Attachment 5

Rappahannock EMS Mass Casualty Incident Plan

(Number of pages including this cover sheet – 33)

RAPPAHANNOCK EMS COUNCIL

Mass Casualty Incident Plan

EMS Mutual Aid Response Plan
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1. PREFACE

The goal of the Rappahannock Emergency Medical Services Council (REMS) Mass Casualty Incident Plan is to prepare on a regional basis for a unified, coordinated and immediate emergency medical services (EMS) mutual aid response by pre-hospital and hospital agencies to, and the effective emergency medical management of, the victims of any type of Mass Casualty Incident (MCI). It includes patients who are involved in any emergency evacuation of any health care facility in the REMS Council region and/or any such facility outside the region. This document should be the primary reference and Standard Operating Guidance for training and response to Regional MCI's.

This Response Guide, as most recently amended, will serve as the basis for in hospital and out-of-hospital response under the Rappahannock EMS Council MCI Plan (hereafter referred to as the MCI Plan) in the 3,071 square mile REMS Council region, Planning Districts 9 and 16, and Colonial Beach.

This document addresses the field criteria that must be employed when the number of patients exceeds immediately available resources.

Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital EMS agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district and related jurisdictions which comprise the REMS Council region as provided in the Code of Virginia, Section 32.1-113.

2. BASIC DEFINITIONS

2.1 For purposes of the MCI Plan and this Operational Guide, the following definitions will apply:

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

2.1.2 HEALTH CARE FACILITY EVACUATION (Evacuation) – An event resulting in the need to evacuate any number of patients from a health

care facility on a temporary basis when the movement of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.

2.1.3 HEALTHCARE FACILITY – Any hospital, clinic, infirmary or other healthcare provider that offers emergency services or acute cares services.

2.1.4 M.C.I. MEDICAL CONTROL – That medical facility, designated by the hospital community, which provides remote overall medical direction of the MCI or Evacuation scene according to predetermined guidelines for the distribution of patients throughout the healthcare community. Generally the initial receiving hospital will contact the designated hospital medical control or Regional Hospital Coordination Center (RHCC) to determine hospital availability and distribution of patients.

2.1.5 PRE-HOSPITAL E.M.S. AGENCY – Any volunteer, career, private or governmental Emergency Medical Services agency or service that is certified by the Commonwealth of Virginia to render pre-hospital emergency care and provide emergency transportation for such and/or injured people as described in the Code of Virginia, Section 32.1-148.

2.1.6 E.M.S. PROVIDER – Any person "responsible for the direct provision of EMS in a given medical emergency" as described in the Code of Virginia, Section 32.1-148.

2.1.7 NATIONAL INCIDENT MANAGEMENT SYSTEM (NIMS) – A management system, adopted and utilized by all participating emergency response agencies, that helps control, direct and coordinate emergency personnel, equipment and other resources, from the scene of an MCI or Evacuation, to the transportation of patients to definitive care, to the conclusion of the incident. Incident Command Worksheet (Appendix A)

2.1.8 VIRGINIA S.T.A.R.T. TRIAGE – The Virginia Simple Triage and Rapid Treatment method whereby patients in an MCI are assessed and evaluated on the basis of the severity of injuries and assigned the following emergency treatment priorities. (START Triage Flow Chart – Appendix B)

2.1.9 NORTHERN VIRGINIA REGIONAL HOSPITAL COORDINATING CENTER (RHCC) – Designated by the Virginia Department of Health to serve EMS and the Northern Virginia Hospital Alliance region and member hospitals, to include those in the Rappahannock EMS Council region, through timely distribution of patients to the most appropriate hospital resources in response to incidents of significance.

3. AUTHORITY

3.1 The REMS Council is one of the regional EMS councils established within the Code of Virginia, Section 32.1-113. Created in 1976 REMS Council is charged by law, "with the development and implementation of an efficient and effective regional emergency medical services delivery system" to include the regional coordination of emergency medical disaster planning and response.

3.2 The Board of Directors of REMS Council has assigned to its Disaster Committee, the responsibility of effectively fulfilling those planning and response functions and with the overall maintenance and oversight of the REMS MCI Plan.

4. SCOPE OF THE MCI PLAN

4.1. The Rappahannock EMS Council is defined by a service area made up of Virginia Planning Districts 9 and 16. The regional MCI Plan involves the counties of: Caroline, Culpeper, Fauquier, King George, Orange, Rappahannock, Spotsylvania, Stafford, the Town of Colonial Beach and the City of Fredericksburg. These localities make up Planning District 9 and Planning District 16 with a total estimated population of 483,000. Our EMS population consists of 57 designated emergency response agencies, over 2,200 providers and is made up of volunteer, career and commercial organizations.

4.2. The MCI Plan addresses only the EMS mutual aid response of the regional emergency medical services (EMS) system, hospital and pre-hospital, to a Mass Casualty Incident or Health Care Facility Evacuation.

4.3. Mass Casualty Incidents with limited fatalities and those that involve mass fatality incidents within the REMS region will be handled in cooperation with, and under the direction of, the Virginia Office of the Chief Medical Examiner, local law enforcement officials and/or Virginia State Police and the Virginia Department of Emergency Management.

5. PURPOSE OF MCI RESPONSE PLAN

5.1 The purposes of the MCI Plan's Mutual Aid Response Plan are to:

5.1.1 Provide a standardized action plan that will assist in the coordination and/or management of any regional EMS mutual aid response to an MCI within the REMS Council region.

5.1.2 Ensure an effective utilization of the various human and material resources from various localities involved in a regional mutual aid EMS response to a disaster or MCI that affects a part or all of the REMS Council region.

5.1.3 Assist in the evacuation and care of a significant number of patients from any health care facility when the care and transportation of those patients exceeds the EMS capabilities of the facility, locality, jurisdiction and/or region.

5.1.4 Ensure the largest number of survivors in mass casualty situations or health care facility evacuations.

5.2 It is recommended that a copy of this document be kept in each licensed EMS response vehicle in the REMS Council region, in each hospital Emergency Department, and in each licensed EMS agency in the region. Additionally, it is recommended that a copy of this document be kept by the various state agencies that may have a role in response to a mass casualty incident. These agencies

include, but are not limited to, the Virginia State Police, the Virginia Department of Emergency Management, and the Virginia Department of Health.

5.3 This document will be reviewed each year by the Disaster Committee. Proposed revisions, amendments and other changes will be referred to the full Committee for its action. The REMS Council will provide updated copies.

6. GENERAL PROVISIONS

6.1 The REMS Council MCI Plan calls for the following general provisions:

6.1.1 Provide a standardized action plan that will assist in the coordination and/or management of any regional EMS mutual aid response to an MCI within the REMS council region.

6.1.2 Predetermined guidelines and the proximity and capabilities of appropriate health care facilities will be the primary considerations of MCI Medical Control when designating the health care facilities to which patients are sent during any local or regional emergency situation that results in the activation of the MCI Plan.

6.1.3 Localities and/or individual pre-hospital EMS agencies will respond with appropriate personnel and equipment as available when the MCI Plan is activated. However, the response will be dispatched by the local Emergency Communications Center and will not reduce any locality's own EMS response capabilities below established, predetermined levels.

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

6.1.5 Trigger points for activating the Regional MCI Plan will vary depending on the involved jurisdiction's available resources, type of incident, time of day, and concurrent responses.

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

6.1.7 Using the NIMS planning concepts, personnel and EMS agencies should work under a predetermined Incident Command System.

6.1.8 Hospital and pre-hospital components in the region will participate when possible in annual training exercises of the MCI Plan. These exercises in various localities in the region will be coordinated in cooperation with the locality by REMS Council through the REMS Disaster Committee.

7. LEVELS AND CATEGORIES

7.1 MCIs within the REMS Council region will be classified by levels, following assessment by EMS providers using the Virginia START or JUMP START for pediatrics triage system:

7.1.1 **Level 1** Multiple-casualty situations resulting in less than 10 immediate/ red surviving victims.

7.1.2 **Level 2** Multiple-casualty situations resulting in 10 to 25 immediate/ red surviving victims.

7.1.3 **Level 3** Mass casually situations resulting in more than 25 immediate/ red surviving victims.

8. RISK ASSESSMENT

8.1 MCIs can occur in varying degrees, at any time, and in practically any conceivable situation. The REMS Council regional population stands at some 483,000 people. These residents live in Planning District 9 and Planning District 16. High risks include:

8.1.1 Heavily traveled highways and interstates between populated areas.

8.1.2 Freight and passenger rail lines, navigable rivers, and recreational lakes.

8.1.3 Nuclear power plant and light industrial plants.

8.1.4. Military installations.

8.1.5 Severe and unusual weather conditions also prevail throughout the region, including tornados, windstorms, hurricanes and heavy rains, heavy snows usually to the west, sleet and freezing rains and flooding in the Rappahannock, Rapidan and Potomac rivers.

8.2 Based on these numerous components, potential MCIs in the REMS Council region could include:

8.2.1 Major vehicular accidents with multiple victims.

8.2.2 Urban, residential and woodland fires.

8.2.3 Tornados or other severe weather-related events.

8.2.4 Public transportation mishaps (aircraft, train, bus).

8.2.5 Construction and/or industrial and farm accidents including hazardous materials, building collapses with multiple victims.

8.2.6 River and/or localized flooding, impassable highways, roads and bridges.

8.2.7 Healthcare facility evacuations.

8.2.8 Acts of terrorism and/or civil disobedience.

8.2.9 Military-related incidents and federal disaster responses

8.2.10 Large-scale planned events

9. MANAGEMENT GOALS

9.1 NIMS Management Components should be considered as follows:

9.1.1 Preparedness.

9.1.2 Communication and Information Management.

9.1.3 Resource Management.

9.1.4 Command and Management.

9.1.5 Ongoing Management and Maintenance.

10. INCIDENT PRIORITIES

10.1 Priorities of an MCI (or other complex emergency situation):

10.1.1 Life safety.

10.1.2 Incident stabilization.

10.1.3 Conservation of property and equipment.

10.1.4 Provide safety, accountability and welfare.

10.1.5 Mobilize and track resources on scene and those enroute

11. PARTICIPANTS

11.1 The regional EMS mutual aid response to an MCI or Evacuation may involve, as required by the scope of the incident:

11.1.1 Certified and/or licensed EMS providers at all levels of emergent patient care, from pre-hospital Basic Life Support (BLS) and Advanced Life Support (ALS) to acute medical and surgical treatment nurses and physicians in the hospital in the region, and related healthcare providers, especially those with facilities to care for critically injured or sick patients.

11.1.2 Healthcare facilities, in particular those with acute-care or emergency facilities to care for critically injured or sick patients.

11.1.3 Mass Casualty Support Units (Appendix E)

11.1.4 Local, state and federal government agencies include, but not limited to: the Virginia Department of Emergency Management; the Virginia Department of Health (VDH) including the Office of Emergency Medical Services (OEMS), Virginia Department of Emergency Management (VDEM), the Northern Virginia Hospital Alliance NVHA / RHCC; the Rappahannock Area and Rappahannock-Rapidan Health Districts, the VDH's Office of the Chief Medical Examiner; the Virginia Department of State Police; the Virginia Department of Transportation; the Virginia Department of Military Affairs; the U.S. Armed Forces (including the U.S.

Coast Guard); the Federal Emergency Management Agency (FEMA); and Local Emergency Planning Committees from jurisdictions within the REMS Council region.

11.1.5 Non-transport and related support components such as the Regional VOAD, American Red Cross, Salvation Army, regular and reserve components of the armed forces, Civil Air Patrol, amateur radio organizations, and any other group that supports EMS operations.

11.2 The key to successful EMS mutual aid response to a major disaster or MCI is the close cooperation and coordination of these components and the REMS Council community through effective communications, planning and training.

12. LOCAL EMERGENCY PLANS

12.1 It is recognized that each county and locality has an emergency operations plan. Regional EMS mutual aid response should conform to the National Incident Management System (NIMS) and whenever possible local emergency guidelines in which the incident occurs.

12.2 Defined procedures for ordering additional resources and replenishing medical supplies during an MCI event shall be covered in each locality's Emergency Operations Plan and through the Statewide Mutual Aid System.

12.3 Regional EMS response planning will be transparent to, and support the health and medical annexes of, jurisdiction emergency operations plans. Planning guidance in this document will be made available to local Emergency Management Coordinators to assist them in the preparation and maintenance of their plans. The REMS Council MCI Plan will be employed in circumstances such as when:

12.3.1 The disaster or MCI is of such magnitude that the locality should institute mutual aid to avoid exhausting its EMS resources.

12.3.2 The disaster or MCI crosses local boundaries to other jurisdictions may need to institute mutual aid to avoid exhausting their EMS resources.

12.3.3 A hospital or other health care facility must evacuate patients on a temporary basis and transportation requirements exceed the EMS capabilities of the facility, locality, and/or region.

12.4 The local Emergency Management Coordinator should be made aware as early as possible that the MCI Plan has been activated, or that there is a need for mutual aid.

13. INITIAL RESPONSE TO AN INCIDENT

13.1 This MCI Plan will use the 5-S approach to an MCI as taught in the Virginia Mass Casualty Incident Management Training Program:

13.1.1 Scene Safety Assessment – Determine providers are safe before entering the scene, while on-scene and enroute from scene. Scene safety assessment is ongoing.

13.1.2 Survey the Scene – Determine type of incident, estimate the number of patients and severity of injuries, and determine best access.

13.1.3 Send information and requests for assistance – Contact dispatch with survey information, request resources, activate the MCI Plan.

13.1.4 Establish scene management structure utilizing NIMS to include extrication, triage, treatment, and transportation.

13.1.5 Begin Simple Triage And Rapid Treatment of incident victims.

13.1.5.1 START - Locate and remove all of the walking wounded into one location away from the incident, if possible. Begin assessing all non-ambulatory victims where they lay, if possible. Each victim should be triaged in 60 seconds or less. Assess respirations, perfusion, and mental status.

13.1.5.2 Initial Triage - (Using the START Method) - Utilize the Triage Ribbons (color coded plastic strips). One should be tied to an upper extremity in a VISIBLE location (wrist if possible). RED – Immediate, YELLOW – Delayed, GREEN – Ambulatory (minor), BLACK – Deceased (non-salvageable.

13.1.5.3 Secondary Triage - Will be performed on all victims during the Treatment Phase. If a victim is identified in the initial triage phase as a RED and transport is available, do not delay transport to perform a secondary assessment. The triage priority determined in the Treatment Phase should be the priority use for transport.

14. ACTIVATING THE MCI PLAN

14.1 The following individuals can active the MCI Plan for EMS mutual aid:

14.1.1 The Incident Commander at the scene of a MCI according to the existing local protocol, usually via the local ECC.

14.1.2 The local Emergency Management Coordinator, or that person's representative, of a political subdivision that has authority for the management of the incident.

14.1.3 The Hospital Incident Commander, or appropriate representative of a health care facility that is required to evacuate or move patients.

14.1.4 Any health care facility in the REMS Council region when additional resources are necessary to provide appropriate patient care.

14.2 This Plan will be activated through the local Emergency Communications Center, which will communicate directly with MCI Medical Control and with localities whose pre-hospital resources may be used within the REMS Council region.

14.3 To activate the MCI Medical Control component of this Plan, utilize the HEAR radio frequency, call land telephone line or cellular phone of hospital, or Regional Hospital Coordinating Center (RHCC).

14.3.1 The person authorized to request activation should identify herself/himself and request activation of this plan (Rappahannock EMS Council Mass Casualty Plan).

14.3.2 The person should give a brief summary of the incident. The information should include time of the incident, type of incident, location, initial number of patients involved, and a callback phone number.

14.4 Depending on local protocol and the scope of the incident, the local Emergency Communications Center will activate the Pre-hospital Component of the MCI Plan through established mutual aid agreements among pre-hospital volunteer and career EMS agencies.

14.4.1 The Emergency Communications Center dispatcher will emphasize that the mutual aid request for ambulances and/or equipment is under the activated REMS Council MCI Plan.

15. RESPONSIBILITES – HOSPITAL

15.1 MCI Medical Control – In the early stages of the incident a coordinating Emergency Department must be established. The Incident Commander (IC) or designee will contact the closest hospital to advise them of the emergency. It is anticipated that the nearest facility will receive many patients who leave the scene on their own, so early notification is essential. The closest hospital should be advised of the situation, number of patients and types of injuries involved. It will be the coordinating ED's decision, based upon capabilities at that time, to accept or decline the role of coordinating ED.

15.1.1 The indicated hospital will designate another acute care medical facility to act as primary MCI Medical Control for any appropriate reason including better communications, better or closer geographical location to the MCI site, or because of any other circumstances that would be in the best interest of effective patient care.

15.1.2 The indicated hospital will notify the designated hospital, by med com or telecommunication, that it is relinquishing the MCI Medical Control function, and will receive an appropriate sign of acceptance of the MCI Medical Control responsibility from the designated hospital.

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

15.4 Hospitals that are activated or alerted under the MCI Plan will provide upon request from MCI Medical Control confirmation or adjusted information on the predetermined numbers of patients they can accommodate in the three START

Triage categories: Red, Yellow and Green (Hospital Triage Level), or confirm or adjust the predetermined numbers and categories of patients they can receive from another hospital through Mutual Aid in the event of an Evacuation/Mutual Aid Capability.

15.5 MCI Medical Control will notify Incident Command to assign patients to the medical facilities closest to the site of an MCI or evacuation and which can provide the appropriate levels of emergency care. The local coordinating hospital or MCI Medical Control may contact the RHCC for assistance in determining most accurate hospital status and bed availability found in the Virginia Hospital Alerting and Status System.

15.6 MCI Medical Control also will be responsible for any on-line medical control during patient transport to designated receiving hospitals. On-line medical direction likely will be affected by limited access to the HEAR radio system during an MCI.

15.7 In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with patient care protocols as established by the Medical Directors of Planning Districts 9 and 16.

15.8 Hospitals will be responsible for providing definitive patient care to the levels of their capabilities during and after the incident.

16. RESPONSIBILITIES – PRE-HOSPITAL

16.1 Transportation of patients under this Plan during an incident or evacuation will be done by licensed pre-hospital EMS agencies in the REMS Council region and from neighboring regions when necessary and available.

16.2 Units and personnel involved in mutual aid response to a regional MCI or an evacuation will be dispatched through the local emergency communications and/or dispatching center.

16.3 Individual providers will report to their respective agencies and will not self-dispatch to the scene of the incident. Providers who so respond in privately owned vehicles (POVs) will be directed to report to their respective agencies or at the discretion of the Incident Commander and if they have appropriate EMS identification and appropriate personal protective equipment, may be directed to the incident Staging Area. No one will be allowed direct access to the MCI site.

16.4 All out-of-hospital providers and/or agencies responding to an MCI site in the REMS Council region agree to operate under the Virginia Mass Casualty Incident Management System, the Virginia START® Triage System and the Pre-hospital Patient Care Protocols of the region.

16.5 Localities affected by an MCI will be responsible for activating mutual aid through their own Emergency Communications Systems. Use of the available resources of the Virginia Office of EMS, Virginia Department of Emergency Management, the Virginia Association of Volunteer Rescue Squads, or the REMS Council is encouraged.

16.6 Pre-hospital EMS agencies and/or localities agree to respond with personnel and equipment when the MCI Plan is activated, but should not be expected to reduce local emergency response capabilities below acceptable levels. When considering their responses to requests for assistance under the MCI Plan, localities and/or individual pre-hospital EMS agencies will be expected to maintain their emergency response capabilities to meet local needs.

16.7 The crews of pre-hospital EMS units responding to an MCI or Evacuation will be required to carry self-identification and proof of affiliation with their agency.

16.8 The crews of pre-hospital EMS units responding to an MCI or Evacuation will be responsible for maintaining all operational documentation, and for making that documentation available to appropriate authorities.

16.9 Pre-hospital agencies in the REMS Council region will participate when possible in annual training exercises of the MCI Plan held in various locations within the council region.

16.10 Pre-hospital agencies will encourage their providers to participate in on-going regional training for rescue and EMS personnel in the National Incident Management System, Virginia START Triage System, hazardous materials awareness programs and other related MCI skills.

17. SPECIAL CONSIDERATIONS FOR HEALTH CARE FACILITY EVACUATIONS

17.1 When a health care facility must evacuate any number of patients on a temporary basis, the following shall apply:

17.1.1 The administrative staff of the evacuating health care facility will be responsible for directing the evacuation and transfer of patients to the designated receiving hospital or health care facility in coordination with MCI Medical Control.

17.1.2 Physicians whose patients have been evacuated will receive Courtesy Medical privileges from the receiving hospital for the duration of the emergency. These privileges will be stipulated in predetermined and pre-negotiated protocols and/or agreements which may be added to this document as an appendix.

17.1.3 Each evacuated patient will be accompanied by his/her medical records.

17.1.4 Receiving health care facility will use routine admitting procedures for patients from the evacuated hospital including, if possible, consent for treatment.

18. FATALITIES AND MASS FATALITIES INCIDENTS

18.1 By Virginia State Statute, the VDH's Office of the Chief Medical Examiner is responsible for the medical investigation of sudden, unexpected, and violent deaths throughout the Commonwealth. Persons who die under those circumstances require the expeditious and skilled attention of the Medical Examiner. Depending on the nature of the incident local, state, and Federal Emergency Management Agency, law enforcement officials, and others may be

involved in activities such as morgue operations, suspicious death investigations, and so forth.

18.2 Incident Command is responsible to notify, as early as possible, the Office of the Chief Medical examiner will be notified as early as possible in any suspected mass casualty incident which involves, or which may involve, fatalities. Suspected or actual exposures to communicable diseases or bio-terrorism agents will be reported to the appropriate health district as soon as practical.

18.3 The Office of the Chief Medical Examiner can be reached by calling 804-786-3174.

18.4 The dead must be treated with respect and dignity in thought and in actions at all times.

18.5 Delineate temporary morgue, moving bodies/parts when released by the medical examiner. Under the direction of the Office of the Chief Medical Examiner or designee the State Funeral Directors MCI Plan may be activated.

18.6 Preliminary setup for dealing with families, news media and by-standers. Information released through Medical Examiner only.

18.7 Transportation to hospital morgue for thorough exam and delineation of cause of death will be by the funeral home or other accepted means.

18.8 MCI also may be a Mass Fatalities Incident.

18.8.1 A Mass Fatalities Incident is any situation where there are more bodies than can be handled using local resources.

18.8.2 In a disaster situation, identification of the dead is a critical issue. Therefore, security of the area in which the dead are located is critical. Close cooperation with the Office of the Chief Medical Examiner and police authorities, both in MCI preplanning and during the incident, is essential.

18.8.3 During a mass fatalities incident, extreme stress and grief are natural and expected reactions by emergency responders and EMS providers, as well as survivors.

19. MEDICAL DIRECTION, PROTOCOLS AND TRIAGE

19.1. In the absence of on-line or on-scene medical direction, out-of-hospital adult and pediatric patient care will be rendered in accordance with REMS Pre-hospital Patient Care Protocols, as most recently revised. Unless otherwise designated, medical documentation will be done through the use of the Virginia Triage Tag.

19.2. Field triage of patients will conform to the guidelines described in the Commonwealth of Virginia Emergency Operations Plan which involves the Virginia START Triage System as outlined in this MCI Plan Mutual Aid Response Guide. General categories are: Red -- Immediate care required; Yellow – Care can be delayed; Green -- Minor injuries; Black -- Dead or non-salvageable.

19.3. The numbers and types of patients which member hospitals will be prepared to receive are suggested in predetermined Hospital Triage Levels and Mutual Aid Capability tables as provided by those facilities.

20. UNIVERSAL PRECAUTIONS

20.1 All EMS personnel involved in a regional response to an MCI or Evacuation will be expected to observe Universal Precautions and other infection control Body Substance Isolation practices as specified by their agency. Suspected or actual exposures to communicable diseases or bio-terror agents will be reported to the appropriate health district as soon as practical. Some communicable diseases are required (under Sections 32.1-36 and 32.1-37 of the *Code of Virginia* and 12 VAC 5-90-80 and 12 VAC 5-90-90 of the Board of Health *Regulations for Disease Reporting and Control) to be reported within 24 hours to public health*. In addition, the infectious control officers for the involved public safety agencies and the appropriate hospital and public health infection control personnel should be notified.

21. EMERGENCY COMMUNICATIONS

21.1 Radio communication, as provided by the REMS Council region's enhanced two-channel HEAR system, will remain the primary method of hospital-to-hospital and hospital-to-field communications during a MCI. The Med Com system provides a dedicated channel for hospital-to-hospital communications.

21.2 Other communications tools that can be used during an MCI include the EMS Statewide Mutual Aid Frequency (155.205), and cellular telephones. During an MCI, routine communication procedures are suspended. TRANSPORTATION or MEDICAL Branch will provide information directly to the coordinating ED. The coordinating ED may contact the RHCC for assistance in determining hospital availability as needed.

21.2.1 The EMS Statewide Mutual Aid Frequency (155.205) should be monitored to provide updated information and to receive information that will assist in staging ambulances, other EMS vehicles or human an/or material resources in line with the Incident Management System.

21.2.2 The HEAR radio frequency 155.340 or established Med Com is the primary channel for communications between the MCI Medical Control hospital and the EMS Transportation Branch at the incident.

21.2.3 The HEAR radio frequency 155.280 or the established Med Com is the primary channel for communications between the MCI Medical Control hospital and other health care facilities involved in the incident.

21.3 Unless there is an extreme emergency, pre-hospital ambulance crews should not use the HEAR frequency or EMS Statewide Mutual Aid frequency for communicating when responding to an incident, or when transporting a patient to a designated hospital from the MCI site.

21.4 If it is absolutely necessary for an ambulance crew to communicate with a hospital or other emergency services agency from the MCI scene, the UHF MED channels should be used in accordance with established radio protocols.

21.5 Per NIMS, “plain talk” will be used for communications during an MCI or evacuation.

21.6 In the case of cellular phones, no cells dedicated to EMS are available at this time. Therefore, because the cellular system is likely to be very busy during an MCI, once an open cell line has been established by the Incident Commander or other key element of the National Incident Management System (i.e., Transportation Director or Command Post/Communications Center), it should be kept open for the duration of the MCI. Ham operations should be considered.

22. EMERGENCY MEDICAL RESPONSE

22.1 The MCI Plan assumes that localities and/or out-of-hospital agencies will respond to all emergency scenes under local dispatch protocols. Units and crews will continue to operate under local protocols until such time as it has been determined that a regional MCI exists and the MCI Plan has been activated by the MCI Medical Control.

22.2 In the interest of safety, efficiency and accountability, response to the scene of an MCI by individual providers in their privately owned vehicles (POVs) is strongly discouraged. Providers who so respond will be directed to report to their respective agencies or, at the discretion of the Incident Commander and if they have appropriate EMS identification, may be directed to the Incident Staging Area. They will not be allowed direct access to the MCI site. (See Article 16.3).

22.3 The MCI Plan stipulates the use of the Virginia Simple Triage and Rapid Treatment (START) system within a standardized Incident Management System that is used by Virginia Emergency Services and Emergency Medical Services agencies. The MCI Plan also calls for the use of the Virginia Triage/MCI Patient Information Tags during any response.

22.4 A standardized National Incident Management System (NIMS), as developed and taught within the REMS Council region, allows EMS personnel from anywhere in the region to quickly and easily become integrated into local and/or regional response efforts. It also provides effective command and control of EMS resources, and provides for integration with other emergency support functions. Under NIMS, position descriptions and roles are clearly defined and supported through this regional MCI Plan (Appendix A).

23. TECHNICAL RESCUE OPERATION

23.1 A technical rescue includes any operation that requires the use of specialized equipment and knowledge to extricate victims from collapsed area, confined spaces, high angle, and search and rescue operations. Personnel shall comply with National Fire Protection Association 1983, Standard on Fire Service Life Safety Rope and System Components and 29 Code of Federal Regulation 1926.650, Excavations.

23.2 Mass Casualty Incidents involving extended technical rescue operations will use the resources available from the local, state, and/or federal system.

23.3 When the incident overwhelms the abilities and assets of the local jurisdiction and local mutual aid, the locality may request aid from several Virginia jurisdictions that have established technical rescue teams. The Virginia Emergency Operations Center, 1-800-468-8892, is the Search and Rescue Coordination Center for Virginia and can initiate contact with State SAR and Technical Rescue teams for the locality.

23.4 All personnel involved in Mass Casualty technical response operations must have appropriate training and maintain compliance with Occupational Health and Safety Administration (OSHA) standards.

24. HAZARDOUS MATERIALS

24.1 Definition: Substances or materials, which pose unreasonable risks to health, safety, property or the environment when used, transported, stored or disposed of, which may include materials which are: gases, liquids, or solids. They may include toxic substances, flammable and ignitable materials, explosives, corrosives, and radioactive materials. (Title 44-146.34)

24.2 The local fire department should be contacted in the event of an incident involving hazardous materials. The local fire department will contact the Virginia Emergency Operations Center at 1-800-468-8892 to request technical assistance or to have the VDEM Regional Hazardous Materials Officer (RHMO) respond to the incident scene. Based on the request and assessment by the RHMO, the RHMO may activate one or more regional hazardous materials response teams and appropriate personnel as required.

24.3 While all hospitals are encouraged to have basic decontamination capabilities to treat patients exposed to or contaminated by hazardous materials, it is recommended that Mary Washington Hospital serve as primary receiving facility for victims that have field decontamination at the hazardous materials incidents within the REMS region. Mary Washington Hospital has the ability to provide additional decontamination over an extended period.

24.4 Public Safety Community, including EMS providers will follow proper decontamination procedures, to include the removal or deactivation of contaminants from people, equipment, or the environment. It protects responders from hazardous substances that may contaminate and permeate their protective clothing, respiratory equipment, tools, vehicles and other equipment used on the scene. By expeditiously removing the contaminant from the victims, first responders may be able to preclude the occurrence of adverse health effects from the materials.

24.5 Actions of local emergency response organizations are based on local response plans and Virginia's Emergency Operations Plan (COVEOP), including the Oil and Hazardous Materials annex (COVEOP Volume 4), the Terrorism Consequence Management annex (COVEOP Volume 8), as well as local government and hospital emergency operations plans and terrorism management annexes.

24.6 All personnel involved in a Mass Casualty Hazardous Materials incident should meet the appropriate training level in accordance with established guidelines as

set forth by U.S. Department of Transportation (USDOT), Occupational Safety and Health Administration (OSHA), National Fire Protection Association (NFPA), State and Local emergency response procedures.

25. CRITICAL INCIDENT STRESS MANAGEMENT

25.1 Critical Incident Stress Management (CISM) has been determined to be an integral part of any emergency medical response to an MCI or evacuation. CISM may be defined as a comprehensive, integrated, multi-component crisis intervention system. Local, regional, state, and national teams of certified mental health and peer debriefers are available for assistance.

25.1.1 No one working in emergency services is immune to critical incident stress, regardless of past experiences or years of service. Request a briefing from a CISM team if stress symptoms continue beyond the first 48-72 hours of an incident. CISM Team Peer Group can be activated and respond to the scene, as needed.

25.1.2 CISM teams in the REMS Council Region can be activated through their 24-hour communications line at 540-752-5883.

25.1.3 Other CISM assets can be activated through the Virginia EOC at 804-674-2400 or 1-800-468-8892.

25.1.4 Members of the Rappahannock CISM Team are certified and listed as Strike Team Component I to the Virginia State Task Force, ESF-8. This team is available for activations and deployments both within and outside the Commonwealth.

25.1.5 Responders should be mindful of the behavioral health needs of patients. Referrals to appropriate mental health resources may be needed, even for those patients that do not have physical injuries.

26. AIRSPACE RESTRICTIONS

26. 1 The airspace over any MCI is regulated by the Federal Aviation Administration (FAA) under Federal Aviation Regulation 91.137. Questions or requests concerning the use or restriction of that airspace during an incident should be referred as early as possible to the appropriate air traffic control tower. The Virginia EOC at 804-674-2400 or 1-800-468-8892 has contact information to assist in this function if needed.

27. AEROMEDICAL OPERATIONS

27.1 EMS Aeromedical services are available 24 hours a day. This resource will be coordinated through jurisdictions' local emergency communication centers.

27.2 In a large-scale emergency, the Virginia EOC will be contacted to alert the Virginia Army National Guard, Virginia Air National Guard, and the U.S. Coast Guard for possible use of the aviation assets of those organizations.

27.3 Fixed-wing and helicopters can be used to evacuate patients from the scene of an MCI with the exception of a Haz-mat incident. However, other possible uses should be considered. These uses for both types of aircraft include:

27.3.1 Initial disaster scene size-up/access; aerial observation/monitoring of the scene and related conditions; weather information; scene lighting; air-to-air and air-to ground communications; and control of airspace over the incident.

27.4 Specific uses for helicopters include:

27.4.1 Use of the Flight Paramedic for triage or treatment; use of the helicopter to deliver or shuttle special personnel, equipment or supplies; use of the helicopter to deliver or remove resources at the scene; use of the helicopter to overcome natural or other physical barriers.

28. HELICOPTER OPERATIONS

28.1 If needed, a helicopter-landing zone (LZ) should be designated as early as possible by the Incident Commander or the IC's designated EMS Air Ambulance Group Supervisor.

28.1.1 The LZ should be as near as possible to the MCI scene but should not affect patient care areas.

28.1.2 The LZ should be away from power lines, towers, trees, buildings and other potential height hazards. It should be selected with consideration for pedestrian and vehicular traffic control needs. The LZ should be a minimum of 200 feet away from any traffic.

28.1.3 Roads or highways, with proper traffic control, make suitable LZs. However, safety considerations must include any nearby power lines.

28.2 The overall size of an LZ should not be less than 500 feet by 500 feet.

28.2.1 The helicopter touchdown site in daylight should not be less than 75 feet by 75 feet.

28.2.2 The helicopter touchdown site at and after dusk should not be less than 100 feet by 100 feet.

28.2.3 The touchdown site should have a wide and clear path of flight approach and departure. Helicopter pilots prefer to land and take off with the aircraft's nose into the prevailing wind.

28.2.4 The helicopter pilot is the final judge in selecting an appropriate site to land the aircraft, and on deciding whether or not to land.

28.2.5 The LZ should be staffed, marked and prepared before, during and after landings and takeoffs.

28.2.5.1 Minimum staff in daylight should be a person with easy-to-spot clothing, with arms above head and back to the down-

draft. LZ personnel should wear effective eye and ear protection and be familiar with dangers of working around helicopters, especially during a "hot" operation, when the aircraft engines and rotors are operating.

28.2.6 Precise marking of the LZ in bright daylight is not essential as long as the intended area is obvious to the helicopters' flight crew.

28.2.7 The LZ at dusk and in darkness shall not be marked with flares but with lights (lantern, vehicular, etc.). All lighting must be secured against the helicopter's downdraft.

28.2.8 LZ personnel must guard against flashing any lights toward the aircraft. Strobe lights bleed through as white.

28.2.9 The LZ should be inspected for loose debris, foreign objects and loose dirt. The LZ can be wet down to reduce dust and enhance visibility.

28.3 Radio contact from the LZ to the helicopter is extremely important.

28.3.1 In the absence of other directives, the EMS Statewide Mutual Aid frequency (155.205) should be used when communicating with the helicopter. Good communications with the flight crew will ensure the prompt and safe landing of the aircraft.

28.3.2 Before and during final approach, the flight crew should be advised of potential hazards, wind direction, ground conditions and, if available, the patient's general status. LZ personnel should check constantly and repeatedly for pedestrian traffic and other hazards in or near the LZ.

28.3.3 The helicopter flight crew should be advised immediately to abort the landing if any threat develops to the flight crew or to ground personnel.

29. TERRORISM RESPONSE AND PREPAREDNESS

29.1 Responders to acts of terrorism are likely to range from untrained civilians, to local and state law enforcement personnel, to public health and public service employees, to certified EMS providers (fire and rescue), to highly trained hazardous materials (hazmat) and technical rescue personnel.

29.2 Hospital physicians, nurses and other staff will be involved with treating patients who are brought by EMS personnel to those facilities, and patients who will arrive by other means of transportation at those facilities.

29.3 Types of Incidents

29.3.1 Terrorism deals specifically with those weapons of mass destruction that generally are categorized as Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE). The initial response will be according to the local emergency plan, followed by the MCI Plan if a regional response is necessary.

29.3.1.1 It is unlikely that emergency responders will immediately be able to determine if an incident is an accident or an act of terrorism. An explosion, the release of chemical, or biological agents could be an accidental incident or a planned act of terrorism.

29.3.1.2 First Responders must be aware that a mass casualty incident could be a possible act of terrorism. They must be aware of methods of protecting themselves from becoming victims by avoiding exposure to Chemical, Biological, Radiological, Nuclear, and Explosive or secondary explosions or devices.

29.4 Preparation Process

29.4.1 Pre-hospital and hospital agencies shall prepare to respond to acts of terrorism through:

29.4.1.1 Regular consultations and interactions among participating leaders to review and revise appropriate documents, plans and procedures, including the MCI Plan.

29.4.1.2 Regular training programs in terrorism awarness and specific MCI skills.

29.4.1.3 Regular review and assessment of the threat(s).

29.4.1.4 Regular review and assessment of regional resources.

29.4.1.5 Regular exercises and evaluations of local/regional MCI response.

29.4.1.6 Regular review of areas of operational responsibility.

29.5 Responding to an incident

29.5.1 Assess and promptly report any incident.

29.5.2 Protect first responders and bystanders.

29.5.2.1 Responding to an Incident

29.5.2.2 Assess and promptly report any incident.

29.5.2.3 Treat victims as appropriate to their assessed injuries, including all phases of decontamination. *

* It should be recognized that once a victim has been properly decontaminated they should no longer be considered a victim and rather a patient that will be triaged, treated and transported.

29.5.3 Attempt to reduce the threat to hospital emergency departments by appropriate decontamination and subsequent treatment of patients.

29.5.4 When possible, assist in the preservation of evidence by including law enforcement investigation and rehab.

29.5.5 Enhance seamless interagency and regional interactions using pre-established agreements and procedures.

29.6 Program Goals

29.6.1 Maximum threat awareness for likely First Responders and hospital staff to include Chemical, Biological, Radiological, Nuclear, and Explosive.

29.6.2 Maximum utilization of the Virginia MCI Management System

29.6.3 Seamless interaction of the local, state and federal agencies that respond to an incident by establishing – in advance – specific areas of responsibilities.

29.6.4 Maximum utilization of human and material resources while minimizing loss of life and suffering among the victims and First Responders.

29.6.5 Enhance effective interaction, to include communications, between hospitals and out-of-hospital EMS agencies during any act of terrorism, or MCI.

29.6.6 Encourage the acquisition by appropriate agencies of specialized equipment necessary to counter the effects of terrorism, including caches of medications and mass decontamination facilities

29.6.7 Expeditious processing of scene samples by the Virginia Department of Consolidated Laboratory Services to insure accurate identification of substances, proper protection of responders, and ultimate capture and successful prosecution of perpetrators.

29.6.8 Program goal is to use practices designed to insure responder and public safety while containing the incident to the fullest extent possible.

30. MEDIA RELATIONS

30.1 Consistent, timely, and accurate public information is a vital function of emergency services; therefore, each jurisdiction's public information office should be notified of all emergency situations that require notification of their county/city leadership and/or fire chief/emergency manager. The PIO should maintain a current contact list to expedite the information to media.

30.2 When the MCI plan is in effect, PIOs in each jurisdiction will serve as the primary source of contact for release of all information when the incident is in their region. Any news media contacting an ECC shall be referred to the PIO in the jurisdiction. Whenever two or more agencies are involved in an incident, PIOs should use the Joint Information System concept. If the event is large or has

significant media coverage, a Joint Information Center (JIC) should be activated, which will be the physical location where media relations will occur. This enables emergency personnel to resolve emergencies and provide media with one source for consistent, timely, and accurate information.

30.3 Emergency services personnel should direct all media requests to the Joint Information Center (JIC), if activated, or the jurisdictional PIO.

30.4 The Emergency Alert System (EAS) will be utilized at the local or state level as needed to deliver life safety information to the public. EAS consists of broadcast and cable network; AM, FM, and television broadcast stations; low power television stations; and other organized entities operating during emergencies at the national, state, and local events. The Virginia Department of Emergency Management will coordinate the public information efforts of state agencies and local governments using the Joint Information System when the emergency affects a widespread area.

31. USE OF VIRGINIA EMS DISASTER TASK FORCES

31.1 In a declared state or local emergency, local resources can be supplemented by requesting deployment of state EMS Disaster Task Forces through the EMS Desk in the Virginia Emergency Operations Center (1-800-468-8892 or 804-674-2400).

31.2 EMS Task Forces will remain under the command of their Task Force commander and should not be broken up.

31.3 EMS Task Forces will attempt to arrive supplied for 72 hours, not including water, fuel or expendable supplies.

32. DEACTIVATING THE MCI PLAN

32.1 The Incident Commander will be responsible for notifying MCI Medical Control that all patients have been assigned to transport units and that all on-scene patient care activities have been completed and ended at the MCI or Evacuation site or sites.

32.2 The on-scene Incident Commander should confer with the appropriate official (e.g., Incident Manager, Emergency Management Coordinator, healthcare facility CEO) to determine any additional patient care need for EMS prior to contacting the MCI Medical Control.

32.3 If appropriate and possible, on-scene contact to MCI Medical Control should be made by phone. Otherwise, radio communication should be used.

32.4 MCI Medical Control will deactivate the MCI Plan among activated hospitals when the designated MCI Medical Control hospital is notified by the on-scene Incident Commander that EMS activities are completed at the MCI or Evacuation site or sites, and when it is determined that all other patient care issues have been resolved.

33. THE DISASTER COMMITTEE

33.1 The Disaster Committee is a working committee of the REMS Council. It is made up of representatives of the hospital and pre-hospital components (career, volunteer, and private services), Health Districts, Law Enforcement, Emergency Management Coordinators, and Red Cross that render emergency medical care in Planning District 9 and 16.

33.2 Other members of the Committee include, but are not limited to, representatives of related local, state and federal agencies (including law enforcement, emergency management, and emergency communications), disaster relief organizations, representatives of major industries, transportation and utilities companies, along with local businesses and other individuals whom members of the committee may call upon from time to time for advice and expertise.

33.3 Members will be recommended by the committee and appointed by the REMS Council President. Members shall serve in an uncompensated capacity on the Committee.

34. AFTER ACTION REPORTS

34.1 An After Action Report (AAR) will be completed within six months after any incident or training exercise and shared through the Regional Disaster Committee as a tool to improve local and regional plans. The purpose of the AAR is to analyze the incident to determine “lessons learned.” The format of the AAR will be consistent with that used in the Homeland Security Exercise and Evaluation Program’s “Corrective Action Plan System”.

35. REVISIONS AND AMENDMENTS TO THE MCI PLAN

35.1 The REMS Council Disaster Committee is responsible for reviewing each year this MCI Plan for proposing revisions and/or amendments to the Mutual Aid Response Guide as necessary to maintain its effectiveness, and for reviewing and evaluating any activation of the MCI Plan

35.2 The development and execution of an exercise every two years that tests at least one aspect of the Regional MCI Plan will be coordinated through the REMS Council Disaster Committee.

35.3 Revisions and/or amendments will be acted upon by the Committee no sooner than 45 days, and not longer than 60 days, after all signatories have been notified of the proposed changes and have had an opportunity to respond through their representatives or in writing to the Committee Chair.

35.4 Revisions and/or amendments to the Plan will require a majority vote of the members present of the REMS Board of Directors to be enacted.

35.5 All EMS agencies, local governments, EMS physicians, regional medical control center(s) and hospitals within the REMS service delivery area will receive annually an updated copy of the Regional EMS MCI Plan, as well as being posted to the REMS Council website for regional use.

Appendix A

Incident Command

As first engine unit on scene, establish command or delegate.

Announce on radio command post location.

Set up command post in a safe location where you can be easily seen and with a clear view of the incident area. Stay at the command post and in contact by radio.

Assess situation and provide size-up to Communications.

Situation and estimated number of victims.
Potential hazards.
Resources on scene and general plan.
Additional resources needed.

Develop an initial strategy.

Hazard elimination.
Incident priorities for extricating and treating victims.
Safety steps to prevent additional casualties.
Develop Incident Action Plan

Assign existing resources to jobs and monitor progress.

Appoint as needed:

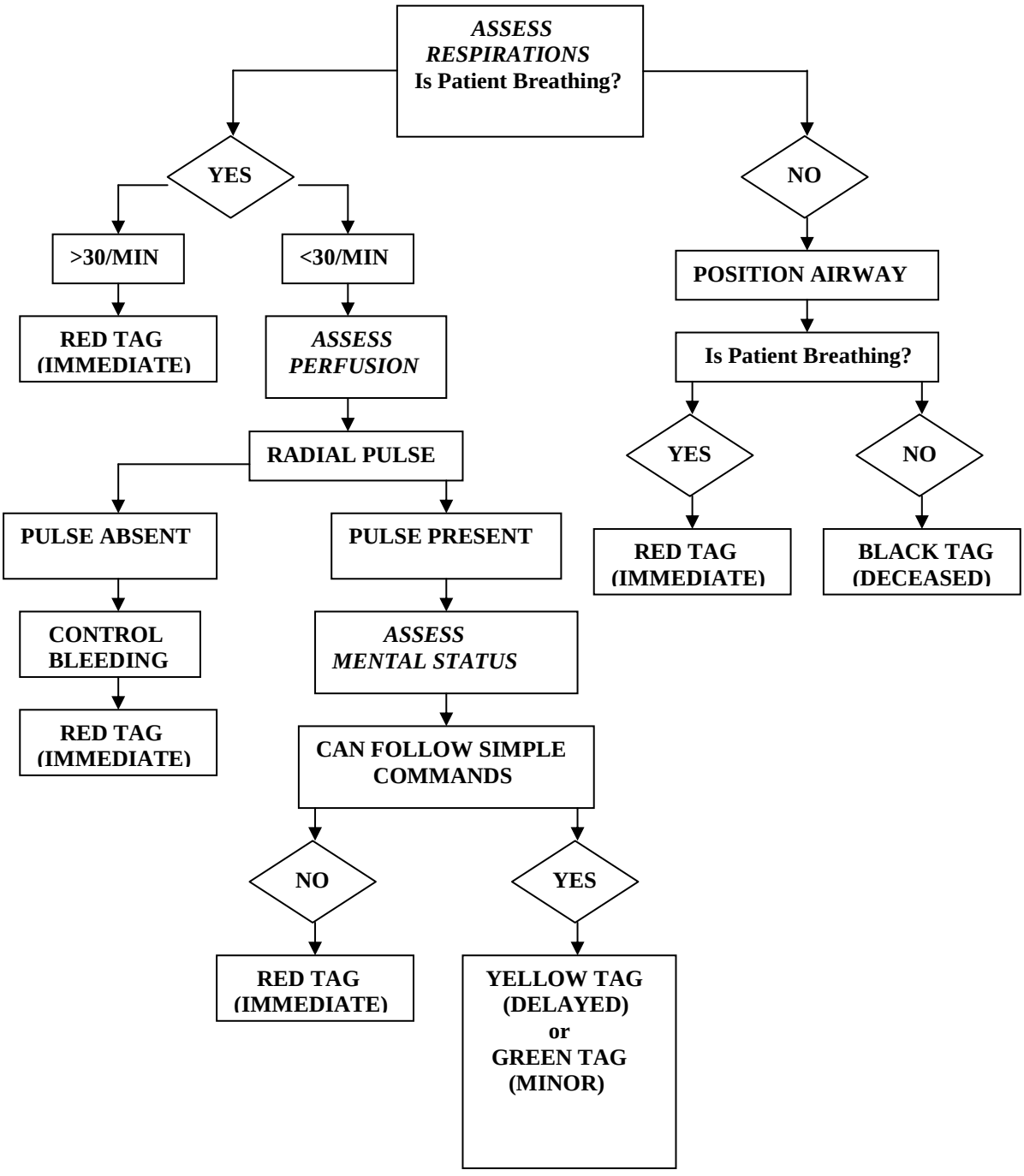
Operations Section Chief
- Air Operations Branch Director
- Extrication Group Supervisor
- Transportation Group Supervisor
- Triage Unit Leader
- Air/Ground Ambulance Group Supervisor
- Treatment Unit Leader

Planning Section Chief
Logistics Section Chief
- Medical Group Supervisor

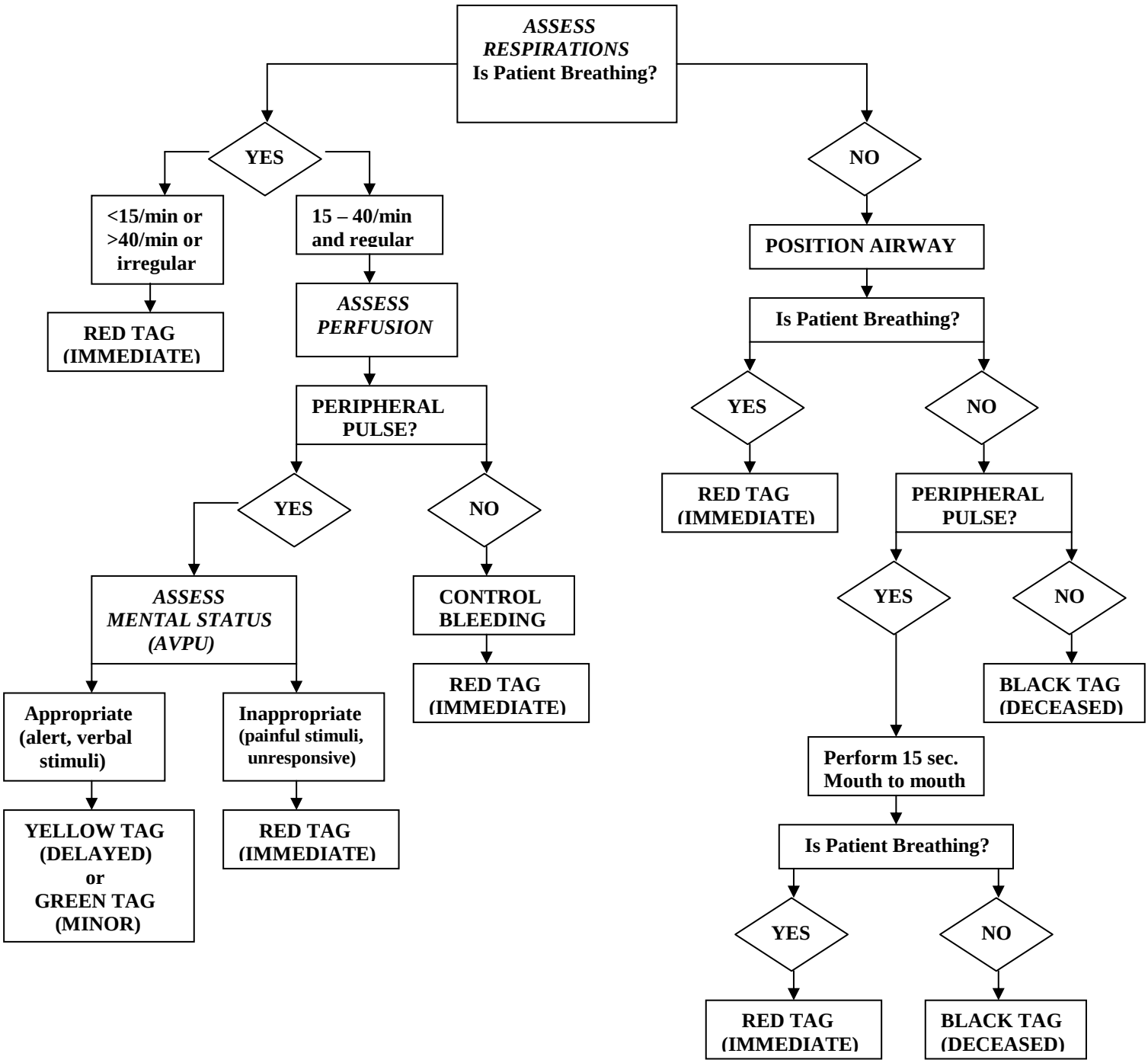
Liaison Officer
Safety Officer
Public Information Officer (PIO)

Appendix B

S.T.A.R.T
Simple Triage and Rapid Transport



Appendix C
JUMPSTART
PATIENTS AGED 1 – 8 YEARS



Appendix D
Mass Casualty Support Unit Deployment

1. **Definitions:**

1.1 **Mass Casualty Support (MCS) Unit -** A vehicle designed to carry supplies and equipment for mass casualty incidents. Designated level one (25 patients), level two (50 patients) or level three (100 patients). The minimum inventory is established by the Council of Government agreement.

1.2 **Medical Supply Unit Team Leader** - Reports to the Medical Group Supervisor. Acquires and maintains control of appropriate medical equipment from units assigned to the Medical Group.

2. **Procedure:**

2.1 The MCS unit will be staffed and operated by the personnel from the housed station.

2.2 In the event the personnel at the housed station is unavailable the next staffed engine will respond and staff MCS unit.

2.3 The station, engine crew or MCS unit will provide a driver and the units travel together. In the event the housed station provides only a driver, an additional engine will be requested to respond and assist the MCS unit.

2.4 Minimum staffing will be three, including one EVOC 2 driver and trained crew.

2.5 The MCS unit radio designation is "Mass Casualty Support Unit XX".

2.6 The MCS unit will be dispatched to the appropriate call type:

- Any incident where 10 or more patients are reported.

2.7 The MCS unit will be dispatched upon request to the following:

- Incident Commander
- Mutual Aid

2.8 The MCS unit crew officer will be designated "Medical Supply Unit Team Leader Coordinator" if required by the Incident Commander and not otherwise assigned and will assume corresponding responsibility.

2.9 The equipment on the MCS unit will be deployed in green, yellow and red treatment areas when designated. Selection of treatment areas will be guided by proximity to transportation, a safe distance from the impact area, or located in the cold zone. A blue tarp designates the equipment cache.

2.10 Upon termination of the incident the deployed equipment will be accounted for, reloaded on the MCS unit and returned to quarters for restocking and inventory. The unit officer is responsible for ensuring that all deployed equipment is returned and the unit is returned to service.

3. **Responsibilities:**

Operations

Maintain, staff, and operate the MCS unit.

The host station shall ensure personnel are trained and proficient in MCSU operations and set up of treatment areas. Next due crews shall be capable of deploying the MCS unit when needed.

Communications

Ensure dispatchers dispatch the MCS unit to incidents identified in 2.7.

Dispatch the MCS unit upon request as specified in 2.8.

Appendix E
Mass Casualty Support Unit
Resource List

The following localities have reported for this plan, resources which are available to support a Mass Casualty Incident. Additional resources may be available by contacting the localities in Planning District 9 and 16.

Caroline County Department of Fire & Rescue
- 3 MCI Trailers (50 BLS patients each)

King George Department of Fire, Rescue & Emergency Services
- 1 MCI Trailer (25 BLS patients)

Spotsylvania Department of Fire, Rescue & Emergency Management
- 1 MCI Trailer (40 BLS patients)

Appendix F
Acute Care Hospitals
Rappahannock EMS Council Region

Culpeper Regional Hospital 501 Sunset Lane Culpeper, Virginia 22701	540-829-4189
Fauquier Hospital 500 Hospital Drive Warrenton, Virginia 20168	540-316-4900
Mary Washington Hospital 1001 Sam Perry Boulevard Fredericksburg, Virginia 22401	540-741-1111
Mary Washington Hospital Freestanding Emergency Department 10401 Spotsylvania Avenue Fredericksburg, Virginia 22408	540-710-0205
Stafford Hospital 101 Hospital Center Boulevard Stafford, Virginia 22554	540-741-9102
Spotsylvania Regional Medical Center 4600 Spotsylvania Parkway Fredericksburg, Virginia 22408	540-498-4960
* Northern Virginia Hospital Alliance Regional Hospital Coordinating Center (RHCC)	888-987-7422

Appendix G
Dispatch Centers
Rappahannock EMS Council Region

Caroline County 804-633-4357
Caroline 911 Center
108-B Courthouse Lane
Bowling Green, Virginia 22427

Culpeper County 540-727-7900
Culpeper Joint Dispatch Center
14022 Public Safety Court
Culpeper, Virginia 22701

City of Fredericksburg 540-373-3122
Fredericksburg Emergency Communications Center
2200 Cowan Boulevard
Fredericksburg, VA 22401
Fredericksburg, Virginia 22404

Fauquier County 540-347-6843
78 W. Lee Street, #102
Warrenton, Virginia 20186

King George County 540-775-2049
King George Sheriffs Department
9483 Kings Hwy.
King George, Virginia 22485

Orange County 540-672-1515
Orange County Emergency
112 West Main Street
Orange, Virginia 22960

Rappahannock County 540-675-5300
Rappahannock Communications
383 Porter Street
Washington, Virginia 22747

Spotsylvania County 540-582-7115
Spotsylvania Communications
9101 Courthouse Road
Spotsylvania, Virginia 22553

Stafford County 540-658-4400
Stafford Dispatch
1300 Courthouse Road
Stafford, Virginia 22554

LifeCare Medical Transports Dispatch Center 540-752-5883
1170 International Parkway
Fredericksburg, Virginia 22406

Appendix H

Virginia Reportable Disease List

Reporting of the following diseases is required by state law (Section 32.1-36 of the *Code of Virginia* and 12 VAC 5-90-80 and 12 VAC 5-90-90 of the Board of Health *Regulations for Disease Reporting and Control – (www.vdh.virginia.gov/epidemiology/documents/regs.pdf)*. Report all conditions to your city/county health department. Those listed in **RED** must be reported within 24 hours of suspected or confirmed diagnosis by the most rapid means available and all others reported on an Epi-1 form within three days of suspected or confirmed diagnosis.

- Acquired immunodeficiency syndrome (AIDS)
- ♿ Amebiasis
- I ♿ **ANTHRAX**
- ♿ Arboviral infection (e.g., EEE, LAC, SLE, WNV)
- ♿ **BOTULISM**
- ♿ **BRUCELLOSIS**
- ♿ Campylobacteriosis
- ♿ Chancroid
- ♿ Chickenpox (Varicella)
- ♿ *Chlamydia trachomatis* infection
- I ♿ **CHOLERA**
- ♿ Creutzfeldt-Jakob disease if <55 years of age
- ♿ Cryptosporidiosis
- ♿ Cyclosporiasis
- I ♿ **DIPHTHERIA**
- **DISEASE CAUSED BY AN AGENT THAT MAY HAVE BEEN USED AS A WEAPON**
- ♿ Ehrlichiosis
- I ♿ *Escherichia coli* infection, Shiga toxin-producing
- ♿ Giardiasis
- ♿ Gonorrhea
- Granuloma inguinale
- I ♿ ***HAEMOPHILUS INFLUENZAE* INFECTION, INVASIVE**
- ♿ Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome (HUS)
- ♿ **HEPATITIS A**
- ♿ Hepatitis B (acute and chronic)
- ♿ Hepatitis C (acute and chronic)
- Hepatitis, other acute viral
- ♿ Human immunodeficiency virus (HIV) infection
- # ♿ Influenza
- **INFLUENZA-ASSOCIATED DEATHS IN CHILDREN <18 YEARS OF AGE**
- Kawasaki syndrome
- ♿ Lead - elevated blood levels
- ♿ Legionellosis
- Leprosy (Hansen's disease)
- I ♿ Listeriosis
- Lyme disease
- Lymphogranuloma venereum
- ♿ Malaria
- ♿ **MEASLES** (Rubeola)
- I ♿ **MENINGOCOCCAL DISEASE**
- **MONKEYPOX**
- ♿ Mumps
- Ophthalmia neonatorum
- **OUTBREAKS, ALL** (including but not limited to foodborne, nosocomial, occupational, toxic substance-related, and waterborne)
- I ♿ **PERTUSSIS**
- I ♿ **PLAGUE**
- I ♿ **POLIOMYELITIS**
- ♿ **PSITTACOSIS**
- ♿ **Q FEVER**
- ♿ **RABIES, HUMAN AND ANIMAL**
- Rabies treatment, post-exposure
- ♿ Rocky Mountain spotted fever
- ♿ **RUBELLA**, including congenital rubella syndrome
- I ♿ Salmonellosis
- ♿ **SEVERE ACUTE RESPIRATORY SYNDROME** (SARS)
- I ♿ Shigellosis
- ♿ **SMALLPOX** (Variola)
- ♿ *Staphylococcus aureus*, infection (invasive methicillin-resistant and any vancomycin-intermediate or vancomycin-resistant)
- I ♿ Streptococcal disease, Group A, invasive
- ♿ *Streptococcus pneumoniae* infection, invasive, in children <5 years of age
- ♿ Syphilis (report **PRIMARY** and **SECONDARY** syphilis by rapid means)
- Tetanus
- Toxic shock syndrome
- ♿ Toxic substance-related illness
- ♿ Trichinosis (Trichinellosis)
- I ♿ **TUBERCULOSIS, ACTIVE DISEASE - (MYCOBACTERIA ~)**
- Tuberculosis infection in children <4 years of age
- ♿ **TULAREMIA**
- ♿ **TYPHOID FEVER**
- **UNUSUAL OCCURRENCE OF DISEASE OF PUBLIC HEALTH CONCERN**
- ♿ **VACCINIA, DISEASE OR ADVERSE EVENT**
- ♿ ***VIBRIO* INFECTION**
- ♿ **VIRAL HEMORRHAGIC FEVER**
- ♿ **YELLOW FEVER**
- I ♿ Yersiniosis

♿ These conditions are reportable by directors of laboratories. In addition, these and all other conditions except MRSA are reportable by physicians and directors of medical care facilities.

I A laboratory identifying evidence of these conditions shall notify the health department of the positive culture and submit the initial isolate to the Virginia Division of Consolidated Laboratory Services (DCLS).

\# Physicians and directors of medical care facilities should report influenza by number of cases only (report total number per week and by type of influenza, if known).

~ A laboratory identifying *Mycobacterium tuberculosis* complex shall submit a representative and viable sample of the initial culture to DCLS or other laboratory designated by the Board to receive such specimen.

Note: Cancers are also reportable. Contact the VDH Virginia Cancer Registry at (804) 864-7866 for information.

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov

Revised October 24, 2007

Appendix I
Recommended MCI Equipment and Training
Rappahannock EMS Council Region and Agencies

Required Training (Course materials are available through on line independent course study at **http://training.fema.gov/is/crslist.asp**

IS-100.b Course Name: Introduction to Incident Command System, ICS-100 – (10/12/2010)
IS-200.b Course Name: ICS for Single Resources and Initial Action Incidents – (10/12/2010)
ICS 300 for mid-level managers and above is not available online (classroom only)
IS-700.a Course Name: National Incident Management System (NIMS) An Introduction
IS-800.b Course Name: National Response Framework, An Introduction

Recommended Training - (Course materials or resources are available through REMS Council)

Mass Casualty Incident Training Module I and II
Incident Command System *
National Incident Management System Course (NIMS) *
START Triage
Hazardous Materials Awareness *
Emergency (Public Safety) Response to Terrorism *

Recommended Personnel Protective Equipment

Standard PPE (gloves, eye protection, paper gowns, vionex)
N95 Respirators
Escape Hoods, Butyl Gloves, Chemical Tape and Overboots
Chemical Resistant Splash Coverall

Recommended Ambulance Equipment

START Triage Cards
Red, Yellow, Green and Black Survey Tape with Dispenser of Choice
Laminated START Triage Cards
Vests – Triage, Treatment, Staging, Transport, and EMS Sector
Five Clipboards; Four Small Notepads and Pens
Flashlights, Headlamps or Glow Sticks
Laminated Quick Reference Cards for Each Sector Officer Position
Colored Boundary Tape or Triage Tarps

Recommended Non-Transport Vehicle Equipment

START Triage Cards
Red, Yellow, Green and Black Survey Tape with Dispenser of Choice
Laminated START Triage Cards
Four Small Notepads and Pens
Flashlights, Headlamps or Glow Sticks

List Approved By REMS Board of Directors: 12/15/04; Updated 06/18/08; Updated 12/10/10