

# Central Virginia Mass Casualty Incident Plan

**OLD DOMINION**



**Emergency Medical Services  
ALLIANCE**

**Emergency Medical  
Services**

**Mutual Aid Response Guide**

Current May 2007

**Planning Districts 13, 14, 15 and 19**

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# Incident Plan

## EMS Mutual Aid Response Guide

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“Please contact ODEMSA if you want the complete Regional MCI Plan”

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Central Virginia

# Mass Casualty Incident Plan

## EMS Mutual Aid Response Guide

Current May 2007

### 1. PREFACE

The goal of the Central Virginia Mass Casualty Incident Plan, as stated in the accompanying Memorandum of Understanding, is to prepare on a regional basis for a unified, coordinated and immediate emergency medical services (EMS) mutual aid response by prehospital 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 Old Dominion Emergency Medical Services Alliance (ODEMSA) region and/or any such facility outside the region that is a signatory to the Central Virginia MCI Plan's Memorandum of Understanding.

This Response Guide, as most recently amended, will serve as the basis for hospital and out-of-hospital response under the Central Virginia MCI Plan (hereafter referred to as the MCI Plan) in the 9,000-square-mile ODEMSA region, Planning Districts 13, 14, 15 and 19.

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 districts which comprise the ODEMSA region as provided in the Code of Virginia, Section 32.1-111.11.

### 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 care 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.
- 2.1.5. **PREHOSPITAL 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 prehospital emergency care and provide emergency transportation for sick 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. **INCIDENT MANAGEMENT SYSTEM (IMS)** -- A written plan, 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.
- 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.

### 3. GENERAL AGREEMENT

- 3.1. The Central Virginia MCI Plan calls for the following general provisions:
  - 3.1.1. Predetermined guidelines and the proximity and capabilities of appropriate health care facilities will be the primary considerations of MCI Medical Control when designating the health care facilities to which patients are sent during any local or regional emergency situation that results in the activation of the MCI Plan.
  - 3.1.2. Localities and/or individual prehospital EMS agencies will respond to a mutual aid request from the locality in which the event takes place with appropriate personnel and equipment as available when the MCI Plan is activated. However, the response will be dispatched by the local Emergency Communications Center (ECC) and will not reduce any locality's own EMS response capabilities below established, predetermined levels.

- 3.1.3. When considering their responses to activation of the MCI Plan, member localities and/or EMS agencies will be expected to maintain their own emergency medical response capabilities to meet local needs.
- 3.1.3. Predetermined EMS mutual aid responses will be employed by hospital and prehospital members when any of the signatory health care facilities must be evacuated under the MCI Plan.
- 3.1.4. Personnel affiliated with all participating EMS agencies and/or jurisdictions will operate during an Incident or Evacuation under the National Incident Management System (NIMS) and a standard Incident Management System (IMS) as endorsed by the Central Virginia MCI Committee and taught within the ODEMSA region.
- 3.1.5. Hospital and prehospital 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 ODEMSA through the Central Virginia MCI Committee.

#### **4. AUTHORITY**

- 4.1. The Old Dominion EMS Alliance is one of eight regional EMS councils established within the Code of Virginia, Section 32.1-111.11. Created in 1980, ODEMSA 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.
- 4.2. The Board of Directors of ODEMSA has assigned to its Central Virginia MCI Committee, and that Committee's Operations Group, the responsibility of effectively fulfilling those planning and response functions and with the overall maintenance and oversight of the Central Virginia MCI Plan.

#### **5. SCOPE OF THE M.C.I. PLAN**

- 5.1. The Old Dominion EMS Alliance is defined as the 9,000-square-mile region made up of Virginia Planning Districts 13, 14, 15 and 19. The regional MCI Plan involves the counties of: Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Cumberland, Dinwiddie, Halifax, Hanover, Henrico, Goochland, Greensville, Lunenburg, Mecklenburg, New Kent, Nottoway, Powhatan, Prince Edward, Prince George, Surry, Sussex; the cities of Colonial Heights, Emporia, Hopewell, Petersburg, Richmond, and South Boston; and the towns of Ashland, Farmville and South Hill.
- 5.2. The MCI Plan addresses only the EMS mutual aid response of the regional emergency medical services (EMS) system, hospital and prehospital, to a Mass Casualty Incident or Health Care Facility Evacuation.
- 5.3. Mass Casualty Incidents with limited fatalities and those that involve mass fatality

incidents within the ODEMSA 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 Services (See Section 19).

## **6. M.C. I. OPERATIONAL GUIDE**

- 6.1. The purposes of the MCI Plan's Mutual Aid Response Guide are to:
  - 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 ODEMSA region.
  - 6.1.2. 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 the entire ODEMSA region to include Planning Districts 13, 14, 15 and 19.
  - 6.1.3. 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.
  - 6.1.4. Ultimately, to ensure the largest number of survivors in mass casualty situations or health care facility evacuations.
- 6.2. A copy of the Central Virginia Mutual Aid Response Guide will be kept in each licensed EMS response vehicle in the ODEMSA region, in each hospital Emergency Department, and in each licensed EMS agency in the region.
- 6.3. The Response Guide will be reviewed each year by the Committee's Operations Group, referencing the MCI Plan Memorandum of Understanding. Proposed revisions, amendments and other changes will be referred to the full Committee for its action. Updated copies will be provided by ODEMSA (See Section 31).

## **7. LEVELS AND CATEGORIES**

- 7.1. MCIs within the ODEMSA region will be classified by levels, following assessment by EMS providers using the Virginia START Triage system:
  - 7.1.1. Expanded Medical Incident - Requires the use of local resources and/or mutual aid to manage the incident.**
  - 7.1.2. Major Medical Incident - **Requires the use of regional and/or multi-regional resources to manage the incident.**
  - 7.1.3. Disaster - **Requires the use of state and/or federal resources to manage the incident.**

7.1.4. **Catastrophe** - Destruction and loss of local infrastructure, outside resources required.

## 8. POTENTIAL INCIDENTS

8.1. MCIs can occur in varying degrees, at anytime, and in practically any conceivable situation. Central Virginia's population stands at some 1.3 million people. These residents live in areas ranging from densely-populated urban such as Richmond and the Petersburg-Hopewell-Colonial Heights areas, to suburban locations, to largely rural areas with farms, forests and recreational areas. High risks include:

8.1.1. Three major Interstate highways (64, 85 and 95), numerous highly-traveled primary highways (U.S. 1, 58, 60, 360 and 460) between major population areas.

8.1.2. Freight and passenger rail lines, a major navigable river, a major hub airport and a number of smaller airports that serve high-speed, multi-passenger aircraft.

8.1.3. Industrial plants ranging from chemical manufacturing, to cigarette manufacturing, to petroleum fuels storage, to light industry.

8.1.4. A major amusement theme park that draws thousands of people to the region during temperate months.

8.1.5. Severe and usual weather conditions also prevail throughout the region, including tornadoes, windstorms, hurricanes and heavy rains, heavy snows usually to the west of Richmond, sleet and freezing rains east of Richmond, and flooding in the James River and Appomattox River basins.

8.2. Based on these components, potential MCIs in the region could include:

8.2.1. Major vehicular accidents with multiple victims.

8.2.2. Urban, residential and woodland fires.

8.2.3. Tornadoes or other severe weather-related situations.

8.2.4. Public transportation accidents (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.

## **9. MANAGEMENT GOALS**

9.1. The goals of MCI management are:

9.1.1. Do the greatest good for the greatest number of people.

9.1.2. Make the best possible use of resources.

9.1.3. Avoid relocating the MCI, especially to any receiving hospitals.

## **10. INCIDENT PRIORITIES**

10.1. The top priorities of an MCI (or other complex emergency situation) are:

10.1.1. Provider safety, accountability and welfare.

10.1.2. Life safety.

10.1.3. Incident stabilization.

10.1.4. Conservation of property and equipment.

## **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 EMS providers from both the out-of-hospital arena (career services and volunteer rescue squads and emergency crews) and trained medical staff from critical care hospitals, especially trauma centers, to provide on-scene care for the critically injured or sick.

11.1.2. Healthcare facilities, in particular trauma centers and hospitals with acute-care or other emergency or special facilities, to receive and treat critically injured or sick patients.

11.1.3. Certified and/or licensed healthcare providers at all levels of emergent patient care, from prehospital Basic Life Support (BLS) and Advanced Life Support (ALS) to acute medical and surgical treatment nurses and physicians in hospitals, local health department personnel, and other related healthcare professionals.

11.1.4.

Trained First Responders and specially trained emergency services personnel to include firefighters, hazardous materials specialists and individuals trained in technical/tactical rescue skills, search and rescue procedures and dive rescue.

11.1.5. Local, state and federal government agencies including, but not limited to: Local Emergency Planning Committees (LEPCs) of jurisdictions within the ODEMSA region; Virginia Department of Emergency Management; Virginia Department of Health (VDH) including the Office of Emergency Medical Services, Office of the Chief Medical Examiner and local public health departments; Virginia Department of State Police; local police and sheriffs' offices; Virginia Commission of Game and Inland Fisheries; Virginia Department of Transportation; Virginia Department of Corrections; Virginia Department of Military Affairs; Federal Emergency Management Agency (FEMA); Federal Bureau of Investigation (FBI); and U.S. Armed Forces (including the U.S. Coast Guard).

11.1.6. Non-transport and/or related support components such as the American Red Cross, Salvation Army, public utilities (gas, power, water), airlines, 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 Central Virginia EMS Community through effective communications, planning and training.

## 12. LOCAL EMERGENCY OPERATIONS PLANS

12.1. It is recognized that each Virginia county and locality has an emergency operations plan. **Whenever possible, regional EMS mutual aid response should conform to the local emergency operations guidelines in which the incident occurs.**

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

12.2.1. The disaster or MCI is of such magnitude that it completely exhausts the EMS resources of one locality.

12.2.2. The disaster or MCI crosses local boundaries and exhausts the EMS resources of one or more of those localities.

12.2.3. 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.

12.3. The local Emergency Services Coordinator should be contacted as soon as possible that the MCI Plan is activated, or of a possible need for mutual aid.

### **13. INITIAL RESPONSE TO AN INCIDENT**

13.1 The MCI Plan calls for the 5-S approach to an MCI as taught in the Virginia Mass Casualty Incident Management training program:

13.1.1. Assess scene for Safety -- Determine if providers will be safe.

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

13.1.3. Send information and requests for assistance – Early contact local Emergency Communications Center (ECC) with survey information, request resources, and to activate the MCI Plan.

13.1.4 Set up scene management structure -- include extrication, triage, treatment and transportation.

13.1.5 Begin START Triage of incident victims.

### **14. ACTIVATING THE M.C.I. PLAN**

14.1. The MCI Plan for EMS mutual aid can be activated by the following individuals:

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

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

14.1.3. The Chief Executive Officer, or that person's representative, of a health care facility that is required to evacuate or move patients.

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

14.2. It is strongly recommended that the MCI Plan be activated through the local ECC which will communicate directly with MCI Medical Control and with localities whose prehospital resources may be used within the ODEMSA region.

14.3. The Medical Control component of the MCI Plan is activated by calling on land telephone line or cellular phone the Virginia Commonwealth University Medical Center (VCUMC) at 804-828-8888.

14.3.1. The person authorized to request activation should identify herself/himself, ask to activate the MCI Plan.

14.3.2. The person should give a brief summary of the incident. The information should include time of the 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 Prehospital Component of the MCI Plan through established mutual aid agreements among prehospital volunteer and career EMS agencies in the region as provided for in this document.

14.4.1. The ECC dispatcher should emphasize that the mutual aid request for ambulances and/or equipment is under the activated Central Virginia MCI Plan.

## **15. RESPONSIBILITIES--HOSPITAL**

15.1. MCI Medical Control – VCU Medical Center will serve as primary MCI Medical Control for the ODEMSA region in the event of an incident that requires activation of the MCI Plan. CJW Chippenham Medical Center and Southside Regional Medical Center will serve as backup MCI Medical Control when appropriate.

15.1.1. VCU Medical Center may designate the backup acute care medical facilities 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. VCU Medical Center will notify the designated hospital, by EMS system messaging, HEAR radio 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.

15.2. Representatives of participating hospitals will establish Hospital Triage Level and Mutual Aid Capability tables. These tables will be reviewed each six months and which will be confirmed or adjusted at the time of the incident.

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 assign patients to be transported to the medical facilities closest to the site of an MCI or evacuation and which can provide the appropriate levels of emergency care. The levels will be contained in the suggested Hospital Triage Level and Mutual Aid Capability tables that are agreed to in advance by hospital officials (See Section 15.4.).
- 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 ODEMSA's Prehospital Patient Care Protocols, as most recently amended and approved by the Old Dominion Medical Control Committee.
- 15.8. Hospitals will be responsible for providing definitive patient care to the levels of their capabilities during and after the incident.

## 16. RESPONSIBILITIES--PREHOSPITAL

- 16.1. Transportation of patients under the MCI Plan during an incident or evacuation will be done by licensed prehospital EMS agencies that respond to the primary locality's mutual aid request and under that locality's incident commander or the IC's designee. The incident "belongs" to the locality in which it occurs.
- 16.2. Units and personnel involved in mutual aid response to a regional MCI or Evacuation will be dispatched through the responding agency's local emergency communications and/or dispatching center (i.e. ECC).
- 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 Manager 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.**
- 16.4. All out-of-hospital providers and/or agencies responding to an MCI site in the ODEMSA region agree to operate under the National Incident Management System (NIMS), the Central Virginia MCI Plan, the Virginia Mass Casualty Incident Management System, the Virginia START Triage system and the Prehospital Patient Care Protocols of the Old Dominion EMS Alliance.
- 16.5. A jurisdiction(s) in which the MCI occurs will be responsible for activating mutual aid in the region through its own Emergency Communications Center(s). 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 Old Dominion EMS Alliance is encouraged.

- 16.6. Prehospital EMS agencies and/or localities agree to respond with personnel and equipment when the MCI Plan is activated, but are 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 prehospital EMS agencies will be expected to maintain their emergency response capabilities to meet local needs. (See Sections 3.1.2. and 3.1.3.)
- 16.7. The crews of prehospital 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 prehospital EMS units responding to an MCI or Evacuation will be responsible for maintaining all medical and operational documentation, and for making that documentation available to IMS officials.
- 16.9. Prehospital agencies in the ODEMSA region will participate when possible in annual training exercises of the MCI Plan held in various locations within Planning Districts 13, 14, 15 ad 19. (See Section 3.1.5).
- 16.10 Prehospital agencies will encourage their providers to participate in on-going regional training for rescue and EMS personnel in the Incident Management System, Virginia START Triage System, hazard awareness programs and other related MCI skills.

## **17. MEDICAL DIRECTION, PROTOCOLS AND TRIAGE**

- 17.1. 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 ODEMSA's Prehospital Patient Care Protocols, as most recently revised. Unless otherwise designated, final medical documentation will be done on Virginia Prehospital Patient Care Reports (PPCRs) and/or the Virginia Triage Tag.
- 17.2. 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.
- 17.3. 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. (See Sections 15.2 through 15.5.)

## **18. SPECIAL CONSIDERATIONS FOR HEALTH CARE FACILITY EVACUATIONS**

- 18.1. When a hospital must evacuate any number of patients on a temporary basis, the following shall apply:
  - 18.1.1. The administrative staff of the evacuating hospital will be responsible for directing the evacuation and transfer of patients to the designated receiving hospital in coordination with MCI Medical Control.
  - 18.1.2. 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.
  - 18.1.3. Each evacuated patient will be accompanied by his/her medical records.
  - 18.1.4. Receiving hospitals will use routine admitting procedures for patients from the evacuated hospital including, if possible, consent for treatment.
  - 18.1.5. Other admitting and billing procedures will be predetermined by the participating hospitals in pre-negotiated protocols and/or agreements which may be an appendix to this document.

## **19. FATALITIES AND MASS FATALITIES INCIDENTS**

- 19.1. By Virginia State Statute, 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.
- 19.2. It is critical that the Medical Examiner's Office be notified as early as possible in any mass casualty incident which involves, or which may involve, fatalities.
- 19.3. The Office of the Chief Medical Examiner can be reached at 804-786-3174.
- 19.4. The dead must be treated with respect and dignity in thought and in actions at all times.
- 19.5. An MCI also may be a Mass Fatalities Incident.
  - 19.5.1. A Mass Fatalities Incident is any situation where there are more bodies than can be handled using local resources.
  - 19.5.2. 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 Medical Examiner and police authorities, both in MCI preplanning and during the incident, is essential.

19.5.3. During a mass fatalities incident, extreme stress and grief are natural and expected reactions by emergency responders and EMS providers, as well as survivors. In these events, Critical Incident Stress Management is highly recommended (See Section 25).

## 20. STANDARD PRECAUTIONS

20.1. All EMS personnel involved in a regional response to an MCI or Evacuation will be expected to observe Standard Precautions (aka Universal Precautions) and other infection control Body Substance Isolation practices as specified by the Centers for Disease Control, OSHA and the NFPA Infection Control Standard 1581, and other applicable state and local infection control regulations.

## 21. EMERGENCY COMMUNICATIONS

21.1. Radio communication, as provided by the ODEMSA region's enhanced two-channel HEAR system, will remain the primary method of hospital-to-field communications during a MCI. The enhanced, voice-only VHF system provides a dedicated channel for hospital-to-field and can provide as a backup a dedicated channel for hospital-to-hospital communications.

21.2. Other communications tools that can be used during an MCI include the EMSsystem web-based information program, the statewide Rescue Mutual Aid Frequency (155.205), the UHF MED channels, and cellular telephones.

21.2.1. The 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 and/or material resources in line with the Incident Management System.

21.2.2. The HEAR radio frequency 155.340 is the primary channel for communications between the MCI Medical Control hospital and the EMS Transportation Sector at the incident.

21.2.3. The HEAR radio frequency 155.280 is the primary channel for communications between the MCI Medical Control hospital and other hospitals involved in the incident.

21.2.4. The EMSsystem initially will be used for hospital-to-hospital communications and information gathering and distribution.

21.3. Unless there is an extreme emergency, prehospital ambulance crews **should not** use the HEAR frequency or 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. A ambulance crews transporting patients from an MCI should contact the receiving hospital as early as possible. Only basic patient information, including START triage classification, need be reported. All radio transmission should be as brief as possible, using established radio protocols.
- 21.5. Because 10-Codes can vary among localities, their use is NOT recommended during an MCI or Evacuation.
- 21.6. In the case of cellular phones, no cells exclusively 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 Manager or other key element of the Incident Management System (i.e. Transportation Officer or Command Post/Communications Center), it should be kept open for the duration of the MCI if at all possible.

## **22. EMERGENCY MEDICAL RESPONSE**

- 22.1. The MCI Plan assumes that localities and/or out-of-hospital agencies will respond to mutual aid requests at 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 Manager 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 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 Incident Management System (IMS), as developed and taught within the ODEMSA region and which complies with the National Incident Management System (NIMS), 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 cooperative integration with other emergency support functions.

## **23. TECHNICAL RESCUE OPERATIONS**

- 23.1. MCIs involving extended technical rescue operations (i.e. large transportation extrications, confined spaces, collapsed man-made or natural structures, search and rescue operations, etc.) should use the resources of the local jurisdiction.

- 23.2. When needs exceed local capabilities or resources, utilize existing methods to locate specialized resources. Several local teams exist in Virginia which have technical rescue capabilities. Local dispatch centers should keep team contact phone numbers available for use during an incident. A regional technical rescue team can be mobilized through fire mutual aid.
- 23.3. The Virginia EOC, 1-800-468-8892, is the Search and Rescue Coordination Center for Virginia and can contact SAR teams for local jurisdictions.
- 23.4. All personnel involved in the technical rescue aspects of an MCI regional response must have appropriate training and maintain compliance with local, state and federal OSHA standards.

## 24. HAZARDOUS MATERIALS

- 24.1. Hazardous materials, as defined in Section 44-146.34 of the Code of Virginia, means substances or materials which may pose unreasonable risks to health, safety, property or the environment when used, transported, stored or disposed of, which may include materials which are solid, liquid or gas. Hazardous materials may include toxic substances, flammable and ignitable materials, explosives, corrosive materials, and radioactive materials and include: those substances or materials in a form or quantity which may pose an unreasonable risk to health, safety or property when transported and which the U.S. Secretary of Transportation has so designated by regulation or order; hazardous substances as defined or designated by law or regulation of the Commonwealth or law or regulation of the U.S. government; and hazardous waste as defined or designated by law or regulation of the Commonwealth.
- 24.2. The local fire department should be contacted for incidents involving hazardous materials. The local fire department will contact Virginia EOC at 1-800-468-8892 for technical assistance or to have a Virginia Department of Emergency Management (VDEM) Regional Hazardous Materials Officer respond to the incident site. The VDEM Hazardous Materials Office can activate one or more regional hazardous materials response teams if required.
- 24.3. 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.
- 24.4. Decontamination is the process of removing or neutralizing contaminants that have accumulated on personnel and equipment that is critical to health and safety at the scene of any hazardous materials incident, including a terrorism incident. **Whenever possible, decontamination should be accomplished at the incident site.** The process is designed to protect emergency care providers, to prevent mixing of incompatible substances, and to protect the community by preventing uncontrolled transportation of contaminants from the incident site.

- 24.5. All hospitals are encouraged to have basic decontamination capabilities to treat patients exposed to hazardous materials.
- 24.6. Decontamination of hazmat patients and/or hospital and prehospital EMS providers will be in accordance with established national guidelines by the U.S. Department of Transportation, the Occupational Safety and Health Administration (OSHA), and the National Fire Protection Association (NFPA), as well as local and regional emergency operations plans, including the regional Domestic Terrorism and Hazmat plans that are annexes to this Response Guide.

## **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. Regional and local teams of mental health and peer debriefers have been trained and are available throughout the ODEMSA region.
  - 25.1.1. The ODEMSA Regional Team can be activated through the Virginia EOC, 804-674-2400 or 1-800-468-8892.
  - 25.1.2. Other CISM teams can be activated through local emergency communications centers or through the ODEMSA Regional Team.

## **26. AIRSPACE RESTRICTIONS**

- 26.1. Airspace over an MCI is regulated by the Federal Aviation Administration (FAA).
  - 26.1.1. Questions or requests concerning the use or restriction of that airspace during an MCI should be referred as early as possible to the FAA's Washington Air Route Traffic Control Center (ARTCC) also known as the Washington Center, at 703-771-3470.
  - 26.1.2. Temporary flight restrictions for disaster areas are designated by the ARTCC which will notify other appropriate FAA facilities.
  - 26.1.3. NOTE: The Virginia EOC, at 804-674-2400 or 1-800-468-8892, has contact information to assist in this function.

## **27. AIR MEDICAL OPERATIONS**

- 27.1. EMS Med-Flight 1 is available 24 hours a day through the Virginia Emergency Operations Center (Virginia EOC) at 804-674-2400 or 1-800-468-8892. To assist in landing zone location, the caller must provide Virginia EOC with precise identification of the intersection of highways/roads nearest to the chosen LZ. (See Annex C)

- 27.2 VCU Medical Center LifeEvac is available 24 hours a day through the LifeEvac dispatch center (1-877-902-7779), or through the Virginia Emergency Operations Center (Virginia EOC) at 804-674-2400 or 1-800-468-8892. (See Annex C)
- 27.3. SkySTAT is a private air medical evacuation firm involved in the interfacility transfer of hospital patients. It is available as a final backup to EMS Med-Flight 1 and VCU LifeEvac when those services are otherwise busy.

**NOTE:** In a large-scale emergency, the Virginia EOC can assist with phone numbers to contact the Virginia Army National Guard and Virginia Air National Guard and the U.S. Coast Guard for possible use of the aviation assets of those organizations.

- 27.4. Fixed-wing and rotorcraft (helicopters) can be used to evacuate patients from the scene of an MCI. However, given their limited space, other possible uses should be considered. These uses for both types of aircraft include:

- 27.4.1 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.

- 27.4.2 Movement of essential medical or public safety personnel and/or medical supplies to or from the MCI site.

- 27.5. Specific uses for rotorcraft may include:

- 27.5.1. Use of Flight Nurses or Flight Paramedics for triage or treatment; use of the helicopter to overcome natural or other physical barriers.

## **28. HELICOPTER OPERATIONS**

- 28.1. A helicopter landing zone (LZ), if needed, should be designated as early as possible by the Incident Manager or the Manager's designed EMS Air Ambulance Coordinator.

- 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 nearby power lines.

- 28.2. The overall size of an LZ should be not less than 500 feet by 500 feet.
  - 28.2.1. The helicopter touchdown site in daylight should be not less than 75 feet by 75 feet.
  - 28.2.2. The helicopter touchdown site at and after dusk should be not 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 appropriately 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 helicopters, especially during a "hot" operation, when the aircraft engines and rotors are not shut down.
  - 28.2.6. Precise marking of the LZ in bright daylight is not essential as long as the intended area is obvious to the helicopter flight crew.
  - 28.2.7. The LZ at dusk and in darkness should be marked with lights (lantern, vehicular, etc.), but not flares. All lighting must be secured against the helicopter's down-draft.
  - 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 if necessary 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 Statewide Mutual Aid radio frequency (155.205) should be used when communicating with the helicopter. Good communications with the flight crew will ensure the prompt and safe landing 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. VIRGINIA E.M.S. DISASTER TASK FORCES**

29.1. In a declared state of 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 (1800-468-8892 or 804-674-2400).

29.2. EMS Disaster Task Forces can be deployed in three configurations. The requesting jurisdiction should identify the specific configuration needed.

29.2.1. **Standard Task Force:** Composed of one Basic Life Support (BLS) ambulance, one Advanced Life Support (ALS) ambulance, one heavy-duty or medium-duty rescue truck, and a disaster truck or trailer if available, with a Task Force Commander and minimum of eight (8) EMS providers.

29.2.2. **Personnel Package:** Composed of standard Task Force staffing with appropriate transportation. No equipment other than personal kits is carried by providers.

29.2.3. **Augmentation Package:** A standard Task Force with vehicles and personnel tailored to meet the needs of the requesting jurisdiction.

29.3. EMS Disaster Task Forces are designed to be used as units to either undertake specific tasks or to supplement the needs of the requesting jurisdiction.

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

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

**30. MOVEMENT OF PATIENTS INTO OR OUT OF THE REGION**

30.1 During a major MCI or a national emergency, it may become necessary to move large numbers of patients into or out of the ODEMSEA region. Such movements will be done in accordance with the Central Virginia National Disaster Medical System (NDMS) Operations Plan and the Richmond Regional Metropolitan Medical Response System (MMRS) plan. Copies of both are included as appendices of this document.

### **31. DEACTIVATING THE M.C.I. PLAN**

- 31.1. The Medical Incident Manager will be responsible for notifying MCI Medical Control that all patients have been assigned to transport units and that all on-scene patient care activities have been completed and ended at the MCI or Evacuation site or sites.
- 31.2. The on-scene Medical Incident Manager should confer with the appropriate official (e.g. Incident Manager, Emergency Services Coordinator, healthcare facility CEO) to determine any additional patient care need for EMS prior to contacting the MCI Medical Control.
- 31.3. If appropriate and possible, on-scene contact to MCI Medical Control should be made by phone (804-828-8888 if the MCI Medical Control hospital is VCU Medical Center). Otherwise, radio communication should be used.
- 31.4. MCI Medical Control will deactivate the MCI Plan among activated hospitals when the designated MCI Medical Control hospital is notified by the on-scene Medical Incident Manager that EMS activities are completed at the MCI or Evacuation site or sites, and when it determined that all other patient care issues have been resolved.

### **32. THE M.C.I. COMMITTEE**

- 32.1. The Central Virginia MCI Committee is a working Committee of the Old Dominion EMS Alliance. It is made up of representatives of the hospital and prehospital components, career and volunteer, that render emergency medical care in Planning Districts 13, 14, 15 and 19. Other members include representatives of health care facilities outside the region, which have signed the Central Virginia MCI Plan's Memorandum of Understanding.
- 32.2. Other members of the Committee include, but are not limited to, representatives of related local, state and federal agencies (including law enforcement 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.
- 32.3. Members will be recommended by the Committee and endorsed by the ODEMSA Board of Directors. Members shall serve in an uncompensated capacity on the Committee for as long as they are willing and able to render service to the cause of regional disaster preparedness.

### **33. ADOPTION OF THE M.C.I. PLAN MEMORANDUM OF UNDERSTANDING**

- 33.1. Participation in the plan shall be through the adoption by the appropriate governing body and signing by an authorized representative of the Central Virginia Mass Casualty Incident Plan Memorandum of Understanding, as most recently revised.
  - 33.1.1. Copies of the Memorandum of Understanding and this Mutual Aid Response Guide shall be provided to each locality and hospital by ODEMSA.

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

33.1.3. Copies of the Memorandum and one copy of the Mutual Aid Response Guide shall be filed by ODEMSA with the Virginia Office of Emergency Medical Services.

33.1.4. In the case of a hospital, a resolution of adoption shall include an appendix that provides for appropriate adjunctive or emergency privileges to be accorded to attending physicians during an MCI (See Section 18).

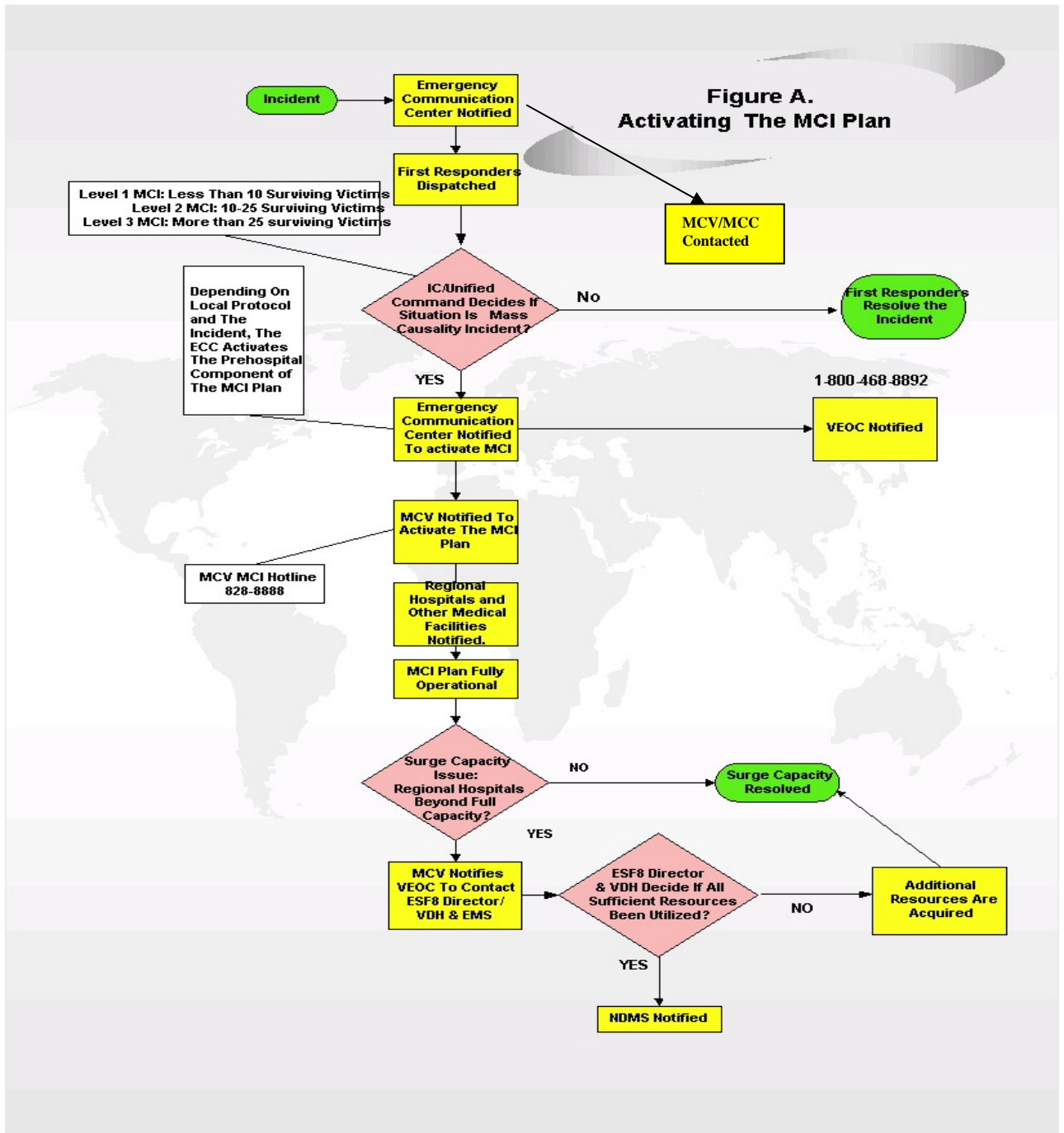
**34. REVISIONS AND AMENDMENTS TO THE M.C.I. PLAN**

34.1. The Central Virginia MCI Committee is responsible for reviewing each year the MCI Plan in line with the Central Virginia MCI Plan Memorandum of Understanding, for proposing revisions and/or amendments to the Mutual Aid Response Guide as necessary to maintain its effectiveness, for reviewing and evaluating any activation of the MCI Plan, and for planning annual MCI exercises in the region.

34.2. 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.

34.3. Revisions and/or amendments to the Plan will require a two-thirds majority of the members present in a quorum to be enacted

## 35. ACTIVATING THE CENTRAL VIRGINIA MASS CASUALTY INCIDENT PLAN



Algorithm Courtesy of Richmond Regional MMRS

Original signed MOUs for the Central Virginia Mass Casualty Incident Plan are on file at the Office of the Old Dominion EMS Alliance, 1463 Johnston-Willis Drive, Richmond, VA 23235-4730. Please direct inquiries to the attention of the Executive Director at 804-560-3300 or by e-mail to [odemsa@vaems.org](mailto:odemsa@vaems.org). A copy of the Central Virginia MCI Plan can be downloaded from ODEMSA's web site, [www.oemsa.vaems.org](http://www.oemsa.vaems.org).

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Reviewed and Revised 04/07



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### Hospital Diversion Policy For Emergency Patients ***Annex B to the Central Virginia***

#### Mass Casualty Incident Plan

Planning Districts 13, 14, 15 and 19  
Current May 2007

**A. PURPOSE:** To maintain an orderly, systematic and appropriate distribution of emergency patients transported by ambulances during a single or multiple hospital diversion situation within the Old Dominion EMS Alliance region.

**B. SCOPE:** This policy pertains to all 17 acute care hospitals and all licensed EMS agencies providing ground ambulance transportation as defined in Virginia Department of Health regulations. It will be Annex B to the Central Virginia Mass Casualty Incident Plan, as most recently revised, of which all 17 hospitals are signatories.

This Policy will have the highest level of impact on the 13 acute care hospitals in the Richmond/Tri-Cities area (PD 15 and 19). However, it also is recognized that the diversion status of those 13 hospitals can have a significant impact on the four remaining acute care hospitals located in Emporia, Farmville, South Boston and South Hill (PD 13, 14 and 19).

#### **C. POLICY ELEMENTS:**

- 1. INDICATIONS:** Acute care hospitals (those with emergency departments) occasionally become overwhelmed with patients, exceeding the capacity for medical staff to adequately treat and monitor those patients. To alleviate this temporary situation, a receiving hospital – after completing an established process – may declare a diversion of acute patients, whereby ambulances are diverted to other area hospitals.

Ambulance diversion should occur only after the hospital has exhausted internal mechanisms to relieve the situation. When an intended hospital has declared a diversion of emergency patients, on-line Hospital Medical Control at the diverting hospital will recommend to an EMS ambulance crew that the patient be taken to another hospital.

**NOTE:** Early contact and notification by the EMS ambulance crew to the intended hospital is essential for optimal patient care. It is highly recommended that the ambulance Attendant in Charge (AIC) use the regional MIVT Report format when providing the hospital with pre-arrival information on the patient. Once an EMS unit has marked on route and a report has been given to the receiving hospital, any later change in diversion status of the receiving hospital will not affect that ambulance.

2. **CONTRAINDICATIONS:** Patients with airway obstruction, uncontrollable airway, uncontrollable bleeding, who are in extremis, or with CPR in progress should be taken immediately to the closest appropriate hospital, without regard to the hospital's diversion status. Level 1 Trauma Centers are never on diversion for major or multi-system trauma patients except in extraordinary circumstances (See Item 5-E, Out of Service, below).

3. **DIVERSION OVERRULE:** Prehospital EMS providers may overrule diversion if a patient is in extremis, or for significant weather/traffic delays, mechanical problems, etc. An EMS provider who believes an acute decompensation is likely to occur if the patient is diverted to a more distant hospital **ALWAYS** has the option to take that patient to the closest Emergency Department regardless of the diversion status. The Attendant-in-Charge also has the option to ask via radio or phone to speak directly to an Emergency Department physician. Good clinical sense and optimal patient care are the ultimate considerations.

**NOTE: Such decisions to overrule a hospital's diversion status may be referred for review to the Old Dominion Medical Control Committee and the provider's agency by the receiving hospital.**

4. **CONSIDERATIONS:** When there are questions about hospital destination in an out-of-hospital situation, the prehospital attendant-in-charge should contact the local hospital as early as possible by radio or phone for destination guidance.

**NOTE: Decisions by on-line Medical Control and prehospital EMS providers about patient destination must always be in the best interest of the patient.**

5. **CATEGORIES OF HOSPITAL STATUS:**

**A) Open** -- When a hospital has full capacity for receiving its usual patient load.

**B) Special Diversion (Case-by-Case)** -- When a hospital is unable to handle certain types of patients (e.g. critical care, adult medical, trauma, pediatric, burns, OB, etc.)

**C) Closed to Ambulances (FULL)** -- When the hospital has exhausted all resources to appropriately treat additional patients. The Emergency Department (ED) is "closed" to all EMS traffic except those noted under Contraindications.

**D) Forced Open** -- The hospital ED would be on diversion, but is open because of multiple hospital ED closures in the region.

**E) Out of Service** -- Critical or catastrophic circumstances result in operational shutdown. Hospital cannot receive any new patients by EMS or other means. Hospital cannot be placed in "Forced Open" category.

**6. METRO/TRI-CITIES HOSPITAL SECTORS (See Appendix A):**

During a diversion crisis (Stages RED and BLACK), every attempt will be made by the Medical Control Hospital to direct ambulances to hospitals in one of five sectors listed below that most closely aligns with their respective localities.

**NOTE:** When the hospitals in Emporia, Farmville, South Boston or South Hill are on diversion or closed to ambulances, patients will be transported to the closest open hospital - which may be outside the EMS agency's catchment area - with or without the direction of the Medical Control Hospital.

HENRICO-EAST	HANOVER/HENRICO WEST
Memorial Regional Medical Center John Randolph Medical Center Richmond Community Hospital VCU Medical Center	Henrico Doctors' Hospital-Forest Henrico Doctors' Hospital-Parham St. Mary's Hospital Memorial Regional Medical Center VCU Medical Center
RICHMOND	CHESTERFIELD
CJW Medical Center-Chippenham Retreat Hospital Richmond Community Hospital St. Mary's Hospital VCU Medical Center	CJW Medical Center-Chippenham CJW Medical Center-Johnston-Willis John Randolph Medical Center Southside Regional Medical Center St. Francis Medical Center
TRI-CITIES	
CJW Medical Center-Chippenham John Randolph Medical Center Southside Regional Medical Center Southern Virginia Regional Medical Center (Emporia) VCU Medical Center	NOTE: There will be times when it is necessary during a Diversion Crisis to send an ambulance outside its primary sector. However, the Medical Control Hospital's goal will be to keep such movements to a minimum.

**7. STAGES OF REGIONAL DIVERSION:**

- A) Stage 1 – GREEN** = Less than 50 percent of total ED volume is on either critical care or adult medical diversion.
- B) Stage 2 – RED** = 50 percent or more of total region ED volume and at least five (5) hospitals are on either critical care or adult medical diversion. Medical Control is established and Medical Control Hospital begins distribution of patients to open hospitals.
- C) Stage 3 – BLACK** = 75 percent or more of total region ED volume is on either critical care or adult medical diversion. Medical Control distribution of patients continues to all hospitals. See Special Considerations, Page 4.

7. STAGES OF REGIONAL DIVERSION (Continued)

STAGE	HOSPITALS ON DIVERSION	ACTION TAKEN	NOTIFICATION	DOWNGRADING
Stage 1 <b>(GREEN)</b>	Less than 50% of total region ED volume is on adult medical diversion.	System-wide notification via EMSsystem.	Hospital name and reason for diversion (as applicable).	N/A
Stage 2 <b>(RED)</b>	<b>General:</b> 50% or more of total Region ED volume and at least five (5) hospitals are on adult medical or critical care diversion.	System-wide notification via EMSsystem.  ECCs to notify EMS providers to call Medical Control Hospital (MCH) for hospital destination.  After Medical Control is established, <b>ALL</b> EMS providers will contact MCH for instructions.	Hospital name and reason for diversion (as applicable).  MCH (VCU Medical Center or alternate) establishes Medical Control and begins weighted distribution of patients via EMS to remaining <u>open</u> hospitals.  Veterans and VA patients to be directed to McGuire VA Medical Center (MVAMC) if open.	When downgrading from <b>Stage 2 (Red)</b> back to <b>Stage 1 (Green)</b> there should be less than 50% of region and less than five (5) hospitals on diversion.
Stage 3 <b>(BLACK)</b>	<b>General:</b> 75% or more of total Region ED volume on diversion  <b>Psych:</b> Four of six psych facilities are on similar types of diversion.  <b>Pediatric:</b> All three hospitals with PICUs are on diversion.	System-wide notification via EMSsystem.  Medical Control is ongoing. MVAMC is included in distribution  ALL EMS providers must continue to contact MCH for instructions regarding each transport.	Hospital name and reason for diversion.  Medical Control continues with 2 following options: 1. Weighted distribution to <u>all</u> area hospitals, i.e., all hospitals are “forced open,” <b>OR</b> 2. Begin Mass Casualty Incident (MCI) response.	When downgrading from <b>Stage 3 (Black)</b> to <b>Stage 2 (Red)</b> there should be less than 75% of the region on diversion.  MCH continues weighted distribution with focus on open hospitals as much as possible.

**SPECIAL CONSIDERATIONS:** Strongly consider Code Black for North Central Region when 5 out of 7 hospitals, excluding MVAMC, are on diversion regardless of the percentage. Strongly consider Code Black for South Central Region when 4 of the 5 following hospitals -- CJW-C, CJW-J, JRMC, SRMS and SFMC -- are on diversion regardless of percentage.

**D. GENERAL PROCEDURE FOR MANAGEMENT:**

1. The Hospital Sector and Stages of Regional Response tables that are part of this document will govern actions taken during a diversion emergency.
2. All participating hospitals will update promptly their status on EMSsystem when going on any diversion status, and when coming off diversion. A hospital on "Closed to Ambulances" must update its status every two hours.
3. The primary Medical Control Hospital will be the Virginia Commonwealth University Medical Center, or an identified alternate facility, as specified in the Central Virginia MCI Plan, Section 15.1.
4. The diverting hospitals will use the EMSsystem "comments" window for pertinent information when changing from Open to any diversion status.
5. During Stage 1 (Green), EMS ambulance crews planning to transport to a hospital should contact the local emergency communications center (ECC) and/or the intended hospital as early as possible, and preferably before leaving the scene, to determine the hospital's status.
6. Once an EMS ambulance has marked on route and a MIVT report has been given to the receiving hospital, any later change in diversion status of the receiving hospital will not affect that ambulance.
7. When Stage 2 (Red) is reached, the Medical Control Hospital will use EMSsystem to notify hospitals that it is assuming medical control and begin "weighted" distribution of ambulance patients to open hospitals in the Hospital Sectors.
8. When Stage 2 (Red) has been declared by the Medical Control Hospital, out-of-hospital EMS ambulances are required by agreement to contact the Medical Control Hospital before transporting patients. They should be directed to do so by the local ECC using information from EMSsystem, or by the diverting hospital when it is contacted.
9. **NOTE: During a Stage 2 (Red) diversion emergency, the Medical Control Hospital will attempt to assign ambulance emergency patients to the closest appropriate medical facility to that patient, and will work to keep ambulances within Hospital Sectors when possible.**
10. The diverting hospital may be asked to provide on-line medical direction to the transporting EMS ambulance crew. If so, the diverting hospital will maintain medical direction until acknowledged by the receiving hospital. The ambulance crew will document the diversion on the Prehospital Patient Care Report (PPCR) form.
11. In a Stage 3 (Black) diversion situation, the Medical Control Hospital has the option to begin weighted distribution of ambulance patients to all 13 hospitals, i.e., all hospitals are "forced open," OR to use the current Central Virginia Mass Casualty Incident Plan Guidelines to direct emergency patient transports and destinations.

12. NOTE: MCI Medical Control Hospital/ODEMSA may consider downgrading or upgrading the regional status at any time based on system conditions and in accordance with the stated purpose of the Policy.
13. Before downgrading from Medical Control (Stage Red) back to Stage Green there should be less than 50% of the region's hospitals and less than five (5) hospitals on diversion.
14. Before downgrading from Stage Black to Stage Red, less than 75 percent of the total Region ED volume should be on diversion, and the Medical Control Hospital would continue with weighted distribution, focusing on open hospitals as much as possible.
15. Nothing in this Hospital Diversion Policy shall supercede or contradict the ODEMSA Regional Trauma Care System Plan.
16. This Hospital Diversion Policy will be reviewed at least once every year by a subcommittee of the Old Dominion Medical Control Committee. The subcommittee will be comprised of representatives of the Medical Control Hospital, other acute care hospitals, out-of-hospital EMS agencies and appropriate local and state healthcare organizations.
17. Proposed major revisions and/or amendments will be acted upon not longer than 60 days after the signatories of the Central Virginia MCI Plan have been notified of the proposed changes and have had an opportunity to respond.

E. **WEIGHTED PATIENT DISTRIBUTION SCHEDULE: \***

**Richmond Area, Based on Annual ED Volumes (See Appendix B)**

CJW Medical Center-Chippenham	4 **	
CJW Medical Center-Johnston-Willis	3	
Henrico Doctors' Hospital-Forest	2	
Henrico Doctors' Hospital-Parham	1	
John Randolph Medical Center	3	
McGuire VA Medical Center	1 ***	
Memorial Regional Medical Center	3	
Retreat Hospital	1	
Richmond Community Hospital	2	
St. Mary's Hospital		3
Southside Regional Medical Center	3	
VCU Medical Center	5 **	

**The Medical Control Hospital can use or adjust this schedule/rotation as needed during the Red/Black stages.**

\* 12 K/year equivalent to 1 patient unit. All ratios are rounded down.

\*\* The largest volume facility distribution ratios were adjusted slightly downward to account for trauma patients.

\*\*\* VA and veteran medical patients will be directed to McGuire VA Medical Center if open to ambulances during Stage 2 (Red). During Stage 3 (Black), McGuire VA Medical Center will receive VA, veteran or

civilian patients per the Weighted Patient Distribution Schedule or the Regional MCI Plan (See Appendix C).

Current May 2007

## Hospital Diversion Policy

### Appendix A

#### Primary Hospital Sectors for the Richmond/Tri-Cities Areas

During a diversion crisis (Stages RED and BLACK), every attempt will be made by the Medical Control Hospital to direct ambulances in one of five sectors that most closely align with their respective localities. For example, hospitals in the Hanover/Henrico-West Sector would be the primary destination for ambulances in Hanover, Henrico, and Goochland counties. Hospitals in the Chesterfield Sector would be the primary destination for ambulances in Chesterfield and Powhatan counties. It must be understood that there will be times when it is necessary during a Diversion Crisis to send an ambulance to a hospital outside its primary sector. The goal, however, is to keep such movements to a minimum.

##### HENRICO-EAST SECTOR

Memorial Regional Medical Center  
John Randolph Medical Center  
Richmond Community Hospital  
VCU Medical Center

##### HANOVER/HENRICO-WEST SECTOR

Henrico Doctors' Hospital -Parham  
Henrico Doctors' Hospital-Forest  
St. Mary's Hospital  
Memorial Regional Medical Center  
VCU Medical Center

##### RICHMOND SECTOR

CJW-Chippenham  
Richmond Community Hospital  
Retreat Hospital  
St. Mary's Hospital  
VCU Medical Center

##### CHESTERFIELD SECTOR

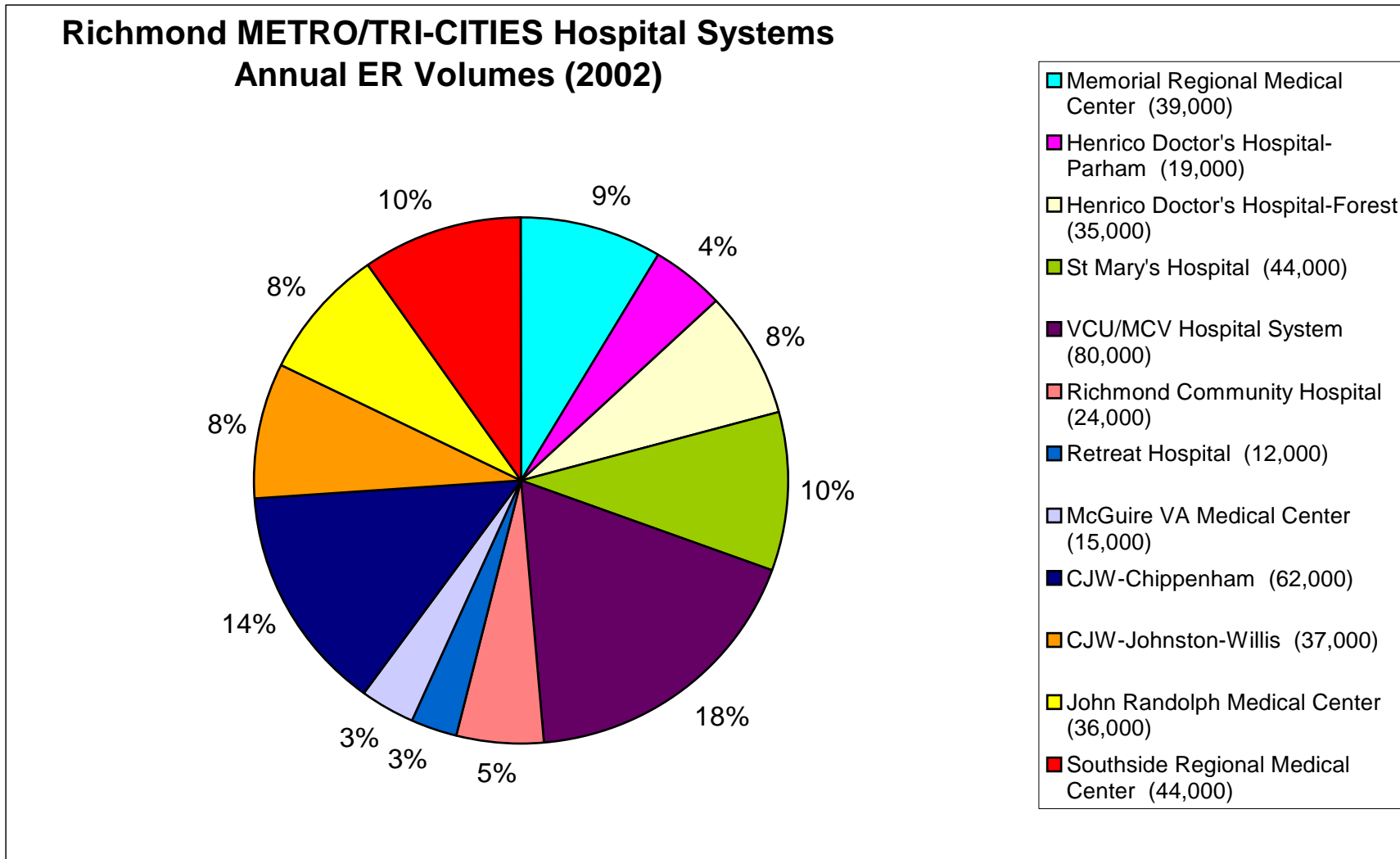
CJW-Chippenham  
CJW-Johnston Willis  
Southside Regional Medical Center  
John Randolph Medical Center  
VCU Medical Center  
St. Francis Medical Center

##### TRI-CITIES SECTOR

Southside Regional Medical Center  
John Randolph Medical Center  
CJW-Chippenham  
VCU Medical Center  
Southern Va. Regional Medical Center (Emporia)

Current May 2007

## Hospital Diversion Policy- Appendix B



**Richmond/Tri-Cities Hospital Systems Annual ED Volumes (2002)**

June 2004

# Hospital Diversion Policy

## Appendix C

### McGuire VA Medical Center Diversion Protocol

By federal law, McGuire Veterans Affairs Medical Center's (MVAMC's) Emergency Department may only care for patients enrolled in the Veterans Affairs (VA) healthcare system (VA Patients), or honorably-discharged veterans of the U.S. armed forces (Veteran Patients).

When MVAMC is Open to Ambulances, it will receive only VA Patients and Veteran Patients.

When on Special Diversion status, MVAMC will not be able to accommodate any VA Patients or Veteran Patients in the particular category or categories stated on EMSystem.

When on Closed to Ambulances status, MVAMC will not be able to receive any patients.

During Stage 2 (Red), the Medical Control Hospital will direct VA Patients and Veteran Patients to MVAMC if it is Open to Ambulances.

During Stage 3 (Black), MVAMC will receive VA Patients, Veteran Patients and civilian patients per the Weighted Patient Distribution Schedule of the Regional MCI Plan.

**G. Current January 2007**

####

# Hospital Diversion Policy

## Appendix D

### Hospitals With Psychiatric and/or Pediatric Intensive Care Units

#### Psychiatric Units:

CJW Medical Center-Chippenham  
7101 Jahnke Road  
Richmond, VA 23225

Community Memorial Healthcenter  
125 Buena Vista Circle  
South Hill, VA 23970

John Randolph Medical Center  
411 W. Randolph Road  
Hopewell, VA 23860

Richmond Community Hospital  
1500 N. 28<sup>th</sup> Street  
Richmond, VA 23228

St. Mary's Hospital  
5801 Bremo Road  
Richmond, VA 23226

Southside Regional Medical Center (2)  
801 S. Adams Street  
Petersburg, VA 23803

VCU Medical Center (1)  
401 N. 12<sup>th</sup> Street  
Richmond, VA 23298

#### Pediatric Intensive Care Units (PICUs):

CJW Medical Center-Chippenham  
7101 Jahnke Road  
Richmond, VA 23225

St. Mary's Hospital  
5801 Bremo Road  
Richmond, VA 23226

VCU Medical Center  
401 N. 12<sup>th</sup> Street  
Richmond, VA 23298

H. Current May 2007

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# Hospital Diversion Policy

## Appendix E

### Acute Care Hospitals in the ODEMSA Region

CJW Medical Center-Chippenham (2)  
7101 Jahnke Road  
Richmond, VA 23225

CJW Medical Center-Johnston-Willis (2)  
1401 Johnston-Willis Drive  
Richmond, VA 23235

Community Memorial Healthcenter  
125 Buena Vista Circle  
South Hill, VA 23970

Halifax Regional Hospital  
2204 Wilborn Avenue  
South Boston, VA 24592

Henrico Doctors' Hospital - Forest  
1602 Skipwith Road  
Richmond, VA 23229

Henrico Doctors' Hospital - Parham  
7700 Parham Road  
Richmond, VA 23294

John Randolph Medical Center  
411 W. Randolph Road  
Hopewell, VA 23860

McGuire VA Medical Center  
1201 Broad Rock Road  
Richmond, VA 23249

Memorial Regional Medical Center  
8260 Atlee Road  
Mechanicsville, VA 23116

Retreat Hospital  
2621 Grove Avenue  
Richmond, VA 23220

Richmond Community Hospital  
1500 N. 28<sup>th</sup> Street  
Richmond, VA 23228

St. Mary's Hospital  
5801 Bremono Road  
Richmond, VA 23226

**Southern Va. Regional Medical Center**  
727 N. Main Street  
Emporia, VA 23847

Southside Community Hospital  
800 Oak Street  
Farmville, VA 23901

Southside Regional Medical Center (2)  
801 S. Adams Street  
Petersburg, VA 23803

**St. Francis Medical Center**  
13700 St. Francis Boulevard  
Midlothian, VA 23114

VCU Medical Center (1)  
401 N. 12<sup>th</sup> Street  
Richmond, VA 23298

**NOTE:** (1) Level 1 Trauma Center  
(2) Level 3 Trauma Center

Current January 2007



**OLD DOMINION EMERGENCY MEDICAL SERVICES ALLIANCE INC.**

**1463 Johnston-Willis Drive  
Richmond, VA 23235-4730  
804-560-3300 • FAX: 804-560-0909  
www.odemsa.vaems.org**

**Central Virginia MCI Plan Annex C  
Guidelines for Emergency**

**Air Medical Evacuation**

The Old Dominion EMS Alliance (ODEMSA) welcomes the PHI SkySTAT, the newest air medical resource within the Central Virginia region. This service joins the Virginia State Police EMS Med-Flight 1 and Virginia Commonwealth University LifeEvac in providing care and air transport for patients throughout the ODEMSA region. In keeping with the goals and values as adopted by the ODEMSA's Air Medical Committee, committee members have reviewed all policies and protocols related to the air medical evacuation of patients. The Committee has developed general guidelines and recommends that all Emergency Communications Centers (ECCs) update their databases with the current contacts of each air medical resource because some have changed recently.

**General Guidelines:**

- 1) Transport of patients from the scene, including the mode of transportation, should be in line with Section 1 of the Regional Transport Guidelines of the ODEMSA Trauma Care System Plan. Protocols for the use of air medical evacuation of medical scene patients remain in the development stage.
- 2) The requesting ECC may utilize the closest air medical resource as determined by computer-aided dispatch or by utilizing the Air Medical Resource List matrix as provided by ODEMSA. It is recommended that requests for air medical resources are made through the city/county ECC whenever possible and be in line with what is best for the patient. When a primary aircraft is unavailable, each of the air medical dispatch centers in the region has agreed to coordinate the response of the next closest, appropriate air medical resource.
- 3) Transfer of patients from local hospitals will continue to utilize existing partnerships or agreements.
- 4) The dispatch numbers for these resources are as follows and the centers are working with ODEMSA in providing seamless dispatch of the primary and any secondary aircraft required:

<b>VSP Med-Flight 1:</b>	<b>1-800-468-8892 or 804-674-2400, 7400 Airfield Dr., Richmond, 23237.</b>
<b>VCU LifeEvac:</b>	<b>1-877-902-7779, 23301 Airport Road, Petersburg, 23803.</b>
<b>PHI SkySTAT:</b>	<b>1-877-SkySTAT (1-877-759-7828), 7300 Airfield Dr., Richmond, 23237.</b>

The ODEMSA Air Medical Committee meets quarterly in January, April, July and October. Please contact ODEMSA at 804-560-3300 if you have any questions or suggestions, or if you want the schedule of meetings in 2006.

Attachments:

ODEMSA Region Helicopter First Due Map  
Air Medical Resource List  
Air Medical Contact Phone Numbers

**Current 01/2007**

**Serving the Citizens, EMS Agencies, Hospitals and Local Governments in Virginia's Planning Districts 13, 14, 15 and 19**