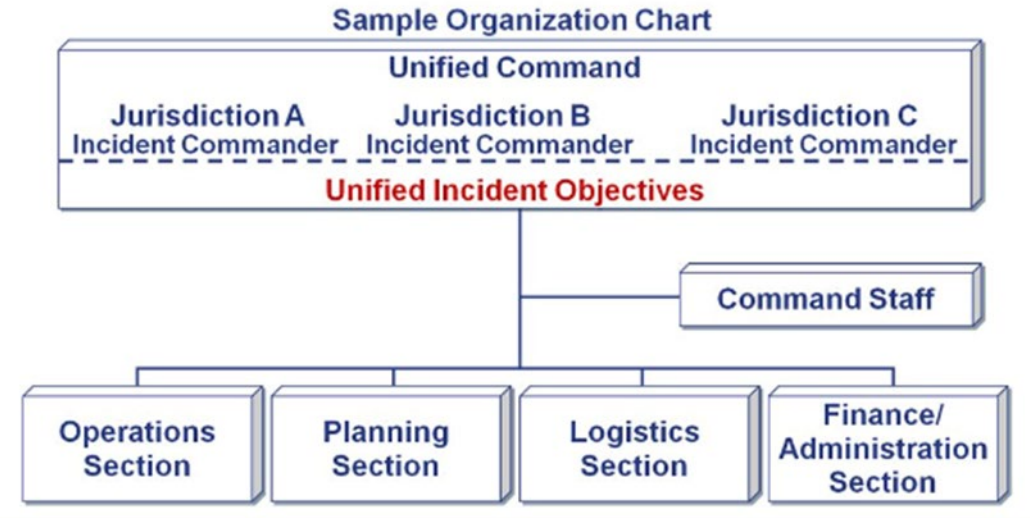
STATIC / DYNAMIC INCIDENTS

Static incidents are those which have, for the most part produced its total casualties when EMS arrives, i.e., plane crash. Dynamic incidents are those which may still be producing casualties when EMS arrives, i.e., complex coordinated attacks.

MASS CASUALTY INCIDENT ACTIVATION / DECLARATION

Effective EMS efforts in a mass casualty incident should begin with the first arriving unit and expand to meet the needs of the incident. The first arriving unit should establish Incident Command. In addition to the initial scene size-up, the Incident Commander, or their designee, is responsible for declaring a mass casualty incident thus activating this MCI response guide and mobilizing resources.

THE INCIDENT COMMAND SYSTEM AND MASS CASUALTY



INCIDENT MANAGEMENT

Incident command begins when the first arriving unit establishes command. Incident command should operate as a scalable and flexible function (i.e., unified command) to meet the needs of the incident. Only those functions/positions that are necessary will be filled. A sample Unified Command organizational chart is illustrated below.

INCIDENT MANAGEMENT PRIORITIES

Good incident command practices focus on meeting these incident management priorities in order:

1. Life Safety (Scene Safety)
2. Incident Stabilization
3. Property Conservation

MASS CASUALTY INCIDENT MANAGEMENT GOALS

Mass casualty incident management goals include:

1. Do the greatest good for the greatest number.

2. Manage scarce resources.
3. Do not relocate the incident.
4. Manage victim and bystander self-referral.

These goals complement the incident management priorities yet focus on those management objectives that must be met to succeed in managing a multiple or mass casualty incident. These goals are described in greater detail in Chapter 2.

INCIDENT COMMAND STRUCTURE

In most multiple or mass casualty incidents, the following ICS positions may be staffed:

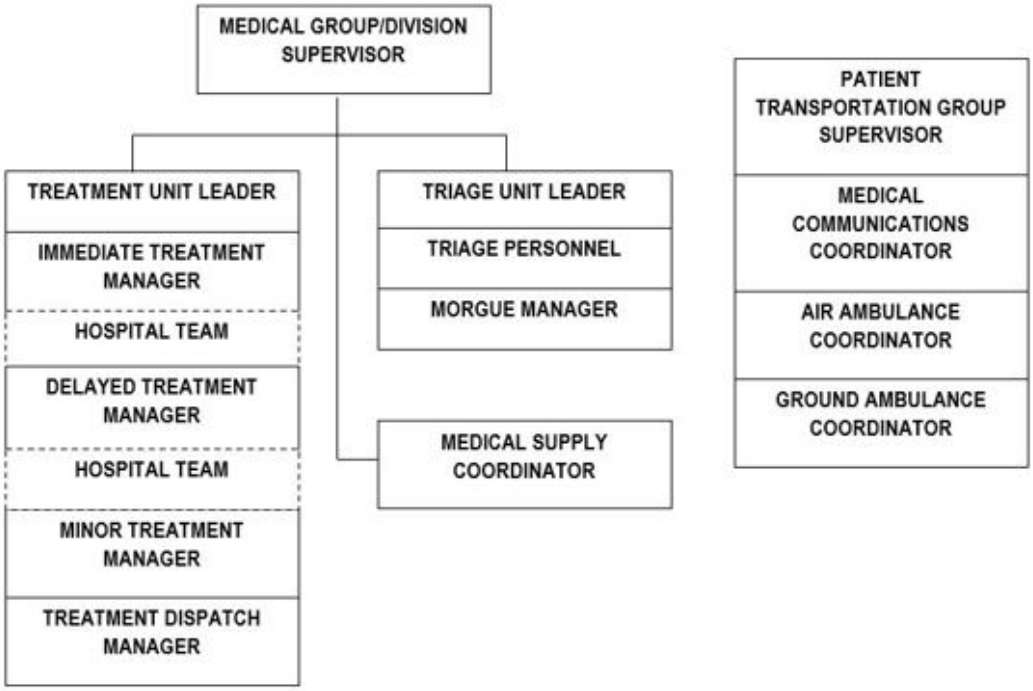
- Incident Commander
- Safety Officer
- Public Information Officer
- Liaison Officer
- Medical Officer

In addition to the ICS positions listed above, the following MCI functional areas may also be staffed:

- Staging Area
- Extrication
- Triage
- Treatment
- Transportation

The intent of this ICS structure is to establish a "Span of Control" to ensure leaders and supervisors can maintain management objectives during a response. 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 can be managed by the same person). In a larger incident, the Incident or Unified Commander may establish a Medical Group or Medical Branch to oversee the functions listed above. One example of the Medical Group/Branch structure is illustrated on the *MCI Medical Branch Worksheet* on the following page.

INCIDENT	DATE	START TIME	END TIME
INCIDENT COMMANDER		MULTICASUALTY BRANCH DIRECTOR	



OTHER RESOURCES
DMSUs / MCI TRAILERS:
MCITUs / BUSES:
AMBULANCES:
RADIO FREQUENCIES:
MEDICAL EXAMINER:
RED CROSS:
CHAPLAIN:
MENTAL HEALTH:

Figure 1: (Example) MCI Medical Branch Worksheet

FIRST RESPONDER ACCOUNTABILITY

Personnel accountability is a critical function of incident command, response, and recovery operations. Having an accountability system increases site safety by ensuring Incident Command's ability to track, account, and control the location, function, and welfare of all EMS responders onsite. The Incident Commander will have overall responsibility for implementing the personnel accountability system in accordance with standard Incident Command System practices. The predominant accountability system used in the Hampton Roads Region is the Passport Icon System. Response agencies not using the Passport Icon System should be prepared to integrate or interoperate with other accountability systems for use at the incident scene.

The U.S. Department of Homeland Security (DHS) and site safety experts have identified the following four core principles that influence the success of personnel accountability at any given incident site[1].

Team Integrity: Personnel accountability is dependent upon teams of responders operating together at an incident site. Response organizations should ensure that team continuity is practiced during all aspects of an incident response, which includes when teams operate in hazardous areas and when teams are assigned to rehabilitation.

Operational Discipline: To prevent accountability breakdowns, responders must strictly adhere to the IC's and other Command Officer's orders at an incident site. Response organizations should stress operational discipline to ensure that responders do not act independent of the IC during critical moments of an emergency response.

Regular Communication: Personnel must continuously communicate their on-site locations to accurately maintain personnel accountability. Response organizations must practice proper radio discipline and always remain aware of their general location at an incident site.

Immediate Implementation: The first arriving unit at an incident scene must implement personnel accountability procedures. Immediate implementation prevents first arriving personnel from operating outside the accountability system and/or IC supervision.

MASS CASUALTY INCIDENT LEVEL CONCEPT

MCI Levels provide the Incident Commander with a suggested minimum number and type of resources that should be requested as part of the initial response package. These MCI levels are based upon the total number of victims involved. The nature of the incident, location and number of victims, and their acuity levels will drive the type and quantity of resources needed to manage the incident. The five levels of MCI are defined as follows:

MCI Level 5	5-9 Victims	"Nickel"
MCI Level 4	10-24 Victims	"Dime"
MCI Level 3	25-49 Victims	"Quarter"
MCI Level 2	50-99 Victims	"50 Cents"
MCI Level 1	100-1000 Victims	"Dollar"

[1] Lessons Learned Information Sharing-BEST PRACTICE-Incident Site Safety Planning: Personnel Accountability

A list of recommended resources for each MCI level is provided later in this chapter. It is important to recognize these numbers are not a "one size fits all" system. Based on the available resources, manpower, and environmental conditions, the resource needs may change or require "just in time" modification.

Note: MCI Levels should not be mistaken for Emergency Operations Center "Activation" Levels. MCI Levels are specific to the number of casualties and resources required for treatment and transportation.

MEDICAL CONTROL

Once an MCI is declared, medical control will be waived for the duration of the MCI. All responders under the medical control of the PEMS and TEMS Regional Medical Protocols have established "Standing Orders" and "Direct Order" protocols. In an MCI, medical direction will be waived, which will allow responders to perform all skills approved for their level of training and certification (for which physicians orders would normally be required) without having to contact Medical Control during the MCI.

MEDICAL CONTROL FOR MUTUAL AID RESPONDERS

Large scale/catastrophic MCIs will require the use of EMS personnel (mutual aid providers) from outside the PEMS and TEMS regions. Outside EMS personnel will be expected to adhere to the patient care protocols of their respective EMS Agency/region. Medical direction will be waived which allows providers to perform all skills approved for their level of training and certification without having to contact Medical Control during the MCI.

SCENE SAFETY AND SECURITY

Life safety/scene safety is always the first consideration in an MCI of any level. Responder safety must be consistently monitored throughout the incident. A Safety Officer should be appointed as soon as is practical to ensure operations are safely conducted.

History has proven that first responders have become choice targets for domestic and international terrorists as seen in the Atlanta, Georgia, bombings. Due to the potential for the presence of secondary devices, or people targeting first responders, operations should be conducted in such a way as to maximize the security of both the first responders and victims. First responders must be alert for the presence of secondary devices and the presence of people who do not fit into the scene picture. All suspicious items, devices, or people must be immediately reported to the Incident Commander. In addition, all first responders should adhere to the prudent safety rule which is, "If you did not bring it into the scene with you, then don't touch it!"

EMS personnel must also be aware that one or more of the victims resulting from a suspicious or terrorist incident may be the perpetrator of the crime and therefore, pose a threat to first responders, the victims, patients, and the public. EMS personnel must be on alert for the presence of armed and possibly violent patients or bystanders.

RESPONDER SAFETY AND HEALTH

Responder occupational safety and health must be considered during an MCI response. Scene safety, occupational health, and responder rehabilitation are the responsibility of the Incident Commander/Unified Commander (IC/UC) and the Incident Safety Officer (ISO), if one has been designated.

RESPONDER REHABILITATION

Life safety and responder rehabilitation is the responsibility of the IC/UC and the ISO if one has been designated. In addition, the IC/UC and ISO are responsible for incorporating responder rehabilitation into their Incident Action Plan, Safety Plan, and Medical Plan. Guidance for responder rehabilitation is provided in individual EMS Agency/Jurisdictional policies and standard operating procedures; NFPA 1584: Standard on the Rehabilitation Process for Members During Emergency Operations and Training Exercises.

CHEMOPROPHYLAXIS AND IMMUNIZATIONS

In case of a biological or radiological incident the IC/UC may specify additional occupational health requirements as needed to protect the health of the responders after the IC/UC consults with public health authorities. For example, a biological incident may require responders to receive chemoprophylaxis with an antibiotic, other medication, or immunoglobulin. In some instances, immunization with a specific vaccine may be prescribed.

BLOODBORNE PATHOGENS EXPOSURE

Responders have increased potential for occupational exposures to blood and other human body fluids. This increases their risk for occupational bloodborne infection. In 1991, the Occupational Safety and Health Administration (OSHA) issued the Bloodborne Pathogens Standard on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030).

In accordance with OSHA's regulations under this standard, EMS personnel should be provided annual bloodborne pathogens training and sufficient Personal Protective Equipment (PPE).

EMS responders will comply with all departmental PPE policies, procedures, and protocols.

PERSONAL PROTECTIVE EQUIPMENT

EMS personnel should use PPE to protect themselves from patient illnesses, diseases, and bodily fluids. Best practices identify eye protection, approved masks/respirators, hand protection, and other PPE to ensure the safety of EMS personnel.

The IC/UC will designate the minimum level of PPE required for personnel responding to an incident. As a minimum, all personnel providing patient care must adhere to and use the PPE required to implement universal precautions commonly referred to as body substance isolation procedures.

PROVIDER WELLNESS

The IC/UC should consider making provider wellness services (also known as critical incident stress management) available to all first responders. Provider wellness services are available through the PEMS Peer and Crisis Support Services and the TEMS Peer and Crisis Support Services. These services are confidential and free to the public safety community. Provider wellness teams provide stress defusing, debriefings, one-on-one sessions, demobilization, family support and educational programs. Any emergency worker in the PEMS and TEMS regions can call for provider wellness support 24-hours a day, 7-days a week. An on-call team leader will respond back to the caller, discuss the situation, and determine if and what type of provider wellness support is needed.

Contact information for the PEMS Peer and Crisis Support Services and TEMS Peer and Crisis Support Services is located in Annex B.

VICTIM/PATIENT ACCOUNTABILITY

Accounting for all victims of an MCI is equally as important as accounting for first responders. Victim and patient accountability begins with the initial triage process when the initial triage report is provided to the Triage Officer. This initial triage report provides an initial count of the number of injured, ill, and deceased victims. This information is then used to determine what additional resources may be required to successfully manage the incident.

This same information is then used to confirm that all living victims have been recovered and moved to the Treatment Area to receive treatment. A unique barcoded wrist band or triage tag will be attached to each patient. The number from the barcoded wrist band or triage tag will be used to identify and track each patient through treatment, transportation, and arrival at the receiving medical facility.

UNIQUE MCI CONSIDERATIONS

There are unique aspects to an MCI that must be considered by the IC/UC. Some of these may drive the need for additional or specialized resources to manage the MCI.

MULTIPLE SIMULTANEOUS INCIDENTS

The resources needed to mitigate multiple simultaneous incidents are dependent on the size and complexity of the incidents as well as their locations. Normal mutual aid resources may not be available or may be significantly delayed. This will cause the IC/UC to request mutual aid from localities further away from the incident scene. Providers must be prepared to sustain their patients for prolonged periods of time.

MANAGEMENT OF A CATASTROPHIC MCI

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 airheads established by the National Disaster Medical System (NDMS).

CONTAMINATED VICTIMS

Consider the activation of the Regional Hazardous Materials (HazMat) Team and the Hampton Roads Metropolitan Medical Response Strike Team (HRMMST) if the victims are contaminated, or potentially contaminated, with a chemical, biological or radiological agent or other hazardous materials. For additional information relating to HazMat incidents, please refer to the Hazardous Materials Incident Playbook.

NON-TRADITIONAL PATIENT TRANSPORTATION

Multiple/mass casualty incidents can be expected to create a demand for ambulances that may exceed the number of ambulances readily available through mutual aid agreements and contracts with private companies. The use of the Mass Casualty Incident Transportation Units (MCITUs), also known as MCI transport units, for patient transportation is recommended. In addition, the use of non-traditional modes of patient transportation and alternate patient transport destinations may need to be considered (MCI transport unit capabilities and locations are described in Annex B).

AMERICANS WITH DISABILITIES ACT

The Americans with Disabilities Act (ADA) for Title II (state and local government services) and Title III (public accommodations and commercial facilities) of September 15, 2010, defines service animals as dogs that are individually trained to do work or perform tasks for people with disabilities. As of March 15, 2011, only dogs are recognized as service animals under Title II and Title III of the ADA. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post-Traumatic Stress Disorder during an anxiety attack or performing other duties.

Service animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. When it is not clear what service an animal provides, you can legally ask only two questions:

1. Is this a service animal required because of a disability?
2. What work or task has the animal been trained to perform?

Owners cannot be required to provide medical documentation, special identification, or proof of animal training, or to demonstrate their animal's abilities.

VICTIMS WITH ACCESS AND FUNCTIONAL NEEDS

Care must be taken to meet the communication, mobility, cognitive, and other needs of victims with access and functional needs. Responders must make certain that assistive devices and equipment are transported with the victim or patient (e.g., glasses, hearing aids, assistive technology, and mobility devices such as walkers and wheelchairs). These items should be labeled with the patient's name and address, if known, and/or the patient's barcoded wristband or triage tag number as many of these devices are very expensive and difficult to replace.

Failure to keep assistive devices and equipment with these individuals may make that victim or patient dependent upon first responders for mobility or care when they could have functioned independently if their assistive devices and equipment remained in their custody.

SERVICE ANIMALS

Patients should not be separated from their service animal. Service animals are vital to the recovery of these patients and their prompt return to the activities of daily living. In addition, removing a service animal from a patient may make that patient dependent upon first responders for mobility or care when they could have functioned independently if their service animal remained in their custody.

WHERE SERVICE ANIMALS ARE ALLOWED

Under the ADA, state and local governments, businesses, and nonprofit organizations that serve the public generally must allow service animals to accompany people with disabilities in all areas of the facility where the public is normally allowed to go. For example, in a hospital, service animals should be allowed in areas such as patient rooms, clinics, cafeterias, or examination rooms. However, it may be appropriate to exclude a service animal from operating rooms or burn units where the animal's presence may compromise a sterile environment.

Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, for example, in a school classroom or at a homeless shelter, they both should be accommodated by assigning them, if possible, to various locations within the room or different rooms in the facility.

A person with a disability cannot be asked to remove their service animal from the premises unless: (1) the dog is out of control and the handler does not take effective action to control it, or (2) the dog is not house broken.

SERVICE ANIMALS MUST BE UNDER CONTROL

Under the ADA, service animals must be harnessed, leashed, or tethered, unless these devices interfere with the service animal's work or the individual's disability prevents using these devices. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

MEDICAL INFORMATION PROVIDED BY THE SERVICE ANIMAL

A service dog's backpack likely contains information about its owner's emergency needs. Even a logo might point you or hospital personnel to a resource with critical information about a patient's condition. That resource might also be able to aid with temporary dog placement if an owner is hospitalized.

VETERINARY CARE AND TEMPORARY SERVICE ANIMAL HOUSING

Public safety agencies and jurisdictions should have a 24-hour emergency veterinary hospital and kennel available in case a patient's service animal is hurt or needs care while their owner is sick or injured. These services can be obtained through the jurisdiction's Animal Control or Animal Shelter through a standing contract, other agreement, or telephone call. Information on the location and care of the animal must be provided to the patient, their next-of-kin, or other care giver. Contact information for the 24-hour emergency veterinary hospitals in the region can be found in Annex B.

Specific information regarding the ADA and Service Animals can be obtained from the U.S. Department of Justice's website at: http://www.ada.gov/service_animals_2010.htm.

PUBLIC SAFETY AND MILITARY WORKING DOGS

Examples of public safety and military working dogs includes search and rescue dogs, bomb detection, drug detection, police dogs, cadaver dogs, and the United States Department of Agriculture's (USDA) animal and plant detector dogs. These dogs provide critical response services during many types of incidents, working long hours, side-by-side with their handlers.

VETERINARY CARE AND TEMPORARY HOUSING

Just as with service animals, public safety agencies and/or jurisdictions should have 24-hour emergency veterinary hospital services available in case a working dog becomes ill or injured and the care required by the dog is beyond the scope of care that can be provided by the handler. These services can be obtained through the jurisdiction's Animal Control or Animal Shelter through a standing contract, other agreement, or telephone call. If a dog handler becomes ill or injured, the custody and care of the working dog is often turned over to the dog handler's parent public safety agency or organization. Contact information for the 24-hour emergency veterinary hospitals in the region can be found in Annex B.

LOGISTICS

A key difference between a routine incident response and an MCI or disaster response is the available quantity of consumable supplies, equipment, and personnel needed to effectively manage the incident. Additional resources must be requested as soon as the potential need for them has been identified. Annex B identifies local, regional, state, and federal MCI resources.

VEHICLE REFUELING AND MAINTENANCE

The IC/UC will establish refueling and emergency vehicle maintenance locations and procedures for accessing these functions as needed by the scale and duration of the incident. Vehicle refueling and emergency maintenance/repairs should be requested using the procedures established by the IC/UC. Vehicle operators are responsible for monitoring and maintaining the fuel level for their respective vehicle. Operators are also responsible for the safe operation, overall mechanical maintenance of their vehicle, and reporting mechanical deficiencies via the chain-of-command. Operators will present their vehicle for inspection and repairs, if required.

RECOMMENDED RESOURCES BY MCI LEVEL

Additional resources must be requested as soon as a potential need for them has been identified. The five MCI Levels are defined on page 5. For each MCI level, there is a list of recommended minimum resources. MCI levels are based upon the total number of victims. These lists serve as a guideline from which to begin requesting additional resources. Agencies are encouraged to develop automatic dispatch protocols for each MCI level.

Larger agencies may be capable of handling incidents with higher numbers of victims without implementing the HRMCIRG or requesting mutual aid resources. The decision to declare an MCI Level 1 is left to the Incident Commander.

MCI LEVEL 5 (5-9 VICTIMS “NICKEL”)

The minimum resources recommended to manage a multiple casualty incident of this magnitude are:

- 5 Ambulances
- 2 Engine Companies or minimum of 6 first responders
- 1 EMS Supervisor/Operation Chief

MCI LEVEL 4 (10-24 VICTIMS “DIME”)

The minimum resources recommended to manage a multiple casualty incident of this magnitude are:

- 10 Ambulances
- 5 Engine Companies or 15 first responders
- 2 EMS Supervisors/Operation Chiefs
- 1 Disaster Medical Support Unit or MCI Trailer

MCI LEVEL 3 (25-49 VICTIMS “QUARTER”)

A mass casualty incident 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 minimum resources recommended to manage this incident are:

- 15 Ambulances
- 10 Engine Companies or 30 first responders
- 3 EMS Supervisors/Operation Chiefs
- The Hampton Roads Metropolitan Medical Strike Team (HRMMST)
- 2 - 4 Disaster Medical Support Units or MCI Trailers
- 1 - 2 Mass Casualty Incident Transportation Units (MCITUs)

MCI LEVEL 2 (50-99 VICTIMS "50 CENTS")

A mass casualty incident 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 minimum resources recommended to manage this incident are:

- 15 Ambulances
- 10 Engine Companies or 30 first responders
- 4 EMS Supervisors/Operation Chiefs
- The Hampton Roads Metropolitan Medical Strike Team (HRMMST)
- 4-6 Disaster Medical Support Units or MCI Trailers
- 1-2 Mass Casualty Incident Transportation Units (MCITUs)
- School or Mass Transit Buses

MCI LEVEL 1 (100-1000 VICTIMS "DOLLAR")

The minimum resources recommended to manage this incident are:

- 20 or more Ambulances
- 10 Engine Companies or 30 first responders
- 5 EMS Supervisors/Operation Chiefs
- The Hampton Roads Metropolitan Medical Strike Team (HRMMST)
- 6-8 Disaster Medical Support Units or MCI Trailers
- 2 or more Mass Casualty Incident Transportation Units (MCITUs)
- 1 Communications Trailer
- School or Mass Transit Buses

DECLARATION OF LOCAL EMERGENCY

The IC/UC request local government Emergency Management to initiate a local state of emergency during a declared mass casualty incident to activate legal authorities for the incident's effective management provided by the Code of Virginia.

REGIONAL, STATE, AND FEDERAL RESOURCES

Annex B identifies regional, state, and federal teams and task forces that may be requested to respond to a mass casualty incident. The Annex includes a synopsis of each team or task force's mission, capabilities, and activation information. Incident resources shall be requested using the procedures established by the IC/UC.

RESOURCE MANAGEMENT

RESOURCE REQUESTS

Resource requests come in several forms with some of these being more formal than others. The most common form of resource request comes through the jurisdiction's Emergency Communications Center (ECC). Once the ECC is overwhelmed, or all local resources are deployed and allocated, the requests for resources will shift over to the Emergency Operations Center (EOC) for resource management support. Other mechanisms to acquire medical caches, supplies, and resources by a jurisdiction or EMS Agency may include procurement procedures or contracts.

Each resource request must specify the desired **Capability** of the resource, **Size** of the resource, **Amount** of the resource, **Location** where the resource is needed, the **Type** of resource required, and the **Time** the resource is needed (**CSALTT**).

Regional mutual aid resources should be requested via the IC/UC using existing EMS agency, local jurisdiction policies, and standard operating procedures unless otherwise specified by the IC/UC.

State and Federal resources must be requested via your local jurisdiction's EOC. The request will then be sent to the Virginia Emergency Operations Center (VEOC) by calling 1-800-468-8892.

PROCUREMENT PROCEDURES

Many jurisdictions have established procurement procedures and contracts that can be used during a local emergency. Procurement procedures will be set by either the host jurisdiction or the IC/UC. Consult your chain-of-command for all cases not covered by instructions.

RESOURCE TRACKING

Resource tracking will be managed by the IC/UC, or their designee. Resource tracking will be performed using ICS forms (i.e., ICS Form 308, ICS Form 310, ICS Form 312, etc.) or other method as directed by the IC/UC.

FINANCIAL CONSIDERATIONS

Responder, EMS Agency, or jurisdiction financial reimbursement, replacement of equipment, worker's compensation, and financial dispute resolutions are the responsibility of the respective locality's administrators. In most cases, these financial issues have been agreed to in existing local and statewide mutual aid agreements (MAAs). Questions regarding these issues should be forwarded up the chain-of-command for resolution of all instances not covered under existing agreements and/or local agency/jurisdictional policies and procedures.

LEGAL CONSIDERATIONS

Responder and agency liability, immunity for responders, worker's compensation, and dispute resolutions are the responsibility of the respective city or county administrators. In most cases, these legal issues have been addressed in existing local and statewide MAAs. Questions regarding these issues should be forwarded up the chain-of-command for resolution for all instances not covered under existing agreements and/or local agency/jurisdictional policies or procedures.

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CHAPTER 2: TRIAGE, TREATMENT, TRANSPORT, AND PATIENT TRACKING

MASS CASUALTY INCIDENT MANAGEMENT GOALS

There are four primary goals of multiple and mass casualty incident management:

1. **Do the Greatest Good for the Greatest Number:** The primary concern is to save as many lives as possible with the resources available while protecting the first responders and bystanders.

2. **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 resource 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.

3. **Do Not Relocate the Disaster:** Do not relocate the incident by transporting all the patients to one hospital. Incident Command should use hospital resources wisely and mitigate overwhelming hospitals by managing where patients are being transported from the scene. Providers must use triage to determine patient prioritization for treatment and transport and communicate as early as possible to an area Hospital(s)/Emergency Department(s). For Level 1, 2 and 3 MCIs, the first arriving EMS units may never transport a single patient. It is better to first establish command and conduct scene size-up, second conduct triage, third establish the Treatment Area, and then wait for more units to arrive and coordinate and provide patient transportation.

4. **Consider Victim and Bystander Self-Referral:** Many victims are likely to leave the scene and seek shelter and/or treatment at the closest/known Hospital/Emergency Department. This is likely to occur before first responders can complete the triage process and establish control of the scene. The unexpected patient influx may overwhelm the closest Hospital/Emergency Department. This is of particular concern when an incident occurs close to a Hospital/Emergency Department. It is essential that IC/Medical Group/Branch communications be established as quickly as possible with the Hospital/Emergency Department closest to the incident scene.

CRITICAL TASKS

The primary objective must be to save as many lives as possible with the resources available, while at the same time protecting the first responders and bystanders. To accomplish this, EMS personnel responding to the incident should perform the sequential critical tasks depicted in Table 1 below:

STEP	ACTION
1	Establish Command/Scene Size Up
2	Triage
3	Treatment
4	Transport
5	Patient Tracking/Accountability

Table 1. Sequential Critical Tasks

FIRST ARRIVING UNIT ACTIONS

The first arriving unit on the scene of an MCI must restrain themselves from rushing into the scene. If the incident involves hazardous materials, all units should remain uphill and upwind of the incident. The successful initial management of an MCI is based upon the first arriving unit establishing incident command and using the "5-S" to accurately assess hazards and report key information to their dispatch center.

ESTABLISH COMMAND

The senior crew member of the first arriving unit or senior officer must establish incident command and report that they have established command to their dispatcher. This individual will remain in command until properly relieved. It is the responsibility of the IC to perform the initial scene size-up using the "5-S" and report their findings to the dispatcher. The 5-S includes:

- Scene Safety Assessment
- Scene Size-Up
- Send Information
- Set Up the Scene for Casualty Care
- SALT Triage Method

COMPONENTS OF THE "5-S"

SCENE SAFETY ASSESSMENT (FIRST S)

Begin by assessing the scene for safety and looking for existing hazards, (e.g., electrical hazards, flammable liquids, hazardous materials, other life-threatening situations and the potential for secondary explosive devices or other security threats). The first arriving unit should make an effort to control the scene by establishing a perimeter with ample ingress and egress routes for incoming responders and by designating a "danger zone" and a "safe zone" if the incident involves hazardous materials. For information relating to initial isolation distances, please refer to the Hazardous Materials Incident Playbook.

SCENE SIZE-UP (SECOND S)

Upon arrival, the IC must perform a size-up of the scene to include an overall assessment of the incident location, size, and complexity. Confirm the physical location of the incident and determine the size of the area affected. Determine the complexity of the incident. Survey the incident scene for the potential type of and/or cause of the incident. Estimate the number of injured, dead, and uninjured. Estimate the severity level of the injuries and determine the level of the MCI. Evaluate the scene for ingress and egress issues and determine safe routes. The First Unit On-Scene position checklist is located in Annex C.

SEND INFORMATION (THIRD S)

This initial report from the incident scene to the dispatcher is essential for the proper management of the incident. The initial report and scene size-up are also critical to the safety of first responders, victims, and the community. Contact dispatch with your scene size-up information. Request additional resources and notify the receiving Hospital(s)/Emergency Department(s).

REQUEST ADDITIONAL RESOURCES

Resources should be requested based on local response protocols or the established alarm system. Once the initial scene size-up has been completed, the IC may request additional resources based on a continuing incident assessment. The IC's request for additional resources should be accompanied by the identification of the incident Staging Area(s).

Additional resources should be requested early in the incident to reduce the amount of time it takes those resources to reach the incident staging area or incident location. Resource requests can be cancelled if it is determined they are not needed.

The MCI Level definitions found in Chapter 1, provide a list of recommended resources for each MCI level. If the incident is determined to be a Level 1, 2, or 3 mass casualty incident, consider requesting the Hampton Roads Metropolitan Medical Strike Team (HRMMST).

HazMat incidents will require a response by the local or regional HazMat Team. For HazMat incidents, all responders (on scene) should have access to and refer to the Hazardous Materials Incident Playbook for specific medical intervention and PPE requirements. Incident Command may request other specialty resources as needed. A list of regionally available resources can be found in Annex B.

HOSPITAL / EMERGENCY DEPARTMENT NOTIFICATION

The Hospital/Emergency Department geographically closest to the scene must be notified immediately that an MCI has been declared and provided with the initial situational report. It is vital that the First Arriving (on-scene) Unit either, contact directly, or request dispatch to contact the area Hospital(s)/Emergency Department(s) and inform the facilities there is an MCI in progress.

The Hospital/Emergency Department notification(s) should include as much information currently known to increase hospital preparedness and include the following:

- Nature or apparent cause of the incident.
- Estimated number of injured.
- Whether or not the victims may be contaminated.
- When they can expect to receive the first patients.
- Whether there is a potential security threat to the Hospital/Emergency Department.

It is critical that Hospitals/Emergency Departments receive alerts from the field or responder dispatch as quickly as possible to allow for patient care facilities to activate internal emergency operation plans and prepare for the surge of patients from the MCI.

SET UP THE SCENE FOR CASUALTY CARE (FOURTH S)

Care should be taken to set up the scene to ensure safe and efficient operations. It is important for responders to establish an orderly ingress and egress flow of patients from the incident scene through the Treatment Area and into the transport area. The layout of the scene should create a funnel effect, where patients are moved from the widest portion of the funnel (the incident location) to the primary and secondary triage area for patient medical intervention, to the patient transportation area where patients are loaded onto ambulances or other designated transport vehicles. Incident Command should request law enforcement to establish perimeter control or security for protection of responders operating within the scene perimeter.

The patient flow diagram (Figure 2 below) is an example of one way to organize the scene. Ultimately, the way a scene is organized depends on scene security and location, terrain, weather, number of patients, etc..

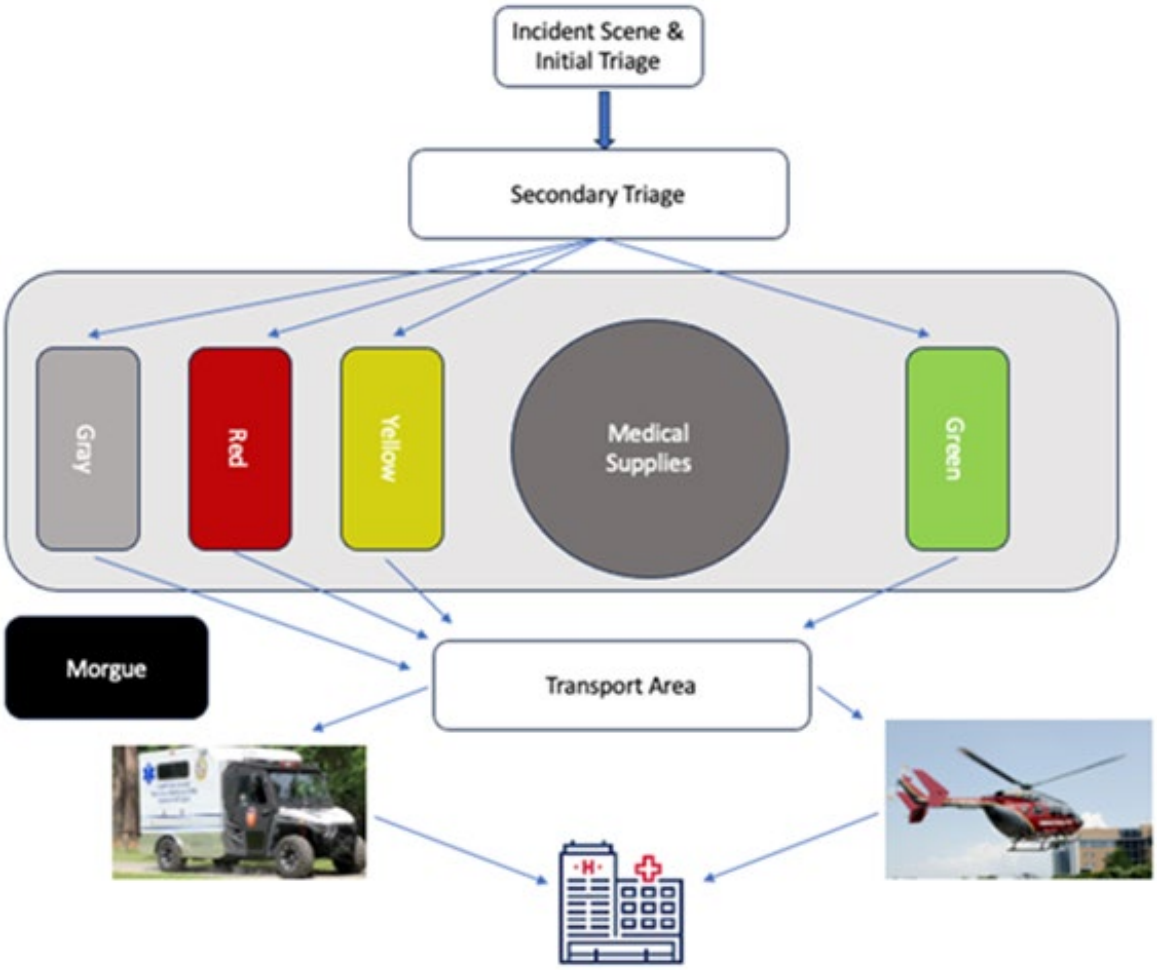

Figure 2. (Example) Patient Flow Diagram

For incidents involving Hazardous Materials, local and regional Fire and HazMat response agencies will assume offensive, defensive, and site decontamination setup. For HazMat specific incidents, refer to the Hazardous Materials Incident Playbook.

CASUALTY COLLECTION / TREATMENT AREA

During an MCI, it may be difficult to direct victims and bystanders to designated Casualty Collection / Treatment Areas. This section provides a framework for operations; however, the specifics of the emergency may require "just in time" modifications to mitigate unexpected consequences.

The intent of the Casualty Collection / Treatment Area is to receive emergency medical care 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, gray tagged/imminent, and green tagged/minimal patients. Personnel, equipment, and supplies are also allocated to patients based on their triage priority.

The red, yellow, gray, and green Casualty Collection/Treatment Areas are often marked using colored tarps, colored flags, or scene tape. Signs may also be used to identify these areas to first responders. During night operations consider the use of colored chemical lights as Casualty Collection/Treatment Area markers. Following the set-up of casualty collection points and ensuring Casualty Collection/Treatment Areas have been identified, ensure communication coordination and integration have been forwarded to the IC and emergency responders.

Note: Gray / Imminent and Black / Dead patients may be required to be left on-scene, as found, for investigative purposes.

Responders should designate a separate, secure, and isolated area for the Incident Morgue. The Incident Morgue is for the placement of victims who die in the Casualty Collection / Treatment Areas. As mentioned above, those who are found dead on scene should remain in place pending the investigation, or release from law enforcement officials. An EMS provider must be assigned to this area to confirm death and track patients transported to and from this area. This area should be secured by Law Enforcement Officers, not EMS providers.

Note: Sorting out patients based on patient criticality and survivability is paramount. In smaller MCIs, taking the time to incorporate an MCI Patient Triage Collection Point with colored tarps, flags or other identifiers may prove to be unnecessary and possibly delay direct patient intervention or transportation. Depending on the situation, capabilities of the EMS agency and trauma systems and local policies, EMS providers may decide independently or in association with online medical direction to transport a patient(s) immediately, bypassing patient collection points or primary and secondary triage areas in lieu of rapid transportation. For larger MCIs that require a greater number of patient care personnel and transport resources, coordinating the MCI with the SALT Triage System may be justified.

CASUALTY COLLECTION / TREATMENT AREA SPACE REQUIREMENTS

It is important to provide enough space on all four sides of each patient to allow providers space to treat, kneel and move safely between patients. There should be three feet of open space on all four sides of each patient as shown in the Figure 3 below. Many agencies utilize their stock-colored tarps for use in designating treatment areas. Be aware that the Casualty Collection / 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.

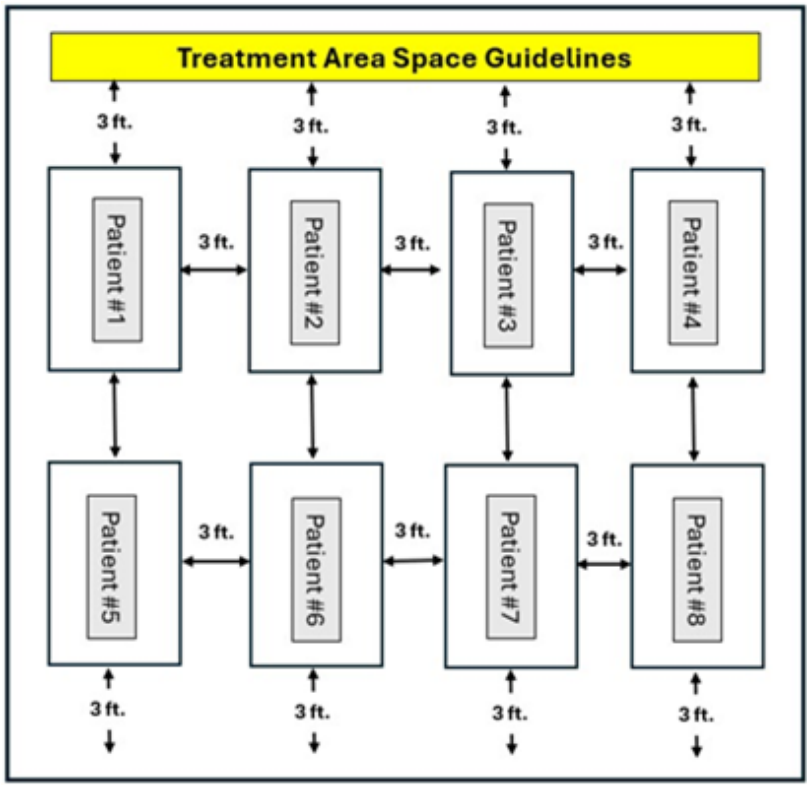

Figure 3. (Example) Treatment Area Set Up

MEDICAL SUPPLY LOCATIONS

A cache of medical supplies should be placed near or in the Casualty Collection/Treatment Area where personnel can easily access them. Medical supply boxes are color coded on the Disaster Medical Support Units (DMSUs). The red, yellow, gray and green color bands on the boxes indicate which Casualty Collection/Treatment Area the boxes should be placed in (e.g., red-taped box should be placed in the red casualty collection/treatment area, etc.).

A second cache of medical supplies may be needed in the Staging Area to provide for the resupply/reconstitution of ambulances and other resources. In each instance, these supplies must be actively monitored and properly secured to ensure the most appropriate distribution of supplies.

TRANSPORTATION AREA

Establish a transportation area in a location between the Casualty Collection/Treatment Area and the patient pick-up point. The pick-up point is where the ambulances, or other designated transportation resources, will drive up and park while waiting for the patients to be loaded into the ambulances or other vehicles. Ideally, all vehicles should follow a one-way traffic pattern (ingress) into the Casualty Collection/Transportation Area and a one-way (egress) traffic pattern exiting the scene. Every effort should be made to avoid having ambulances and other vehicles backing up in order to reduce the risk of having personnel, patients or equipment run over during the patient loading process.

SALT TRIAGE (FIFTH S)

SORT, ASSESS, LIFESAVING INTERVENTIONS, TREATMENT / TRANSPORT

Over the past decade, the response to MCIs has been impacted by the active threat environment which challenges the traditional approach to MCI management. In this environment, there is no time to methodically triage, set-up colored triage tarps, build elaborate treatment areas, or put triage tags on every patient. Injured persons are often transported by family, friends, bystanders, or law enforcement before there are adequate EMS resources on scene. As defined in this guide, MCI Levels 4 and 5, as well as active threat incidents, are typically of the size and complexity that do not require an elaborate EMS branch, division, or group; this is typically reserved for MCI Levels 1, 2, and 3. It is the responsibility of IC/UC to determine the most appropriate strategy for managing the MCI.

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 in this HRMCIRG is the SALT (Sort, Assess, Lifesaving interventions, Treatment and/or Transport) Triage method for adult patients. Pediatric patients will also be better served by using the SALT Triage method. The SALT algorithm is illustrated on page 24.

There are some incidents where SALT Triage may not be the most appropriate tool to sort patients. Patients who have been exposed to various HazMat or Chemical, Biological, Radiological, Nuclear and Explosive (CBRNE) weapons 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. SALT Triage is the preferred tool for sorting trauma patients.

The SALT Triage system is a tool responders can use to rapidly separate the critically injured from the less injured and walking wounded. The purpose of triage is to obtain a total count of the number of patients, to determine and assign each victim a treatment and transportation priority based upon the severity of their injury or illness, and trigger resource requests. It is important to note that Triage is a tool - not a mandate or regulation. Triage was designed to support the classification of casualties. Local EMS jurisdictions and medical advisership should set the standard on how triage should be used and in what circumstances.

The SALT Triage algorithm is not without inadequacies. This triage algorithm should not take the place of clinical judgment by trained providers when assigning treatment priorities. For example, emotional turmoil and preexisting conditions will alter the initial triage assessment. It is essential that rescue efforts are directed to obtain the best possible outcome for all patients, while avoiding over-triage or under-triage.

The following colors are used to indicate the patient's treatment priority:

- Red – Immediate
- Yellow – Delayed
- Gray – Imminent
- Green – Minimal
- Black – Deceased

Once a patient's triage status has been determined by a colored piece of surveyor's tape or triage tag that has been tied around the patient's wrist or other appendage (if their wrist is not accessible due to injury or absence), the patient should be placed in an area with like-triaged patients waiting for secondary triage assessment and transport.

INITIAL TRIAGE (TAPE)

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 all the victims are triaged. When using the SALT Triage method, all ambulatory patients are initially directed to a designated Green/Minor Casualty Collection/Treatment Area where they will be assessed and re-triaged. It is appropriate to provide these patients with self-care kits, if available, so they may begin treating themselves while awaiting the arrival of EMS providers. For all other patients, triage personnel must promptly apply a unique identifier wristband. If an electronic triage system is utilized, they should electronically capture each patient's current triage status and color. If an electronic system is unavailable, the appropriate color-coded triage tape should be applied in conjunction with the unique identifier wristband.

The initial triage status of each patient also determines the order in which non-ambulatory patients will be moved from the site of the incident to the Treatment Area. Porters must move the Red Tagged/Immediate victims first, Yellow Tagged/Delayed second, Gray/Imminent third, and Green/Minimal patients last. However, all efforts should be made to keep minor children with a family member and patients with access and functional needs with their caregivers.

Deceased (Black) and Imminent (Gray) tagged victims will initially be left where they are found. Deceased victims shall not be disturbed unless the remains must be moved to gain access to living patients or if the remains are in danger of being destroyed. In such circumstances, the use of a unique identifier wristband becomes essential. These wristbands serve a dual purpose, preventing duplication of triage efforts and aiding in the tracking of the victims' remains. When these wristbands are attached to deceased victims, they ensure a systematic and organized approach to managing the situation, enabling accurate identification and the maintenance of necessary records for future reference.

SALT TRIAGE ALGORITHM[2]

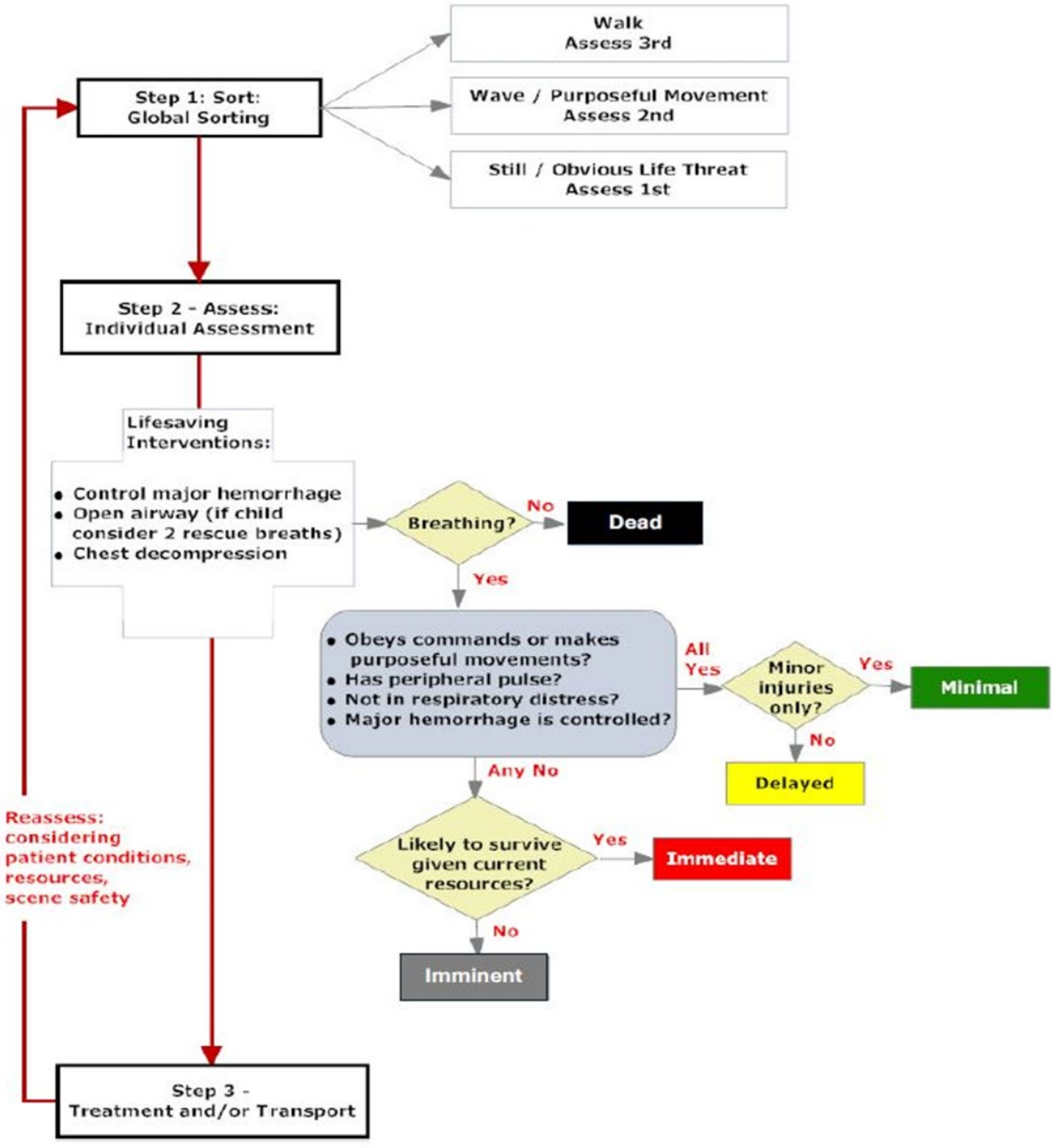

Figure 4. SALT Algorithm

[2] https://chemm.hhs.gov/salttriage.htm

SECONDARY TRIAGE (TAG)

A more in-depth assessment method, known as secondary triage, must be conducted on all patients arriving at the Casualty Collection/Treatment Area from the incident scene. 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 Casualty Collection/Treatment Area (entry point), in the patient treatment area, and/or en route to the hospital. To facilitate this process, the electronic triage system application should be launched. The unique identifier wristband must be scanned to access the patient's triage systems channel and capture the most up-to-date status. If a patient lacks a unique identifier wristband, one should be applied, and the triage status recorded. In cases where an electronic triage system is unavailable, a Virginia Triage Tag will be affixed to each patient upon their entry into the Treatment Area.

In some cases, a patient may be reclassified as red, yellow, or green after secondary triage. Findings from secondary assessment will further determine patient transportation priorities. For example, a yellow-tagged patient with an open humerus fracture should be transported before a yellow-tagged patient with a sprained ankle.

CONTINUAL EVALUATION

Patients in the Casualty Collection/Treatment Area must continually be re-evaluated and re-triaged as part of the patient assessment until the patient arrives at a Hospital/Emergency Department.

TRIAGE AND MASS PATIENT CARE

Today's EMS providers can expect to face a non-traditional multiple or mass casualty incident. Incidents may result from a man-made biological incident (e.g., anthrax attack), a naturally occurring pandemic disease incident (e.g., influenza), natural disaster or other incident resulting in a large number of victims becoming ill. Massive region-wide infrastructure damage may also result from these types of incidents resulting in the loss of hospitals, physician 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.

TREATMENT

REGIONAL PROTOCOLS AND MEDICAL CONTROL

Once an MCI has been declared, responders will follow the PEMS and TEMS Regional Medical Protocols and perform all skills approved for their level of training and certification (for which physicians orders would normally be required) without having to contact Medical Control for the duration of the MCI.

MEDICAL CONTROL FOR OUTSIDE RESPONDERS

Large scale/catastrophic MCIs will require the use of EMS personnel from outside the PEMS and TEMS regions. Outside EMS personnel will be expected to adhere to the patient care protocols of their respective EMS Agency/region. Medical direction will be waived which allows providers to perform all skills approved for their level of training and certification without having to contact Medical Control during the MCI.

DOCUMENTATION OF PATIENT CARE

In cases where an electronic triage system is unavailable, the care of each patient may be documented solely on the Commonwealth of Virginia Triage Tag when the following section of Virginia EMS regulations has been met:

> **12VAC5-31-560. Patient care records:**
>
> "The required minimum data set shall be submitted on a schedule established by the Office of EMS as authorized in § 32.1-116.1 of the Code of Virginia. This requirement for data collection and submission shall not apply to patient care rendered during local emergencies declared by the locality's government and states of emergency declared by the Governor. During such an incident, an approved triage tag shall be used to document patient care provided unless a standard patient care report is completed."

Use of the Virginia Triage Tag provides for limited documentation of patient care. Completed triage tags should accompany each patient to the hospital. The original triage tag will be left with the patient at the hospital. The completed triage tag will then be placed into the patient's hospital record.

If there are no copies of the triage tag, EMS personnel must make a copy of the completed triage tag at the hospital if they will be required to complete a Prehospital Patient Care Report at a later time. EMS Agencies are encouraged to determine how, or if, the agency will record the triage tag information into their respective electronic medical records system.

TRANSPORTATION

All patients are re-triaged and continually re-evaluated while receiving care in the Casualty Collection/Treatment Area. The Treatment Unit Leader will collaborate with the Transportation Unit Leader to assign a transportation priority to every patient based on their current medical condition and circumstances.

The Transportation Group Supervisor/Unit Leader will conduct immediate and early notifications to the receiving Hospital/Emergency Department to support hospital preparedness efforts by adding the facility to the electronic triage system's incident. This process also enables Hospital/Emergency Department personnel to include self-reporting patients in the electronic triage system's incident, streamlining patient tracking, counts, and facilitating later reunification.

Using an electronic triage system, the Transportation Unit Leader can assign and track the destination of individual patients. The platform also offers a summary of all patients based on their condition and current location. In cases where an electronic triage system is unavailable, it becomes necessary to actively monitor and track the number of patients requiring transport and available transportation resources. For this purpose, utilize the Patient Count & Distribution Worksheet (ICS-MC-308) located in Annex D to monitor this information.

Once a destination is selected within the electronic triage system and the patient channel is activated, the Hospital/Emergency Department will receive automatic alerts regarding the patient's condition and estimated time of arrival. In situations where an electronic triage system is not available, the Transportation Group Supervisor/Unit Leader will notify Hospitals/Emergency Departments when ambulances depart the scene and provide them with as much known information to include the following information for each transport:

- EMS Agency and Ambulance Number with the destination hospital.
- Patient Triage Tag Number(s)

- Triage Color of each patient.
- Age and gender of each patient.
- Nature of each patient's injuries.
- Estimated time of arrival.

PATIENT TRACKING AND ACCOUNTABILITY

Accounting for all victims of an MCI is equally as important as accounting for first responders. Victim and patient accountability begins with the initial triage process when the EMS personnel conducting triage report their triage information to the Triage Officer. After all the reports have been received the Triage Officer will have an initial count of the number of injured, ill, and deceased victims. This information is used to determine what additional resources may be required to successfully manage the incident. This same information is used to confirm that all living victims have been moved from the incident site to the Treatment Area to receive emergency medical care.

All the objectives mentioned above can be met using an electronic triage application, which helps in tracking and ensuring accountability of all patients during an MCI. It provides the Incident Commander and Unit Leaders with instant access to a clear patient count, information on patient conditions, and their current locations. This real-time information makes it much easier to allocate resources efficiently and manage the incident.

In situations where an electronic triage system is unavailable, a Commonwealth of Virginia Triage Tag will be attached to each patient as they enter the Treatment Area. Each Commonwealth of Virginia Triage Tag has a patient number found on the upper right corner on the front of the tag. This patient number is unique to each tag and is not repeated. This number becomes the primary method of identifying all patients during an MCI. The identification number is used to identify and track each patient through treatment and transportation processes, as well as through their arrival at the receiving medical facility.

The peel-off patient number bar codes can be attached to the MCI Patient Tracking Form (ICS-MC-306) and the Hospital/Emergency Department patient tracking forms. The ICS-MC-306 can track up to 75 patients. EMS personnel should use this form to track patients when other patient tracking systems are not available. The ICS-MC-306 is located in Annex D. Hospitals/Emergency Departments may use the ICS-MC-306, the Hospital Incident Command System equivalent form, or a similar, locally developed form.

After all living patients have been transported from the scene, the Transportation Officer/Unit Leader should contact the Hospitals/Emergency Departments and complete a final accounting of each patient transported from the scene. The purpose of this accounting is to make certain every ambulance, transportation vehicle, and patient arrived safely at a Hospital/Emergency Department and to confirm that no patients remain at the incident scene.

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CHAPTER 3: COMMUNICATIONS

TACTICAL COMMUNICATIONS

RADIO LANGUAGE

Plain English will be used at all times for communications throughout the region. During MCI incidents, units will identify themselves using the Agency's name as a prefix, followed by their unit's number (e.g., Hampton Medic 3, Norfolk Medic 4, etc.).

F.C.C. RULES AND REGULATIONS

All radio operators should familiarize themselves with pertinent sections of Federal Communications Commission (FCC) Rules and Regulations applicable to radio voice communications. The use of profanity, or obscenities, is expressly forbidden. Persons broadcasting false call letters or initiating a false distress call are subject to fine and imprisonment. A current station authorization card shall be posted adjacent to each base transmitter.

COMMUNICATIONS ORDER

When an order has been received, briefly restate the order to confirm that the receiving person or unit received and understood the order.

VHF COMMUNICATIONS

Many neighboring jurisdictions have 800 MHz mutual aid channels for routine use. However, in a large-scale incident, resources may be called to the scene from outside their normal response area. Statewide VHF frequencies are designed to provide a standard communications mechanism throughout Virginia.

Use of the following VHF frequencies may be employed in a region-wide incident:

- 155.205 MHz – Statewide Mutual Aid: Used for communications between incoming units and staging officer.
- 154.265 MHz or VFIRE 22 – Peninsulas Mutual Aid Frequency. The fire service mutual aid frequency used for scene operations.
- 154.295 MHz or VFIRE 23 – Tidewater Mutual Aid Frequency. The fire service mutual aid frequency used for scene operations.
- 155.340 MHz or VMED 28 – VCU Hospital on Peninsulas HEAR Radio Frequency.
- 155.400 MHz – Peninsulas Hospital HEAR Radio Frequency

INCIDENT COMMUNICATIONS

SCENE-TO-EMERGENCY DEPARTMENT COMMUNICATIONS

The immediate and early notification of Hospitals/Emergency Departments is vital to the preparation of the Hospitals/Emergency Departments to receive patients. The responding EMS agency will contact the receiving Hospital(s)/Emergency Department(s) immediately after a multiple or mass casualty incident has

been identified. The responding EMS agency should advise Hospitals/Emergency Departments on the nature of the incident, incident location, and the approximate number of patients, possible types of injuries involved, suspected or confirmed HazMat exposures, or security threats.

Early Hospital/Emergency Department notification allows Hospitals/Emergency Departments time to move, release, or postpone the care of less acute patients to make room for patients arriving from the MCI scene. It also gives the Hospitals/Emergency Departments time to activate their emergency procedures and begin calling in additional staff members.

TRANSPORTATION GROUP/MEDICAL COMMUNICATIONS

The Transportation Group Supervisor/Unit Leader will establish communications with the receiving Hospitals/ Emergency Departments. The Transportation Group Supervisor/Unit Leader will provide as much information as possible to support hospital preparedness efforts to include the following information for each transport:

- EMS Agency and Ambulance Number.
- Patient Triage Tag Number(s).
- Triage Color of each patient.
- Age and gender of each patient.
- Nature of each patient's injuries.
- Estimated time of arrival.

AMBULANCE-TO-EMERGENCY DEPARTMENT COMMUNICATIONS

During an MCI, routine ambulance-to-Emergency Department communications are suspended. The Transportation Group Supervisor/Unit Leader or Medical Communication Coordinator will communicate patient information directly to the receiving Hospitals/Emergency Departments.

The Transportation Group Supervisor/Unit Leader or Medical Communication Coordinator will work with the receiving Hospitals/Emergency Departments via the most reliable communication methods and channels. Contact options are as follows:

- Local agency-to-hospital 800 MHz radio channel *
- COR (UHF)
- HEAR
- Telephone

***Note:** If the Transportation Group Supervisor/Unit Leader is using a dedicated EMS Agency to Hospitals/Emergency Departments channel and it becomes overwhelmed by non-incident traffic affecting clear communications, the IC should request that the dispatcher restrict usage of the channel to the MCI incident only. Ambulances working calls elsewhere in the community will need to utilize alternate means of communications.

REGIONAL HEALTHCARE COORDINATING CENTERS

Throughout the PEMS and TEMS Regions, the Eastern Virginia Healthcare Coalition (EVHC) provides Hospital to Hospital and Hospital/Healthcare System resource coordination through the Regional Healthcare Coordinating Center (RHCC). This center is responsible for serving as the contact between healthcare facilities, other regions, and the statewide response system through the hospital representative seat at the Virginia Communications Center. This system is a healthcare-to-healthcare coordination platform intended to enhance the communication and coordination of specific issues related to the healthcare component of the emergency response system. The RHCC communicates with hospitals and the Virginia Department of Health/Emergency Communications Center (VDH/ECC) using the Virginia Hospital Alerting and Status System (VHASS) software program.

It must be emphasized, that the structure noted above is in addition to, and does not replace the relationships and coordinating channels established between the individual healthcare facilities and their local Emergency Operations Center and/or health department officials.

A mobile RHCC is on standby at Riverside Regional Medical Center as a backup to the fixed facility located at the EVHC Office in Chesapeake.

CAPABILITIES AND FUNCTIONS OF THE EVHC REGIONAL HEALTHCARE COORDINATING CENTER

The EVHC RHCC has a 24-hour in-house contact available by multiple communication methods (e.g., VHASS, RIOS, 800MHz radios, landline phones, fax, cell phones and/or e-mails) as normal communication modalities. The RHCC is supplied with emergency power, phones, a satellite phone, video teleconferencing (Polycom), and Radio Amateur Civil Emergency Service/Amateur Radio Emergency Services radios may be available for disaster purposes and a backup radio system that are inter-operable with state agency systems. It should be noted that functions of RHCCs are not standardized and may differ by regions. For the RHCC Emergency Line, call (757) 243-2134.

Video conferencing is available in the EVHC RHCC by multiple commercial means (MS Teams, Zoom, Big Blue Button, etc.). The EVHC RHCC activation phone number is (844) 757-7422

If multi-regional assistance is required, the EVHC RHCC will communicate with other coalition RHCCs or hospitals and function as a communications center during an incident requiring the coordination of hospital needs within the eastern region, or throughout the Commonwealth.

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CHAPTER 4: AIR OPERATIONS

AIR OPERATIONS BRANCH

The IC/UC or Operations Section Chief may establish an Air Operations Branch depending upon the needs of the incident. The Air Operations Branch Director must be filled by someone who is familiar with aircraft communications, landing area designation, hazard identification, and aircraft safety rules.

Air operations at major incidents are complicated. Flight safety is, and must remain, a vital concern of all personnel involved in air operations. All aircraft communications must comply with Federal Aviation Administration (FAA) standards and regulations.

Note: For large scale air operations, consider referencing Air Operations Branch information located in the Virginia Statewide and Regional Hurricane Rescue and other HART Operations plans.

AIR MEDICAL TRANSPORT DECISION

Aeromedical ambulances should be considered when their use can:

- Decrease transport time from the incident scene to the hospital.
- Provide advanced critical care not available from ground EMS Units.
- When special medical resources must be brought to the scene or moved to an intermediate care facility.
- When ground EMS Units cannot access or egress the scene.
- Evacuate critically ill patients from the affected disaster area or local hospitals.
- Provide the Incident Commander with an aerial scene evaluation.

REQUESTING AIR AMBULANCE SERVICES

The initial request for air ambulance services will follow normal request procedures from the IC via the jurisdiction's dispatch center to the dispatch center of an air ambulance service provider.

Contact the Virginia Emergency Operations Center (VEOC) at 1-800-468-8892 or the VEOC Situational Awareness Unit (SAU) (manned 24/7) at 1-804-674-2400 if air ambulance services are needed from providers outside of the Hampton Roads region. The VEOC can assist in providing the telephone numbers for other air ambulance service providers such as the Virginia Army National Guard, Virginia Air National Guard, U.S. Coast Guard, and the Department of Defense (e.g., Air Force, Army, Marine Corps, and Navy).

Note: VEOC does not refer medevac flight requests to agencies other than the Virginia State Police (VSP) Aviation Division (i.e., the other full-time providers in the state). While VSP medevac units are a resource especially as it relates to interface with state/federal resources, a civilian air medical dispatch center may be better positioned with current information of other medevac resources.

PATIENT DESTINATIONS

The Transportation Group Supervisor/Unit Leader will determine patient destinations based upon the closest Hospital/Emergency Department. Specialty patients must be transported to the appropriate facilities (e.g., burns and pediatric). The aircraft's pilot has the authority to change the patient's destination due to severe weather or other aircraft safety issues.

ALTERNATIVE USES OF AIRCRAFT

Air ambulances may also be used to transport medical supplies and equipment to an MCI incident. The air ambulances are limited to carrying what is safe for them to transport, what will fit into the aircraft, and what will not exceed the aircraft's weight capacity.

AIRSPACE RESTRICTIONS

Airspace over an MCI is regulated by the FAA. Questions or requests concerning the use or restriction of that airspace during an MCI should be directed to the FAA's Washington Air Route Traffic Control Center (ARTCC) also known as the Washington Center at 1-703-771-3470.

Temporary flight restrictions for disaster areas are designated by the ARTCC which will notify other FAA facilities as appropriate. The VEOC at 1-800-468-8892 or VEOC SAU at 1-804-674-2400 has access to additional contact information to assist in this function.

AIRCRAFT COMMUNICATIONS

The primary incident Emergency Communications Center/911 Dispatch Center normally contacts air ambulance services to request medevac services. The scene Helispot or landing zone (LZ) location, coordinates, control, and frequency information will be given to the pilots by their agency's dispatch center when the aircraft is dispatched.

SCENE TO AIRCRAFT COMMUNICATIONS

The Virginia Medevac Committee recommends using the VHF Statewide Mutual Aid channel to communicate with air ambulances. Helicopters whose primary bases of operations are not in Virginia, including those operated by the U.S. Coast Guard and the Department of Defense cannot communicate on 700 or 800 MHz channels. However, these helicopters can communicate using VHF frequencies. The designated mutual aid VHF frequencies are as follows:

- 155.205 MHz - Statewide Mutual Aid (No PL)
- 154.265 MHz - Peninsulas Mutual Aid Frequency (No PL)
- 154.295 MHz - Tidewater Mutual Aid Frequency (No PL)

Private Line (PL): In wired telephony, a tie-line service that involves dedicated circuits, private switching and/or predefined transmission paths, virtual or physical, that provide communication among specific locations. Most connect only two locations though they may be switched at either end or both. Some have multiple drop points.

Ground to helicopter communications may also be performed on a locally assigned VHF channel that does not interfere with incident communications. Communications may also be established using 700 or 800 MHz channels if the responding air ambulance service has that capability. For example, the nationally standardized 700 MHz interoperability channels include eight dedicated air-ground channels, available in both repeated pairs and simplex/direct modes. While direct radio frequency (RF) communications is preferred, ground communications may also be achieved by means of a "patch" via Virginia COMLINC, available at most jurisdictions' emergency communications centers (ECCs) and many state agency dispatch centers.

LANDING ZONE CONTROLLER TO AIRCRAFT COMMUNICATIONS

The flight crew will contact the Landing Zone Controller within 5 to 10 minutes prior to their arrival and request LZ information. The Landing Zone Controller should be standing by on a mobile radio to give the LZ report. Use of handheld radios is discouraged as this often leads to poor reception for the Flight Crew due to the aircraft's distance, even when the Landing Zone Controller has no problems receiving transmission from the aircraft.

As the aircraft approaches, the Landing Zone Controller should be ready to stand outside the LZ and direct the aircraft if requested, or if the aircraft appears as if it is headed somewhere other than the LZ. Simple directions should be used. For example: "Turn right," then as the nose of the aircraft starts to line up with your location, say "Stop." Remember the aircraft's turn will not stop suddenly. Repeat the process, "Left" and "Right" until the aircraft is properly aligned within the landing site.

Once the helicopter has landed, do not approach the helicopter. The flight crew will approach you when it is safe to do so.

The Landing Zone Controller should have one firefighter staged off the nose of the aircraft who will serve as the initial point of contact for the flight crew. This firefighter should have a portable radio to enable them to talk directly to the Landing Zone Controller should the flight crew request additional resources.

AIRCRAFT TO AIRCRAFT COMMUNICATIONS

Helicopter to helicopter communication is accomplished using the 123.025 VHF frequency allowing pilots to communicate flight or scene hazards to each other.

COMMUNICATIONS AND MULTIPLE AIRCRAFT RESPONSE

The use of multiple aircraft in an incident response brings with it an increased risk of an aircraft-related mishap. The Air Operations Branch Director must establish effective and clear communications with each responding aircraft. During landing area operations, all aircraft-ground communications must occur on an assigned and common incident radio frequency, ideally the VHF 155.205 MHz – Statewide Mutual Aid channel as recommended by the Virginia Medevac Committee. Alternate radio communications between aircraft may be accomplished using VHF 123.025 MHz. Assigned frequencies should be documented on the Air Operations Summary Form (ICS 220) and included in an overall Incident Communications Plan Form (ICS 205). ICS 220 and ICS 205 can be found in Annex C.

The following multiple aircraft response communications procedure has been recommended for adoption by all agencies involved in air operations at any incident where more than one air ambulance, or aircraft is responding.

This procedure was designated as a "Best Practice" by the Virginia Medevac Committee in January 2008:

1. The initial request for medevac services should be made to the jurisdiction's primary medevac service provider (air ambulance service).
2. If requests were made for additional air ambulances or other aircraft to respond to the scene, the requesting emergency communication center must contact the dispatch center for each air ambulance or other aircraft and advise this is a multiple aircraft response.
3. The medevac service provider/air ambulance service's dispatch or communications center should take the following actions after they are notified another aircraft has been requested.

4. Contact all other responding aircraft communications centers and advise of the multiple aircraft response.
5. Inform prospective aircraft that multiple helicopters or aircraft are responding and relay the following information to the individual flight crews:
    a. The number of inbound aircraft
    b. The assisting aircrafts' names (e.g., LifeEvac III)

HELISPOT (LANDING ZONE) REQUIREMENTS, SAFETY, AND SECURITY

LANDING ZONE REQUIREMENTS

PRE-DESIGNATED EMERGENCY LANDING AREAS (PELAS)

Pre-designated emergency landing areas (PELAs) are clear and level areas near the scene of an accident or incident that the local emergency response team designates as the place where the helicopter air ambulance is directed to land to transport an injured person to a hospital. Provide such sites in various locations within a jurisdiction to support fast response to medical emergencies and accidents. Pre-designating these areas provides the opportunity to inspect potential sites in advance and to select sites that have adequate clear approach/departure airspace and adequate clear ground space. See the aeronautical information manual (AIM), chapter 10, for guidance on setting up offsite scenes or PELAs.

HELISPOTS AND GLOBAL POSITIONING SYSTEM (GPS) COORDINATES

Many jurisdictions have designated one or more Helispot (landing areas) within their jurisdiction. But many incidents will require new landing areas to be designated for use during a particular incident. If the GPS coordinates for these sites are known, this information should be included in the scene flight request information given to the air ambulance service's dispatch center. If the GPS coordinates are not readily available or unknown, the nearest cross-street intersections should be provided. The dispatch centers operated by the individual air ambulance services have the technology to convert scene landing area information, (i.e., nearby roads, intersections) into GPS coordinates for the pilot to enter into the aircraft's navigational system. Civilian medevacs typically use GPS formats in DD MM.MMM format. Additionally, the Virginia Office of Emergency Medical Services (OEMS) and the licensed air ambulance services maintain an online database of all hospital helipads.

HELISPOT (LANDING ZONE) SELECTION

The following guidelines should be used to select and establish a Helispot for rotary wing aircraft:

Locate an area large enough to land a helicopter safely. The touchdown or landing area should be 100 X 100 feet during the day and 100 X 100 feet at night for most civilian (EC-145/BK-117) air ambulances such as LifeEvac and Nightingale. The area should be on level, firm ground which is free of overhead obstructions, rocks, and other ground debris. If landing more than one helicopter each aircraft must have its own 100' x 100' area to land in.

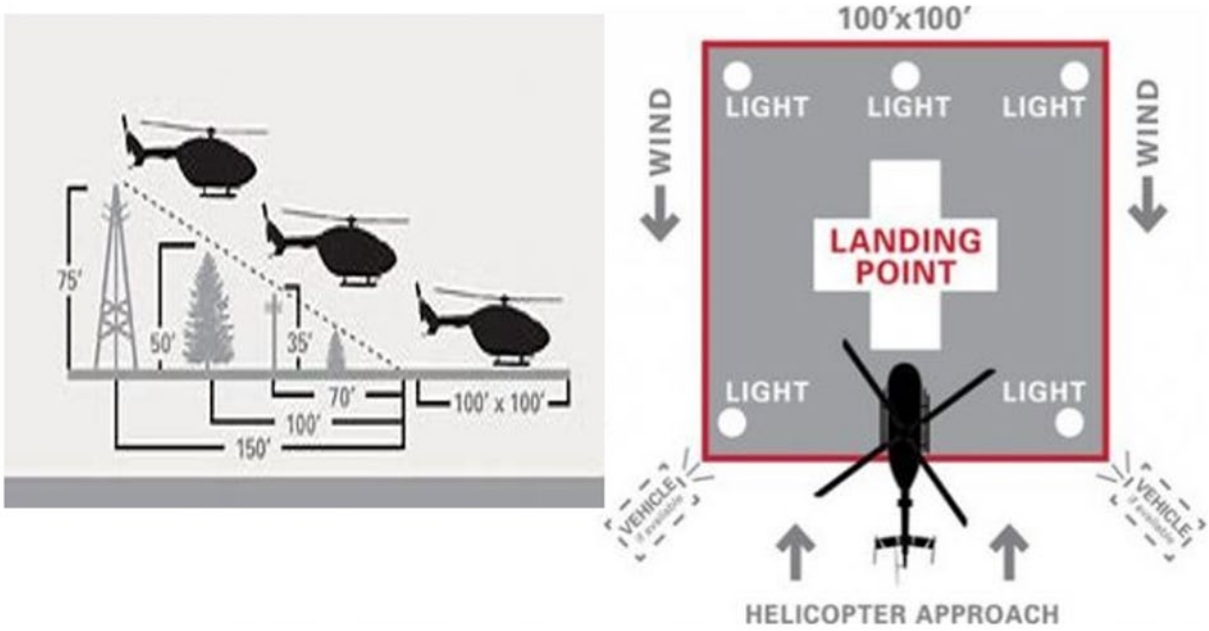

Figure 5. Landing Zone Approach

The required size of the landing area varies depending on the type of helicopter. Some military helicopters (i.e., CH-46) require a larger landing area. Care must be taken not to land civilian air ambulances too close to the larger military rotary wing aircraft as the powerful rotor wash from the larger military aircraft can push a civilian air ambulance on its side. Questions on military or larger helicopters should be referred to the FAA Advisory Circular 150/5390-2D on Heliport Design. For additional references, see the Aeronautical Information Manual (AIM), Chapter 10, for guidance on setting up offsite scene or PELAs.

For the purposes of Figure 6 (below), the following are provided as examples of relative helicopter size:

- Small Helicopter: Bell 206/407, Eurocopter AS−350/355, BO−105, BK−117.
- Medium Helicopter: Bell UH−1 (Huey) and derivatives (Bell 212/412), Bell 222/230/430 Sikorsky S−76, Eurocopter SA−365.
- Large Helicopter: Boeing Chinook, Eurocopter Puma, Sikorsky H−60 series (Blackhawk), SK−92.

Note: For a more conservative approach use twice the helicopter controlling dimension as the minimum landing zone dimension.

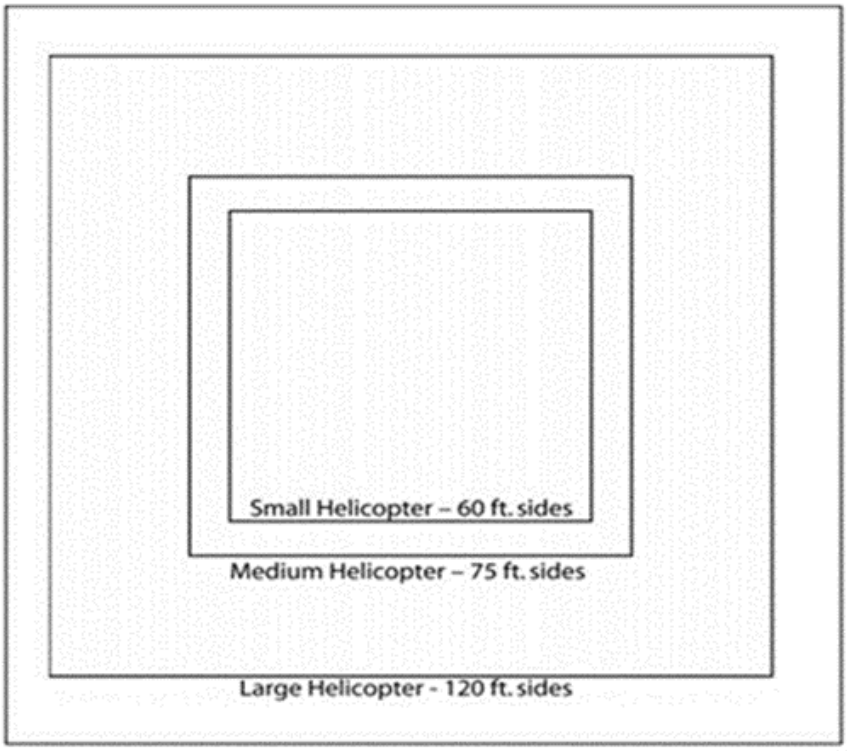

Figure 6. Minimum LZ Dimensions

LANDING ZONE HAZARDS AND OBSTRUCTIONS

The LZ should be clear of people, vehicles, and obstructions such as trees, poles, and wires. Keep in mind that wires cannot be seen from the air. Also, the LZ must be free of stumps, brush, posts, and large rocks (Figure 7). The LZ should be level, firm, and free of loose debris that could possibly blow up into the rotor system.

Recently plowed fields should not be the first choice of a LZ as the stretcher wheels will bog down into the soft soil and require more personnel to move and load the aircraft. Staff support requirements for LZ safety can be found in local protocol and procedures.

Figure 7. LZ Hazards and Obstructions

WIND DIRECTION

Helicopters must land and take off into the wind. The approach and departure path should be clear of obstructions, including ground personnel and apparatus. If there are obstructions in and around the LZ, advise the crew of all obstructions on the radio when the LZ report is given.

LANDING ZONE MARKINGS

Mark the four corners of the landing zone. Road flares are an intense source of ignition and must be closely managed. Other light sources are preferred, if available. At night, ensure spotlights, floodlights, and hand

lights used to define the area are not pointed toward the helicopter. Turn off non-essential lights. White light ruins the pilot's night vision and temporarily blinds him/her. Red lights are extremely helpful in finding accident locations and do not affect the pilot's night vision.

LANDING ZONE SAFETY

This information is provided for use by helicopter emergency medical services (HEMS) pilots, program managers, medical personnel, law enforcement, and fire and rescue personnel to further their understanding of the safety issues concerning LZ. It is recommended that HEMS operators establish working relationships with the ground responder organizations they may come in contact with during their flight operations and share this information to establish a common frame of reference for LZ selection, operations, and safety.

The information provided is largely based on the booklet, *LZ − Preparing the Landing Zone*, issued by the National Emergency Medical Services Pilots Association (NEMSPA), and the guidance developed by the University of Tennessee Medical Center's LIFESTAR program and is used with their permission.

For additional information, go to http://www.nemspa.org/. Information concerning the estimation of wind velocity is based on the Beaufort Scale. See http://www.spc.noaa.gov/faq/tornado/beaufort.html for more information.

WORKING IN THE LANDING ZONE

Spectators must be kept at least 200 feet from the touchdown area and emergency service personnel at least 100 feet away. Have fire equipment standing by. Ensure everyone working near the helicopter wears eye protection. If helmets are worn, chin straps must be securely fastened. Have firefighters wet down the touchdown area if it is extremely dusty and any dry areas where road flares are going to be utilized to mark the landing zone. All personnel should have apparatus or some barrier between them and the aircraft during take-off and landing to protect them from flying debris. This barrier also serves to protect first responders in case of an aircraft mishap resulting in a hard or crash landing of the aircraft.

APPROACHING THE AIRCRAFT

Once the patient is packaged and ready to load, allow the crew to select two or three personnel to assist with loading the patient onto the helicopter. When approaching or departing the helicopter, always be aware of the tail rotor and always follow the flight crew's direction for your safety.

When working around helicopters, never approach the aircraft from the rear. Always approach and depart the aircraft towards the front so you can see the pilot and they can see you. When approaching the helicopter, remember to keep low to avoid the main rotor as winds can cause the rotor to flex downward. If the helicopter has landed on sloped terrain, approach and depart from the down-slope side only.

When the helicopter is loaded and ready for takeoff, keep the departure path free of vehicles and spectators. If an emergency were to occur, the aircraft may need this area to execute an emergency landing.

HELICOPTER AND HELISPOT (LANDING ZONE) SECURITY

Be prepared to assist the flight crew by providing security for the helicopter. If asked to provide security, do not allow anyone but the flight crew to approach the helicopter. Ideally, the responsibility for this function should rest with local law enforcement.

David Long to check with State Air Medical to confirm.

Mike Player to provide image of hand signals used in Hampton Roads.

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CHAPTER 5: DEMOBILIZATION, EVALUATION, AND POST-INCIDENT ACTIVITIES

DEMOBILIZATION

The objective of demobilization is to return operational personnel, apparatus, and equipment to full service in an orderly fashion and as soon as is feasible to do so. This requires making certain that all the individual's or unit's supply and logistics needs have been met to ensure they can return to service.

Personnel should be demobilized in the same manner and order they checked into the organization, as individuals, units, or teams. Units providing vehicles, apparatus, boats, support equipment, and personnel, should be demobilized at the same time, if possible.

The Transportation Group Supervisor/Unit Leader should notify both the Medical Group Supervisor/Medical Branch Director and the Hospitals/Emergency Departments when all living patients have been transported from the incident scene and all patient care activities have been completed. This notifies the chain-of-command that they should consider demobilizing at least some of the EMS personnel and assets or make them available for reassignment.

Demobilization of responding personnel should be accomplished in accordance with the Demobilization Plan developed by the Planning Section/Demobilization Unit. If a Demobilization Plan was not developed, then demobilization should precede at the direction of the IC or their designee.

PROVIDER WELLNESS

Consider making provider wellness available to all first responders. Peer and Crisis Support Services are available from the PEMS Council and the TEMS Council. These services are confidential and free to the emergency services community. The Peer and Crisis Support Services provide stress defusing, debriefings, one-on-one sessions, demobilization, family support and educational programs. Any emergency worker in the PEMS and TEMS regions can call for Peer and Crisis Support Services. An on-call team leader will respond back to the caller, discuss the situation, and determine if and what type of provider wellness response is needed. The teams are available 24 hours/day.

- PEMS Peer and Crisis Support Services: Call (757) 220-4356 and ask for Provider Wellness
- TEMS Peer and Crisis Support Services: Call (757) 414-2476 / (757) 414-CISM

EVALUATION AND POST-INCIDENT ACTIVITIES

DEBRIEFING/HOT WASH

Immediately following the resolution of the mass casualty incident, the IC/UC should facilitate an incident debriefing or hot wash with responders representing the various incident assignments. The incident debriefing/hot wash is an opportunity for first responders to voice their opinions regarding the response to the incident and their own performance. All ICS forms should be completed and turned in before the individual responsible for completing the form(s) is demobilized. At this time agency leaders can also seek clarification regarding actions taken during the incident, and what prompted first responders to take those

actions. The incident debriefing/hot wash should not last more than 30 minutes. Scribes should be assigned to take notes during the incident debriefing/hot wash. The resulting notes will be used to compile the incident After Action Report (AAR).

AFTER ACTION REPORT

The AAR is the culmination of the incident response. It is a written report outlining the strengths and areas for improvement identified by the response. The AAR will include the incident timeline, executive summary, incident description, mission outcomes, and capability analysis. The AAR will be drafted by a core group of individuals from each of the public safety and other agencies involved in the incident response. Copies of the AAR from actual mass casualty incidents should be forwarded to the licensed EMS Agency's respective EMS Council and the Virginia Office of EMS.

AFTER ACTION REPORT CONFERENCE

The AAR Conference is a forum for jurisdiction and agency officials to hear the results of the evaluation analysis, validate the findings and recommendations in the draft AAR, and begin development of the Improvement Plan (IP).

IMPROVEMENT PLAN

The IP identifies how recommendations for improvement will be addressed, including what actions will be taken, who is responsible, and the timeline for completion. It is created by key stakeholders from participating agencies during the AAR Conference.

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CHAPTER 6: MASS CASUALTY TRAINING AND EXERCISES

ANNUAL MCI TRAINING RECOMMENDATION

All EMS agencies within the Peninsulas and Tidewater EMS Councils' regions are strongly encouraged to conduct annual multiple/mass casualty training. This MCI training should then be assessed by means of an annual MCI drill or exercise. Guidance on recommended training courses and MCI drills/exercises are provided below.

Annual MCI training should be based on the Hampton Roads Mass Casualty Incident Response Guide. The PEMS Council, TEMS Council, and the RHCC staff support MCI training by providing:

- Pre-hospital MCI training courses/continuing education classes
- Mass casualty incident management training for hospitals
- Hospital to Hospital and RHCC Communications training (VHASS)

MASS CASUALTY INCIDENT MANAGEMENT COURSES

MASS CASUALTY INCIDENT MANAGEMENT – MODULE I COURSE

This course is designed by the Virginia Office of Emergency Medical Services (OEMS) and taught by an OEMS-certified Emergency Operations Instructor, and/or Education Coordinators (EC). This awareness-level course addresses basic concepts for the management of mass casualty incidents. The course recognizes key on-scene indicators of a mass casualty incident as well as appropriate notification measures. The course also covers the command-and-control structure, triage processes using SALT and START, the Virginia Triage Tag, and initial steps to be taken at an MCI associated with on-scene activities. Contact your local EMS Council or the OEMS for information on upcoming courses.

MASS CASUALTY INCIDENT MANAGEMENT – MODULE II COURSE

This course is designed by the Virginia Office of Emergency Medical Services and taught by an OEMS-certified Emergency Operations Instructor. This operations-level course prepares students who would assume staff positions and direct effective actions within the Medical Group/Branch during a mass casualty incident response. This course provides the student with in-depth information on managing mass casualties, including creating the medical command structure. A tabletop exercise helps practice the skills taught in the class. Contact your local EMS Council or the OEMS for information on upcoming courses.

EMS: INCIDENT OPERATIONS COURSE (R0147)

In this 6-day course, EMS personnel/officers/supervisors review ICS and study proper incident command techniques for management of medium to large incidents involving multiple sick or injured patients. Topics covered include problem-solving and EMS functions within incident command, resource management, interagency and mutual aid, size-up and strategy, tactics and action plans, EMS company operations, pre-incident preparation, incident organization, and strategic command.

PREREQUISITES:

- ICS 100 level and ICS 200 level training. Preferred courses are Q462 and Q463 available through NFA Online at www.nfaonline.dhs.gov. Chief's signature attests that the applicant has completed this required training.
- IS-700 National Incident Management System (NIMS), An Introduction (http://training.fema.gov/IS/).
- IS-201 Forms Used for the Development of the Incident Action Plan (http://training.fema.gov/IS/)

This course is delivered on-campus at the National Fire Academy resident facility in Emmitsburg, Maryland. Any person with substantial involvement in fire prevention and control, emergency medical services, or fire-related emergency management activities is eligible to apply for Academy courses.

SELECTION CRITERIA:

Emergency response personnel with responsibilities to implement the initial and early expanding EMS functions of an ICS at medium- or large-sized incidents. In addition, prospective students must meet the Volunteer Incentive Program eligibility requirements.

A prospective student must:

1. Be a volunteer in a volunteer or combination department, OR
2. Be a paid person in a predominantly volunteer combination department (more volunteers than career personnel). If paid, you must provide a letter from the chief verifying a predominantly volunteer combination department AND identifying how you will use the training requested to help the volunteers with whom you work.

Future students must apply to the National Fire Academy to attend this course. The Academy employs a competitive application process. Application procedures vary with the different courses and programs. Each course or program has specific application requirements listed. Applicants should carefully read the course descriptions and requirements and follow the procedures listed; this will save time and speed up the application process. To apply go to: http://www.usfa.dhs.gov/nfa/

MASS CASUALTY INCIDENT MANAGEMENT (MODULE I & II) INSTRUCTOR COURSE

These courses are designed and taught by the Virginia Office of Emergency Medical Services staff. Successful completion of this course of instruction, completion of prerequisites, and submission of appropriate application and supporting documents certifies the student as an Emergency Operations Instructor. Emergency Operations Instructors may teach both the Mass Casualty Incident Management – Module I and Module II courses. To be eligible to take this course, students must have successfully completed both the Mass Casualty Incident Management Module I & II within the previous 12 months, in addition to SALT Triage Training, and existing instructor qualifications to include: OEMS, Virginia Department of Fire Programs, Virginia Association-Volunteer Rescue Squad, American Hospital Association, American Red Cross, or Department of Criminal Justice Services. Contact your local EMS Council or the OEMS for information on upcoming courses.

ADDITIONAL OR RECOMMENDED MCI TRAINING

SPECIALIZED EMERGENCY MEDICAL SERVICES TRAINING

The two courses listed below will replace the Emergency Medical Services: Special Operations (R0152) course:

1. Fundamentals of Planning Specialized Operations for EMS (Q0176-Online)
2. Management and Planning of Specialized Operations for EMS (R0168-In classroom).

These courses are designed to provide emergency personnel with the knowledge, skills, and abilities to effectively plan and manage the response of their EMS systems for incidents/events requiring specialized resources, specialized preparation, and/or multiagency response, in compliance with NIMS guidelines.

The EMS R0168 course is a 6-day practical application of National Incident Management System Incident Command System (ICS-300) knowledge and skills focused on the emergency medical services (EMS) aspects. Key topics addressed are designed to effectively manage the EMS components of planned events and complex incidents, including identifying potential hazards. This training comprehensively covers the support of specialized operations, including hazardous materials, law enforcement, public health, search and rescue incidents, dignitary visits, and planned special events. It also covers identifying resource needs and the development of Incident Action Plans.

PREREQUISITES:

- ICS 100 level and ICS 200 level training. Preferred courses are Q462 and Q463 available through NFA Online at: https://www.usfa.fema.gov/training/nfa/courses/online.html.
- IS-201 Forms Used for the Development of the Incident Action Plan (online).
- IS-700 National Incident Management System (NIMS), An Introduction (online).
- IS-800 National Response Framework, An Introduction (online).
- Completion of National Fire Academy class "Emergency Medical Services: Incident Operations" (R0147 or N0147).

Note: IS-201, IS-700, and IS-800 are located at: http://training.fema.gov/IS/NIMS.aspx

These courses are delivered on-campus at the National Fire Academy resident facility in Emmitsburg, Maryland. Any person with substantial involvement in fire prevention and control, emergency medical services, or fire-related emergency management activities is eligible to apply for Academy courses.

SELECTION CRITERIA:

These courses are for those who have management and planning responsibilities for an EMS system. The courses are targeted primarily to middle managers at an operational level and to senior planners within their agency.

Future students must apply to the National Fire Academy to attend this course. The Academy employs a competitive application process. Application procedures vary with the different courses and programs. Each course or program has specific application requirements listed. Applicants should carefully read the course descriptions and requirements and follow the procedures listed; this will save time and speed up the application process. To apply go to: http://www.usfa.dhs.gov/nfa/

EMERGENCY MEDICAL SERVICES: FUNCTIONS IN THE INCIDENT COMMAND SYSTEM (W/F0166)

This course will present scenarios requiring responders to structure their EMS resources within the guidance of NIMS ICS, as appropriate to the needs of the different incident types. Through simulation and role-playing, students will demonstrate the implementation of EMS components in an ICS system at medium- or large-sized incidents. Currently, this course is available only during NFA-Sponsored State Weekends. This course can also be offered as an in-state class, handled through the Virginia Department of Fire Programs as a "hand-off" class.

PREREQUISITES:

ICS 100 and ICS 200 level training. Preferred courses are Q462 and Q463 available through NFA Online at http://www.nfaonline.dhs.gov. A Chief's signature attests the applicant has completed this required training.

SELECTION CRITERIA:

Emergency response personnel with responsibilities to implement the initial EMS functions of an Incident Command System at medium- or large-sized incidents.

DRILLS AND EXERCISES

All EMS agencies within the PEMS and TEMS regions are strongly encouraged to conduct and/or participate in annual multiple/mass casualty drills and exercises. Where required, the HSEEP should be used to design and document, conduct, and evaluate these drills and exercises. Both the PEMS Council and the TEMS Council support MCI drills and exercises by providing:

- HSEEP implementation guidance
- Regional exercise design support (e.g., regional triage tag exercises)
- Exercise Evaluation Guide development
- Moulage support
- Evaluation/observation of multiple/mass casualty drills and exercises

Additional drill/exercise support may be obtained from the Hampton Roads Metropolitan Medical Response System (HRMMRS) Program Office which can be reached by contacting the TEMS Office at (757) 963-0632.

In addition to drills and exercises, the Hampton Roads Mass Casualty Incident Response Framework includes this Guide along with the six incident-specific playbooks. The Framework was developed as an EMS resource to support planning and preparation in response to a series of probable MCIs within the Region. The content included in the Playbooks is based on best practice research and lessons learned analysis conducted by the U.S. Fire Administration, the American College of Surgeons, the Federal Bureau of Investigation, and the Hartford Consensus Group.

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ANNEXES

ANNEX A: EMERGENCY COMMUNICATIONS DIRECTORY

EMERGENCY DISPATCH CENTERS

EASTERN SHORE EMERGENCY DISPATCH CENTER

Jurisdiction	Primary Telephone Number	Facsimile Number
Eastern Shore of Virginia 911 Center (Accomack & Northampton County)	757-787-0911	757-787-1044

PENINSULAS EMERGENCY DISPATCH CENTERS

Jurisdiction	Primary Telephone Number	Facsimile Number
Essex County (Sheriff's Dept.)	804-443-3346	804-443-3340
Gloucester County (Sheriff's Dept.)	804-693-3890	804-693-1444
Hampton	757-727-6111	757-727-6030
James City County	757-890-3621	757-890-3608
King and Queen County (Sheriff's Dept.)	804-785-7400	804-785-5489
King William County (Sheriff's Dept.)	804-769-0492	804-769-0334
Lancaster County (Sheriff's Dept.)	804-462-5111	804-462-5191
Mathews County (Sheriff's Dept.)	804-725-7177	804-725-5982
Middlesex County (Sheriff's Dept.)	804-758-2779 804-758-2195	804-758-0440
Navy Region Mid-Atlantic-Regional Dispatch Center	757-444-2324	
Newport News	757-247-2500	757-245-2977
Northumberland County (Sheriff's Dept.)	804-580-2100	804-580-2541
Poquoson (Joint center with York County)	757-890-3621	757-890-3608
Richmond County (Sheriff's Dept.)	804-333-3611	804-333-5418
Town of West Point	804-843-2670	804-769-0334
Westmoreland County (Sheriff's Dept.)	804-493-8066	804-493-8715
Williamsburg (Joint center with York County)	757-890-3621	757-890-3608
York County Public Safety	757-890-3621	757-890-3608

SOUTHSIDE HAMPTON ROADS EMERGENCY DISPATCH CENTERS

Jurisdiction	Primary Telephone Number	Facsimile Number
Chesapeake	757-382-6161 Dial *1	757-382-6149
Franklin	757-562-8575	757-562-0877
Isle of Wight County	757-357-2151	757-357-0706
Navy Region Mid-Atlantic-Regional Dispatch Center	757-444-2324	
Norfolk	757-441-5610	757-466-9387
Portsmouth	757-393-5300	757-393-5305
Southampton County	757-653-2100	757-653-9452
Suffolk	757-925-2030	757-514-4229
Surry County	757-294-5264	757-294-5111
Virginia Beach		757-385-5688
Animal Control	757-385-5000	
Emergency Dispatch Supervisor	757-385-1804	
Police Info/Miscellaneous	757-385-5000	

NORTHEASTERN NORTH CAROLINA EMERGENCY DISPATCH CENTERS

Agency or Jurisdiction	Primary Telephone Number	Facsimile Number
Camden County (Joint Center with Pasquotank County & Elizabeth City)	252-331-1500	252-331-7444
Currituck County	252-232-2216	252-232-2750
Gates County	252-357-0210	252-357-4131
Dare County	252-473-3444	252-473-4563
NC Highway Patrol	252-792-4101	252-792-6740
Pasquotank County	252-331-1500	252-331-7444

STATE POLICE DISPATCH CENTERS

Agency or Jurisdiction	Primary Telephone Number	Facsimile Number
Virginia		
Virginia State Police Headquarters - Richmond	804-674-2000	
Virginia State Police - Division Five (Eastern Shore, Hampton Roads)	757-424-6800	757-361-3080
Virginia State Police – Division One (King & Queen County)	804-553-3444	804-553-3416
Maryland		
Maryland State Police (Princess Anne Barracks)	410-651-3101	443-260-3764
Maryland State Police (Berlin Barracks)	410-641-3101	410-641-3259
Maryland State Police (Salisbury Barracks)	410-749-3101	410-548-5191
North Carolina		
North Carolina Highway Patrol	252-792-4101	252-792-6740

AEROMEDICAL (AIR AMBULANCE) RESOURCES

Agency	Primary Telephone Number	Comments
Virginia		
Life Evac	1-877-902-7779	LifeEvac I - based in Dinwiddie County. LifeEvac III - based at West Point.
Nightingale (Norfolk, VA)	Dispatch: 1-800-572-4354 Alternate Dispatch: 757-388-5597	Office: 757-388-2500 Based at Sentara Norfolk General Hospital in Norfolk
MedFlight Virginia State Police	804-553-3445	
PHI Air Care	1-703-776-2930 or 866-417-1821	1 - Based at Manassas 2 - Base at Fredericksburg 3 - Based at Leesburg
USCG Search & Rescue-Sector Hampton Roads	757-638-6641 *1 or 757-483-8567	Sector Hampton Roads will coordinate requests for helicopter assistance.

Agency	Primary Telephone Number	Comments
Maryland		
Maryland State Police (Systems Communication Center or SYSCOM)	410-706-8080 or 410-783-7525	SYSCOM dispatches MD State Police Helicopters; monitors hospital bed status statewide;arranges communications between the air assets and the hospitals

AIRPORTS

Agency	Primary Telephone Number	Comments
Virginia		
Norfolk International Airport		
Emergency Dispatch	757-857-3344 or 757-857-3223	Airport Authority Police Dispatch is manned 24/7/365
Emergency Operations Center	Primary: 757-857-3320 Secondary: 757-857-3321	FAX: 757-857-3252 Note: the EOC is only staffed during an emergency or MCI.
Newport News/Williamsburg International Airport		
Williamsburg International Airport Police Dept – Newport News	757-877-0221	

VIRGINIA DEPARTMENT OF TRANSPORTATION

The Eastern Region Traffic Operations Center has direct contact with all bridges and tunnels in the eastern region of Virginia from Greenville and Emporia, the Eastern Shore south to the North Carolina state line. Use them as your primary point-of-contact for all Virginia Department of Transportation (VDOT) related needs/issues.

Regional Traffic Operations Centers	Region Served	Primary Telephone Number
Eastern Virginia Traffic Operations Center	Eastern Region of Virginia	Control Room Supervisor 757-424-9920
Central Virginia Traffic Operations Center	Central Region (Richmond)	804-796-4520
Northern Virginia Traffic Operations Center	Northern Region	703-877-3401
Northwest Virginia Traffic Operations Center	Northwest Region	540-332-7789
Southwest Virginia Traffic Operations Center	Southwest Region	540-375-0170
Hampton Roads District Office, Suffolk	Hampton Roads	757-925-2500

VDOT Eastern Region Residency Office	Area Served	Primary Telephone Number (Daytime Only)
Accomack Residency Office	Accomack & Northampton Counties	757-787-1550
Croaker Area Headquarters, Croaker	Upper James City County	757-566-8615
Norfolk Residency Office, Norfolk	Interstate systems for south side up to the Hampton Roads BridgeTunnel	757-494-5470
Seaford Area Headquarters, Seaford	Lower York County	757-898-7237
Williamsburg Area Headquarters	Williamsburg, James City County, & Upper York County	757-253-5138
Williamsburg Residency Office, Williamsburg	James City County, York County	757-253-4832

BRIDGES AND TUNNELS

Trucks that are 13 feet 6 inches in height and lower can safely transit all bridges and tunnel unless otherwise noted in the table below.

Bridge or Tunnel Name & Jurisdiction	Weight & Height Restrictions
Berkley Bridge (Draw Bridge)	No restrictions.
Centerville Turnpike	Height restriction: 13’ 9”No weight restrictions
Chesapeake Bay Bridge Tunnel (Toll)	Height restriction: 13’ 6” Weight restriction: 80,000 lbs. (Weights ≥80,000 lbs. contact the TOC.)
Chincoteague Channel Bridge, Rte. 175	Height restriction: N/A Weight: 80,000 lbs.
Coleman Bridge, Route 17 (Toll) (Double Swing Span)	Height restriction: 20’ 0”
Deep Creek Bridge (Draw Bridge)	Weight Restriction: 20 tons single unit; 29 tons semi-trailers (3 axle); 29 tons twin trailers (5 axle)
Dominion Boulevard (Steel) Bridge (Draw Bridge)	No restrictions.

Bridge or Tunnel Name & Jurisdiction	Weight & Height Restrictions
Downtown Tunnel	Height restriction: 13’ 6”
Eltham Bridge, Rte. 30 & Rte. 33 (Draw Bridge)	This bridge is not manned unless there is an actual lift.
Gilmerton Bridge, Military Highway (Draw Bridge)	Weight restriction: 14 tons; 20 tons for semi-trailers, 27 tons – twin trailers
Great Bridge (Draw Bridge)	No restrictions.
Gwynn’s Island Bridge, Rte. 223 (Swing Span)	Height restrictions: 13’ 9” Weight Restrictions: 30 tons Width Restriction: 24 feet
Hampton Roads Bridge Tunnel I-64	East bound height restriction: 14’ 6” West bound height restriction: 13’ 6”
High-Rise Bridge (Treakle Bridge) I-64 (Draw Bridge)	No restrictions.
James River Bridge, Rte. Rt 17 (Draw Bridge)	No restrictions.
Jordan BridgeToll Bridge	
Midtown Tunnel	Height restriction: 13’ 6” Width restriction: 8 feet 6 inches
Monitor Merrimac Bridge Tunnel I-664	Height restriction: 14’ 6”
North Landing Bridge (Double Swing Span)	Weight restriction: 13 tons

TOLL ROADS

Toll Road	Tolling Information
Berkley Bridge	Contact your dispatch center and request that they contact the Control Room as needed. All electronic tolling is in place. Some ambulances may be exempt from tolls. Contact Elizabeth RiverTunnels for details.
Chesapeake Expressway (Rte. 168)	Emergency Response - no toll with lights & sirens.Use EZ-Pass lanes; Routine travel use a gated toll. $3 2-axle
Chesapeake Bay-Bridge Tunnel	Call ahead to arrange payment clearance at the tolls.Do not use E- Z Pass lanes. Vehicles operating in emergency response mode use three right lanes & slow speed to 15 mph due to gates. Toll Fees: $12 2-axle, 4 tire, $17 2-axle, 6 tire $21 3-axle, ($7 each additional axle)
Coleman Bridge (North Bound Toll Only)	Vehicle must be operating in emergency mode with lights and sirens; use E-Z Pass lanes if possible North bound toll only. No toll south bound.
Downtown Tunnel - 757-313-0422	Contact your dispatch center and request that they contact the Control Room as needed. All electronic tolling is in place. Some ambulances may be exempt from tolls. Contact Elizabeth RiverTunnels for details.
Jordan Bridge	Call the Chesapeake Dispatch Center.All electronic tolling is used.
Mid-Town Tunnel - 757-313-0416	Contact your dispatch center and request that they contact the Control Room as needed. All electronic tolling is in place. Some ambulances may be exempt from tolls. Contact Elizabeth RiverTunnels for details.

FERRY SYSTEMS

Ferry Name & Operating Location	Primary Telephone Number	Weight & Height Restrictions
Virginia Ferry System		
Elizabeth River Ferry between Portsmouth and Norfolk (Operated by Hampton Roads Transit)	1-800-700-RIDE (7433) Office Hours: 0800-1700 daily.	Passengers Only – open deck space on the main deck could be used to transport litter patients and/or EMS equipment. USCG licensed capacity ranges from 138 – 150 passengers depending upon which ferry is used. Cash Fare: $1.50 Seniors and persons with disabilities: 75¢ Three Landings: Norfolk – Waterside Drive behind Waterside Market Place Portsmouth - High Street Landing and North Landing located off of Water Street.
Jamestown-Scotland Ferry, Rte. 31 operating between Surry County and James City County.(Operated by VDOT)	757-294-3354	From the south, contact Surry County Dispatch Center at 757-294-4306 to hold the ferry. From the north, contact James City County Dispatch Center at 757-566-0112 to hold the ferry. • Height restriction: For M/V Virginia:12' 6"; all other vessels 13' 6" • Weight restriction: 16 tons for large trucks, 28 tons for semi-tractor combinations • Width restriction: Legal limits for highway travel • Length restriction: Legal limits for highway travel • HazMat: The ferry cannot transport placarded vehicles. Note: The ferry will shut down operations if high tides are >3 feet above normal high tides.
Tangier Island Ferry (Privately Operated)	757-891-2505	Passengers only. USCG licensed capacity: 24 passengers.

Ferry Name & Operating Location	Primary Telephone Number	Weight & Height Restrictions
North Carolina Ferry System		
Knotts Island – Currituck Ferry Rte. 168 & follow the signs approximately 18 miles south of the NC state line.	252-232-2683	Contact Knotts Island-Currituck Ferry Office at 252-232-2683 to hold the ferry. • Height restriction: 13' 3" • Weight restriction: 80,000 lbs. for 4 & 5-axle vehicles • Width restriction: Legal limits for highway travel • Length restriction: Legal limits for highway travel

REGIONAL SPECIALTY TEAMS

Resource Name	Primary Telephone Number	Secondary Telephone Number
Hampton Roads Metropolitan Medical Strike Team	York County ECC: 757-890-6321	Norfolk ECC: 757-441-5610
Regional Hazardous Materials Team	VEOC: 1-800-468-8892 or 804-468-8892	
Tidewater Technical Rescue Team	Call the Virginia Beach ECC: 757-385-5000 or Emergency Dispatch Supervisor: 757-385-1804	

U.S. COAST GUARD

Resource Name	Primary Telephone Number	Secondary Telephone Number
USCG Search & Rescue-Sector Virginia Command Center (Note: Sector Virginia will coordinate all requests for small boat & helicopter assistance.)	757-638-6641 *1	757-483-8567

DEPARTMENT OF DEFENSE

Resource Name	Primary Telephone Number	Comments
Commander Navy Regional Mid-Atlantic (CNRMA) – Regional Emergency Operations Center	Main Number: 757-322-2609 Fire Desk: 757-445-9129 and 757-322-2607	Area of responsibility includes Maine south to & including North Carolina as well as Indiana & Illinois.
Naval Station Norfolk Emergency Operations Center	757-322-2323	For Naval Station Norfolk (including Craney Island)

PEER AND CRISIS SUPPORT SERVICES

Peer and Crisis Support Services are available from the PEMS and TEMS Regions. These services are confidential and free to the emergency services community and are available 24 hours/day.

Resource Name	Primary Telephone Number	Comments
PEMS Peer and Crisis Support Services	757-220-4356	Ask for Provider Wellness
TEMS Peer and Crisis Support Services	757-414-2476 / 757-414-CISM	

VIRGINIA DEPARTMENT OF HEALTH

Health District	Director	Emergency Healthcare Coordinator	Epidemiologist
Virginia Department of Health - Eastern Region	NA	John Cooke Office: 757-894-7879 Cell: 757-435-3858 email: john.cooke@vdh.virginia.gov	Ana Colon Office: 757-683-2847 Cell: 757-328-6535 Fax: 757-683-2494
	Public Information Officer: Larry Hill Office: 757-683-9175 Cell: 757-449-4287 Fax: 757-683-2494		
Chesapeake Health District Main Office: 757-382-8600 24-Hour Emergency Number:757-382-8600	Dr. Nancy Welch Direct: 757-382-8627 Cell: 757-641-6880	Jerry Tucker Office: 757-382-8654 Cell: 757-435-2439 Fax: 757-382-8644	Lisa Engle Office: 757-382-8642 Cell: 757-435-6078 Fax: 757-382-8675

Health District	Director	Emergency Healthcare Coordinator	Epidemiologist
Eastern Shore Health District (Accomack & Northampton County) Main Office: 757-787-5880 24-Hour Emergency Number:757-787-5880 x 266	Dr. David Matson Office: 757-302-4229 Cell: 757-647-7670	Jennifer Justis Office: 757-302-4267 Cell: 757-710-4536 Cell 2: 757-387-7032 Fax: 757-787-5841	Kim Wright Office: 757-302-4268 Cell: 757-387-7716 Fax: 757-787-5841
Hampton Health District (Cities of Hampton, Newport News, Poquoson, Williamsburg & the Counties of James City & York) Hampton Main Office: 757-727-1172 24 Hour Emergency Number:757-727-1172 Peninsula Main Office: 757-594-7300 24 Hour Emergency Number:757-268-8711	Dr. Natasha Dwamena Hampton Location: Office: 757-594-7305 Cell: Peninsula Location: Office: 757-594-7305 Cell:	Kevin Pearce Office: 757-594-7515 Cell: 757-218-9439 Fax: 757-218-9439 After Hours: Fax: 757-268-8711	Hampton: Nancy Lemis, RN Office: 757-315-3772 Cell: 757-880-9219 Fax: 757-727-1185 Peninsula: Cynthia Rieken Office: 757-594-7427 Cell: 757-951-7936 Fax: 757-594-7286
Norfolk Health District Main Office: 757-683-2796 24 Hour Emergency Number:757-683-2796	Dr. Demetria Lindsay Office: 757-683-2798 Cell: 757-412-7656	Eve Zentrich Office: 757-683-2834 Cell: 757-639-9939 Fax: 757-683-8878	Michelle Burnette Office: 757-683-8384 Cell: 757-435-5809 Fax: 757-683-8878
Portsmouth Health District Main Office: 757-393-8585 24 Hour Emergency Number:757-435-9616	Dr. David Chang Office: 757-393-8585 x8509 Cell: 757-273-2119	Office: 757-393-8585 Ext. 8518 Cell: 757-779-0812 Fax: 757-393-8027	Michelle Winz Office: 757-393-8585 Ext. 8701 Cell: 757-435-3280 Fax: 757-393-8027
Crater Health District (Surry County) Main Office: 804-863-1652 24 Hour Emergency Number:1-866-531-3068	Dr. Alton Hart Jr. Office: 804-863-1652 Cell:	Deborah Whitacre Office: 804-862-8903 Cell: 804-840-0614 Fax: 804-862-6126	Louise Lockett Office: 804-862-8986 Cell: 804-840-1619 Fax: 804-862-6294

Health District	Director	Emergency Healthcare Coordinator	Epidemiologist
Three Rivers Health District (Middle Peninsula & Northern Neck) Main Office: 804-758-2381 24 Hour Emergency Number:866-531-3068	Dr. W. Ted Tweel Office: 804-758-2381 x17 Cell: 804-396-5331	Matthew Carpentier Office: 804-758-2381 Ext. 34 Cell: 804-592-8051 Fax: 804-758-4828	Phillip Carr Office: 804-769-4988 Ext. 54711 Cell: 804-396-5351 Fax: 804-769-2155
Virginia Beach Health District Main Office: 757-518-2700 24 Hour Emergency Number:757-518-2700	Dr. Heidi A. Kulberg Office: 757-518-2630 Cell:757-328-5476	Bob Engle Office: 757-518-2784 Cell: 757-969-9390 Fax: 757-518-1393	Anna Barringer Office: 757-518-2649 Cell: 757-438-0173 Fax: 757-518-2644
Western Tidewater Health District Main Office: 757-514-4700 24 Hour Emergency Number:757-477-3202	Dr. Chris Wilson Office: 757-514-4705 Cell: 757-788-1345	Brittany Powell Office: 757-514-4766 Cell: 757-435-4428 Fax: 757-514-4873	Amal Patel Office: 757-514-4767 Cell: 757-435-6453 Fax: 757-514-4873

REGIONAL HEALTHCARE COORDINATING CENTER (RHCC)

District	Address	Telephone Number
RHCC Activation Number: (844)-757-7422		
Southside (Eastern Virginia Healthcare Coalition)	1104 Madison Plaza Chesapeake, VA 23320	844-757-7422

OFFICE OF THE CHIEF MEDICAL EXAMINER

District	Address	Telephone Number
Central District	400 East Jackson Street Richmond, VA 23219-3694	804-786-3174
Tidewater District	830 Southampton Avenue Suite 100 Norfolk, VA 23510	757-683-8366

HOSPITAL COMMUNICATIONS TABLE

Peninsulas Hospital Radio, Telephone & Facsimile Directory							
Hospital Name	**HEAR Frequency**	**HEAR DPL**	**HEAR Dial Code**	**COR (MED) Channel**	**COR "PL"**	**ED Telephone Number**	**ED Fax Number**
Bon Secours Mary Immaculate	155.400	107.2	170-7522	4	107.2	757-886-6271	757-886-6121
Hampton Veterans Affairs	155.400	146.2	172-6522	NA	NA	757-722-9961 x3524/23	757-728-3165
Joint Base Langley-Eustis (633rd Medical Group)	155.400	192.8	170-6222	1	100	757-764-6800	757-764-8408
McDonald Army Health Center	155.400	162.2	147-8922	NA	NA	757-314-7859	
Bon Secours Rappahannock General Hospital	155.400	77	172-5822	3	123	804-435-8545	804-435-0596
Riverside Doctors	155.400	225	757-903-2138 757-903-2139	468.175 / 463.175	2B	757-585-2250	757-903-2767
Riverside Regional Medical Center	155.400	156.7	174-0422	8	107.2	757-594-2050	757-594-2434
VCU Tappahannock	155.340	82.5	170-2222	2	146.2	804-443-6297	804-443-6161
Riverside Walter Reed	155.400	167.9	172-5522	1	162.2	804-693-8899	804-693-8875
Sentara CarePlex	155.400	206.5	170-0922	6	91.5	757-736-3200	757-736-1029
Sentara Williamsburg Regional Medical Center	155.400	118.8	172-0922	7	107.2	757-984-7155	757-984-7156
VCU Medical Center	155.340		172-5722	9	192.8	804-628-3580	804-828-4686

Tidewater (Southside & Eastern Shore) Hospital Radio, Telephone & Facsimile Directory						
Hospital Name	**HEAR CTCSS (Hz)**	**HEAR Dial & DTMF**	**Call Sign**	**COR (MED) Channel**	**ED Telephone Number**	**ED Fax Number**
Bon Secours Harbour View	114.8	172-4322		1	757-673-6065	757-638-1020
Bon Secours Maryview Medical Center	173.8	172-4822	KVC500	7	757-398-2200	757-398-2162
Chesapeake Regional Medical Center	85.4	172-4622	KXV695	2	757-312-6200	757-312-6181
Children Hospital of the King's Daughters	79.7	172-4222	WPKC842	NA	757-668-8000	757-668-9198
Naval Medical Center Portsmouth	136.5	170-9822		8	757-953-1365	757-953-5527
Riverside Shore Memorial Hospital	123	182-4822	KNDG602	5	757-302-2100	757-789-0615
Sentara BelleHarbour	127.3	NA		4	757-983-0040	757-983-0024
Sentara Independence	74.4	172-5622	WPGZ470	7	757-363-6137	757-363-6175
Sentara Leigh	131.8	172-5022	KJR400	6	757-261-6804	757-233-1006
Sentara Norfolk General	100	172-4022	KNGA812	5	757-388-3551	757-388-3239
Sentara Obici	110.8	172-4722	KYO241		757-934-4815	757-934-4265
Sentara Princess Anne	82.5	NA			757-507-1020	757-507-0026
Sentara Virginia Beach General	141.3	172-4522	WNCF438	1	757-395-8890	757-395-6328
Bon Secours Southampton Medical Center	192.8	172-5922	KXX440	NA	757-569-6100	757-516-1058

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ANNEX B: LOCAL, REGIONAL, STATE & FEDERAL MCI RESOURCES

GENERAL

First and foremost, the IC/UC must practice scarce resource management. Single resources will be requested from the Emergency Communications/911 Center and told to report to the designated Staging Area, where they may be assembled into Strike Teams or Task Forces.

This leaves to the IC/UC or Operations Section Chief to manage the number of ambulances assembled. As patients are transported, units should be directed by the Transportation Group Supervisor/Unit Leader Group on whether they should clear then return to staging, or clear and return to their stations. The capacity to assemble Strike Teams will be limited by available resources and by the time needed to assemble and deploy them.

LOCAL MCI RESOURCES

DISASTER MEDICAL SUPPORT UNITS

Resource Description	Jurisdiction / Agency	NIMS Typing	Comments
Each DMSU is a 16', climate-controlled trailer equipped to respond to all types of medical disasters.	Chesapeake Fire Department	NA	Call Chief James Reynolds at 757-406-0093.
	Hampton Division of Fire and Rescue	NA	Call Hampton ECC at 757-727-6111 or on duty EMS Field Supervisor at 757-810-4346
	Isle of Wight County Emergency Services	NA	Call Will Drewery.
	James City County Fire-Rescue	NA	Call Jason Sweet.
	Newport News Fire Department	NA	Contact the Newport News ECC at 757-247-2318 or the Emergency Dispatch Supervisor: 757-926-3883.
	Norfolk Fire-Rescue	NA	Call Damon Langley at 757-618-5245.
	Northampton County Emergency Medical Services	NA	Call the Eastern Shore of Virginia 911 Center at 757-787-0911
	Portsmouth Fire, Rescue and Emergency Services	NA	Primary: EMS2 at 438-7511 or office at 393-8122 or Station 11 at 393-8364.
	Suffolk Fire Rescue	NA	Call BC Keith Johnson at 757-636-5415.
	Virginia Beach EMS (VBEMS)	NA	VBEMS has 2 DMSUs whose supplies are carried on box trucks. 757-385-5000 or Emergency Dispatch Supervisor 757-385-1804
	York County Fire & Life Safety	NA	Call Assistant Chief Joel Acree at 757-890-4967.

MASS CASUALTY TRAILERS

The table below is a list of deployable mass casualty trailers. The size of the trailer and equipment stocked on each trailer varies.

General Service Area	Jurisdiction / Agency	NIMS Typing	Comments
Peninsulas	Lancaster County EMS	NA	Mike Player (PEMS) – will do an update of Peninsulas' information.
Peninsulas	Northumberland County Volunteer Rescue Squad	NA	Mike Player (PEMS) – will do an update of Peninsulas' information
Peninsulas	York County		Located at Station 6
Southside	Boykins Volunteer Fire Department and Rescue Squad, Inc.	NA	David Long (TEMS) – will do an update of Southside information.
Southside	Navy Region Mid-Atlantic Fire & Emergency Services	NA	14' climate-controlled trailer equipped to respond to all types of medical disasters.

COMMERCIAL AMBULANCE SERVICES - MEDICAL TRANSPORTATION

Note: This is not an all-inclusive list. Check local listings for additional private transport agencies and resources.

Resource Description	Agency Name	NIMS Typing	Comments
Ambulances Wheelchair Accessible Vans	AMR (American Medical Response)		Main Phone Number: 757-827-3040 Dispatch Number: 757-534-6975 Services: BLS, ALS, Bariatric, Wheelchair Vans & Air Ambulance Services
Ambulances	Children's Hospital of the Kings Daughters Transport Team		Pediatric Critical Care Ambulances: 757-668-7777 or 757-473-1823
Ambulances	Fast Track EMS		757-347-1226
Ambulances	Life Care Medical Transport		757-882-8788
Ambulances	Midwest Medical Transport (MMT)		757-962-6904
Ambulances	Reliance Medical Transport		757-456-5147
Ambulances	Tidewater Medical Transport, Inc.		757-399-0999

MASS CASUALTY INCIDENT TRANSPORTATION UNITS

The Mass Casualty Incident Transportation Units (MCITU), also known as MCI Transport Units, are converted paratransit buses designed to transport delayed (yellow) and minimally injured/ill (green) patients only. Capacity: 9 litter patients, 10 seated patients and 2 wheelchairs. Attendants must stand to carry 10 seated patients, or if attendants are seated the seating capacity will carry 8 seated patients.

Jurisdiction / Agency	NIMS Typing	Comments
Chesapeake Fire Department		Located at Station 6, Call Chief James Reynolds at 757-406-0093.
Hampton Division of Fire and Rescue		MCI Bus located at Fire Station 11; Call Hampton ECC at 757-727- 6111
Isle of Wight County Emergency Services		Located at Windsor Rescue Squad; Call Will Drewery.
James City County Fire Department		Estimated delivery September 2024
Riverside Health System		MCI Bus located at Riverside Doctor's Hospital Williamsburg 1500 Commonwealth Dr. Williamsburg, VA 23185 Contact York County, James City, Williamsburg ECC at 757-890-6231
Naval Medical Center Portsmouth (NMCP)		MCI Bus. Contact NMCP EM.
Newport News Fire Department		Call Newport News Dispatch at 757-247-2500. David Long (TEMS) – will do an update of information.
Norfolk Fire-Rescue		Located at Station 2; Call Damon Langley at 757-618-5245.
Portsmouth Fire, Rescue, and Emergency Services		Located at Station 11, Call Brian McIntosh.
Suffolk Fire Rescue		Located at Station 5 (Bridge Rd), Call BC Keith Johnson at 757-636-5415.
Virginia Beach Fire Department		MCI Bus located at Station 21 (General Booth Blvd.). Contact the Virginia Beach ECC at 757-385-5000 or the Emergency Dispatch Supervisor 757-385-1804
York County Department of Fire and Life Safety		MCI Bus located at Station 6 (501 Back Creek Rd.). Contact York County ECC at 757-890-6321

MOBILE RAPID ACCESS TRANSPORT UNITS

The Mobile Rapid Access Transport Units. These are 16-foot-long off-road capable vehicles that can carry one litter patient and an attendant. These can be employed for special events, mass gatherings or in response to a call for EMS in off-road terrain where regular ambulances cannot gain access.

Jurisdiction / Agency	NIMS Typing	Comments
Chesapeake Fire Department	NA	Located at Fire Station 7; Call Chief Reynolds at 757-406-0093.
Hampton Division of Fire and Rescue	NA	Located at Fire Station 4; Call Hampton ECC at 757-727-6111 or Randy Price at 757-727-1316.
Isle of Wight County Emergency Services	NA	Located at Isle of Wight Rescue Squad; Call Chris Smith.
James City County Fire Department	NA	Scheduled to receive delivery in November 2024.
Newport News Fire Department	NA	Located at 2389 G Ave. Newport News; Call Brett Abraham at 757-652-8239.
Norfolk Fire-Rescue	NA	Located at City Garage; Call Tim Walsh.
Portsmouth Fire, Rescue, and Emergency Services	NA	Scheduled to receive delivery in November 2024. Will be located at Fire Station 11. Call Brian McIntosh.
Suffolk Fire rescue	NA	Scheduled to receive delivery in January 2024. Will be located at Fire Station 5; Call BC Keith Johnson at 757-636-5415.
Virginia Beach Emergency Medical Services	NA	Located at EMS Logistics; Call Rob Gramkowski at 757-408-0783.
York County Fire and Life Safety	NA	Located at Fire Station 2; Call Assistant Chief Joel Acree at 757-890-4967.

MEDEVAC (AIR AMBULANCE) RESOURCES

Jurisdiction / Agency	NIMS Typing	Comments
LifeEvac I		Based at Dinwiddie County. Dispatch Center: 1-877-902-7779
LifeEvac III		Based at West Point. Dispatch Center: 1-877-902-7779
Nightingale Regional Air Ambulance		Dispatch Center: 1-800-572-4345 Alternate Dispatch: 757-388-5597
PHI Air Care 2		Based at Fredericksburg. PHI Dispatch Center: 1-703-776-2930

DECONTAMINATION RESOURCES

Jurisdiction / Agency	NIMS Typing/Description	Comments
Newport News Regional Hazardous Materials Team	Decontamination tent & detection equipment	Mike Player (PEMS) – will do an update of information
Southside Regional Hazardous Materials Team	Decontamination tent & detection equipment	Contact Portsmouth Fire Dispatcher at 757-393-5300
Hampton Roads Metropolitan Medical Strike Team (HRMMST)	Decontamination Tent (3 lane) & detection equipment	Call York County ECC at 757-890-3621. If the York County ECC cannot be reached, the jurisdiction's ECC should call the Norfolk ECC at 757-441-5610
James City County Fire Department	Decontamination Trailer (3-lane)	Located at Station #2, PocahontasTrail
Williamsburg Fire Department	Decontamination Trailer (3-lane)	Located at Station #1, Lafayette Street

DIVE TEAMS

Jurisdiction / Agency	NIMS Typing	Comments
Chesapeake Police Department	NA	Call Chesapeake Dispatch at 757-382-6161
Hampton Division of Fire and Rescue	NA	City of Hampton Dive Team asset is comprised of police and fire. Call Hampton ECC to activate all DT assets. ECC: 757-727-6111
James City County Fire Department	NA	Boat in the water at Jamestown Marina; Zodiac boat accompanies the Dive Van
Newport News Fire Department & Newport News Police Department	NA	Contact the Newport News ECC at 757-247-2318 or the Emergency Dispatch Supervisor 757-926-3883.
Norfolk Police Department	NA	David Long (TEMS) – will do an update of information.
Suffolk Police Department	NA	Call Suffolk Emergency Dispatch Center at 757-925-2030
Virginia Beach Department of Emergency Medical Services	NA	Contact the Virginia Beach ECC at 757-385-5000 or the Emergency Dispatch Supervisor 757-385-1804

Jurisdiction / Agency	NIMS Typing	Comments
Virginia Beach Police Department	NA	Contact the Virginia Beach ECC at 757-385-5000 or the Emergency Dispatch Supervisor at 757-385-1804
York County Department of Fire & Life Safety	NA	Mike Player (PEMS) – will do an update of information

MOBILE EMS TEAMS AND EQUIPMENT

Resource Description	Jurisdiction / Agency	NIMS Typing	Comments
Mobile EMS Team / Bike Teams	James City County Fire Department	NA	Can be deployed as either ALS or BLS, normally deployed as an ALS team; 4 mountain bikes deployed in teams of two.
Bike Team	York County		Works with James City County and Williamsburg
Mobile EMS Bike Team & Golf Cart (1 litter patient)	Navy Region Mid-Atlantic Fire and Emergency Services		David Long (TEMS) – will do an update of information.
Mobile EMS Bike Team & Golf Cart (1 litter patient)	Virginia Beach Department of Emergency Medical Services	NA	Can deploy 4 teams of 2 ALS/BLS providers. Contact the Virginia Beach ECC at 757-385-5000 or the Emergency Dispatch Supervisor 757-385-1804

4-WHEEL DRIVE ALL TERRAIN VEHICLES

Resource Description	Jurisdiction / Agency	NIMS Typing	Comments
4 Wheel Drive All-Terrain Vehicle	Abingdon Volunteer Fire-Rescue	NA	Mike Player (PEMS) – will do an update of information

Resource Description	Jurisdiction / Agency	NIMS Typing	Comments
4 Wheel Drive All-Terrain Vehicle (1 available, carries 1 litter patient)	Chesapeake Beach Volunteer Rescue Squad	NA	Contact the Virginia Beach ECC at 757-385-5000 or the Emergency Dispatch Supervisor at 757-385-1804
4 Wheel Drive All-Terrain Vehicle	Chesapeake Fire Department	NA	Chesapeake Dispatch: 757-382-6161
4 Wheel Drive All-Terrain Vehicle	James City County Fire - EMS	NA	Gators for special events.
4 Wheel Drive All-Terrain Vehicle	King and Queen County Emergency Services	NA	Scheduled to receive 2 Gators in Fall 2024.
3 DARTS & 1 UTV	Navy Region Mid-Atlantic Fire and Emergency Services		DARTS (UTXs with stretchers mounted. Utilized on the military installation during large events.) Capability for off base use may not be dependable due to the logistics of towing the unit to the location
2 Gators	Newport News		One located at Storage Facility on G-Street and the other located at Station 4 on Jefferson Ave.
4 Wheel Drive All-Terrain Vehicle (2 available)	Norfolk Fire-Rescue	NA	David Long (TEMS) – will do an update of information.
4 Wheel Drive All-Terrain Vehicle	Suffolk Fire Rescue	NA	David Long (TEMS) – will do an update of information.
4 Wheel Drive All-Terrain Vehicle	Tappahannock Essex Volunteer Fire Department	NA	Two Gators – One located at Essex Sheriff's Office and one at Essex Rescue.
4 Wheel Drive All-Terrain Vehicle (1 litter patient)	Williamsburg Fire Department – Station #1, Lafayette Street	NA	Mike Player (PEMS) – will do an update of information
4 Wheel Drive All-Terrain Vehicle	Windsor Volunteer Rescue Squad		David Long (TEMS) – will do an update of information.
4 Wheel Drive All-Terrain Vehicle (3 available)	York County Department of Life Safety	NA	One located at York High; one at Yorktown; one at Station 6.

SEARCH AND RESCUE TEAMS & RESOURCES

Jurisdiction / Agency	NIMS Typing	Comments
K9 Alert		Based in Chesterfield. Capabilities: Wilderness & urban air scent, trailing, HRD land, & wilderness cadaver search capabilities. Contact: VEOC
Suffolk Fire Rescue	NA	Has a search and rescue trailer.
Trailing Resources Search & Rescue		Based in Virginia Beach. Will respond to call throughout Virginia & North Carolina. Capabilities: Scent specific trailing K-9s. Call: 757-385-2887
Tidewater Search and Rescue (TSAR)		1st contact is the VEOC Alert1@cox.net (TSAR Dispatch 24/7 365) or 757-508-8727 (TSAR Commanders cell)

TECHNICAL RESCUE TEAMS

Jurisdiction / Agency	NIMS Typing	Comments
Tidewater Regional Technical Rescue Team		Call Virginia Beach ECC at 757-385-5000 or the Emergency Dispatch Supervisor at 757-385-1804

RESPONDER REHABILITATION UNITS

Jurisdiction / Agency	NIMS Typing	Comments
Note: Each DMSU can provide responder rehabilitation.		
Chesapeake Fire Department	NA	Call Chesapeake Dispatch at 757-382-6161
Portsmouth Fire, Rescue and Emergency Services	NA	Call Portsmouth Emergency Dispatch Center at 757-393-5300
Suffolk Fire Rescue	NA	Call Suffolk Emergency Dispatch Center at 757-925-2030

Jurisdiction / Agency	NIMS Typing	Comments
Virginia Beach Fire Department "Support 8"	NA	Located at Fire Station #8 Call the Virginia Beach Emergency Communications Center at 757-385-5000 or the Emergency Dispatch Supervisor 757-385-1804

PEER AND CRISIS SUPPORT SERVICES

Team Name	Telephone Number
PEMS Peer and Crisis Support Services	24-Hour Team Access 757-220-4356
TEMS Peer and Crisis Support Services	24-Hour Team Access 757-414-2476 / 757-414-CISM

EMERGENCY VETERINARY HOSPITALS

Name	Address	Telephone Number	Web Address & Comments
Animal Emergency Center	2025 George Washington Memorial Highway Yorktown VA 23693	757-364-0667	www.animalemergencyyorktown.com Open After Normal Working Hours: Monday-Friday 1730 – 0830 Holidays and weekends: 24 hours
Veterinary Emergency & Specialty Center	3312 West Cary St., Richmond, VA 23221	804-353-9000	**Note:** On contract with the City of Richmond
The COVE (Center of Veterinary Expertise)	6550 Hampton Roads Parkway #113, Suffolk, VA 23435	757-935-9111	www.thecovevets.com 24 hrs. – call ahead if outside M-F 7am – 4 pm
Blue Pearl Pet Hospital	1100 Eden Way North, Chesapeake, VA 23320	757-366-9000	www.affiliatedanimalcare.com
Bay Beach Veterinary Emergency Hospital	2476 Nimmo Pkwy Virginia Beach, VA 23456	757-340-3913	www.baybeachvets.com/emergency-hospital **Note:** Dr. Mark Honaker, NVRTmember
Blue Pearl Veterinary Partners	364 South Independence Blvd., Virginia Beach, VA 23452	757-499-5463	www.bluepearlvet.com/hospital/virginia-beach-va **Note:** On contract with the Army for Government Owned Animals

REGIONAL SPECIALTY TEAMS

HAMPTON ROADS INCIDENT MANAGEMENT TEAM

MISSION

The mission of the Hampton Roads Incident Management Team (HRIMT) is to provide, upon request a professional, Type-3 All-Hazards Incident Management Team (IMT) services in of support major incidents and events in the Hampton Roads region, the Commonwealth of Virginia, and outside the State.

CAPABILITIES

The Hampton Roads Incident Management Team (HRIMT) is a multi-discipline, multi-jurisdictional regional team staffed by highly trained, experienced, and credentialed personnel. Members are specialized in Incident Command System (ICS) roles and responsibilities, the National Incident Management System (NIMS) and the National Preparedness Goal Mission Areas. The HRIMT is a self-contained, Type-3 All-Hazard Incident Management Team (IMT) recognized at the local, state, and national level.

The HRIMT may deploy individual assets or as a full team specializing in Command, Finance/Administration, Logistics, Operations, Planning, Safety Officers, Liaison Officers, and/or Public Information Officers. If needed, the HRIMT can deploy a fully equipped team of 12-15 trained members as a self-contained team in stark conditions.

The HRIMT can respond to a wide range of pre-planned events and/or emergencies, including mass casualty incidents, fires, floods, earthquakes, hurricanes, tornadoes, tsunami, riots, spilling of hazardous materials, and other natural or human-caused incidents.

The HRIMT can manage the logistical, fiscal, planning, operational, safety, and community issues related to the event/incident/emergency. The HRIMT can provide and/or assist with the command and management infrastructure that is required when requested by the Authority Having Jurisdiction (AHJ).

EMERGENCY TEAM ACTIVATION – IN THE HAMPTON ROADS REGION

The HRIMT can be activated by contacting one of the following:

- City of Chesapeake Emergency Dispatch Center (24-hours) 757-382-6161
- City of Chesapeake Fire Department (Regular Business Hours) 757-382-6297
- Program Manager, HRIMT (William (Skip) Hibner (24-hours) 757-641-8281

EMERGENCY TEAM ACTIVATION – OUTSIDE THE HAMPTON ROADS REGION

Virginia Emergency Operations Center at 1-800-468-8892 or 804-674-2400.

HAMPTON ROADS METROPOLITAN MEDICAL STRIKE TEAM (HRMMST)

MISSION AND TEAM DESCRIPTION

The HRMMST is a 44-member, regionally available, CBRNE trained, all-hazards capable, emergency medical response team. The HRMMST is a 213-member call group, which provides depth and redundancy, and includes an assortment of public safety (EMS, Fire & Law Enforcement) and health care (physicians and physician extender) members.

HRMMST RESPONSE AREA

The HRMMST will respond to incidents in the following jurisdictions:

Chesapeake	Newport News	Suffolk
Franklin	Norfolk	Surry County
Gloucester County	Poquoson	Virginia Beach
Hampton	Portsmouth	Williamsburg
Isle of Wight County	Smithfield	York County
James City County	Southampton County	Other Jurisdictions as Needed

OPERATIONAL CAPABILITIES

The HRMMST is trained and equipped to provide operational assistance and expertise to IC/UC regarding the medical effects of an incident whether CBRNE, conventional, or weather-related. The seven specific capabilities include:

- Medical casualty management and patient movement coordination
- Warm zone triage, decontamination, monitoring, and detection
- Rehabilitation and medical force protection
- Medical consultation and coordination
- Chemical weapon and toxic industrial chemical antidote administration
- Functional/medical needs sheltering assistance
- Mass fatality assistance

TEAM TYPING

TYPE I TEAM

The HRMMST Type I Operational Level represents a minimum of 44 CBRNE trained personnel, equipment, and supplies to function for a 72-hour period at incidents involving weapons of mass destruction, accidental releases, or catastrophes resulting in more casualties than local resources can effectively manage. Type I team personnel are capable of performing mass patient care, antidote administration, long-term patient care, medical decontamination, force protection, and force rehabilitation missions. Type I personnel are also trained to assist local jurisdictions by augmenting the existing Incident Command/Unified Command structure or the personnel can be used to fill vacancies within the existing command structure to assist with Incident Management.

TYPE II TEAM

The HRMMST Type II Operational Level represents a minimum of 26 CBRNE trained individuals and equipment to assist with patient care or patient decontamination at incidents involving weapons of mass destruction, accidental releases, or resulting in casualties that result in more victims than local resources can manage independently. Type II personnel are capable of assisting with Incident Management functions such as Incident Action Plan development, operational group management, medical decontamination, force protection and force rehabilitation.

TYPE III TEAM

The HRMMST Type III Operational Level represents a minimum of 14 personnel to provide resources that support an incident such as a large-scale rehabilitation operation. Personnel assigned represent logistical and medical staff who provide responder rehabilitation for extended operations. The level does not provide transport assets for ill or injured responders who may need to be transported to a receiving facility. The personnel can set-up a rehabilitation facility that is climate controlled and provide rehabilitation and medical monitoring of first responders.

TYPE IV TEAM

The HRMMST Type IV Operational Level represents a minimum of 8 personnel specifically trained in CBRNE response that can be deployed to help a local jurisdiction manage the impact of a CBRNE-type incident that generates multiple causalities. These subject matter experts can be used to assist the existing Incident Command/Unified Command structure with consequence management or they can be used to fill vacancies within the existing command structure to assist with Incident Management.

TEAM ORGANIZATION

The HRMMST is a specialized emergency medical strike team, which includes:

- Strike Team Leader
- Command Staff (Medical Director and Safety Officer)
- Planning Section (Planning Manager and Planning Specialists)
- Operations Section (Operations Manager; Law Enforcement Group; EMS/Medical Group.)
- Logistics Section (Logistics Manager, a Communications Group, and a Supply Group)

HRMMST RESOURCES

Equipment caches are located on the Southside and Peninsula. Each cache is identical and consists of all equipment and supplies needed for initial HRMMST operations. The closest, most accessible and available equipment cache will deploy to the incident.

MEDICAL EQUIPMENT CACHE

Each medical equipment cache consists of a 37-ft gooseneck equipment trailer and tow vehicle, command and control equipment, medical equipment cache, pharmaceuticals, monitoring and detection equipment, and decontamination equipment.

LOGISTICS EQUIPMENT CACHE

Each logistics equipment cache consists of a 28' logistics truck, personal protective equipment, logistical support equipment, Western Shelter Systems, HVAC, and generators.

COMMUNICATIONS CACHE

Each communications cache consists of a 12' single-axle trailer with a 65' extendable tower, an accompanying tow vehicle, 68 – Motorola HT1250 portable VHF radios, a repeater, portable marine radios and 50 – Motorola XTS-5000 800 MHZ radios, and satellite capability to provide internet access and satellite telephone.

The HRMMST equipment trailer (37' Gooseneck Trailer and Tow Vehicle)

The HRMMST communications cache (12' Single Axle Trailer with a 65' Extendable Tower; Accompanying Tow Vehicle; Portable VHF Radios; Repeater; and Portable Marine Radios)

EMERGENCY HRMMST ACTIVATION

The following personnel are authorized to activate the HRMMST*:

- Chief Public Safety Officers or their designee.
- Jurisdiction's ECC.
- Emergency Manager of the affected jurisdiction.

* Your jurisdiction's policies and procedures take precedence over this guidance.

The HRMMST is activated by a telephone call from your jurisdiction's ECC to the **York County ECC at 757-890-3621.**

If the York County ECC cannot be reached, the jurisdiction's ECC should call the **Norfolk ECC at 757-441-5610.**

EMERGENCY ACTIVATION INFORMATION

The following information is required to complete the activation request:

- Name of the requesting Agency.
- Name/Rank of Requesting Official.
- Name of whom the HRMMST Leader will report to upon arrival.
- Brief description of the Incident Mission Tasking.
- The HRMMST Assembly Point (selected from this guide). The HRMMST Assembly Point is where the team members will initially report and assemble.
- A call back telephone number, talk group, and on-scene cell phone contact number, if available.
- Any other pertinent information.

Note: The requesting jurisdiction may receive a request to assist the HRMMST in obtaining transportation for HRMMST members from the Assembly Point to the Incident Staging Area.

HRMMST ASSEMBLY POINTS

I-264:

- Kmart: 550 First Colonial Rd, Virginia Beach, VA 23451 / GPS Coordinates: 36°50”52.85” N 76°1’5.67” W
- Old HQ Parking Lot: 4625 Virginia Beach Blvd., Virginia Beach, VA 23462 / GPS Coordinates: 36°50’36.60” N 76°08’10.36” W
- Best Square Shopping Center: 415 N. Military Highway, Norfolk, VA 23502 / GPS Coordinates 36°50’47.89” N 76°12”42.53” W
- Victory Crossing Shopping Center: 4000 Victory Blvd., Portsmouth, VA 23701 / GPS Coordinates : 36°48’37.69” N 76°21’31.19” W

I-64:

- Food Lion: 2800 Yadkin Road Chesapeake, VA 23323 / GPS Coordinates: 36°46’13.57” N 76°20’40.85” W
- Greenbrier Mall: 1401 Greenbrier Parkway, Chesapeake, VA 23320 / GPS Coordinates: 36°46’39.55” N 76°13’41.76” W
- Norfolk Workforce Development Center: 201 E. Little Creek Road, Norfolk, VA 23505 / GPS Coordinates: 36°54’52.83” N 76°16’2.62” W
- Peninsula Town Center: 1800 W. Mercury Blvd., Hampton, VA 23666 / GPS Coordinates: 37°02’35.81” N 76°23’31.87” W
- Newport Square Shopping Center: 838 J. Clyde Morris Blvd., Newport News, VA 23601 / GPS Coordinates: 37°05’03.97” N 76°27’25.55” W
- Target: 200 Marquis Parkway, Williamsburg, VA 23185 / GPS Coordinates: 37°15’32.36” N 76°38’28.33” W

I-664:

- Chesapeake Square Mall: 4200 Portsmouth Blvd., Chesapeake, VA 23321 / GPS Coordinates: 36°49’27.26” N 76°24’59.12” W
- Jolliff Middle School: 1021 Jolliff Road, Chesapeake, VA 23321 / GPS Coordinates: 36°47’23.36” N 76°25’0.401” W

HRMMST ACTIVATION REQUEST FORM

Name of the Requesting Agency:
Name/Rank of the Requesting Official:
Name of whom the HRMMST Strike Team Leader will report to upon arrival AND phone number:
Brief description of the incident:
Mission Tasking:
The HRMMST Assembly Point (selected from the list above):
A call back telephone number, talk-group, and on-scene cell phone number, if available:
Any other pertinent information:

MARINE INCIDENT RESPONSE TEAM

MISSION

The mission of the Marine Incident Response Team (MIRT) is to provide immediate on-scene maritime advice and agency liaison to Incident Commanders responding to fires, hazardous materials, and other all-hazard emergencies in the marine environment. The MIRT promotes marine firefighting team building efforts in the Port of Hampton Roads through an ongoing program of training and drills.

CAPABILITIES

The MIRT consists of over 200 participants from local fire and law enforcement departments, the Virginia Port Authority, U.S. Coast Guard, U.S. Navy, the Virginia and Maryland Pilots Association, and the Virginia Department of Emergency Management (VDEM).

MIRT provides specialized marine firefighting and response equipment which includes a mobile command unit, four support trucks, and three—3,000 gallon-per-minute portable pumps which are prepositioned in Hampton Roads. MIRT can assist IC by providing liaison with and coordinating local governmental and commercial marine resources in response to a marine incident. The MIRT also provides equipment and training for local fireboats crews.

EMERGENCY TEAM ACTIVATION

The MIRT can be activated by contacting one of the following:

- Virginia Port Authority Police Dispatch 757-683-2196
- USCG Sector Virginia Command Center 757-483-8567
- Bill Burkett 757-615-6661 / Rob Darling 757-769-9808

REGIONAL HAZARDOUS MATERIALS (HAZMAT) TEAMS

MISSION

The Newport News Regional Hazardous Materials Team and the Southside Tidewater Regional Hazardous Materials Team are prepared to provide highly trained and equipped personnel who will respond to HazMat incidents that exceed the capabilities of local fire departments. Furthermore, the Team will perform offensive mitigation procedures to rapidly protect citizens, critical infrastructure, and the environment.

CAPABILITIES

The Newport News Regional Hazardous Materials Team and Southside Tidewater Regional Hazardous Materials Team have the training and equipment to respond to any Hazardous Material incident. The teams also have the capability to respond to incidents involving CBRNE.

EMERGENCY TEAM ACTIVATION

The Newport News Regional Hazardous Materials Team and Southside Tidewater Regional Hazardous Materials Team are available on a 24-hour basis. Activation is initiated by calling the Virginia Emergency Operations Center at 1-800-468-8892 or 804-674-2400.

BASE OF OPERATIONS FOOTPRINT

The teams' footprint will vary depending upon the size of the responding apparatus and associated equipment.

COST OF OPERATIONS

Any costs for a response by the Newport News Regional Hazardous Materials Team or the Southside Tidewater Regional Hazardous Materials Team shall be the responsibility of the Responsible Party, after an investigation has determined who that Party is.

Note: In order to have cost recovery take place, it is necessary that the response of either team is the result of a request for response through VDEM.

TIDEWATER REGIONAL TECHNICAL RESCUE TEAM

MISSION

The mission of the Tidewater Regional Technical Rescue Team (TRTRT) is to provide specialized equipment, resources, manpower, and expertise needed to perform technical rescues throughout Southeastern Virginia at the scene of an incident when local resources are inadequate or unavailable.

CAPABILITIES

The team responds to incidents requiring the use of specialized equipment to include trench and excavation rescue, structural collapse operations, confined space entry and rescue, rope and vehicle rescue operations, extended extrications, and technical helicopter operations. TRTRT is comprised of highly trained firefighters and rescue personnel from the Tidewater cities of Chesapeake, Norfolk, Portsmouth, Virginia Beach, and Navy Region Mid-Atlantic Fire and Emergency Services Department. All team members are trained in NFPA 1670 and 1006 Operations or Technician level certifications for the disciplines of Rope Rescue, Confined Space Rescue, Trench Rescue, and Collapse Rescue.

COST

Personnel costs are absorbed by the jurisdictions from which team members operate. Highly trained firefighters and rescue personnel from the Tidewater cities of Chesapeake, Norfolk, Portsmouth, Virginia Beach and the Navy Region Mid-Atlantic Fire and Emergency Services Department participate as team members. Operational costs are funded by regional utilities, building contractors, professional and community organizations.

EMERGENCY TEAM ACTIVATION

The team may be requested by any public safety organization by contacting the City of Virginia Beach ECC at 757-385-5000 or the Emergency Dispatch Supervisor 757-385-1804.

STATE MCI RESOURCE

STATE EMS RESOURCE ASSISTANCE

The Virginia Department of Health Office of Emergency Medical Services (OEMS) staff are available to assist with the deployment of EMS assets at a state level, including working with VDEM through the Statewide Mutual Aid request process.

FEDERAL MCI RESOURCES

NATIONAL DISASTER MEDICAL SYSTEM

The National Disaster Medical System (NDMS) is a federally coordinated system that augments the Nation's medical response capability. The overall purpose of the NDMS is to establish a single integrated National medical response capability for assisting State and Local authorities in dealing with the medical impacts of major peacetime disasters. In addition, the NDMS provides support to the military and the Department of Veterans Affairs medical systems in caring for casualties evacuated back to the U.S. from overseas armed conventional conflicts. The purpose of the NDMS is to support State, Local, Tribal and Territorial authorities following disasters and emergencies by supplementing health and medical systems and response capabilities.

The National Response Plan utilizes the NDMS as part of the Department of Health and Human Services, Office of Preparedness and Response under Emergency Support Function (ESF) #8, Health and Medical Care. NDMS supports Federal agencies in the management and coordination of the federal medical response to major emergencies and federally declared disasters including natural disasters, technological disasters, major transportation disasters, and acts of terrorism including weapons of mass destruction incidents.

MISSION

It is the mission of the National Disaster Medical System to design, develop, and maintain a national capability to deliver quality medical care to the victims of - and responders to - a domestic disaster. NDMS provides state-of-the art medical care under any conditions at a disaster site, in transit from the impacted area, and into participating definitive care facilities.

Components of the National Disaster Medical System:

- Medical response to a disaster area in the form of teams, supplies, and equipment.
- Patient movement from a disaster site to unaffected areas of the nation.
- Definitive medical care at participating hospitals in unaffected areas.

The mission of the Emergency Services Sector (ESS) is to save lives, protect property and the environment, assist communities impacted by disasters, and aid in recovery during emergencies. Five distinct disciplines compose the ESS encompassing a wide range of emergency response functions and roles: Law Enforcement, Fire and Rescue Services, Emergency Medical Services, Emergency Management, and Public Works.

NDMS TEAMS

NDMS teams are organized and trained groups of professionals who help devastated communities by providing emergency medical care, staffing medical shelters or medical stations, augmenting hospital staff, providing veterinary care, conducting disaster mortuary operations, managing logistics, synthesizing data, and more. NDMS Operations are partially supported by the various teams that comprise the NDMS.

NDMS ACTIVATION

The NDMS cannot be activated by local emergency management authorities. The state must request NDMS activation as a component of the Federal response package.

DISASTER MEDICAL ASSISTANCE TEAM (DMAT)

A 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 incident. NDMS recruits personnel for specific vacancies, plans for training opportunities, and coordinates the deployment of the teams.

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. The personnel are activated for a period of two weeks.

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, patient reception at staging facilities, and preparing patients for evacuation.

Under the rare circumstance that disaster victims are evacuated to a different locale to receive definitive medical care, DMATs may be activated to support patient reception and disposition of patients to hospitals. DMATs are principally a community resource available to support local, regional, and State requirements. However, as a National resource they can be federalized.

NDMS/DMAT personnel are required to maintain appropriate certifications and licensure within their discipline. When personnel are activated as Federal employees, licensure and certification are recognized by all States. DMAT personnel have the protection of the Federal Tort Claims Act, in which the Federal Government becomes the defendant in the event of a malpractice claim.

DISASTER MORTUARY OPERATIONAL RESPONSE TEAMS (DMORT)

The National Response Framework (NRF) utilizes the National Disaster Medical System (NDMS) as part of the Department of Health & Human Services, Administration for Strategic Preparedness and Response (ASPR), Office of Preparedness and Operations (OPEO) under Emergency Support Function (ESF) #8, Health and Medical Care to provide victim identification and mortuary services.

DMORT responsibilities:

- Temporary morgue facilities.
- Victim identification.
- Forensic dental pathology.
- Forensic anthropology methods.
- Processing.
- Preparation.
- Disposition of remains.

DMORT capabilities:

- Tracking and documenting human remains and personal effects.

- Establishing temporary morgue facilities.
- Assisting in the determination of cause and manner of death.
- Collecting ante-mortem data.
- Collection of medical records, dental records, or DNA of victims from next of kin to assist in victim identification.
- Performing postmortem data collection.
- Documentation during field retrieval and morgue operations.
- Performing forensic dental pathology and forensic anthropology methods.
- Preparing, processing, and returning human remains and/or personal effects to appropriate recipients.
- Processing and re-interment of disinterred remains.
- Providing technical assistance and consultation on fatality management and mortuary affairs.

DMORTs are composed of private citizens who have a particular field of expertise and who are activated in the event of a disaster. NDMS/DMORT personnel are required to maintain appropriate certifications and licensure within their discipline. When personnel are activated, licensure and certification are recognized by all States, and the personnel are compensated for their duty time by the Federal government as an intermittent Federal employee. During an emergency response, DMORTs work under the guidance of local authorities by providing technical assistance and personnel to identify and process deceased victims.

The DMORTs are directed by ASPR/OPEO/NDMS. Teams are composed of funeral directors, medical examiners, pathologists, forensic anthropologists, medical records technicians and transcribers, fingerprint specialists, forensic odontologists, dental assistants, x-ray technicians, mental health specialists, computer professionals, administrative support staff, and security and investigative personnel.

The Department of Health & Human Services, Assistant Secretary for Preparedness and Response, in support of the NDMS DMORT program, maintains three Disaster Portable Morgue Units (DPMUs). These DPMUs are staged at locations on the East coast and the West coast for immediate deployment in support of DMORT operations. The DPMU is a depository of equipment and supplies for deployment to a disaster site. It contains a complete morgue with designated workstations for each processing element and prepackaged equipment and supplies.

NATIONAL VETERINARY RESPONSE TEAM (NVRT)

The National Veterinary Response Team (NVRT) is a cadre of individuals within the NDMS system who have professional expertise in areas of veterinary medicine, public health, and research. In addition to supporting the NRF mission requirements of NDMS under ESF 8, operational support may also be rendered by the NVRT to other Federal partners such as the USDA under ESF 11, Agriculture, and FEMA under ESF 6, Mass Care, in the support of the Pets Evacuation and Transportation Standards Act (PETS Act) .

The National Veterinary Response Team (NVRT) provides assistance in identifying the need for veterinary services following major disasters, emergencies, public health, or other incidents requiring Federal support in assessing the extent of disruption to animal and public health infrastructures.

NVRT responsibilities include:

- Assessing the Veterinary Medical Needs of the Community.
- Medical Treatment and Stabilization of Animals.

- Animal Disease Surveillance.
- Zoonotic Disease Surveillance and Public Health Assessments.
- Technical Assistance to Assure Food Safety and Water Quality.
- Hazard Mitigation.
- Care and Support of Animals Certified as Official Responders to a Disaster or Emergency.

The personnel are comprised of individuals with diverse expertise to include Veterinarians, Animal Health Technicians, Pharmacists, Epidemiologists, Safety Officers, Logisticians, Communications Specialists, and other support personnel.

A regional cache of equipment, supplies and pharmaceuticals is available for the team if they get deployed. Personnel are required to maintain the appropriate and current professional certifications and licensure of their discipline. As intermittent Federal employees, when personnel are activated, during the length of a deployment their licensure is recognized by the state(s) requesting assistance.

STRATEGIC NATIONAL STOCKPILE

The Centers for Disease Control and Prevention (CDC) maintains the Strategic National Stockpile (SNS). The SNS has massive quantities of medicine and medical supplies to protect the American public if there is a public health emergency (i.e., terrorist attack, flu outbreak, earthquake) severe enough to cause local supplies to run out. Once Federal and local authorities agree that the SNS is needed, medicines will be delivered to any state in the U.S. within 12 hours. The Virginia Department of Health (VDH) has plans in place to receive and distribute SNS medicine and medical supplies to local communities as quickly as possible.

The SNS is a national repository of antibiotics, chemical antidotes, antitoxins, life-support medications, IV administration supplies, airway maintenance supplies, and medical/surgical items. The SNS is designed to supplement and re-supply state and local public health agencies in the event of a national emergency anywhere and at any time within the U.S. and its territories.

The SNS is organized for flexible response. The first line of support lies within the immediate response 12-hour Push Packages. These caches of pharmaceuticals, antidotes, and medical supplies are designed to provide rapid delivery of a broad spectrum of assets for an ill-defined threat in the early hours of an incident. These Push Packages are positioned in strategically located secure warehouses and are ready for immediate deployment to a designated site within 12 hours of the federal decision to deploy SNS assets.

If the incident requires additional pharmaceuticals and/or medical supplies, follow-on vendor-managed inventory (VMI) supplies will be shipped to arrive within 24 to 36 hours. If the agent is well defined, VMI can be tailored to provide pharmaceuticals, supplies and/or products specific to the suspected or confirmed

agent(s). In this case, the VMI could function as the first option for immediate response from the SNS Program.

REQUESTING THE SNS

The decision to deploy the SNS will be a collaborative effort between local, State, and Federal officials. It will start at a local level when health officials identify a potential or actual problem that they believe will threaten the health of their community. Local health officials will notify and coordinate with state level officials through the State EOC and VDH. When the health officials confirm they have a problem that is anticipated to deplete local and state medical resources, a request for the SNS will be channeled through the Governor's Office in coordination with emergency management and Health officials. The designated State official (Health Commissioner and/or VEOC (ESF 8) will contact CDC to seek delivery of the SNS. CDC will make the decision to activate the SNS after discussions with health officials and Federal officials. Before deploying the SNS, the CDC will evaluate the actual or potential threat and the local resources and planning for dealing with the threat. When CDC confirms that local and State resources will be insufficient to respond to the incident, the Department of Homeland Security will deploy the SNS.

FEMA URBAN SEARCH AND RESCUE TASK FORCES

If a disaster incident warrants national US&R support, FEMA will deploy the three closest task forces within six hours of notification and additional teams, as necessary. The role of these task forces is to support state and local emergency responders' efforts to locate victims and manage recovery operations.

Currently, there are 28 FEMA US&R Task Forces strategically located throughout the continental United States. They are comprised of local fire and emergency services personnel and civilian volunteers from nineteen states. Each US&R Task Force can be configured as either a Type I or a Type III. Their complement is geared toward the nature of the disaster. A Type I US&R task force is comprised of 70 members and capable of performing heavy rescue on large concrete structural collapse incidents either as a full team for 12 hours or split the team in half and operate for two – 12-hour periods to allow for around-the-clock operations. A Type III US&R task force is comprised of 35 members and is capable of performing at the same level as a Type I but for only 12-hour operational periods. Type III teams are not expected to split the team and operate during multiple operational periods. Both types are organized into four major functional elements: search, rescue, technical, and medical. Task force members include structural engineers and specialists in the areas of hazardous materials, heavy rigging, search (including highly trained search dogs), logistics, rescue, and medicine.

Each task force is supported by a comprehensive 65,000-pound equipment cache. The cache includes communications, locating, rigging, hauling, lifting, and pulling equipment. Tools and equipment for shoring, structural movement sensing, victim extrication, cutting, and drilling are also included in the cache.

Task Force Capabilities:

- Physical search and rescue operations in damaged/collapsed structures.
- Emergency medical care for entrapped victims, task force personnel and search canines.
- Reconnaissance to assess damage and needs and provide feedback to local, state and federal officials.
- Assessment/shut off of utilities to buildings.
- Hazardous materials survey/evaluations.

- Structural/hazard evaluations of buildings needed for immediate occupancy to support disaster relief operations.
- Stabilizing damaged structures, including shoring and cribbing operations on damaged buildings.

US&R resources may be activated or placed on alert when a major disaster threatens or strikes a community. Each US&R task force is responsible for deploying its personnel and equipment within six hours of activation. The task force travels to the disaster site by ground or air in a matter of hours.

TYPE 1 US&R TASK FORCE STRUCTURE - (70 personnel and up to 10 additional support):

- Task Force Leader (2)
- Safety Officer (2)
- Search Team Manager (2)
- Tech Search Specialist (2)
- Canine Specialist (4)
- Medical Team Manager (2)
- Medical Specialist (4)
- Rescue Team Manager (2)
- Rescue Squad Officer (4)
- Rescue Specialist (20)
- Heavy Rigging Specialist (2)
- Planning Team Manager (2)
- Technical Information Specialist (2)
- Structural Specialist (2)
- HazMat Team Manager (2)
- HazMat Specialist (8)
- Logistics Team Manager (2)
- Logistics Specialist (4)
- Communications Specialist (2)
- Additional Support (up to 10)

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ANNEX C: PREHOSPITAL POSITION CHECKLISTS

This Annex contains representative checklists for organizational positions and functions needed during most multiple or mass casualty incidents. The position checklists include relevant ICS organizational charts, forms, and support tools as appropriate. A checklist for the Incident Commander is provided as a guidance tool in support of the MCI incident from response to demobilization. Checklists contained in this Annex represent identified EMS/Medical roles and responsibilities.

These checklists are not routinely used for MCI Level 1 and 2 incidents or for multiple casualty incidents involving active threats. It is understood that municipalities and agencies have developed response plans for such threats. Positions may be assigned in those incidents such as Rescue Task Force Leader or Casualty Collection Point Leader may be used based on local policy. It is the intent of the HRMCIRG and this Annex to provide position checklists for the point in the emergency when patients can be safely triaged and moved to a treatment and transportation area. This document or the associated checklists do not attempt to create a regional active threat policy.

SALT (Sort, Assess, Lifesaving Interventions, Treatment/Transport) is a triage algorithm designed to assess the severity of casualties and trigger resource requests. Triage algorithms should not take the place of clinical judgment by trained providers when assigning treatment priorities. It is essential that rescue efforts are directed at the best possible outcome for all patients, while avoiding over-triage or under-triage.

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POSITION: FIRST UNIT ON SCENE

Mission: First unit on scene gives visual size-up, assumes and announces command, confirms incident location, and then performs the 5 Ss (Safety, Size-Up, Send, Set Up, SALT):

Tasks:

SAFETY assessment: Assess the scene observing for:

- ☐ Electrical hazards.
- ☐ Flammable liquids.
- ☐ Hazardous Materials.
- ☐ Other life-threatening situations.
- ☐ Be aware of the potential for secondary explosive devices.

SIZE UP the scene: How big and how bad is it? Survey 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.

SEND information:

- ☐ Contact dispatch with your size-up information and declare a Mass Casualty Incident Level.
- ☐ Request additional resources.
- ☐ Notify the closest Hospital/Emergency Department of the incident.

SET UP the scene for management of the casualties:

- ☐ Establish staging.
- ☐ Identify access and egress routes.
- ☐ Identify adequate work areas for Triage, Treatment, and Transportation.

SALT Triage:

- ☐ Begin where you are.
- ☐ Ask anyone who can walk to move to a designated area.
- ☐ Use a unique barcoded wrist band or surveyor's tape to mark patients.
- ☐ Move quickly from patient to patient.
- ☐ Maintain patient count.
- ☐ Provide only minimal treatment.
- ☐ Keep moving!

Remember…Establish COMMAND, SAFETY, SURVEY, SEND, SET UP AND SALT Triage

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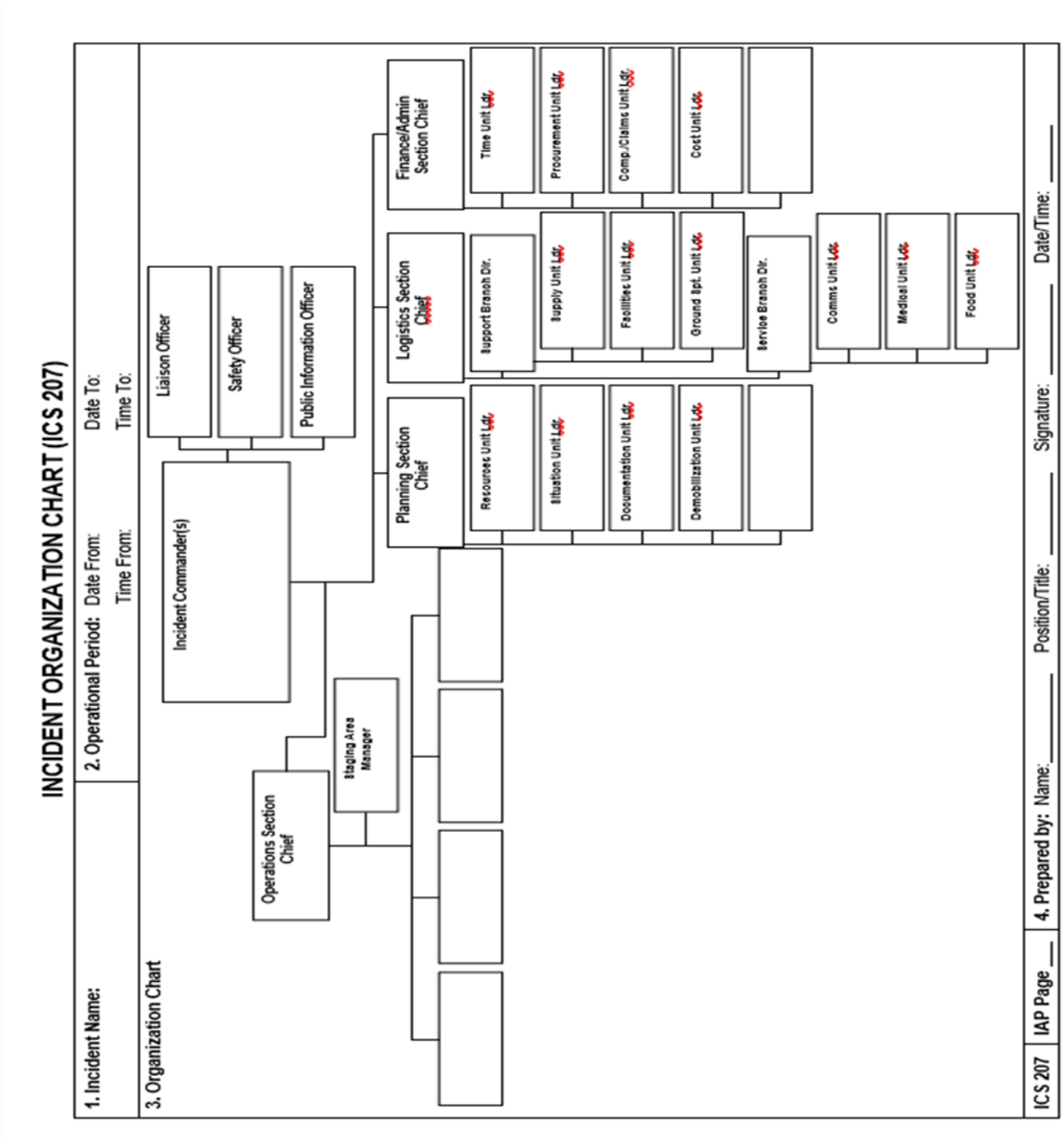
POSITION: INCIDENT COMMANDER

Mission: Responsible for the overall management and coordination of personnel and resources responding to the incident.

Tasks:

- ☐ Assumes command and announces name and title to the communications center.
- ☐ Don an identifying vest and establish a visible command post.
- ☐ Initiate, maintain, and control communications. Consider additional tactical channels to accommodate suppression operations, medical operations, staging, etc.
- ☐ Conduct a scene size-up.
- ☐ Estimate number of patients.
- ☐ Declare a Mass Casualty Incident Level ____.
- ☐ Notify the closest Hospital/Emergency Department of the MCI.
- ☐ Request additional resources as appropriate.
- ☐ Assign an IC aide (if needed).
- ☐ Assign critical EMS ICS positions:
  - Medical Group Supervisor/Branch Director.
  - Triage Officer.
  - Treatment Unit Leader.
  - Transportation Group Supervisor.
- ☐ Assign a personnel accountability officer.
- ☐ Assign a Safety Officer.
- ☐ Establish a Staging Area and assign a Staging Officer.

INCIDENT ORGANIZATION CHART (ICS 207)



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POSITION: MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR

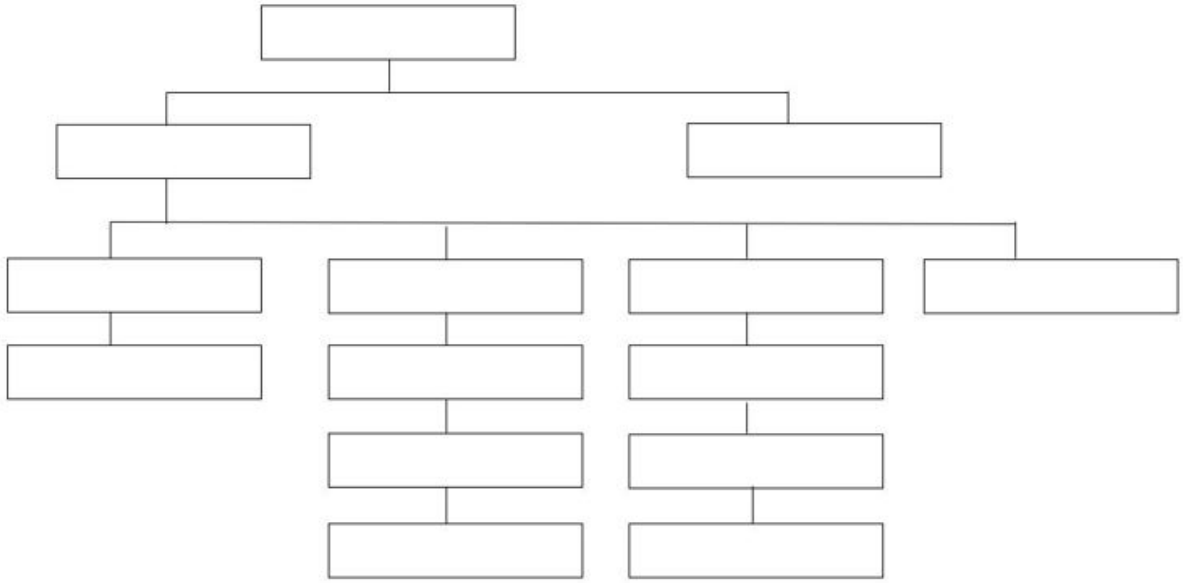
Mission: Ensure supervision and coordination are provided for extrication, triage, treatment, and transportation of all patients.

Tasks:

- ☐ Report and provide frequent updates to the INCIDENT COMMANDER or OPERATIONS SECTION CHIEF. The Medical role may be assumed by the Incident Commander during small incidents.
- ☐ Don an identifying vest.
- ☐ Locate in a visible position.
- ☐ Assume responsibility of MEDICAL GROUP/BRANCH.
- ☐ Coordinate, direct, and manage all MEDICAL GROUP/BRANCH operations.
- ☐ Assign Medical Group/Unit Leaders including Triage, Treatment, Transportation, etc. as necessary.
- ☐ Use the Multi-Casualty Branch Worksheet/Position (ICS Form 305) to document assignments.
- ☐ Identify & request resources. Consider using local and regional mutual aid resources; refer to Annex B for a list of available resources.
- ☐ Maintain accountability of all personnel assigned to this group/branch.
- ☐ Monitor safety and welfare of group personnel.
- ☐ Consider need for responder rehabilitation.
- ☐ Consider need for Peer and Crisis Support Services assistance.
- ☐ Establish and maintain accountability for all victims/patients.
- ☐ Assign a Staging Officer (If more than one operational period, assign a Staging Officer for each operational period).
- ☐ Maintain the Unit Log (ICS Form 214).

MULTI-CASUALTY BRANCH WORKSHEET/POSITION ASSIGNMENTS FORM (ICS-MC-305)

INCIDENT	DATE	START TIME	END TIME
INCIDENT COMMANDER		MULTICASUALTY BRANCH DIRECTOR	



OTHER RESOURCES
DMSUs / MCI TRAILERS:
MCITUs / BUSES:
AMBULANCES:
RADIO FREQUENCIES:
MEDICAL EXAMINER:
RED CROSS:
CHAPLAIN:
MENTAL HEALTH:

MULTI-CASUALTY BRANCH WORKSHEET/POSITION ASSIGNMENTS FORM (ICS-MC-305) (cont.)

Resources Summary						
	Resources Ordered	En Route	Resources Identification	ETA	On Scene	Location/Assignments
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
Summary of Current Actions						

POSITION: STAGING AREA MANAGER

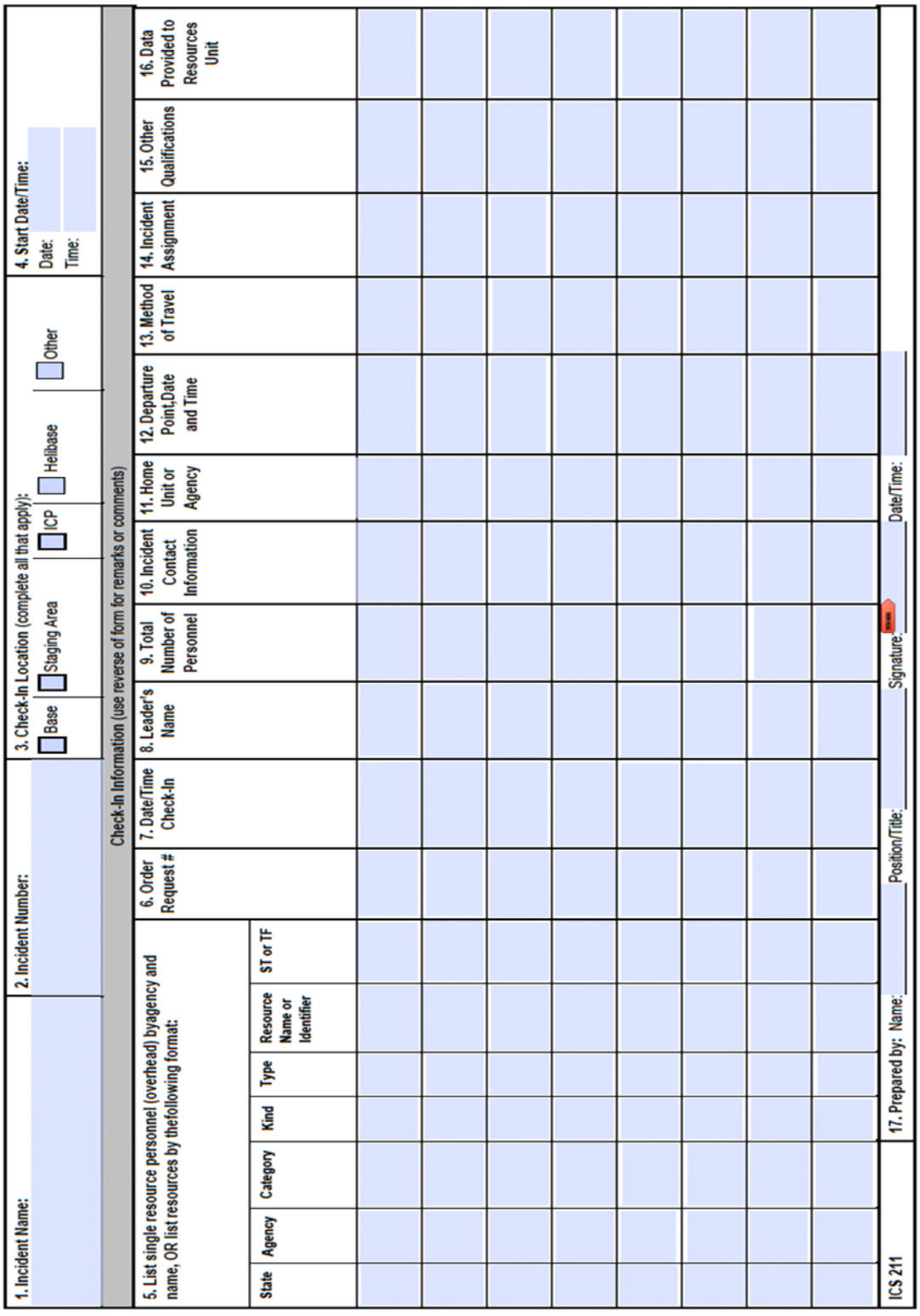
Mission: Maintain separate stockpiles of manpower, reserve equipment, and expended equipment at a staging area away from the incident.

Tasks:

- ☐ Report to INCIDENT COMMANDER (or OPERATIONS SECTION CHIEF, if appointed)
- ☐ Don an identifying vest.
- ☐ Locate in a visible position.
- ☐ Establish STAGING AREA in conjunction with the Incident Commander or Operations Section Chief, as needed.
- ☐ Provide appropriate staffing, vehicles, equipment, and supplies as requested.
- ☐ Maintain status of number and types of resources in the Staging Area.
- ☐ Recommend additional staffing, equipment, and resources when necessary.
- ☐ Order all personnel to remain with their units until assigned.
- ☐ Verify the equipment pool location.
- ☐ Control and document all resources entering and leaving the Staging Area.
- ☐ Ensures unimpeded access and egress to and from staging area.
- ☐ Request/maintain services for equipment at the Staging Area, as needed.
- ☐ Coordinate security for the Staging Area.
- ☐ Maintain the Unit Log (ICS Form 214).

INCIDENT CHECK-IN LIST FORM (ICS 211)

INCIDENT CHECK-IN LIST (ICS 211)



POSITION: TRIAGE UNIT LEADER

Mission: Assess and sort casualties to appropriately establish priorities for treatment and transportation.

Tasks:

- ☐ Report and provide updates to INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR)
- ☐ Don an identifying vest.
- ☐ Locate in a visible position between the incident site and the Treatment Area.
- ☐ If the patients are in imminent danger, move all patients out of the INCIDENT AREA before establishing TRIAGE.
- ☐ Establish controlled pathway from the incident site to the Treatment Area.
- ☐ Direct walking wounded to designated Treatment Area.
- ☐ If SALT not yet completed by first arriving crews, appoint triage teams to perform SALT using an electronic triage system, triage ribbons, or tags.
- ☐ Obtain an accurate count of all victims by triage category (Red/Yellow/Gray/Green & Black) report the count to the MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR.
- ☐ Coordinate the transfer of patients to Treatment Unit Leader and/or Transportation Group Supervisor.
- ☐ Affix a unique barcoded wrist band, triage tape, or tag to each patient upon initial triage
- ☐ Appoint "porters" to move non-ambulatory patients using lift assist devices and/or patient movers to the Treatment Area. At hazardous materials incidents requiring patient decontamination, a team must be assigned to assist patients from the warm zone/decontamination area to the Cold Zone Treatment Area.
- ☐ Maintain communications with the MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR, and other units as needed.
- ☐ Work with the Treatment Unit Leader and Transportation Group Supervisor to account for all victims who were initially triaged to ensure all living patients have been moved to the Treatment Area or transported to a healthcare facility.

Treatment Area Patient Count						
	RED	YELLOW	GRAY	GREEN	BLACK	TOTAL # PATIENTS
Patient Care Area						
No. of Patients Present						
No. of Patients Sent to Transportation Area						
Total Number of Patients						

POSITION: TREATMENT UNIT LEADER

Mission: Provide patient counts, triage, treatment & track patients.

Tasks:

- ☐ Report and provide updates to the INCIDENT COMMANDER (or MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR)
- ☐ Don an identifying vest & locate in a visible position.
- ☐ Appoint Treatment Area Managers for the Red, Yellow, and Green patient care areas.
- ☐ Establish a Treatment Area large enough to accommodate all patients allowing for a 3-foot clearance on all sides of each patient.
- ☐ Re-triage each patient and affix unique barcoded wrist band or a triage tag to each patient upon entry into the Treatment Area and establish and maintain a patient accountability system.
- ☐ Appoint a MEDICAL SUPPLY COORDINATOR, if needed.
- ☐ Working with the Treatment Area Managers determine the transportation priority and most appropriate transport method for each patient.

Treatment Area Patient Count						
Victim Location	**RED**	**YELLOW**	**GRAY**	**GREEN**	**BLACK**	**Total # of Patients By Location**
Total Number of Patients by Triage Category						

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SECONDARY TRIAGE DECISIONS

Most secondary triage decisions in an MCI are based on clinical experience and judgment. Consider the following:

IMMEDIATE (RED TAGGED)

- Life threatening injuries/illnesses.
- Risk of asphyxiation or shock is present or imminent.
- High probability of survival if treated and transported immediately.
- Can be stabilized without requiring constant care or elaborate treatment.

DELAYED (YELLOW TAGGED)

- Potentially life-threatening injuries/illnesses.
- Severely debilitating injuries/illnesses.
- Can withstand a slight delay in treatment and transportation.

IMMINENT (GRAY TAGGED)

- Expected to die. No possible medical intervention.

MINOR (GREEN TAGGED)

- Non-life-threatening injuries.
- Patients who require a minimum of care with minimal risk of deterioration.

DECEASED (BLACK TAGGED)

- Expired en route to or in the Treatment Area.
- Unresponsive with no circulation; cardiac arrest.

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POSITION: RED, YELLOW, GRAY, OR GREEN TAGGED TREATMENT AREA MANAGERS

Mission: For MCI Level 3 and 4 incidents, provide patient counts, triage, and treatment to patients awaiting transportation.

Tasks:

- ☐ Report and provide updates to the TREATMENT UNIT LEADER.
- ☐ Don an identifying vest.
- ☐ Consider establishing a Treatment Area large enough to accommodate all patients. If possible, allow for a 3-foot clearance on all sides of each patient.
- ☐ Consider identifying the Treatment Area with the appropriate colored flag, tarp, and/or chemical light.
- ☐ Ensure patients are re-triaged upon entry to the Treatment Area using Secondary Triage and ensure a unique barcoded wrist band or triage tag is applied to each patient.
- ☐ Maintain accountability of all patients in your Treatment Area.
- ☐ Determine the transportation priority and the most appropriate transport method for each patient.
- ☐ Report the transportation priority of patients and recommended transport method for each patient to the Treatment Unit Leader.
- ☐ Continually reassess each patient's condition and triage status.
- ☐ Consider the establishment of special patient care teams (e.g., IV team, bandaging team, etc.) as necessary to support the care of your patients.
- ☐ Consider additional personnel as needed to provide the care for your patients.
- ☐ Provide palliative care for catastrophically injured (Gray) patients until resources allow for their transportation to a hospital.
- ☐ Coordinate the relocation of any patient who dies in the Treatment Area to the Incident Morgue (Black Tagged). Leave all medical devices in place.

Treatment Area Patient Count						
	RED	YELLOW	GRAY	GREEN	BLACK	TOTAL # PATIENTS
Patient Care Area						
No. of Patients Present						
No. of Patients Sent to Transportation Area						
Total Number of Patients						

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POSITION: INCIDENT MORGUE AREA MANAGER

Mission: Establish and maintain an incident morgue area for deceased persons who expire en route to or in the Treatment Area prior to transport.

Tasks:

- ☐ Report to the TREATMENT UNIT LEADER.
- ☐ Don an identifying vest.
- ☐ Verify with the TREATMENT UNIT LEADER that the Office of the Chief Medical Examiner has been notified of deceased persons:
- ☐ Norfolk Office: (757) 683-8366 or Richmond Office: (804) 786-3174
- ☐ Establish a secure morgue area separate from the Treatment Area and accessible to vehicles (i.e., emergency vehicles, law enforcement).
- ☐ With the assistance of Law Enforcement, secure the area from all unauthorized personnel and provide security to the morgue area.
- ☐ Reassess each patient upon entry to the Incident Morgue / Black Tagged Area to confirm death. Annotate the patient assessment on the triage tag. If the patient does not have a unique barcoded wrist band or triage tag, affix one to the patient.
- ☐ Leave all medical interventions in place (i.e., IVs, bandages, etc.).
- ☐ Cover patient(s) with sheets or enclose remains in disaster pouches or similar body bags.
- ☐ Ensure that no human or animal remains are moved from the incident site prior to the arrival and approval of the Medical Examiner/Chief Law Enforcement Officer.
- ☐ Coordinate activities with the Medical Examiner's Office, funeral directors, and law enforcement, as necessary.
- ☐ Maintain accountability of all victims received in the Treatment Area using the MCI Patient Tracking Form (ICS-MC-306).

POSITION: MEDICAL SUPPLY COORDINATOR

Mission: For MCI Level 3 and 4 incidents, acquire, distribute, and maintain the status of medical equipment and supplies.

Tasks:

- ☐ Report and provide updates to the MEDICAL GROUP SUPERVISOR/MEDICAL BRANCH DIRECTOR).
- ☐ Don an identifying vest.
- ☐ Locate medical supplies in a central position in the Treatment Area using caution not to block access and egress into and from the Treatment Area.
- ☐ Maintain an inventory list of equipment, supplies, and Disaster Medical Support Units (DMSUs)/MCI Trailers received and distributed. Provide receipts upon request.
- ☐ Continually assess status of medical supplies and equipment. Request additional supplies and equipment through the Medical Group Supervisor/Medical Branch Director as needed.
- ☐ Distribute medical supplies and equipment to the patient care areas.
- ☐ Request personnel to assist in the collection and distribution of supplies and equipment. Consider a need to have a vehicle(s) transport supplies and equipment.
- ☐ Do NOT strip ambulances of medical supplies and equipment unless absolutely needed to manage the initial phase of the incident.
- ☐ Establish a perimeter around the medical supply area to assist in controlling the distribution of supplies and equipment.
- ☐ Use the CSALTT acronym to request resources.

C – Capability

S – Size

A – Amount

L – Location

T – Type

T - Time

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POSITION: TRANSPORTATION GROUP SUPERVISOR / UNIT LEADER

Mission: For MCI Level 3 and 4 incidents, track and distribute patients to medical facilities by assigning the mode of transportation and destination for each patient.

Tasks:

- ☐ Report and provide updates to the INCIDENT COMMANDER (MEDICAL GROUP SUPERVISOR/ MEDICAL BRANCH DIRECTOR.)
- ☐ Don an identifying vest and locate in a visible position.
- ☐ Verify the Staging Area location.
- ☐ Collaborate with the Triage Unit and Treatment Unit Leaders to determine patient transportation priorities and patient destinations using the ICS-MC-308 Form.
- ☐ Communicate transportation resource needs to the MEDICAL GROUP SUPERVISOR/BRANCH DIRECTOR.
- ☐ Appoint a TRANSPORT RECORDER.
- ☐ Track each patient by their unique barcoded wrist band or triage tag number using the MCI Patient Tracking Form (ICS-MC-306).
- ☐ Appoint TRANSPORT LOADERS.
- ☐ Inform transport crews of their destination. Tell crews to return to the Staging Area after their patients are turned over at the hospital unless otherwise directed.
- ☐ Remind ambulance crews not to contact the receiving facility unless there is significant deterioration in the patient's condition.
- ☐ Maintain close communications with INCIDENT COMMAND/UNIFIED COMMAND or MEDICAL GROUP/BRANCH, TREATMENT, GROUND & AIR OPERATIONS.
- ☐ Once the last patient has been transported, and before demobilization begins, work with the Transport Recorder, Transport Loader, Medical Communications Coordinator and the Hospitals/Emergency Departments to account for 100% of the patients/victims.
- ☐ Incident Benchmark: Announce over the radio and notify the Hospitals/Emergency Departments when all patients have been transported from the scene.

It is the responsibility of the Transportation Group Supervisor to distribute patients in an equitable manner while also considering the need for specialty services (i.e., trauma, burn, pediatrics). The transportation of patients from the incident scene will begin as soon as EMS has the assets to do so. Hospitals will likely implement their respective Surge Plans to accommodate the surge in patients from the MCI. Hospitals may also use commercial/private EMS agencies to transfer patients between healthcare facilities.

The ICS-MC-308 form below provides the Transportation Group Supervisor with a table to manually track the number of Red, Yellow, Gray, and Green triaged patients who were transported to each facility.

PATIENT COUNT AND DISTRIBUTION WORKSHEET (ICS-MC-308)

Date:_____ Incident Name / Location:_____

Number of Patients Reported By Triage Category						
On-Scene Location	Red (Immediate)	Yellow (Delayed)	Gray (Imminent)	Green (Minimal)	Black (Deceased)	Total Number of Victims

Available Transport Units					

Patient Distribution															
ED or Hospital Name															
Capacity (R/Y/G)															
No. of Pts Sent															
ED or Hospital Name															
Capacity (R/Y/G)															

POSITION: TRANSPORT RECORDER

Mission: For MCI Level 1 and 2 incidents, to assist in ensuring proper documentation of victim/patient and unit movements.

Tasks:

- ☐ Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- ☐ Don an identifying vest.
- ☐ Position yourself at the assigned patient egress point in the TRANSPORT area.
- ☐ If the electronic triage system is off-line, and the patient does not have a unique barcoded wrist band or triage tag, affix one to the patient. Complete an entry on the triage tag and the MCI Patient Tracking Form (ICS-MC-306) for each patient leaving the Transportation Area. Complete then remove and save the tear-off portion of the triage tag, if used.
- ☐ Deliver triage tag Transportation Record to MEDICAL COMMUNICATIONS/TRANSPORTATION, if used.

POSITION: TRANSPORT LOADER

Mission: For MCI Level 1 and 2 incidents, ensure patients are safely loaded into the assigned ground ambulance, air ambulance, or other vehicle, and verify vehicle destination and travel directions.

Tasks:

- ☐ Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- ☐ Don an identifying vest.
- ☐ Ensure patients selected for transportation are:
  - Ready for transport.
  - Safely loaded aboard the ambulance or other vehicle designated by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- ☐ Provide the following information to ambulance personnel:
  - Destination Hospital/Emergency Department.
  - Provide travel directions to the receiving Hospital/Emergency Department (available in Annex E). (**Note:** Live directions to Southside hospitals can be found on the TEMS Protocol App.)
  - Remind ambulance crews that they do not need to contact receiving facility unless there is significant deterioration in the patient's condition.
  - Remind crews to return to the Staging Area upon completion of their assignment unless otherwise directed.
- ☐ Ensure all patients being loaded have a unique barcoded wrist band or triage tag attached and the transport stub has been removed, if used.
- ☐ Maintain close communications with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER and TRANSPORT RECORDER.

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POSITION: MEDICAL COMMUNICATION COORDINATOR

Mission: For MCI Level 3 and 4 incidents: To maintain and coordinate medical communications at the incident scene between the TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER and the receiving Hospital/Emergency Department.

Tasks:

- ☐ Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- ☐ Don an identifying vest.
- ☐ Remain in close proximity to the TRANSPORT and TREATMENT areas.
- ☐ In the event the electronic triage system is off-line, establish and maintain a dependable communications link with the receiving Hospital/Emergency Department. The following minimal information should be provided and updated:
  - Type of incident.
  - Number of patients.
  - Severity of injuries.
- ☐ As necessary, report individual patient information to the receiving Hospital/Emergency Department as relayed by TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER to include:
  - Unit transporting.
  - Destination hospital.
  - Number of patients.
  - Triage tag numbers.
  - Triage category, major injuries and age of patients.
- ☐ Assist the TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER with documentation.

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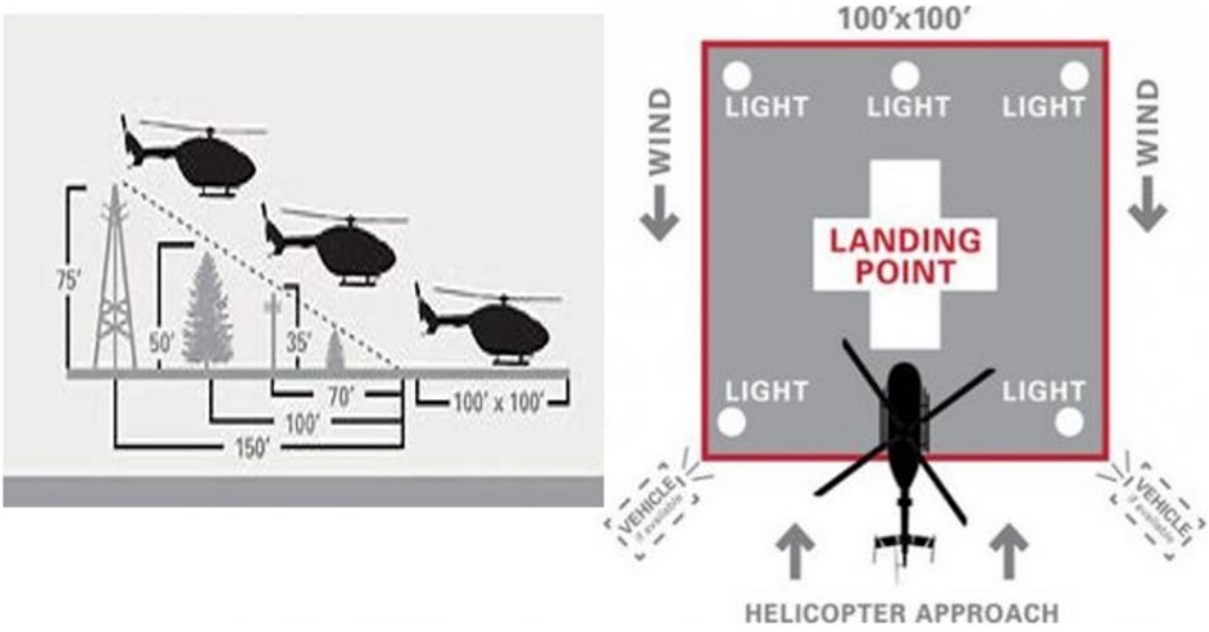
POSITION: AIR OPERATIONS GROUP SUPERVISOR

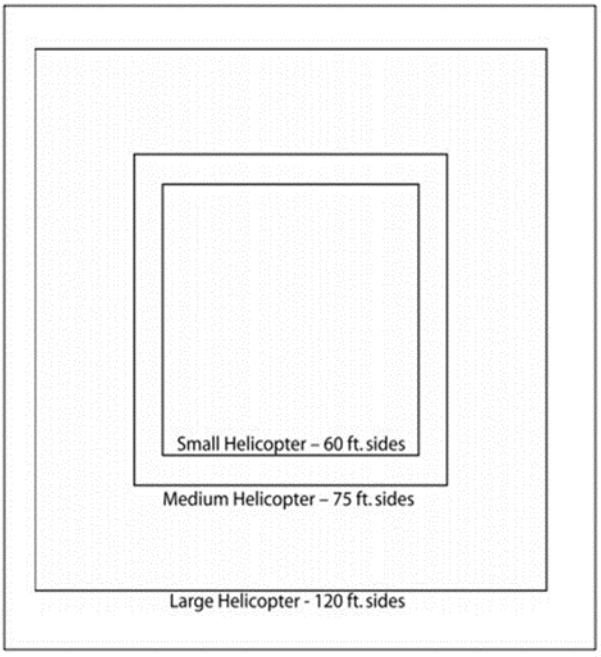
Mission: For MCI Level 3 and 4 incidents, assume responsibility for the coordination, landing, and communication with multiple air ambulance aircraft.

Tasks:

- ☐ Report to TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- ☐ Don an identifying vest.
- ☐ Assign a fire unit and personnel to establish a Helispot (a.k.a. landing zone.)
- ☐ Secure and maintain a Helispot of sufficient size on the most firm and level surface available (less than 5° slope) and clear of debris. Night operations and low visibility conditions require a larger Helispot.
- ☐ Locate Helispot at least one mile upwind from HazMat incident sites when explosive gases, vapors, or chemicals are in danger of exploding or burning on sites, or when a plume is present. For radioactive materials incidents with no steam or smoke, the Helispot can be located ¼ mile upwind from the incident site.
- ☐ Clearly mark the area with five weighted cones, flares, or beacons.
- ☐ Maintain Helispot/landing zone security. Request law enforcement assistance, if needed.
- ☐ Maintain radio contact with incoming helicopters (All civilian helicopters stationed in Virginia can communicate on the Statewide Mutual Aid channel, VHF 155.205).
- ☐ Advise the pilot of the following BEFORE landing:
  - Obstructions at the landing area, as well as "near-by" (e.g., radio or cell towers, antennas, telephone lines, other wires, cranes, tall buildings, etc.)
  - Wind direction or ground wind gusts.
  - Location of any HazMat incidents, plume location and direction.
- ☐ Assign a designated Landing Zone Controller or Helicopter Marshall with an understanding of helicopter landing operations and standard hand signals to support landing zone to helicopter communications.
- ☐ Relay patient information from the Medical Communication Coordinator to the air ambulance crew (e.g., patient condition, patient weight, and airway status).
- ☐ Coordinate loading and transport of patients with TRANSPORTATION GROUP SUPERVISOR/UNIT LEADER.
- ☐ Pilot has final say of the aircraft. Pilot can refuse patient transport or destination based on their judgment.



Helispot Setup



Recommended Minimum LZ Dimensions

For the purposes of the recommended minimum LZ dimensions (above), the following are provided as examples of relative helicopter size:

- Small Helicopter: Bell 206/407, Eurocopter AS−350/355, BO−105, BK−117.
- Medium Helicopter: Bell UH−1 (Huey) and derivatives (Bell 212/412), Bell 222/230/430 Sikorsky S−76, Eurocopter SA−365.
- Large Helicopter: Boeing Chinook, Eurocopter Puma, Sikorsky H−60 series (Blackhawk), SK−92.

LANDING ZONE HAZARDS AND OBSTRUCTIONS

- The LZ should be level, firm and free of loose debris that could possibly blow up into the rotor system.
- The LZ should be clear of people, vehicles, and obstructions such as trees, poles, and wires. Remember that wires are difficult to see from the air. The LZ must also be free of stumps, brush, posts, and large rocks.

Insert new hand signals diagram (to be provided by Mike Player)

INCIDENT RADIO COMMUNICATIONS PLAN (ICS 205)

INCIDENT RADIO COMMUNICATIONS PLAN (ICS 205)

1. Incident Name:	2. Date/Time Prepared: Date: Time:	3. Operational Period: Date From: Date To: Time From: Time To:

4. Basic Radio Channel Use:

Zone Grp.	Ch #	Function	Channel Name/Trunked Radio System Talkgroup	Assignment	RX Freq N or W	RX Tone/NAC	TX Freq N or W	TX Tone/NAC	Mode (A, D, or M)	Remarks

5. Special Instructions:

6. Prepared by (Communications Unit Leader) Name: Signature:

ICS 205 IAP Page _____ Date/Time:

AIR OPERATIONS SUMMARY FORM (ICS 220)

AIR OPERATIONS SUMMARY (ICS 220)

1. Incident Name:	2. Operational Period: Date From: Time From: Date To: Time To:	3. Sunrise: Sunset:
4. Remarks (safety notes, hazards, air operations special equipment, etc.):	5. Ready Alert Aircraft: Medivac: New Incident:	6. Temporary Flight Restriction Number: Altitude: Center Point:
	8. Frequencies: AM FM	9. Fixed-Wing (category/kind/type, make/model, N#, base):
	Air/Air Fixed-Wing	Air Tactical Group Supervisor Aircraft:

7. Personnel:	Name:	Phone Number:	Air/Air Rotary-Wing – Flight Following			Other Fixed-Wing Aircraft:
Air Operations Branch Director			Air/Ground			
Air Support Group Supervisor			Command			
Air Tactical Group Supervisor			Deck Coordinator			
Helicopter Coordinator			Take-Off & Landing Coordinator			
Helibase Manager			Air Guard			

10. Helicopters (use additional sheets as necessary):

FAA N#	Category/Kind/Type	Make/Model	Base	Available	Start	Remarks

11. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 220, Page 1 Date/Time: _____

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ANNEX D: PREHOSPITAL AND HOSPITAL PATIENT MANAGEMENT FORMS

This Annex contains forms that may be used by first responders during a multiple or mass casualty drill or incident.

The following forms contained in this Annex are:

- MCI Patient Tracking Form (ICS-MC-306)
- Patient Count & Distribution Worksheet (ICS-MC-308)

MCI PATIENT TRACKING FORM (ICS-MC-306)

#	Triage Tag No.	Priority R/Y/Gr/G	Patient's Closest or Primary Injuries	Unit Transporting Pt to ED/Hospital	Time Left Scene	Patient Destination
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						

PATIENT COUNT & DISTRIBUTION WORKSHEET (ICS-MC-308)

Date: _____ Incident Date / Location: _____

Number of Patients Reported By Triage Category					
On-Scene Location	**Red (Immediate)**	**Yellow (Delayed)**	**Green (Minimal)**	**Black/Gray (Deceased/Imminent)**	**Total Number of Victims**

Available Transport Units					

Patient Distribution																	
ED or Hospital Name																	
Capacity (R/Y/G)																	
No. of Pts Sent																	
ED or Hospital Name																	
Capacity (R/Y/Gr/G)																	
No. of Pts Sent																	

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ANNEX E: DRIVING DIRECTIONS TO HOSPITALS

Hospital	Address	Directions
Bon Secours Harbour View Emergency Room	5818 Harbour View Blvd., Suffolk, VA 23435	From U.S. 17 North (from the James Bridge): • Follow US-17 South. • Turn left onto Harbour View Blvd. • Harbour View Health Center & Emergency Department will be on the right.
		From I-664 South (from the Monitor-Merrimac Bridge Tunnel): • Take Exit 9 to merge onto US-17 North/Bridge Rd (toward James River Bridge). • Follow US-17 North. • Turn right onto Harbour View Blvd. • Harbour View Health Center & Emergency Department will be on the right.
		From I-164 (from the Portsmouth): • Take I-164 until it merges with US-17 North. • Follow US-17 North. • Turn right onto Harbour View Blvd. • Harbour View Health Center & Emergency Department will be on the right.
Bon Secours Mary Immaculate Hospital	2 Bernadine Drive, Newport News, VA 23602	From I-64 East or West: • Exit 255 B onto Jefferson Blvd. toward the Newport News/Williamsburg International Airport. • Travel approximately 1 mile and turn right onto Turnberry. Go to the end of the road. • Turn left onto MacManus Blvd. • Follow the road almost to the end and turn right into the hospital (Bernadine Drive).
Bon Secours Maryview Medical Center	3636 High Street, Portsmouth, VA 23707	From I-264 East or West: • Exit 5 and turn north onto Frederick Blvd (Rte. 17). • Travel approximately 1 mile and turn left onto High Street (still Rte. 17). • Travel approximately .25 mile and emergency department will be on the right.
Chesapeake Regional Medical Center	736 (North) Battlefield Blvd., Chesapeake, VA 23320 From I-64	East or West: • Exit 290 B onto Battlefield Blvd South. • Travel approximately 1.75 miles and turn right onto Medical Parkway, just past hospital. • Turn right behind hospital. • Emergency department is on the right.
Children's Hospital of the King's Daughters	601 Children's Lane, Norfolk, VA 23507	From I-264 West • Exit 11B (Brambleton Ave.) • Travel approx. 2 miles to Colley Ave. • Turn right onto Colley Ave., then left onto Raleigh Ave. • Emergency department will be on the left.
		From I-264 East and I-464 East:

Hospital	Address	Directions
		• After crossing the Elizabeth River Bridge, follow signs to St. Paul's Blvd. • At base of ramp, turn right onto St. Paul's Blvd. • Turn left at Brambleton Ave. • Travel approx. 2 miles to Colley Ave. • Turn right onto Colley, then left onto Raleigh Ave. • The Emergency Department will be on the left.
Hampton Veterans' Administration Hospital	100 Emancipation Drive, Hampton, VA 23667	From I-64 East or West: • Exit 268 onto S. Mallory St. • Enter VA hospital complex and make first RIGHT turn onto Martin Luther King, Jr. Blvd. • Make next left turn, pass a chapel and turn left again. • Look for the "Outpatient Clinic Services." • The ambulance entrance will be on the side of that building (Bldg. 110B) marked as "Urgent Care."
Naval Medical Center Portsmouth	620 John Paul Jones Circle, Portsmouth, VA 23708	From I-264 East or West: • Exit 7 onto Effingham Street North. • Travel approximately 2 miles through security gate. • Turn first right. • After curve, second left is driveway to ambulance entrance.
Peninsula Regional Medical Center (Level 3 Trauma Center)	100 East Carroll Street, Salisbury, MD 21801	From the South: • Take Rte. 13 North and cross into Maryland. • Merge onto US-13 Bus N toward Fruitland/Salisbury. • Turn left onto E Carroll St. • Destination will be on the right.
Bon Secours Rappahannock General Hospital	101 Harris Drive, Kilmarnock, VA 22482	From western portions of the PEMS region: I-64 East or West: • Exit 220 (north to West Point). Follow Rte. 33 north to Rte. 17. • Turn left onto Rte. 17 north towards Saluda. • Turn right onto Rte. 33 (stop light). • Follow Rte. 33 and turn left onto Rte. 3 towards White Stone. • Cross Rappahannock River Bridge and travel approximately 7 more miles to Kilmarnock. • Turn left onto Harris Dr. - Hospital is on the right. From eastern portions of the PEMS region: I-64 East or West: • Exit 250B (Ft. Eustis Blvd to Rte. 17) or Exit 258B to Rte. 17. • Travel approximately 3.5 miles and turn left onto George Washington Hwy (Rte. 17 North). • Cross the York River Bridge and follow the above directions from "17 north towards Saluda."
Riverside Doctors' Hospital	1500 Commonwealth Ave, Williamsburg, VA 23185	From Newport News: • Take Interstate 64 W to Williamsburg / Richmond. • Take exit 242A onto VA-199 W / Humelsine Parkway toward. Williamsburg / Jamestown. • Take the US 60 W ramp. • Turn left onto US 60 W / Pocahontas Trail. • Turn left onto Battery Boulevard. From Richmond: • Take Interstate 64 E to Williamsburg / Newport News. • Take exit 242A onto VA-199 W / Humelsine Parkway toward Williamsburg / Jamestown. • Take the US 60 W ramp. • Turn left onto US 60 W / Pocahontas Trail. • Turn left onto Battery Boulevard.
Riverside Regional Medical Center	500 J. Clyde Morris Blvd, Newport News, VA 23601	From I-64 East or West: • Exit 258 A onto J. Clyde Morris Blvd.

Hospital	Address	Directions
(Level 2 Trauma Center)		• Hospital is approximately 2.25 miles on left.
Riverside Shore Memorial Hospital	20480 Market Street, Onancock, VA 23417	From Rte. 13 South (Virginia Beach): • Take Rte. 13 North. • Turn left onto W Main St/VA-179. Continue to follow VA-179. (VA-179 is 0.1 miles past Bank St.) • Then travel 0.26 miles to 20480 Market St, Onancock, VA 23417-4309.
		From North of Onancock: • Take Rte. 13 South. • Turn right onto W Main St/VA-179. Continue to follow VA-179. • VA-179 is 0.9 miles past Taylor Rd. • If you reach Bank St, you have gone about 0.1 miles too far • 20480 Market St, Onancock, VA 23417-4309, 20480 MARKET ST. • Your destination is 0.2 miles past Shore Pkwy.
VCU Tappahannock Hospital	486 Hospital Rd Tappahannock, VA 22560	From I-64 West: • Exit 258B onto George Washington Hwy (Rte. 17). • Follow Rte. 17 across York River Bridge. • Travel approximately 55 miles and turn LEFT onto Rte. 360 (stoplight) just prior to the town of Tappahannock. • Immediately merge into far-right lane and turn into the first RIGHT. Follow this road up a hill to the hospital, and the ED will be on the RIGHT.
		From I-64 East: • Exit 250B onto Ft Eustis Blvd (Rte. 105). • Travel approximately 3.5 miles and turn LEFT onto George Washington Hwy (Rte. 17 North). • Follow Rte. 17 across the York River Bridge. • Travel approximately 45 miles and turn left onto Rte. 360 (stoplight) just prior to the town of Tappahannock. • Immediately merge into far-right lane and turn into the first right. • Follow this road up a hill to the hospital, and the Emergency Department will be on the right.
		Alternate, if coming from the western portion of the PEMS area: From I-64 East or West: • Take Exit 220 (to West Point). • Follow Rte. 33 north to Rte. 17. • Turn left onto Rte. 17 north and travel approximately 30 miles to Rte. 360.
Riverside Walter Reed Hospital	7519 Hospital Dr. Gloucester, VA 23061	From I-64 East: • Exit 250B onto Ft Eustis Blvd. (Rte. 105). • Travel approximately 3.5 miles and turn left onto George Washington Hwy (Rte. 17 north). • Follow Rte. 17 across the York River Bridge to Gloucester. • The hospital will be on the right after the Gloucester Court House area.

Hospital	Address	Directions
		From I-64 West: • Exit 258B onto George Washington Hwy (Rte. 17). • Travel approximately 3.5 miles and turn left onto George Washington Hwy (Rte. 17). • Follow Rte. 17 across York River Bridge to Gloucester. • Hospital will be on the right after the Gloucester Court House area.
Sentara BelleHarbour Emergency Department	3920 A Bridge Road, Suffolk, VA 23435	From the Peninsula: • Merge onto I-64 E toward Norfolk/Virginia Beach. • Merge onto I-664 S toward the Monitor-Merrimac Tunnel via EXIT 264 (toward Suffolk/Chesapeake). • Take Exit 9B (US-17 N/Bridge Rd.) toward James River Bridge. • Go through traffic light at Harbour View Blvd to next light (Plummer Road) in front of Sentara BelleHarbour campus.
		From Franklin - Suffolk - Windsor: • Merge onto US HWY 58 E toward Norfolk. • Exit onto I-664 North toward Newport News / Hampton. • Take Exit 9A toward US-17 N / James River Bridge. • Merge onto US-17 N / Bridge Rd. • Go through traffic light at Harbour View Blvd. to next light in front of Sentara BelleHarbour campus.
		From Virginia Beach - Norfolk: • Merge onto I-264 W toward Portsmouth through Downtown Tunnel. • Merge onto I-664 N towards Newport News. • Take exit 9A toward US-17 N / James River Bridge. • Merge onto US-17 N / Bridge Rd. • Go through traffic light at Harbour View Blvd. to next light in front of Sentara BelleHarbour campus.
		From Smithfield: • Take US-258 / 10 to Benns Church Blvd. • Turn left onto Benns Church Blvd. and proceed to Rte. 17 (Carrollton Blvd.). • Merge onto Rte. 17 and go approximately 8.5 miles.
Sentara Careplex Hospital	3000 Coliseum Dr Hampton, VA 23666	From I-64 East or West: • Exit 262 B onto the Hampton Roads Center Parkway. • Turn right onto Coliseum Drive. • turn left into the main entrance. The Emergency Department is around the right to the rear.
Sentara Independence Emergency Room	800 Independence Blvd., Virginia Beach, VA 23455	From I-264 East or West: • Exit 17B (Independence Blvd./Pembroke Area). • Go approximately 2.6 miles; it will be on the right.
Sentara Leigh Memorial Hospital	830 Kempsville Rd Norfolk, VA 23502	From I-264 East: • Exit 15B (Newtown Rd South). • At base of off-ramp, turn right on Newtown Rd. • Turn right onto Kempsville Rd (approximately 0.4 miles). • Hospital is approximately 0.4 miles on the right.

Hospital	Address	Directions
		From I-264 West: • Exit 15B (Newtown Rd South). • At base of off-ramp, turn left on Newtown Rd. • Turn right onto Kempsville Rd (approximately 0.2 miles). • Hospital is approximately 0.4 miles on the right.
Sentara Norfolk General Hospital (Level 1 Trauma Center)	Gresham 600 Drive, Norfolk, VA 23507	From 264 West: • Exit 11B (Brambleton Ave.) • Travel approx. 2 miles past Colley Ave. • First right turn past Colley Ave. onto Gresham Drive. • Emergency Department will be approximately 0.1 mile on right.
		From Rte. 58 / I-264 East and I-464 East: • After crossing the Elizabeth River Bridge, follow signs to St. Paul's Blvd. • At base of ramp, turn right onto St. Paul's Blvd. • Turn left at Brambleton Ave. • Travel approx. 2 miles past Colley Ave. • First right turn past Colley Ave. onto Gresham Drive the Emergency Department will be approximately 0.1 mile on right.
		From I-64 East (from the Peninsulas): • Exit 276 onto I-564 then exit onto Terminal Blvd. Follow Terminal Blvd. to the end and turn left on to Hampton Blvd. • Follow Hampton Blvd for approximately 5 miles. • Turn left onto Gresham Dr. and follow Gresham around hospital. Emergency Department will be on the left.
Sentara Obici Hospital	2800 Godwin Boulevard, Suffolk, VA 23434	From I-460 East (Petersburg/Richmond): • Take Route 460 East to exit Route 10 turn left. • Proceed to third traffic light and Obici Hospital campus is on the right.
		From I-64/I-264 (Norfolk/Virginia Beach): • Take I-64 to I-264 toward Suffolk. • At Bowers Hill exchange, take Suffolk exit onto Rte. 58/460. • Proceed approximately 12 miles to exit Rte. 10 (Newport News/Smithfield). • At the traffic light turn right. • Hospital campus is on the right at the second light.
		From Rte. 58 (Franklin): • Take Route 58 Bypass to Suffolk to Rte. 10 (Newport News/Smithfield) exit. • Turn left at traffic light. Proceed to third traffic light. • Hospital campus is on the right.
		From Rte. 10 (Smithfield): • Obici Hospital is located approximately 10 miles from the Benns Church intersection. • Proceed on Route 10 the hospital will be on your left directly across the street from the YMCA.
Sentara Princess Anne Hospital	1925, 1950 & 1975 Glenn Mitchell Drive, Virginia Beach, VA 23456	The Sentara Princess Anne Health Campus is located at the intersection of Princess Anne Road and Concert Drive near Dam Neck Road near the Virginia Beach Amphitheater. • Turn onto Concert Drive to enter the campus and follow directional signs to the Emergency Department.

Hospital	Address	Directions
		From I-264: • Take Independence Blvd. S to Princess Anne Road. • Turn left onto Princess Anne Road. • Turn right onto Concert Drive.
		From I-64 Chesapeake: • Go north on Greenbrier Parkway. • Merge onto I-64 West towards Virginia Beach. • Take the First Indian River Road East exit. • Merge onto Indian River Road. • Slight left on Ferrell Parkway. • Take ramp onto Princess Anne Road. • Turn right onto Concert Drive.
		From southern Chesapeake (Great Bridge) area: • From Great Bridge at South Battlefield Boulevard go right on Mount Pleasant Road. • Continue straight as road turns into North Landing Road. • Left on Princess Anne Road. • Left on Concert Drive.
Sentara Virginia Beach Hospital (Level 3 Trauma Center)	1060 First Colonial Road, Virginia Beach, VA 23454	From I-264 East or West: • Exit 21B (First Colonial Rd North). • Hospital is approximately 1.5 miles on the right.
Sentara Williamsburg Regional Medical Center	100 Sentara Circle, Williamsburg, VA 23188	Directions from West: • I-64 East, take Exit 234A, Route 199 Lightfoot. • Exit at Rte. 603 East, Mooretown Road to Rochambeau Drive. • Proceed through stoplight to the second hospital entrance. • Once on the hospital campus turn left at the "T" and proceed around to the rear of the hospital complex to the ambulance bay, located next to the loading dock.
		Directions from East: • I-64 West, take Exit 234A, Route 199 Lightfoot.
Bon Secours Southampton Memorial Hospital	100 Fairview Dr Franklin, VA 23854	From Rte 58 West: • Exit onto South St. (Rte. 258) towards Franklin (Do NOT use the "258 Truck" exit.). • Turn right (north) toward Franklin. • Travel approximately 0.5 mi. and turn left onto South College Drive. • Travel approximately 2 mi. and at the fourth stoplight, turn right onto Fairview Drive. • Travel approx. ¾ mi. and the hospital will be on the left.
		From Rte. 58 East: • Exit onto South St. (Rte. 258) towards Franklin (Do NOT use the "258 Truck" exit.). • Turn left (North) toward Franklin. • Travel approximately 0.5 mi. and turn left onto South College Drive. • Travel approximately 2 mi. and at the fourth stoplight, turn right onto Fairview Drive. • Travel approximately. ¾ mi. and the hospital will be on the left.
Bon Secours Southern Virginia Medical Center	727 North Main Street, Emporia, VA 23847	From Rte. 58 West: • Take Rte. 58 West (Southampton Parkway) to Rte. 301 South exit.

Hospital	Address	Directions
		• Merge right (South) onto Rte. 301. • Go ½ mile and turn right.
Bon Secours Southside Regional Medical Center (Level 3 Trauma Center)	200 Medical Park Boulevard, Petersburg, VA 23805	From Route 460 East: • Turn right on to Wagner Road. • Go through one stoplight. • Turn left on to Medical Park Boulevard. From Route 460 West: • Turn left on to Wagner Road. • Go through one stoplight. • Turn left on to Medical Park Boulevard.
Virginia Commonwealth University Medical Center (Medical College of Virginia)	1250 East Marshall Street, Richmond, VA 23298	From the Peninsula: • Take I-64 West to I-95 South. • Take I-95 South (Richmond-Petersburg Turnpike) via Exit 190 on the left. • Take Exit 74C Broad Street/ US-33 W/ US-250 W. • Turn right at the second light at 11th St. • Turn right onto Clay St. • Turn right again into the tunnel underneath the hospital. From Western Tidewater: • Take Rte. 58 Bypass to Courtland. • Merge right onto Rte. 58 West Business. • Rte. 58 Business turns into Rte. 35 North. • Take Rte. 35 North to I-95 North. • Get off I-95 at Exit 74C Broad Street/ US-33 W/ US-250 W. • Turn right at the second light on 11th St. • Turn right onto Clay St. • Turn right again into the tunnel underneath the hospital.

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ANNEX F: GLOSSARY

ACRONYM / TERM	DEFINITION
800 MHz Radio	A robust 2-way radio system; used by most local jurisdictions for public safety communication; a repeated radio system capable of extended transmission distances; all transmissions are recorded by the jurisdiction's Emergency Communications/911 Center
AAR	After-Action Report
AIM	Aeronautical Information Manual
Americans with Disabilities Act (ADA)	Prohibits discrimination against people with disabilities in several areas, including employment, transportation, public accommodations, communications and access to state and local government programs and services.
ARTCC	The Federal Aviation Administration's Washington Air Route Traffic Control Center. It is also known as the "Washington Center"
ASPR	Assistant Secretary for Preparedness and Response
Branch	The Incident Command System (ICS) organizational level having functional or geographical responsibility for major aspects of incident operations. A Branch is organizationally situated between the Section Chief and the Division or Group in the Operations Section, and between the Section and Units in the Logistics Section. Branches are identified using Roman numerals or by functional area.
CBRNE	Chemical, Biological, Radiological, Nuclear & Explosive
CDC	Centers for Disease Control and Prevention
Chief	The ICS title for individuals responsible for management of functional sections: Operations, Planning, Logistics, Finance/Administration, and Intelligence (if established as a separate section).
CFR	Code of Federal Regulations
Cold Zone	The control zone for a hazardous materials incident; contains the Incident Command/Unified Command Post and other incident support facilities. Also referred to as the clean zone or support zone.
Command	The act of directing, ordering, or controlling by virtue of explicit statutory, regulatory, or delegated authority.
Command Staff	(Officer in an incident management organization) - The Command Staff consists of the Incident Command/Unified Command and the special staff positions of Public Information Officer, Safety Officer, Liaison Officer, and other positions as required, who report directly to the Incident Commander. They may have an assistant or assistants, as needed.

ACRONYM / TERM	DEFINITION
Coronary Observation Radio (COR)	A non-repeated, UHF radio in the 400 range which consists of ten frequencies referred to as Med channels; an open radio which means that all transmissions can be monitored by the public; an ambulance transmits on one frequency while the hospital transmits on another frequency which is "paired" with the EMS Agency frequency; paired frequencies make the transmissions hard to follow by publicly available scanners unless someone is monitoring both frequencies. The FCC restricted the use of these frequencies (Med Channels) back in the 1970s. "Back in the day" the COR was used to transmit EKG telemetry. The PEMS and TEMS regions use Med channels 1-8. The same Med channel may be used by more than one agency or hospital if the facilities are located far enough apart to prevent interference with their respective transmissions. UHF does not carry the signal as far as the HEAR does.
Critical Care Transport	An ambulance transport of a patient from a scene or a clinical setting whose condition warrants care commensurate with the scope of practice of a physician or registered nurse (e.g., capable of providing advanced hemodynamic support and monitoring, use of ventilators, infusion pumps, advanced skills, therapies, and techniques).
CSALTT	The critical components of a resource request: Capability of the resources, Size of the resource, Amount of the resource required, Location where the resource is needed; the Type of resource required, and the Time the resource is needed.
DHS	U.S. Department of Homeland Security
Division	The partition of an incident into geographical areas of operation. Divisions are established when the number of resources exceeds the manageable span of control of the Operations Chief. A division is located within the ICS organization between the branch and resources in the Operations Section.
Disaster Medical Support Unit (DMSU)	A proactive asset in the rapid delivery of medical logistics and support services at incidents.
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Assistance Team
DNA	Deoxyribonucleic Acid
DPMU	Disaster Portable Morgue Unit
ECC	Emergency Communications Center
EMS	Emergency Medical Services
Engine Company	A Fire apparatus consisting of a minimum of three (3) firefighters one of which is assumed to be qualified as a company level officer. Additional manpower is encouraged. In an MCI, the Engine Company can expect to be used both as manpower and to perform patient care to their level of training. There should be

ACRONYM / TERM	DEFINITION
	an expectation that they will be broken up into Individual Resources at the discretion of Command.
EOC	Emergency Operations Center
ESF	Emergency Support Function
ESS	Emergency Service Sector
ETA	Estimated Time of Arrival
EVHC	Eastern Virginia Healthcare Coalition
FAA	Federal Aviation Administration
FCC	Federal Communications Commission
FEMA	Federal Emergency Management Agency
Function	Function refers to the five major activities in ICS: Command, Operations, Planning, Logistics, and Finance/Administration. The term function is also used when describing the activity involved. (e.g., the planning function.) A sixth function, Intelligence, may be established, if required, to meet incident management needs.
General Staff	A group of incident management personnel organized according to function and who report to the Incident Commander. The General Staff normally consists of the Operations Section Chief, Planning Section Chief, Logistics Section Chief, and Finance/Administration Section Chief.
GPS	Global Positioning System
Group	Established to divide the incident management structure into functional areas of operation. Groups are composed of resources assembled to perform a special function not necessarily within a single geographic division. Groups, when activated, are located between branches and resources in the Operations Section. (See Division.)
HazMat	Hazardous Materials
HEAR	Hospital Emergency Administrator Radio: a VHF, non-repeated (line-of-sight), open channel radio system where everyone is on the same frequency.
Helispot	A temporary location where helicopters can land, load and off load personnel and mission equipment. May also be referred to as Landing Zone (LZ).
HEMS	Helicopter Emergency Medical Services
Hot Zone	The area that immediately surrounds a hazardous materials incident; normally extending in a 360-degree radius around the incident scene and far enough to prevent adverse effects from hazardous materials releases to personnel outside

ACRONYM / TERM	DEFINITION
	the zone. Also referred to as the exclusion zone or restricted zone in other documents.
HRMCIRG	Hampton Roads Mass Casualty Incident Response Guide
HRMMST	Hampton Roads Metropolitan Medical Strike Team
HRMMRS	Hampton Roads Metropolitan Medical Response System
HSEEP	Homeland Security Exercise and Evaluation Program
Incident Action Plan (IAP)	An oral or written plan containing general objective reflecting the overall strategy for managing an incident. It may include the identification of operational resources and assignments. It may also include attachments that provide direction and essential information for management of the incident during one or more operational periods.
Incident Command System (ICS)	A standardized on-scene emergency management construct specifically designed to provide for the adoption of an integrated organizational structure that reflects the complexity and demands of single or multiple incidents, without being hindered by jurisdictional boundaries. ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure designed to aid in the management of resources during incidents. It is used for all kinds of emergencies and is applicable to small as well as large and complex incidents. ICS is used by various jurisdictions and functional agencies, both public and private, to organize field-level incident management operations.
Incident Commander (IC)	The individual responsible for all incident activities including the development of strategies, tactics, ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site.
IC/UC	Incident Commander/Unified Commander
IMT	Incident Management Team
IP	Improvement Plan
ISO	Incident Safety Officer
IST	Incident Support Team
IV	Intravenous
JIC	Joint Information Center
Liaison Officer	A member of the Command Staff responsible for coordinating with representatives from cooperating and assisting agencies.
Logistics	Providing resources and other services to support incident management.

ACRONYM / TERM	DEFINITION
Logistics Section	The section responsible for providing facilities, services, and material support for the incident.
LZ	Landing Zone
MAA	Mutual Aid Agreement
Mass Casualty Incident	A mass casualty incident (MCI) describes an incident in which emergency medical services resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties.
Mass Fatality Incident	Mass fatality incident (MFI) is a situation where more fatal accidents take place than can be managed by local resources.
MCITU	Mass Casualty Incident Transportation Unit; a converted bus capable of transporting Yellow and Green tagged patients. MCITU Capacity: 18 litter patients, 10 or more seated patients and 2 attendants.
MHz	Megahertz
MIRT	Marine Incident Response Team
Multiple Casualty Incident	An incident involving multiple victims that can be managed, with heightened response (including mutual aid, if necessary), by a single EMS agency or system. Multi-casualty incidents typically do not overwhelm the hospital capabilities of a jurisdiction and/or region but may exceed the capabilities of one or more hospitals within a locality. There is usually a short, intense peak demand for health and medical services, unlike the sustained demand for these services typical of mass casualty incidents.
NDMS	National Disaster Management System
NEMSPA	National Emergency Medical Services Pilots Association
NFA	National Fire Academy, Emmitsburg, Maryland
NFPA	National Fire Protection Association serves as the world's leading advocate of fire prevention and is an authoritative source on public safety.
NIMS	National Incident Management System
NRF	National Response Framework
NVRT	National Veterinary Response Team
OEMS	The Virginia Office of Emergency Medical Services
OCME	The Office of the Chief Medical Examiner; responsible for determining the cause and manner of deaths that occur under certain circumstances in Virginia.
OPEO	Office of Preparedness and Operations

ACRONYM / TERM	DEFINITION
Operations Section	The section responsible for all tactical incident operations. In the Incident Command System this section will normally include subordinate branches, divisions, and/or groups.
OSHA	Occupational Safety and Health
Passport Icon System	The predominant accountability system used in the Hampton Roads region.
PELA	Pre-designated Emergency Landing Area
PEMS	Peninsulas Emergency Medical Services Council - Serves and assists local emergency medical services components (the emergency medical services agencies, hospitals and sixteen jurisdictions of the Virginia Peninsula, Middle Peninsula and Northern Neck.)
Personal Protective Equipment (PPE)	Equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses. May include items such as gloves, safety glasses and shoes, earplugs, hard hats, respirators, or coveralls, vests, full body suits.
Personnel Accountability	The ability to account for the location and welfare of incident personnel. It is accomplished when supervisors ensure ICS principles and processes are functional with personnel working within established incident management guidelines.
PETS Act	Pet Evacuation and Transportation Standards Act
PL	Private Line
Plain English	Clear, concise organized, and appropriate language for the intended audience. Presents information in a way that helps others to understand the message the first time they read or hear it.
Planning Section	Responsible for the collection, evaluation, and dissemination of operational information related to the incident, and for the preparation and documentation of the IAP. This section also maintains information on the current and forecasted situation and on the status of resources assigned to the incident.
RF	Radio Frequency
RHCC	Regional Healthcare Coordinating Center; the RHCC is located at Riverside Regional Medical Center.
Safety Officer	A member of the Command Staff responsible for monitoring and assessing safety hazards or unsafe situations and who develops measures for ensuring personnel safety.
SALT Triage	SALT Triage is the product of a CDC-sponsored working group to propose a standardized triage method. The guideline, entitled SALT (Sort, Assess, Life-saving interventions, Treatment and/or Transport) triage.
SAU	Situational Awareness Unit

ACRONYM / TERM	DEFINITION
Section	The organizational level having responsibility for a major functional area of incident management, (e.g., Operations, Planning, Logistics, Finance/Administration, & Intelligence, if established). The section is organizationally situated between the branch & IC.
SNS	Strategic National Stockpile
Span of Control	The number of individuals a supervisor is responsible for, usually expressed as the ratio of supervisors to individuals. (Under the NIMS, an appropriate span of control is between 1:3 and 1:7.)
Staging Area	Location established where resources can be placed while awaiting a tactical assignment. The Operations Section manages Staging Areas.
Strike Team	A set number of resources of the same kind and type that have an established minimum number of personnel.
Task Force	Any combination of resources assembled to support a specific mission or operational need. All resource elements within a Task Force must have common communications and a designated leader.
TEMS	Tidewater Emergency Medical Services Council – Serves the cities of Chesapeake, Franklin, Norfolk, Portsmouth, Suffolk, and Virginia Beach and the counties of Accomack, Isle of Wight, Northampton, and Southampton.
TCL	Target Capabilities List
Transport Unit	An ambulance capable of transporting patients from the scene. Minimum staffing will be at least two Virginia EMT-B's one of which is released as an Attendant-In-Charge.
Trauma Center	A specialized hospital facility distinguished by the immediate availability of specialized surgeons, physician specialists, anesthesiologists, nurses, and resuscitation and life support equipment on a 24-hour basis to care for severely injured patients or those at risk for severe injury. In Virginia, trauma centers are designated by the Virginia Department of Health as Level I, II or III.
TRTRT	Tidewater Regional Technical Rescue Team
Unit Command (UC)	An application of ICS used when there is more than one agency with incident jurisdiction or when incidents cross political jurisdictions. Agencies work together through the designated members of the UC, often the senior person from agencies and/or disciplines participating in the UC, to establish a common set of objectives and strategies and a single IAP.
UC	Unified Commander
Unit	(Unit Leader) The organizational element having functional responsibility for a specific incident planning, logistics, or finance/administration activity.

ACRONYM / TERM	DEFINITION
US&R	National Urban Search and Rescue Response System
USAR	Urban Search and Rescue
USCG	United States Coast Guard
USDA	United States Department of Agriculture
USFA	United States Fire Administration
UTL	Universal Task List
VBEMS	Virginia Beach Emergency Medical Services
VDEM	Virginia Department of Emergency Management
VDFP	Virginia Department of Fire Programs
VDH	Virginia Department of Health
VDOT	Virginia Department of Transportation
VEOC	Virginia Emergency Operations Center, Richmond, Virginia
VHASS	The Virginia Healthcare Alerting & Status System. A real-time, internet-based emergency management information system, designed to deliver real-time emergency information to hospitals and other healthcare organizations, or exchange information between multiple hospitals, other healthcare organizations and EMS personnel in the field.
VHF	Very high frequency
VMI	Vendor-Managed Inventory
VSP	Virginia State Police
Warm Zone	Area where personnel and equipment decontamination and hot zone support takes place; includes control points for access corridor. Also referred to as the decontamination, contamination reduction, or limited access zone.