ATTACHMENT G: EMERGENCY MEDICAL SYSTEMS / MASS CASUALTY INCIDENT PLAN

This attachment is part of Annex F of the State of Oregon Emergency Management Plan and should be used in conjunction with the other attachments and appendices. It is not a stand-alone plan.

1 INTRODUCTION

This document describes how resources regulated by the Oregon Department of Human Services (DHS) Emergency Medical Services & Trauma Systems (EMS & TS) will respond to potentially catastrophic events. It is the intent of DHS to create an environment where the fullest degree of cooperation among agencies who assist or require assistance under this plan is exercised. By providing a comprehensive framework for mass casualty medical preparedness and response, the ultimate goal of preventing unnecessary suffering and loss of life may be achieved.

This plan outlines key assumptions for a response, and refers to relevant legal and statutory authorities. It adopts the Incident Command System (ICS) as promulgated by the National Fire Academy under the Federal Emergency Management Agency's National Emergency Training Center. This provides a proven model that will allow the implementation of an incident management system. The ICS is flexible enough to use in all types of emergencies.

DHS will carry out the response activities described in this plan in collaboration with the state Office of Emergency Management (OEM), health care workers, other local, state and federal agencies and health departments. DHS recognizes that medical care and ambulance services are provided in large part by private sector entities. Integrating non-governmental and governmental providers throughout the process to assure resource availability and access to reimbursement will be critical to the success of the plan. It is the intent of this document to provide guidance, rather than direct the operations of responding agencies. It is the responsibility of all agencies to ensure that their respective local incident management plans used for day-to-day operations encompass all aspects of the ICS in structure and terminology.

This plan does not prevent any of the parties from entering into cooperative agreements with any other party for mutual cooperation during day-to-day operations. It is incumbent upon all agencies to ensure that all personnel affected by this plan receive the training, and have the qualifications, necessary to perform the function outlined within.

2 PURPOSE AND AUTHORITIES

2.1 Purpose

The purpose of the EMS Mass Casualty Incident Plan is to reduce loss of life, injury, suffering, and other medical consequences of a major event by ensuring a rapid, effective, and coordinated State medical response. This plan focuses on elements necessary to ensure that high-quality community resources are available to respond to medical emergencies in Oregon.

Wherever response is typical to any public health emergency, reference will be made to Annex F, ESF-8 Health and Medical Services. Annex F can be found on the Health Alert Network (HAN) web site (https://www.oregonhan.org), or can be requested by contacting the OPHD Emergency Preparedness Program (971-673-1308).

2.2 Authorities

DHS EMS & TS has a primary responsibility to ensure that EMS responders are trained to minimum standards, emergency vehicles are properly equipped, and pre-hospital emergency systems are functioning efficiently and effectively. EMS responders are responsible for the assessment, stabilization, and transport of victims to appropriate destinations.

Oregon Revised Statute

30.80	Good Samaritan Law
401.015	Statement of Policy and Purpose (emergencies)
401.035	Responsibility for Emergency Services Systems
401.045	Interstate Emergency and Disaster Assistance Compact
401.065	Police Powers During Emergencies, Suspension of Agency Rules
401.515	Non-liability for Emergency Services, Exception
401.654	Registry of Emergency Health Care Providers
431.110	General Powers of Department of Human Services
431.120	Duties of Department of Human Services
431.150	Enforcement of Health Laws, Generally
431.530	Authority of Local Health Administrator in an Emergency
431.607	Trauma System
433.019	Procedure to Impose Public Health Measure, Enforcement
433.035	Examination of Persons Prior to Imposing Health Emergency
433.106	Power to Impose Public Health Measures
433.441	Proclamation of State of Impending Health Crisis
443.433	Quarantine
433.452	Detention for Health Investigation
448.160	Emergency Plans
682	Ambulance and Emergency Medical Personnel
820.300	Emergency Vehicles: Traffic Laws, Records, and Equipment
847.035	Board of Medical Examiners: Scope of Practice

Oregon Administrative Rule

333.200	Oregon Trauma System
333.250	Ambulance Service Licensing
333.255	Ambulance Licensing
333.260	Ambulance Service Area
333.265	Emergency Medical Technicians

3 SITUATION AND ASSUMPTIONS

3.1 Situation

DHS EMS & TS is responsible for certifying 8,000 Emergency Medical Technicians in Oregon. Additionally, they provide coordination to the State Trauma System. During a mass casualty event that overwhelms local ability to respond, DHS may assist by providing a coordination of resources to local health officials, first responders, state and federal agencies, and Incident Command. Coordinated and consistent efforts will be necessary to prevent an event from depleting local resources, and to diminish unnecessary suffering and loss of life. Response to mass casualty incidents will focus on provider safety and protecting human health.

A variety of incidents may initiate this plan. In any situation, the impact on human health can be extensive and enduring. Incidents may threaten the health and safety of first responders, emergency hospital personnel, and other workers in various occupational settings. Such incidents may result in environmental contamination, thus generating risk for ongoing human exposures and unforeseen long-term health consequences. Research indicates there may be psychological impacts on people who are not directly exposed to an incident, but who are still concerned about their health.

Administrative, procedural, and statutory barriers may exist impeding the implementation of the plan. DHS EMS & TS will consider appropriate changes as necessary to fully implement the plan.

3.2 Assumptions

Local jurisdictions vary widely by the threats they may face, the vulnerability of their populations, and the response resources immediately available to them. It is firmly held that emergency response is best coordinated at the level of government involved in the emergency. When local resources are overwhelmed, and additional assistance is necessary, such assistance should be available. Rapid response is essential at all levels of government, as disaster medical response is time critical.

This plan does not replace local response plans or mutual aid agreements. DHS EMS & TS encourage local jurisdictions to establish an Emergency Medical Systems / Mass Casualty Incident Plan (EMS/MCI Plan). Local plans should be in accordance with regional preparedness plans. It is encouraged that areas adopt an all-hazards and capabilities-based planning approach. Capabilities-based planning prepares for a wide range of challenges, while working within an economic framework that necessitates prioritization and choice.

Mutual Aid should be requested when needed, and provided when available. It will be necessary for public and private medical resources to operate in a coordinated manner for maximum effectiveness. It is important to note that agencies should follow existing dispatch protocol during the early phases of a large emergency response, self-dispatching is not recommended and is expressly forbidden in this plan.

Mass casualty incidents often reduce response capacity through their impact on local resources. Public safety resources may find that they have dual roles, further limiting capabilities. Ambulances supported by fire departments may be overwhelmed with fire suppression, hazardous material response, etc. Additionally, many EMS personnel work for multiple agencies, and any individual entity may be required to operate below typical staffing levels.

State and local agencies will have response roles in a catastrophic mass casualty incident. Resources need to be coordinated through a unified command structure to efficiently handle large numbers of injured, ill, and worried persons. Many are likely to converge at medical and health care facilities in or near affected areas.

Special needs populations rely on government assistant during disaster situations, and may be especially vulnerable. Additionally, there may be areas where the population has limited proficiency in English. Communities should establish relationships with local media outlets (television and radio) to deliver immediate messages if necessary. Giving real-time instructions to survivors can be life-saving. Non-traditional resources should be available for immediate use.

Federal agencies, including the Department of Homeland Security, may coordinate resources when Oregon's resource demands exceed availability, or when an event extends beyond state boundaries.

Ongoing training and planning updates will be necessary. Local agencies should provide courses on first aid, search and rescue, disaster care, and provide public education on the limitations of disaster response when possible. Such training may mitigate the severity of some types of disasters.

4 CONCEPT OF OPERATIONS

4.1 Notification

DHS EMS & TS may receive notification of a catastrophic mass casualty incident through the Public Health Emergency Preparedness (PHEP) Duty Officer, or directly from the Oregon Emergency Response System (OERS), as managed by the Oregon Office of Emergency Management (OEM) in Salem. It is also possible that DHS EMS & TS may receive notification from mass media, local health departments, other governmental agencies, or members of the public.

Incident command shall request state mobilized resources (specifying the type of asset needed) via the local Public Safety Answering Point (PSAP) or appropriate Emergency Manager. Rally point, urgency of request, and contact information should be obtained. Requests will be relayed to the Oregon Office of Emergency Management, Emergency Response System (OERS).

- If State Emergency Coordination Center (ECC) is not active, OERS will contact the OEM Executive Duty Officer.

- If State Emergency Coordination Center (ECC) is active, OERS will forward the request to the County Liaison position in the State ECC.

    - County Liaison will enter the request into OpsCenter software, and forward to the ECC Operations Manager.

        - ECC Operations Manager reviews request, and forwards to ESF 8 at the State EOC, notifying the State Public Health Emergency Preparedness (PHEP) Duty Officer.

            - The PHEP Duty Officer will notify appropriate EMS & TS staff.

        - ESF 8 at the State EOC may, if necessary, coordinate with ESF 4 & 9 for the deployment of EMS resources. A determination must be made for regular deployment, or for a "Rapid Activation," based upon the resource request.

        - ESF 8 will contact County Emergency Managers, or designees, to deploy EMS assets, based upon the pre-determined asset list provided to DHS EMS & TS, ESF 8, and the PHEP Duty Officer.
            - ESF 8 will notify the Operations Manager to advise that the request has been filled, or that the resources are not available.

- If request cannot be filled, Ops Manager will request federal resources via an Action Request Form.

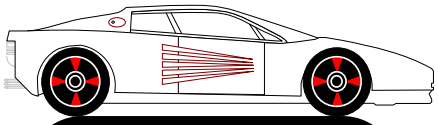
- Upon deployment, ESF 8 at the State EOC will:
  - Provide the rally point location, and on site coordinator contact information, as suggested by the requesting incident commander.
  - Provide radio frequency information for the affected area to the Team Leader(s). Additional communication information will be provided as available.
  - Update DHS EMS & TS, and OERS, with response information (responding unit capabilities and ETA)
    - OERS will update local incident command or PSAP if applicable.
  - Notify cities, counties, and regions neighboring affected areas regardless of deployment status. Local or regional plans may need to be activated to accommodate local resource depletion in areas that are deploying resources. All hospitals within affected areas, and deployment areas should be notified.

During a mass casualty incident, specialty personnel may be requested. Such requests are generally deployed as a single resource, based on availability. Some ICS positions have their own mass casualty deployment plans. Examples of these types of positions include public information officers, dispatchers, and specialized Search and Rescue resources.

A clandestine attack or an unnoticed accident, such as a slow leak of toxic materials into the environment, may come to the attention of OPHD, or OERS because of tracking systems. If is first to learn of an event, the PHEP Duty Officer will alert OERS, and OERS shall notify local responders via appropriate PSAPs.

EMS & TS will develop an internal procedure to assure 24-hour availability in the event of a catastrophic mass casualty incident. This will include procedures for multi-directional communication within and outside of DHS.

EMS & TS will work with County Emergency Managers, or designees, to pre-identify resources, both personnel and equipment. Resource lists should be maintained by EMS & TS, ESF 8 at the State EOC, and the PHEP Duty Officer. County Emergency Managers, or designees, will serve as a liaison between OEM and the available EMS assets.



Disaster Occurs

First Responders Arrive

ICS is Established

Local & State Agencies Respond

Counties Request State Assistance

OEM

Governor Proclaims Disaster

State Resources Authorized

Multi-Agency Coordination of State Resources Occurs from this site

Oregon ECC Per ORS 401

Agency Operations Remain the responsibility of the Agency, but coordination occurs through the State CC

Lead Agency Provides Operational Direction and/or Technical Advice for Response

All Agencies Serve as a Unified Management Team

Support Agencies Provide Support to Lead Agency

Agency Operational Control

OSP CP

ODOT CP

OHD CP

DEQ CP

ORNG CP

4.2 Operational Priorities

The operational priorities for DHS EMS & TS upon activation of this plan are as follows:

- Provide a subject matter expert (SME) to the Incident Commander and / or the OPHD Agency Operations Center. The SME may be from a range of personnel within the EMS & TS, including but not limited to:
    - Training and Certification Personnel, or Mobile Training Unit for just in time training needs or emergency credentialing.
    - Prehospital Systems Manager knowledgeable about availability of personnel and equipment resources statewide.
    - Trauma Systems Manager able to assist with hospital resource issues.
    - EMS for Children Coordinator knowledgeable about specialty transport and receiving hospital resources.
- Provide coordinated information on hospital or alternative care site capacity.
- Provide coordinated information on ambulance and other resource available necessary to stabilize and transport persons to appropriate destinations.
- Coordinate with other state agencies on threat assessments and resource needs.

5 ROLES AND RESPONSIBILITIES

5.1 Federal

Department of Homeland Security has the ability to support major incidents through the National Disaster Medical System.

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

DMATs are designed to be a rapid-response element to supplement local medical care until other Federal or contract resources can be mobilized, or the situation is resolved. DMATs deploy to disaster sites with sufficient supplies and equipment to sustain themselves for a period of 72 hours while providing medical care at a fixed or temporary medical care site.

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

DMORTs are designed to pro provide victim identification and mortuary services. They have they have the ability to provide temporary morgue facilities, victim identification, and process, prepare, and dispose of remains.

3. **Veterinary Medical Assistance Teams (VMAT)**

VMATs provide assistance in assessing the extent of disruption, and the need for veterinary services following major disasters or emergencies.

4. **National Nurse Reponses Team (NNRT)**

The NNRT is a specialty team used in any scenario requiring hundreds of nurses to assist in chemoprophylaxis, a mass vaccination program, or a scenario that overwhelms the nation's supply of nurses in responding to a weapon of mass destruction event.

5. **National Pharmacy Reponses Team (NPRT)**

The NPRT assist in chemoprophylaxis or the vaccination of hundreds of thousands, or even millions of Americans, or perhaps in another scenario requiring hundreds of pharmacists, pharmacy technicians, and students of pharmacy.

6. **Disaster Portable Morgue Units Team (DPMU)**

The DMORT DPMU promotes the most dignified handling and positive identification of fatalities in federally declared emergencies by supporting all DMORT teams through the efficient and effective management of federal mortuary assets throughout the planning, preparation and response phases.

When disaster medical resource needs cannot be met by resources within Oregon, the Governor may request assistance from federal agencies having statutory authority to provide assistance in the absence of Presidential Declarations. The Governor may also request a Presidential Declaration of an Emergency or Major Disaster. A federal declaration allows access to federal disaster medical assets and for federal disaster recovery funding for disaster medical response activities.

5.2 State

5.2.1 Oregon Public Health Division

5.2.1.1 Emergency Medical Services

DHS EMS & TS is responsible for the regulation of EMS responders and agencies. Facilitating necessary preparation for a catastrophic mass casualty event by providing regulatory systems that will assure access to quality emergency care for victims of such events is necessary.

Pre-event:

- Assure an integrated statewide ambulance system.
    - Ensure statewide mutual aid agreements exist
    - Develop a statewide asset list of license ambulances, personnel, and strike team units
    - Ensure interoperative communications
    - Develop an adequate surge plan
    - Ensure continual ambulance strike team availability

- Establish and maintain necessary regulatory framework to implement this plan.

- Deliver emergency medical training to rural areas that do not have educational resources through the Mobile Training Unit and distance learning. Enhance training opportunities to include Strike Team / Task Force preparation, and Ambulance Overhead Team training.

- Inspect and license ambulances and ambulance services.

- Inspect and certify trauma hospitals.

- Review and provide technical assistance for local / regional EMS plans.

Event:

- Facilitate the deployment of EMS resources as requested by OERS and OPHD.
- Provide technical expertise as requested.
- Waive certain requirements for a limited duration if appropriate. As an example, some areas may not be able to provide an EMT certified ambulance driver.
- Recommend the deployment of Oregon's Disaster Medical Assistance Team (OR-DMAT) if necessary.
- Coordinate the availability of anti-catastrophic agent supplies to responders from the Strategic National Stockpile and CHEMPACK.

Post-Event:

- Provide an after action analysis and report.

5.2.1.2 Public Health Emergency Preparedness

Pre-event:

- Prepare and maintain Memoranda of Agreement and operational plans with local CHEMPACK sites.
- Work with CDC and local CHEMPACK sites to manage CHEMPACK assets.
- Develop Regional EMS and Hospital Medical Surge Plans with local stakeholders.

Event:

- Facilitate the deployment of EMS resources as requested by OERS.
- Provide technical expertise as requested.
- Coordinate the availability of anti-catastrophic agent supplies to responders from the Strategic National Stockpile and CHEMPACK.

Post-Event:

- Ensure that mental health issues of emergency response personnel are addressed by

referring them to appropriate resources.

- Provide an after action analysis and report.

5.3 Local Health Departments (LHDs)

Local Health Departments are a branch of county government. They vary greatly in their resource availability. Regardless of size, county health departments are recognized as critical partners during all phases of a medical disaster. They should develop county and regional plans, including mutual aid agreements, to attach as an addendum to this document.

In general, the County Health Administrator is responsible for coordinating health, medical, mental health, and sanitation services required to cope with disasters on a County level. The Health Administrator or designee will serve as the Health Department representative for the County Emergency Operations organization, as necessary.

5.3.1 Pre-event

- Identify special needs populations
- Identify medical laboratory services, and their respective capabilities
- Provide disease surveillance and reporting
- Provide public health emergency planning and coordination

5.3.2 Event

- Provide a department coordinator or liaison to participate in all phases of a County's emergency management program, when necessary.
- Local Health Departments may provide expertise to the Oregon Office of Public Health AOC and liaison with EMS & TS staff as needed during an event.
- Direct the delivery of health and medical services
- Provide disease surveillance and reporting
- Assimilate health information, and provide accurate timely information about the health or medical aspects of the disaster.
- Identifying health hazards, including those from damage to water and sewage systems and disseminating emergency information on sanitary measures to be taken.

- Coordinating with the appropriate agencies for the provision of food and potable water to victims.

- Inspecting occupied emergency temporary housing and feeding areas.

- Coordinating with hospitals, clinics, nursing homes / extended care centers, and

- mental health organizations. Make provisions for populations with special needs.

- Coordinating with the Medical Examiner and Funeral Directors to provide identification and disposition of the dead.

- Providing emergency counseling for disaster victims and emergency response personnel suffering from mental and emotional disturbances.

5.4 Hospitals and Health Care Systems

Oregon's medical and medical care resources are primarily private sector. Local Health Departments and OPHD work closely with these resources and facilities to promote emergency preparedness and a coordinated response.

Private sector medical facilities and other resources in affected areas may have response obligations to their patients, clients, or communities. During emergencies with significant impact, private sector entities may
be incorporated within a local response, including field level activities. Requests for assistance should be processed through the respective local government entity to the EOC. The EOC may also request these resources to accept response tasks identified by the OPHD AOC.

Private sector medical resources should share status information and coordinate any response with the respective local government jurisdiction and EOC. ICS should be used to manage response activities.

Affected areas may require assistance from private sector resources in unaffected areas. Such resources may be acquired through three methods:

- Government requests through Local EOC, State OERS, or State OPHD AOC.
- Pre-established mutual aid or assistance agreements.
- Pre-existing contractual or corporate relationships (e.g., hospital to hospital under the same corporate umbrella).

The EOC in the receiving area, and the Local Health Authority (e.g. ASA administrator for ambulance services) of the sending area should be notified of the request, and the extent of resources to be provided.

Oregon Office of Health Preparedness and the Regional HPP Coordinators should establish relationships that bridge governmental and private health resources prior to an event. Items that may be beneficial in a disaster or mass casualty incident include:

- Regional disaster response plans
- Mutual aid agreements
- Assistance with private and public sector eligibility for Federal preparedness programs

5.5 CHEMPACK Cache Sites

CHEMPACK is a component of the CDC's Strategic National Stockpile Program to provide locally stored supplies of antidotes and other supporting medical equipment for people who have been exposed to nerve agents or organophosphate pesticides (which have similar harmful effects as nerve agents). These assets are stored in self-monitoring containers at hospitals and EMS sites throughout Oregon and are available for immediate use during a catastrophic emergency for which locally available supplies are insufficient.

Each CHEMPACK cache site has a DEA registrant with the authority to verify the need for CHEMPACK assets and to open the sealed containers. Each cache site has a local Point of Contact (POC) who coordinates communication with OPHD and coordinates the distribution of supplies.

6 TRAINING AND EXERCISES

6.1 Training

Catastrophic mass casualty incident training for EMS responders should be conducted on a regular basis. The training schedule and materials are available on the Oregon HAN Web site (*www.oregonhan.org*). Training materials can also be requested by contacting DHS EMS & TS.

Specific Training: Triage may be required during a mass casualty incident. A common triage system may enhance the effectiveness of mutual aid responders. The Disaster Management Systems, All Risk Triage Tags® are a simple yet effective tool, utilizing START Triage, First Responder Operational Objectives, Mass Decontamination Procedures, Patient Care Criteria, and Evidence Tagging. Responders should practice using a common system during realistic exercises to ensure compatibility during actual incidents.

6.2 Exercises

Exercises shall rigorously test the capabilities within complex response conditions. Design team members shall be representative of, and work in collaboration with regional and local agencies. An inter-departmental approach in exercise development helps build valuable relationships, provides for a forum for sharing best practices, and fosters coordinated efforts among different agencies and organizations.

Training efforts shall be reinforced, and operational skills tested in a realistic but simulated environment. Frequent table top, functional, and full-scale exercises shall be utilized. These exercises shall be designed following Department of Homeland Security guidelines.

In coordination with the OPHD Exercise Design Committee, the Office of Public Health Systems will design and deliver orientations, tabletop exercises, functional, and full-scale exercises as needed.

Exercises of this plan shall be conducted with scenarios based upon the actual experience catastrophic events in Oregon. Known hazards have included:

- Windstorms
- Severe flooding
- Temperature extremes
- Intentional mass poisoning
- Major transportation related accidents including aircraft or highway vehicles
- Accidental radiation release

After an exercise has been conducted, or an actual major incident has occurred, DHS EMS & TS shall perform an after-action review to identify the lessons learned. Actions that can be taken to enhance preparedness for future events shall be identified. The after-action review shall lead to a written After Action Report (AAR) to evaluate the effectiveness of, and adherence to, standard operating procedures.

Based upon an analysis of the AAR findings, an Improvement Plan will be drafted, which incorporates and expands upon the AAR recommendations and conclusions. The final improvement plan will include the training recommendations, equipment or procedural changes; recommendations for improvements, identification of circumstances not covered or anticipated, and a detailed work plan regarding how to implement the lessons learned.

7 SPECIAL POPULATIONS

Special populations are groups whose needs are not fully addressed by traditional service providers, or those who cannot comfortably or safely access standard resources. There are general categories of disabilities:

- Mobility impairments
  - Wheelchair users, ambulatory mobility disabilities, respiratory impairments.
- Visual impairments
  - Partial or total vision loss, inability to distinguish light and dark, cannot read small print, cannot distinguish colors.
- Hearing impairments
  - Echo, reverberations, and extraneous background noise can distort hearing aid transmission. Those who rely on lip reading must be able to clearly see the face of the person who is speaking. Sign language can be adversely affected by poor lighting.
- Speech impairments
- Cognitive impairments

Catastrophic incidents that pose health risks to adults in the general population, pose a significantly higher risk to special populations because of the potential for longer exposures, pre-existing medical conditions, and potential for not understanding disaster preparedness. Special populations should be given the highest priority for evaluation, shelter-in-place, removal, and medical attention due to the high probability that these individuals could suffer serious injury or loss of life without immediate attention.

The appropriate action for a special needs population may be very different than the appropriate action for the general population. Local area responders should work to identify special populations, develop individual and regional evacuation plans, and pre-plan incidents involving special populations. Community-based preparedness will help strengthen the overall infrastructure.

Facilities will rely heavily on 9-1-1 and the emergency response system to assist during disaster or mass casualty incidents. Successful mitigation will require the ability to rapidly identify and access a variety of resources. Being able to identify specific populations will be crucial.

Preplanning may help identify evacuation shelters and transportation necessities, or shelter-in-place requirements. Preplanning also allows responders to encourage individuals with special needs to have a support network of friends or family who will assist them in an emergency. Members of the public and private sector should be included in preplanning efforts, as EMS resources may be exhausted during catastrophic events.

Local jurisdictions should work with programs such as Meal on Wheels, county disability offices, and OMAP non-emergent brokerage call centers to preplan. Community-based

organizations (advocacy organizations, agencies that serve transportation-dependent populations, employment and training providers, health and human service agencies, faith and community based organizations, etc) may also be of benefit. Consider developing voluntary registries. All resources should be built into regional plans, and be coordinated through the local EOC.

Special needs populations may benefit from carrying information that explains their condition, and any special instructions for assistance or treatment. Listing additional information such as the names, addresses, and telephone numbers of doctors, pharmacies, family members, and friends will be even more beneficial.

This short, non-inconclusive list may help responders identify facilities to pre-plan:

Schools / Child Care Facilities:

- Elementary and Middle Schools
- High Schools
- Colleges
- Day Care Facilities

Detention Facilities

- Youth detention facilities
- Jails
- Prisons

Medical Facilities

- Hospitals
- Mental Health
- Urgent Care
- Residential Care Facilities
- Skilled Nursing Facilities
- Group Homes

Shelters
Major Employers

If evacuation is necessary, consider the basic information that is necessary:

- Notification
- Way out
- Access to the way out (is assistance required)
- Assistance necessary (who, what, where, when, how)

If disaster circumstances are predicted, evacuate as early as possible.

In the event of disaster circumstances and a pre-plan does not exist, call for appropriate resources as soon as possible. Transporting multiple victims may require specialized

transportation (school bus, ambulance, etc), mobilize necessary resources as soon as possible. Additional personnel may be required to provide critical information to the parents of minors (such as when an incident involving a school).

Local resources such as *Community Emergency Response Teams* may play a crucial role if door-to-door notifications or evacuations are required. Consider the use of numbered triage tags or other tracking system to rapidly identify where victims were moved to. If non-EMS resources are used to move victims, documentation should be maintained by the operator to include; name of driver, telephone number, time departed the staging area, time arrived at the shelter location, vehicle number, sheltering location, trip mileage.

Regionally coordinated evacuation plans may result in the most efficient utilization of resources. Creating a list of current resources, identifying special populations, and utilizing operations centers to connect multiple resources will help ensure a timely evacuation. The use of GIS is undeniably beneficial, but may be cost prohibitive in many areas.

8 PLAN MAINTENANCE

The EMS Mass Casualty Response Plan was developed by DHS EMS & TS. It will be updated periodically, and following actual events. During initial plan development, and the updating process, input is solicited from all stakeholders. Input is sought from academic and professional experts in the field.

Upon approval, this plan is distributed to state agency partners, local emergency response agencies, hospitals, local public health officers, related associations, community clinics, skilled nursing facilities, and is available on the DHS EMS & TS website.

All changes or updates will be posted on the EMS & Trauma Systems website, and be distributed through the EMS list serve.

Record of Revisions

REVISION NUMBER	DATE	COMMENT
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

9 WEB SITES

Oregon Emergency Medical Services and Trauma Systems
http://www.oregon.gov/DHS/ph/ems

Oregon Public Health Emergency Preparedness
http://www.oregon.gov/DHS/ph/preparedness

Oregon Health Alert Network
https://www.oregonhan.org

Oregon Emergency Management
http://www.oregon.gov/OMD/OEM

Oregon Local Health Departments
http://www.oregon.gov/DHS/ph/lhd/lhd.shtml

HOSCAP
https://oregonhospitals.org

Other References:

Annals Of Emergency Medicine, The Importance of Evidence Based Disaster Planning, Volume 47, No 1. Jan, 2006

US Department of Homeland Security, FEMA 508-3. Typed Resource Definitions, EMS Resources. May, 2005

US Department of Health and Human Services, Public Health Emergency Response: A Guide for Leaders and Responders. May, 2007

California Emergency Medical Services Authority, California Disaster Medical Response Plan

State of Florida, Department of Health, Ambulance Deployment Plan.

Connecticut Fire Services, Statewide Fire-Rescue Disaster Response Plan. February, 2002.

EMSA #218A, EMSA #215, EMSA #216. September, 2007

US Department of Homeland Security, FEMA Typed Resource Definitions. 508-3, May, 2005

HPP Regional Coordinators

10 ACRONYMS AND GLOSSARY

10.1 Acronyms

AAR	After Action Report
ADP	Ambulance Deployment Plan
ALS	Advanced Life Support (EMT-P)
AST	Ambulance Strike Team
AOC	Agency Operations Center
BLS	Basic Life Support
CDC	Centers for Disease Control and Prevention
DHS	Department of Human Services
ECC	Emergency Coordination Center
EMS	Emergency Medical Services
EMSC	Emergency Medical Services Children
EMS & TS	Emergency Medical Service & Trauma Systems
EMT-B	Emergency Medical Technician – Basic
EMT-I	Emergency Medical Technician – Intermediate
EMT-P	Emergency Medical Technician - Paramedic
EOC	Emergency Operations Center
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
FOG	Field Operations Guide
GPS	Global Positioning System (satellite tracking system)
HAN	Health Alert Network
HAZMAT	Hazardous Materials
HHS	U.S. Department of Health and Human Services
HO	Health Officer
HRSA	Health Resources and Services Administration
ICS	Incident Command System
IMT	Incident Management Team
LEMSA	Local Emergency Medical Services Agency
LHD	Local Health Department
MCI	Mass Casualty Incident
MRE	Meal Ready to Eat
MTF	Medical Task Force
OARs	Oregon Administrative Rules
OR-DMATs	Oregon Disaster Medical Assistance Team

OEM	Office of Emergency Management
OERS	Oregon Emergency Response System
ORS	Oregon Revised Statute
OPHD	Oregon State Public Health
OPHDL	Oregon State Public Health Laboratory
PCR	Patient Care Report
PHPLT	Public Health Preparedness Leadership Team
PHEP	Public Health Emergency Preparedness
PIO	Public Information Officer
POC	Point of Contact
SNS	Strategic National Stockpile
SOP	Standard Operating Procedure
UHF	Ultra High Frequency
VHF	Very High Frequency

10.2 Glossary

Ambulance Strike Team (AST): Five (5) similar type licensed ambulances with common communications and an assigned Strike Team Leader. The leader should be in a separate vehicle for mobility and will meet with the Team at a staging area or other designated location and coordinate their response to and efforts during, the incident.

Ambulance Task Force (ATF): Five (5) transport capable units, staffed with certified EMTs, with common communications and an assigned Task Force Leader. The leader should be in a separate vehicle for mobility and will meet with the Team at a staging area or other designated location and coordinate their response to, and efforts during, the incident.

Ambulance Overhead Team: Four (4) Command level personnel from ambulance services with advanced training in ICS and ambulance deployment.

Company Staffing: Individual personnel that make up a company for staffing purposes are designated in Appendix *(Personnel & Miscellaneous Equipment).*

CHEMPACK: A portion of the CDC Strategic National Stockpile program, to provide locally stored supplies of antidotes and other medical supplies for people who have been exposed to nerve agents.

Emergency Support Function (ESF): A functional area of response activity established to facilitate the delivery of Federal assistance required during the immediate response phase of a disaster to save lives, protect property and public health, and to maintain public safety.

Emergency Medical Task Force (EMTF): Any combination of resource assembled for a medical mission.

Epidemiology: The study of the distribution and determinants of disease in populations, and the application of this to the control of health problems.

Health Alert Network (HAN): A Internet / web based platform used to communicate health and emergency messages.

Incident Command System (ICS): A standardized management system that enables multiple agencies and jurisdictions to work on single or multiple incidents using an integrated organizational structure.

Medical Director: A licensed physician authorized by DHS EMS & TS to supervise emergency responders.

Nerve Agents: Catastrophic warfare agents, including sarin, tabun, soman, and VX.. Nerve agents are highly toxic and in severe exposures can lead to paralysis and death. They are similar to certain kinds of pesticides called organophosphates in terms of how they work and what kind of harmful effects they cause. However, nerve agents are usually more potent than organophosphate pesticides.

Organophosphate Pesticides: A group of pesticides widely used to control insects. Exposure to organophosphates can have similar harmful effects as exposure to a nerve agent. Diazinon and malathion are examples of organophosphate pesticides.

Single Resource: Individual ambulances, equipment, or specific personnel that may be requested to support the incident. If a single resource is a piece of equipment, the individual required to properly operate it will be included.

Standing Orders or Protocols: A set of medical treatment guidelines for emergency responders, legally authorized by an appropriate medical director.

Strategic National Stockpile (SNS): A federal cache of medical supplies and equipment used during emergencies and disasters.

Surveillance: The collection, analysis and dissemination of data about a disease.

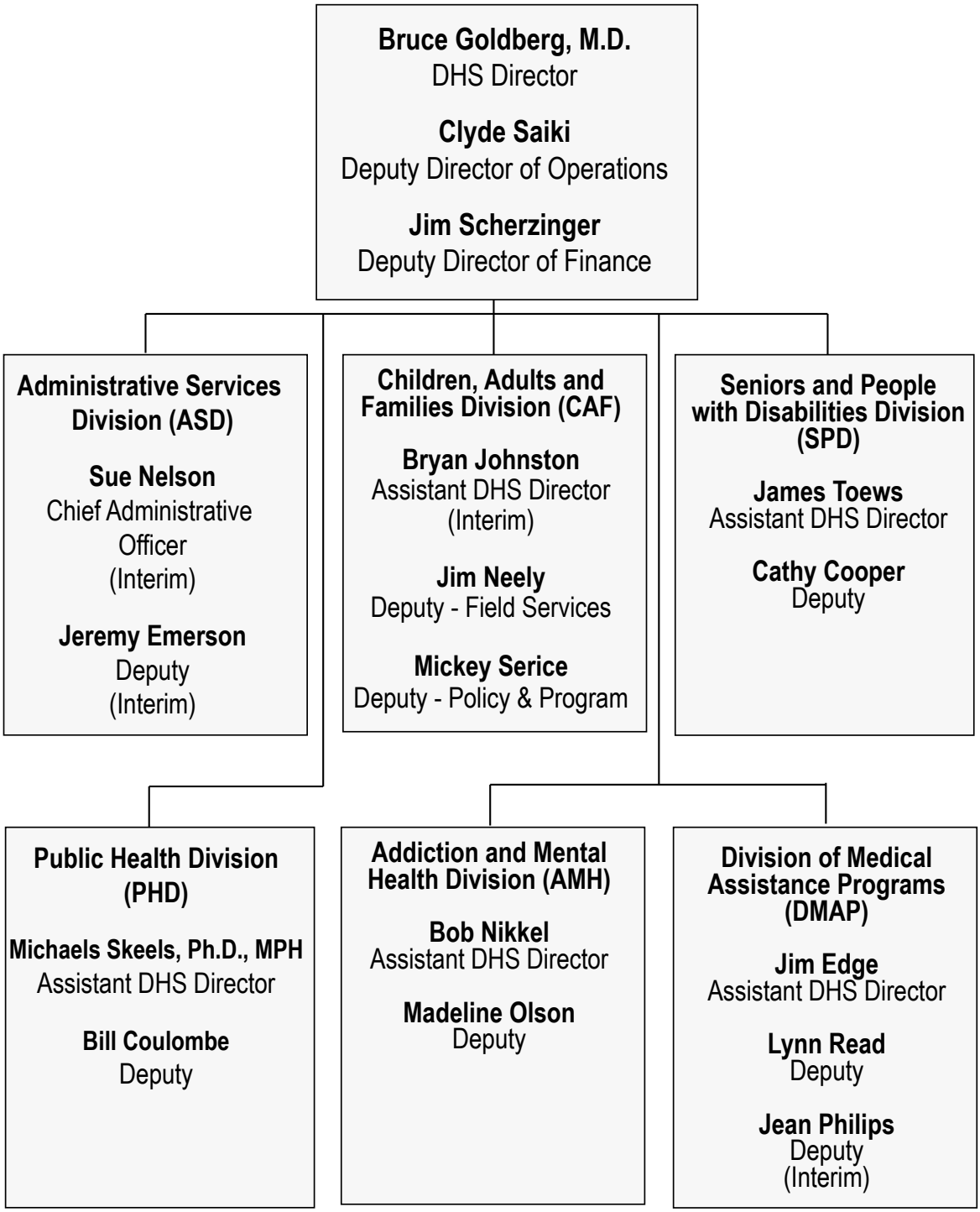
Toxicology: Is the study of the adverse effects of catastrophic on living organisms.

11 TABS

11.1 Tab G-1 DHS EMS & TS Organization Chart, and AOC Plan

The focal point for all activities will be the DHS Emergency Coordination Center (ECC). The DHS ECC, in accordance with the National Incident Management System (NIMS), will coordinate with state and local EOC's, and will work within the Incident command System (ICS).

DHS Structure Overview



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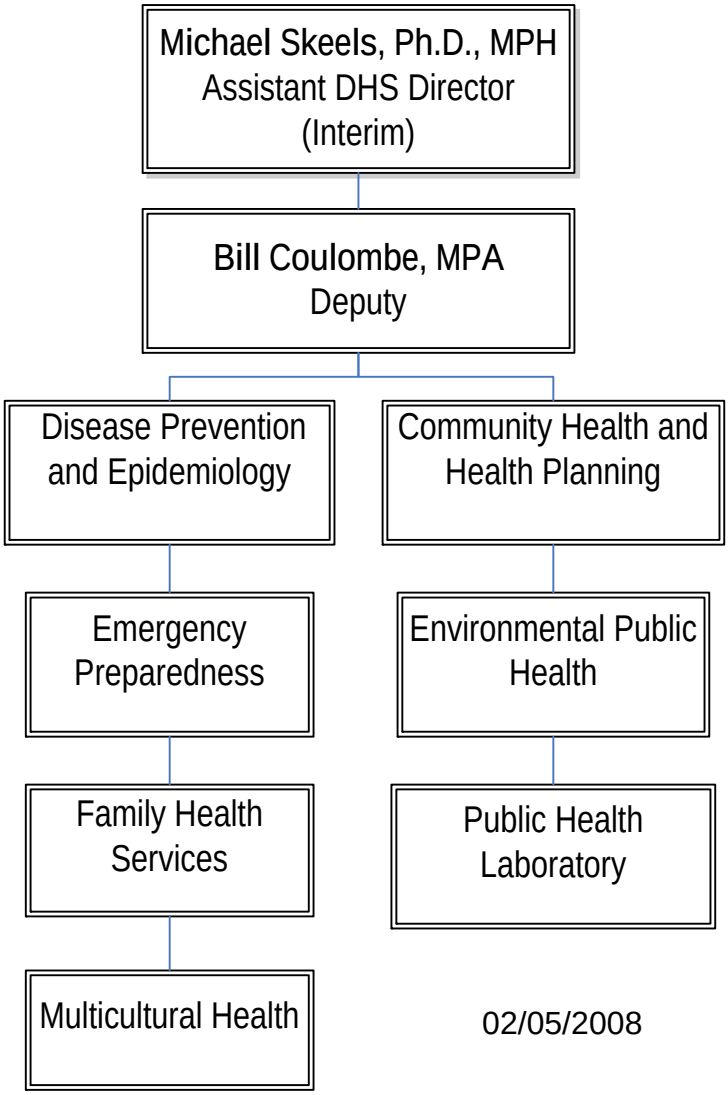
Public Health Division (PHD)



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11.2 Tab G-2 CHEMPACK Point of Ambulance Contact

Please refer to OPHD Office of Health Preparedness website for most up to date CHEMPACK plan.

Oregon Health Division

CSEPP Medical Plan

Introduction

Most agencies have either "Standard Operating Procedures" or "Policies and Procedures" that dictate the manners in which both day-to-day operations are handled as well as emergency situations. This document serves as a reference and guide to assist agencies in the proper Chemical Stockpile Emergency Preparedness (CSEPP) guidelines that have been created to operate in a chemical weapons environment.

Threat Assessment

The threat in the area of the Umatilla Chemical Depot is two-fold. Both are directly related to the storage and imminent destruction of the chemical agents. One threat is the direct consequence of exposure to chemical warfare agents. The second is collateral injuries and illness associated with the stress of an event and traffic accidents that occur during evacuation.

In the UMCD communities, there are approximately 30,000+ residents in or adjacent to the IRZ. This does not include the transient population associated with two Interstate Freeways, a major East-West rail line, and a Commercially Navigable waterway. All of which run directly through the IRZ. Based on these numbers alone, there could be as many as 40,000+ people at risk.

Assumptions of Chemical Exposure

If an affected person is within the plume and does not receive an incapacitating dose and they are able to drive to a hospital or decontamination site, the following assumptions can GENERALLY be made as to the cross contamination threat to first responders posed by the exposed person.

If the person is ambulatory, and has traveled for 10 minutes, the agent should have either, (a) evaporated to a level that significantly reduces the threat to responders, or (b) was at a low enough level originally, as to not pose a threat to first responders.

In either case, the patients clothing should still be removed and they should be de-contaminated with soap and water to ensure any quantity of agent has been removed from the clothing, hair or skin of the patients.
If a patient is exhibiting signs and symptoms of exposure before or after decontamination, they should be treated in accordance with the treatment protocols.

If a patient has traveled by means of an enclosed motor vehicle, and passed through a chemical plume, the exposure may be limited. Whether they arrive at a treatment facility

or at a de-contamination site, they should be handled the same way. Since the vehicle itself could be contaminated, it should be parked as far away as practical. The occupants should be coached to get out of the vehicle without touching the exterior. They should then be sent through the decontamination process while being observed further for signs and/or symptoms of chemical agent exposure. If after completing the decontamination process, the people are still not exhibiting signs or symptoms, they may be sent on to a county reception center. If the people are exhibiting signs and/or symptoms, they should be transported to a medical facility for further treatment and observation.

Dealing with patients who have been exposed to VX will be the same as for GB exposure. The patients clothing and external portions of any vehicle become even more of a concern with VX due to its persistance.

In dealing with HD exposure, it is important to realize that the signs and symptoms may not manifest themselves for hours. For this reasons, if the release is confirmed to be HD, everyone who traveled in the vicinity of, or came from the area of the protective wedge has to be considered as exposed. They should be decontaminated and then observed for 24 hours to confirm that they are asymptomatic. Treatment of HD exposed patients is currently limited to supportive care as there are no antidotes for this agent.

Concept of Operations, Fire and EMS

After the initial notification phase of a chemical incident, all of the local agencies will respond to their assigned duty stations.

The Umatilla, Hermiston, Heppner and Boardman fire departments all have mobile de-contamination units that will be deployed by the Incident Command Post. The deployment locations are predetermined but can be changed by the Operations Sections Chief based upon the available information (See Annex D of the CSEPP Plan)

Concept of Operations, Hospitals

After the initial notification of a chemical agent incident, Pioneer Memorial, St. Anthony and Good Shepherd hospitals should activate their respective Mass Casualty Plans which should include decontamination operations for a chemical event.. Under certain chemical circumstances, Good Shepherd Hospital may be forced to over-pressurize instead of deploying their decontamination trailer. St. Anthony and Pioneer Memorial hospitals will then have to carry the load for receiving all patients related to a chemical incident. See Annex ? for General Hospital Procedures.

Auto-Injectors for Pre-Hospital Personnel.

Auto-Injectors will be issued to all responders wearing personal protective equipment (PPE) for a CSEPP event. Each responder will receive one pack containing 3 sets of auto-injectors which will be stored with their PPE pack at their respective duty stations.

The injectors will be stored in neon green, nylon pouches, within a black response bag within the PPE pack. Along with the injectors in each pouch, there will also be three orange wrist bands to be used in case of treatment. One wrist band, per set of Mark I injections, should be place on the wrist of the injected person to indicate the dose of both atropine and 2-PAM. One orange band indicates 2 mg of Atropine and 600 mg of 2-PAM. The green pouches issued to responders are for self treatment and therefore should not be used to treat the general public. Other bulk Mark 1 kits have been issued to responding departments to treat the public.

Oregon Health Services personnel will maintain and track all injectors that have been issued. The injectors must be stored at room temperature and protected from extremes of heat and cold, as well as direct sunlight. Each Auto-Injector has a shelf life of 5 years and will be replaced on a rotational schedule, based on expiration date.

Bulk Atropine and 2-Pam Chloride and Auto Injector Storage

Bulk Atropine and 2-Pam Chloride supplies are also maintained at Good Shepherd, St. Anthony, and Pioneer Memorial hospitals within Umatilla and Morrow counties. These supplies of bulk will allow for the treatment of children and the elderly because the doses can be controlled.

Current supplies for Patient Use:

	Atropene	**2-PAM Chloride**
Good Shepherd	100 boxes of 25, 1g/ml	34 boxes of 6 vials, 1g/20ml
St. Anthony	50 boxes of 25, 1g/ml	17 boxes of 6 vials, 1g/20ml
Pioneer Memorial	4 boxes of 25, 1g/ml	8 boxes of 6 vials, 1g/20ml
As of July 2006		

Supplies of bulk auto injectors are also kept at the following departments to allow for patient treatment.

Current Supplies of Bulk Auto Injectors for Patient Use:

Boardman EMS	72 injector kits in ambulance bay
Boardman Fire	72 injector kits in decontamination trailer
Boardman Health Clinic	30 injector kits in a box
Good Shepherd Hospital	372 injector kits
Heppner Fire	72 injector kits in decontamination trailer
Hermiston Fire	144 injector kits and 60 kits (two boxes) in decontamination trailer
Irrigon Fire	72 injector kits
Pendleton Fire	72 injector kits
Pioneer Memorial Hospital	72 injector kits
Stanfield Fire	72 injector kits
St. Anthony Hospital	190 injector kits

Umatilla Fire	72 injector kits

First responders also have pre-packaged, bulk caches of auto injectors available to them in case the need arises for antidote.

Current Auto Injector Supplies for First Responders: BULK SUPPLIES

Location	Nylon Pouches of Injectors	Total # of Injectors
East Bulk Trailer	80 cases x 3	240
West Bulk Trailer	50 cases x 3	150
Good Shepherd Hospital	25 cases x 3	75
Pioneer Memorial	25 cases x 3	75
St. Anthony Hospital	25 cases x 3	75
Umatilla Police	20 cases x 3	60
Hermiston Police	20 cases x 3	60

Medical Supply Caches

In the event there is a mass casualty incident during a CSEPP incident, medical cashes have been distributed throughout each county to allow for the rapid distribution of the supplies. The medical supplies are grouped in a paramedic jump kit which includes a trauma bag, intravenous start bag, bandage/trauma bag, and bulk dressing bags. The bags are distributed as follows:

	Paramedic Jump Kit				
	# of Trauma Bags	# of IV Bags	# of Bandage Bags	# of Bulk Dressing Bags	# of Oxygen Kits
Hermiston Fire	6	6	6	1	4
Umatilla Fire	6	6	6	1	
Pendleton Fire	3	3	3	1	3
Boardman Fire	1	1	1	0	
Heppner Fire	1	1	1	0	
Heppner EMS	1	1	1	1	
Irrigon EMS	3	3	3	0	
Boardman EMS	3	3	3	2	3
MC Health	1	1	1	0	0

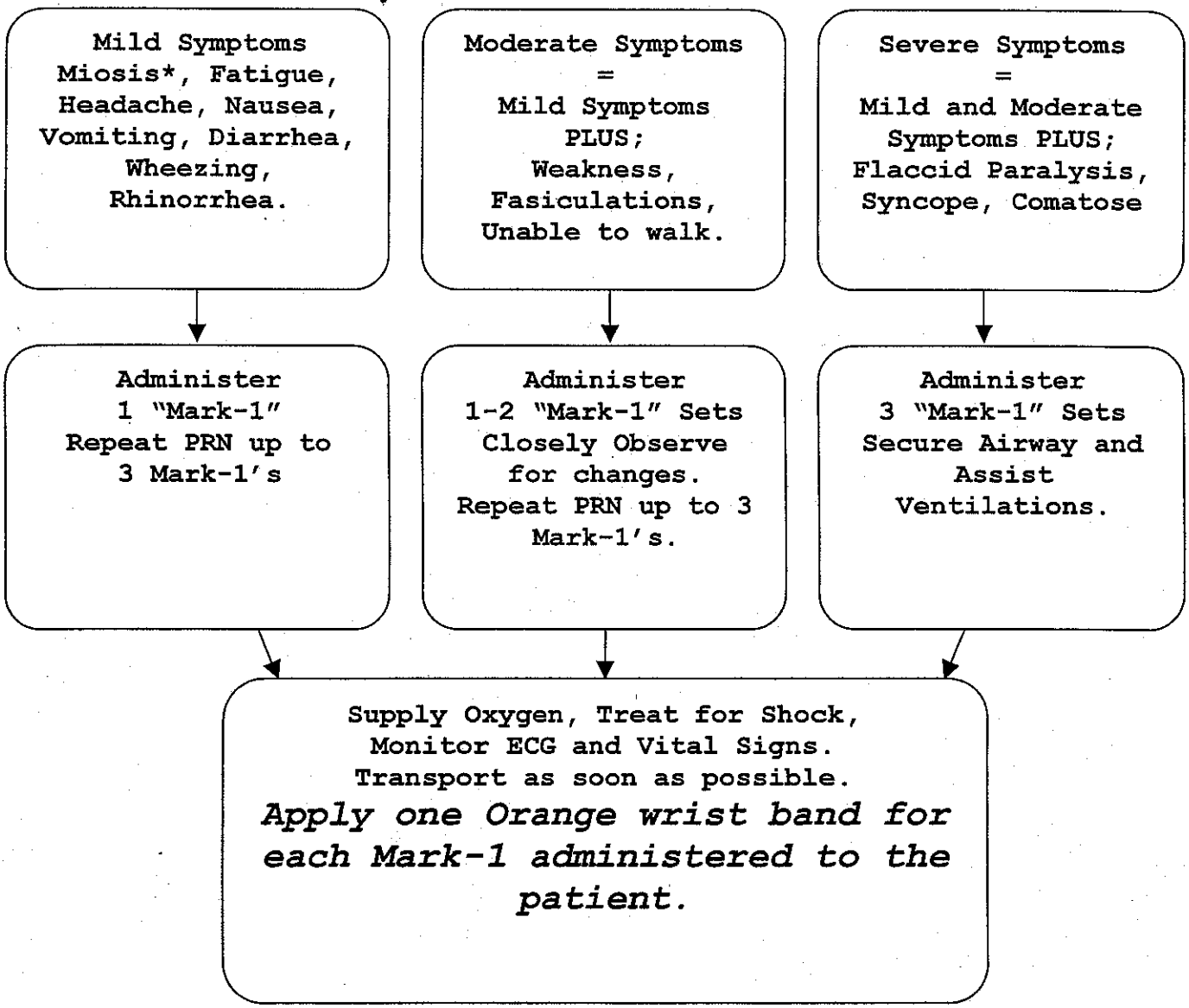
Note: Umatilla Fire does have oxygen but it is stored in bulk on Rescue 92 with bags of O2 masks, bottles and regulators. There are also large supplies of backboard, C collars, straps, blankets etc.

Treatment Protocols

Treatment of Chemical casualties is a continually evolving process. The protocols listed are current as of the writing of this document. They may change as new information or procedures are developed.

Pre-Hospital

All Potentially Contaminated Patients MUST be De-Contaminated.



- WARNING! Miosis alone does not indicate exposure to Nerve Agents
- NO MORE THAN 3 MARK-1's or equivalent IV Dosage to be given until Medical Control has been contacted and the increase approved.
- Atropine and 2-Pam Cl may complicate existing cardiac conditions, Use with Caution.
- Pediatric dosage of Atropine is 0.05 mg/kg
- Pediatric dosage of 2-Pam Cl is 25 mg/kg

Triage Procedures

START Triage System

Many jurisdictions across the U.S. are using the Simple Triage and Rapid Treatment (START) system. The advantage of START is its simplicity and its ease of use by individuals with very little medical training. START merely requires an understanding of basic first aid. Under START, all victims who are able to walk on their own ("walking wounded") are directed by the first emergency personnel on the scene to a designated area upwind of the hazard area and are labeled as **minimal** (green tag). This reduces the number of victims to be evaluated. These victims will require supervision and might be detained for further assessment and possible decontamination.

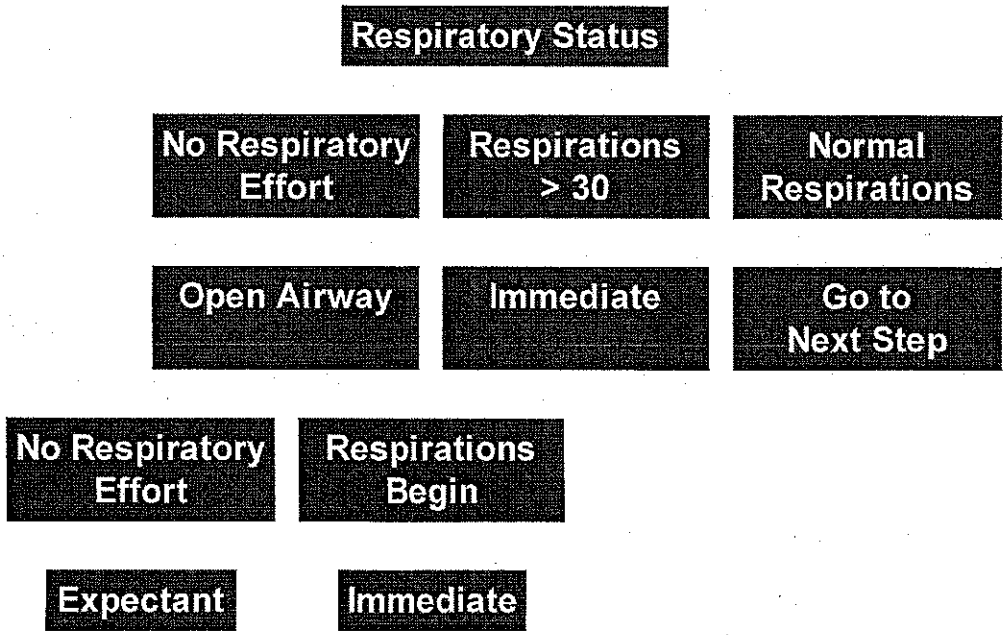
The remaining victims will be evaluated using the START triage system. This should take no longer than 1 minute per patient and will focus on three primary areas:

- Respiratory status
- Perfusion and pulse
- Neurological status.

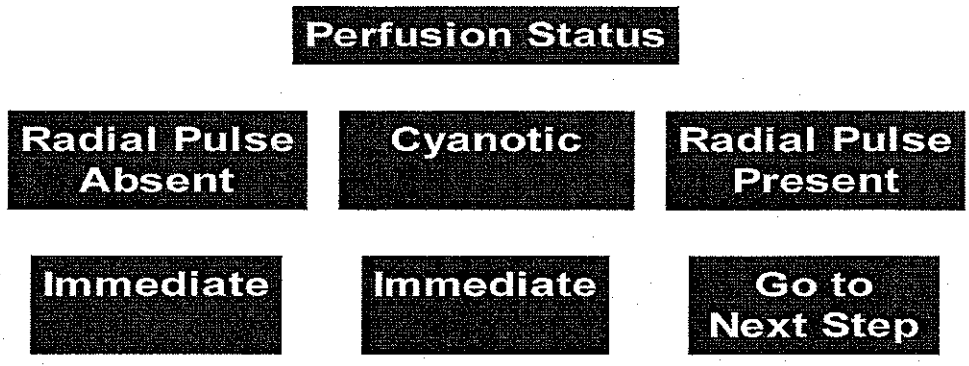
As the responder moves through each level of assessment, any condition that is deemed **immediate** (red tag) stops the evaluation process. Life-threatening injuries will be addressed, if necessary, during primary triage. The patient is tagged, and the responder moves on to the next patient.

Ventilation – If the patient is adequately ventilating (breathing), the triage officer moves on to the next step. If, however, ventilation is inadequate, the triage officer attempts to clear the airway by either repositioning the victim or clearing debris from the patient's mouth. If these attempts are unsuccessful, the victim is classified as follows:

- No respiratory effort - **Expectant** (black tag)
- Respirations greater than 30 or unstable airway - **Immediate**
- Normal respirations - Go to next step.

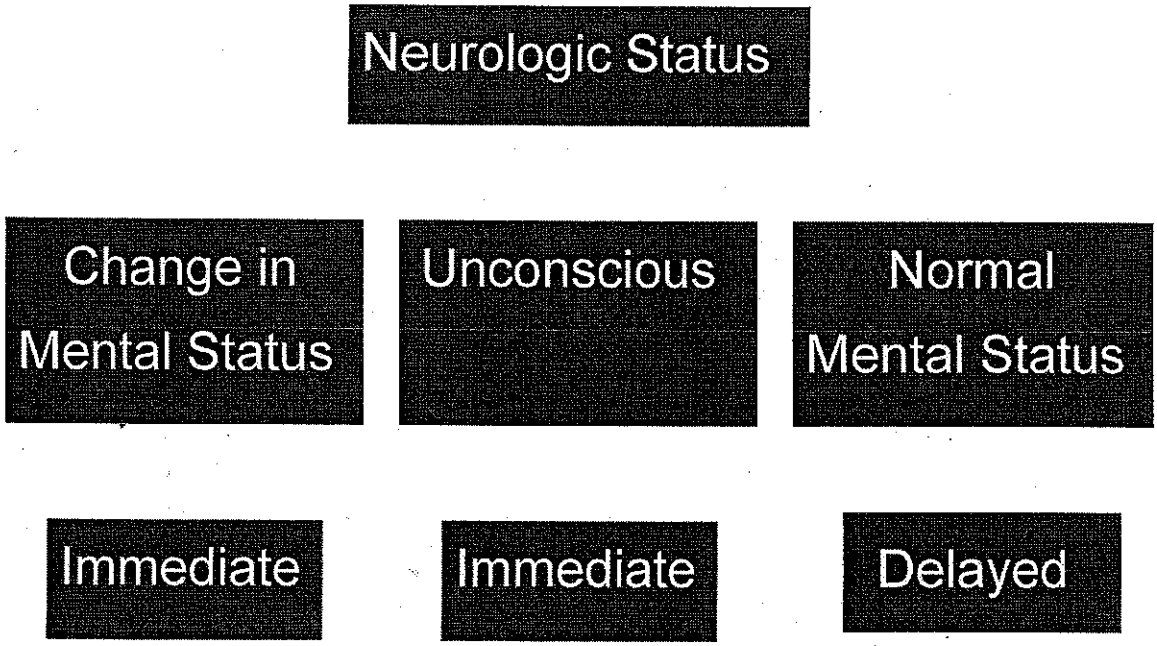


Perfusion – Initial evaluation is made by measuring capillary refill. [If the casualty has normal capillary refill (less than 2 seconds), proceed to the next step.] If the patient's blood return is delayed (greater than 2 seconds) or appears cyanotic, then the patient is classified as **immediate**. If the triage officer is unable to obtain capillary refill due to either the patient's color or poor lighting conditions, then the radial pulse is checked. If the radial pulse is not detected, the patient is classified as **immediate**. If present, the pressure is assumed to be adequate (80mm Hg), proceed to the next step.



Neurologic Status – The third and final level of assessment is the patient's neurologic status. Depending on the level of consciousness, the following classification is made:

- Unconscious – **Immediate**
- Altered level of consciousness – **Immediate**
- Change in mental status – **Immediate**
- Normal mental responses – **Delayed**, then move to next victim.



11.3 Tab G-3 Statewide EMS Interoperable Communication Plan

The EMS Communications Interoperability Plan should mirror the "Oregon Statewide Communications Interoperability Plan". Every attempt has been made to follow the guidelines set fourth in the statewide plan. Subsequent revision of this plan may be necessary to conform with the Statewide Plan.

Communication systems vary drastically between EMS agencies within the State of Oregon. A common finding is that EMS systems operate within one of three frequency spectrums, complicating radio communications during a large scale event. This plan outlines basic framework so that all EMS agencies can communicate via radio during a given event without added expense of adding additional radios.

Existing operational channels from adjacent agencies should be pre-programmed. Radio managers should agree to allow other responders on the same frequency band to use their radio system on designated channels when necessary. Adjacent agencies should follow a predictable rationale use common nomenclature for channel identification.

Nationwide Interoperability frequencies have been established by the FCC. Every portable and mobile radio in Oregon should include all interoperable frequencies that are within the same band of operation as the basic radio. Interoperability Channels are available in all of the public safety bands, and are designed to allow communications anywhere in the country within a given band.

Ambulance Strike Teams, and Task Forces should be equipped with VHF radios containing the identified frequencies.

Use of Amateur (HAM) Radio Operators: In the event of communication overload or failure, amateur radio operators may provide crucial services. Local jurisdictions should work with amateur radio operators (such as ARES / RACES groups) to ensure compatibility.

Satellite Phones: Many agencies have Satellite phone capability. Each agency with a Sat phone should pre-program crucial numbers into the phone, and keep a written log with the phone. Such numbers may include local agencies (police, fire, EMS), PSAPS, Poison Center, Local Emergency Managers, Local Health Departments, OEM, and DHS EMS & TS.

Cellular Phones: In some instances, the most expedient communication will be by cell phone. The AST/MTF Leader is responsible for ensuring that all members of the team have each team member's cellular number.

VHF

Frequency	Type	Label	Description
150.775		DHS EMS 1	DHS EMS & TS 1
150.790		DHS EMS 2	DHS EMS & TS 2
155.475		OPEN	Oregon Police Emergency Network
155.060		SAR	OEM Search and Rescue
154.280		FireNET	OEM / State Fire Marshal
155.340		HEAR	Hospital Emergency Administrative Radio
155.7525	Base / Mobile	VCALL	National Calling
151.1375	Base / Mobile	VTAC 1	National Tactical
154.4525	Base / Mobile	VTAC 2	National Tactical
158.7375	Base / Mobile	VTAC 3	National Tactical
159.4725	Base / Mobile	VTAC 4	National Tactical

UHF

Frequency	Type	Label	Description
458.2125	Mobile	UCALL	National Calling
453.4625	Base / Mobile	UTAC 1a	National Tactical
458.4625	Mobile	UTAC 1	National Tactical
453.7125	Base / Mobile	UTAC 2a	National Tactical
458.7125	Mobile	UTAC 2a	National Tactical
453.8625	Base / Mobile	UTAC 3a	National Tactical
458.8625	Mobile	UTAC 3a	National Tactical

800 MHz

Frequency	Type	Label	Description
821/866.0125		ICALL	National Tactical
821/866.5125		ITAC-1	National Tactical
822/867.0125		ITAC-2	National Tactical
822/867.5125		ITAC-3	National Tactical
823/868.0125		ITAC-4	National Tactical
821/866.3250		OROPS1	Oregon Tactical
821/866.3875		OROPS2	Oregon Tactical
821/866.7500		OROPS3	Oregon Tactical
821/866.7750		OROPS4	Oregon Tactical
821/866.8000		OROPS5	Oregon Tactical
867.5375		STATEOPS-1	Washington Tactical
867.5625		STATEOPS-2	Washington Tactical
867.5875		STATEOPS-3	Washington Tactical
867.6125		STATEOPS-4	Washington Tactical
867.6375		STATEOPS-5	Washington Tactical

TAB G-4 STRIKE TEAMS AND TASK FORCES

Each county is responsible for developing ambulance Strike Teams, Ambulance Task Forces, and Emergency Medical Task Forces that conform to the standard definitions. Counties may combine efforts to form regional Strike Teams and Task Forces. A coordinator must be identified, and work closely with county Emergency Managers.

The County Emergency Manager, or designee, will serve as the point of contact when an activation request is received. He or She should have a deployment roster, and must have the ability to immediately communicate with the appropriate team members to mobilize resources.

Success of the deployment plan is contingent upon three (3) primary elements:

1. Efficient time frame for deployment.
2. Pre-identified Strike Teams and Task Forces within each region.
3. Ability to pre-stage resources in advance of a pending disaster.

It is critical that all deployed resources are documented and tracked by the sponsoring Region. In addition, it is imperative that personnel arrive on scene of a disaster with complete and appropriate personal protective equipment (PPE).

Time Frame for Deployment: Unless otherwise specified at the time of request, the standard mobilization for deployment of emergency medical resources shall be within three (3) hours of the mission assignment from the State EOC.

> "Rapid Activation": Under certain circumstances, a more rapid deployment may be deemed necessary by the State EOC, and authorized as a "Rapid Activation". Time frame for deployment of these missions shall be within one (1) hour of the mission assignment from State EOC. It is anticipated that the pre-identified Strike Teams will fill resource requests. It is understood that many regions in Oregon will not be able to commit that level of response.

Pre-identified Teams: Each region is encouraged to pre-identify Teams, made up of five (5) like resources, and/or Task Forces made up of five (5) mixed resources. Each is to have a designated, trained Leader and common radio communications. The primary mission of the Team will be to respond to a catastrophic mass casualty incident or potential disaster area, and to work within the Incident Command Structure at affected area. The most common use of these pre-identified teams will be for incidents requiring a rapid response, particularly those designated "Rapid Activation". It is anticipated that "Rapid Activations" will peak quickly and terminate within a shorter period, thereby allowing for a shorter preparation time. To accomplish rapid deployment, all of the required deployment documentation should be compiled and maintained by the County Emergency Manager, or designee, in advance.

Pre-Staged Resources: Based on the forecast of an imminent disaster, it may be necessary to stage resources in advance, to better position them geographically for a timely response into an affected area. That decision will be made with the concurrence of the State EOC,

the ESF 4 and 9 representatives, and the sponsoring Regional Coordinator(s). Once a mission has been tasked, the resources shall be prepared for deployment and sent to the identified staging area. The staging area designated must be under the direct supervision of a Staging Area Manager, providing necessary logistical support to accommodate deployed resources for a prolonged time period, and to provide a high degree of safety and security. Once deployed to a staging area, all resources shall be considered in, "active mission" status. Staged resources will only be released into an affected area, after confirming mission orders have been issued from the State EOC, and the ESF 4 & 9 representative.

ACTIVATION

Until the Ambulance Deployment Process (ADP) is fully operational, ambulance providers should identify and train personnel to participate on an Ambulance Strike Team / Task Force, and ESF 8 should have resource lists available for disaster response. This includes supply and equipment caches according to the guidelines in this document.

Once a Member Agency/Individual Member is notified of a deployment:

1. Ambulance/medical personnel should report as quickly as possible to the location requested. Personnel are to take a 3-day kits with them to the assignment.

2. ESF 8 and ESF 4 & 9 representatives, if requested and assigned, will respond to the incident site and liaison with the ESF 8 and ESF 4 & 9 desks at the State EOC.

RESOURCE MANAGEMENT

En-route:

All units will report to the rally point designated by ESF 8, to meet with ST/TF Leaders. At the rally point, the ST/TF Leader will be responsible for the following:

- Introducing team members.
- Briefing the team members on current incident conditions and safety.
- Issuing potential assignments.
- Determining response routes, considering time of day, traffic, food, fueling and stops.
- Making and communicating travel plans.
- Identifying a travel radio frequency for en route communications.
- Conducting a checklist assessment of the ST/TF readiness and equipment availability.

- Notifying the jurisdictional dispatch of the status and ETA to the incident site/staging area.

If an ambulance unit is unable to continue to respond for any reason (mechanical failure, illness of team members, etc.) the ST/TF Leader shall contact the ESF 8 desk at the State EOC to advise and request replacement of the unit.

Each ambulance crew shall maintain responsibility for their personal equipment, their ambulance, and their medical equipment/supplies. Any problems shall be reported to the ST/TF Leader. Ambulances and team members are not considered incident resources until the team has checked in at the incident.

At the Incident:

The ST/TF shall report to and check in at the incident staging area. The ST/TF Leader will be responsible for the following:

- Initiating and use ICS Form 214 (Unit Log) for the entire incident.
- Providing information, including resource order and request number for check-in (ICS form 211).
- Receiving an incident briefing (IAP, Communications Plan, and Medical Plan).
- Briefing team members on the incident and their assignments.
- Reporting to line assignment(s), or to staging area as directed.
- Obtaining orientation to hospital locations (Local information and ICS 206).
- Determining preferred travel routes, and briefing team members.
- Provide daily Situation Reports to the ESF 8 desk at the State EOC. The ESF 8 desk will assure that the ambulance deployment situation reports are placed in State EOC Tracker.

Logistical Support:

The ST/TF should not expect support services to be in place during the early stages of the incident. For this reason, all ADTs are expected to be self-sufficient for up to 3 days, or have a plan to be supported in the response area. The location and magnitude of the disaster will determine the level of support services available. The ST/TF Leader may have to utilize commercial services for food, fuel, and supplies until logistical support services are established. Obtaining replacement medical supplies during the first days of a disaster may also be difficult. Consider MCI Caches as part of initial deployment ADTS. The

ST/TF Leader will work within the local EMS structure to replenish medical supplies for the ADT.

The ST/TF Leader is expected to attend all operational shift briefings, and to keep all personnel on the team informed of conditions. If the units are assigned to a single resource function, i.e., patient transportation, triage, or treatment, the ST/TF Leader will make contact with the personnel at least once during each operational period. If possible, all units in an ambulance deployment will stay together when off-shift unless otherwise directed by the EST/EF Leader. At minimum, all team members will remain in constant communications. Until incident facilities are established, each ST/TF Leader will coordinate with their respective support services to provide facilities support to their ambulance deployment team.

PROTOCOLS

During a response outlined in this plan, as part of an ambulance deployment, EMTs may utilize the scope of practice for which s/he is trained and certified according to policies and procedures established by his/her local EMS Medical Director.

If the Ambulance Deployment Team Leader provides medical care during the incident, they will utilize the scope of practice for which s/he is trained and certified according to policies and procedures established by his/her local EMS Medical Director.

EMS personnel may not overextend their medical scope of practice regardless of direction or instructions they may receive from any authority while participating on an ambulance deployment. Medical protocols may be limited during a deployment due to unavailability of supplies or other events.

DEMOBILIZATION

The ESF 8 is responsible for preparing and implementing a Demobilization Plan. Such a plan will ensure an orderly, safe, and cost effective movement of personnel and equipment. At no time should an ambulance deployment team or individual crew member leave without receiving departure instructions from their ST/TF Leader.

ST/TF Leaders should obtain necessary supplies to assure that the ambulances leave in a “state of readiness” whenever possible. If unable to replace lost, used or damaged equipment, the ST/TF Leader shall notify the ESF 8 desk at the State EOC prior to leaving the incident. The ST/TF Leader will return all radios and equipment on loan from the incident. Timekeeping records will be recorded, and shall be submitted to the appropriate personnel at the incident prior to departure. All ambulance deployment personnel will receive a debriefing from the ST/TF Leader prior to departure from the incident.

The ESF 8 at State EOC desk will coordinate any required decontamination processes of equipment and personnel.

The ESF 8 desk at the State EOC will notify ESF 4 & 9 of ambulance release time, travel route, and estimated time of arrival back to home base. The ambulance deployment is still a team upon return, and may be reactivated at any time.

REIMBURSEMENT PROCEDURES

Financial Assistance

When a disaster or catastrophic mass casualty indecent occurs, exceeding local resources, aid and assistance is made available on a supplemental basis through a process of application and review. If community resources are insufficient, the local government may apply to the State for assistance. The Governor reviews the application, studies the damage estimates and, if appropriate, declares the area a state disaster. The official declaration makes state funds, personnel, and resources available.

If damages are so extensive that the combined state and local resources are not sufficient, the Governor applies to the President for federal disaster assistance. A similar assessment of the application and damage estimates is competed. If the need for federal assistance is justified, the President issues a disaster declaration, and resources are made available.

Reimbursement

This section serves as a reference on disaster cost recovery to assist individuals in documenting disaster-related expenditures following Presidential and/or State Declaration, to facilitate reimbursement from the federal government, the State of Oregon, and County insurance carriers. This section may appear tedious and burdensome, but it reflects Homeland Security requirements, and emphasizes the need for close compliance. **Payment is not guaranteed.**

If the type and extent of documentation is not comprehensive, detailed and accurate, portions of the claim and possibly the entire claim will be disallowed, and the department will be required to absorb the costs.

Reimbursement Eligibility

To meet eligibility requirements for reimbursement, an item of work must:

- Be required as the result of the major disaster event.
- Be located within a designated disaster area.
- Be the legal responsibility of the eligible applicant.

Disaster-Related Expenditures

FEMA will provide reimbursement of expenditures to perform emergency protective measures. Reimbursements must be in accordance with Federal Financial Management Annex and 44 CFR, Part 206.

Examples of eligible reimbursement activities include, but are not limited to:

- Payroll expense for personnel operating at the incident.
- Hourly cost to operate capital equipment (ambulances, rescues, monitors etc.)
- Expendable materials used at the incident.
- Equipment leased/purchased specifically for the incident.
- Contracted services made necessary by the disaster.
- Expenses for Personnel

According to federal regulations, only actual hours worked, either overtime or regular, can be claimed. If time and one-half or double time is paid to regular hourly employees for overtime or holiday work, these payments must be in accordance with rates established prior to the disaster (i.e. Collective Bargaining Agreements).

On occasion, FEMA approves reimbursement for an option known as "backfilling". If approved, this option would allow the department to be reimbursed when personnel are called to replace an employee already approved to perform disaster related activities elsewhere.

Accurate payroll records must be maintained to clearly identify the employee's regular and overtime hours. Records must identify each employee, by location and purpose of the work, in order to designate the proper FEMA category. The record must also include the Mission Tracking Number. It is imperative that each member of a deployed resource is accounted for daily on an ICS 214, "Unit Log".

Expenses for Equipment:
Each department/agency may be eligible for reimbursement if the equipment owned by the department/agency was used in disaster work. To assist in the reimbursement process, FEMA has developed an equipment rate schedule. The Finance Section Chief should obtain the most recent version of the FEMA equipment rate schedule prior to submitting for reimbursement.

Each request for reimbursement of department/agency owned equipment must contain the following information:

- Mission Tracking Number.
- Type and description of equipment.
- Location equipment was used.
- Number of hours actually used each day (show dates).
- Category of work performed.

Damage or Loss of Equipment:
Equipment that is damaged and/or lost during disaster incidents may be eligible for reimbursement. The damage and/or loss must be documented along with sufficient supportive documentation, such as video and/or photographs. If the documentation is not comprehensive, detailed, and accurate, portions of the claim and possibly the entire claim may be disallowed, and the department/agency will be required to absorb these costs.

Reimbursement Processing:
Each department/agency is responsible for preparing the necessary documentation and submitting a reimbursement claim for resources deployed. The County Coordinator is responsible for collecting all documentation relative to the disaster incident from each department deployed. The County Coordinator will compile the documentation and identify eligible reimbursement in accordance with current FEMA guidelines.

The County Coordinator must coordinate the collection and documentation of all disaster-related forms and supportive documents for final review and possible submission to Regional Coordinator.

TYPED RESOURCE DEFINITIONS

Resource types are in accordance with the FEMA Type Resource Definitions. Additional definitions are available within the FEMA 508-3 document. Items listed below are the assets most likely to be requested.

Emergency Medical Task Force

- Type I: *Any combination of resources assembled for a medical mission, with common communications and a leader.*
    - Ambulance, Rescues, Engines, Squads, etc.
    - Self-sufficient for 12-hour operational periods, although may be deployed longer, depending on need.
    - Temperature control support may be required for medical supplies in some environments.
    - Ambulance Strike Team / Medical Task Force Leader

Ambulance Task Force

- Type I: *Any combination of Type I – IV Ambulance Strike Team Vehicles capable of patient transport and out-of-hospital emergency medical care.*
    - Staffing determined by local supply, and demand.
    - Can be deployed to cover 12 or 24-hour periods. Must be self-sufficient for at least 72-hours.
    - Personnel must have ICS 100, ICS 200, and Basic MCI Field Operations Training.
    - 1 Task Force Leader with the TFL–Ambulance Course (8 Hours), and at least one year of experience.

Ambulance Strike Team

- ALS (Type II): *5 ambulances, each capable of transporting 2 patients.*
  - 1 paramedic + 1 EMT-Basic or higher on each ambulance.
  - Can be deployed to cover 12 or 24-hour periods. Must be self-sufficient for at least 72-hours.
  - Personnel must have ICS 100, ICS 200, and Basic MCI Field Operations Training.
  - 1 Strike Team Leader with the STL–Ambulance Course (8 Hours), and at least one year of experience.

- BLS (Type IV): *5 ambulances, each capable of transporting 2 patients.*
  - 2 EMT-Basics or higher on each ambulance.
  - Can be deployed to cover 12 or 24-hour periods. Must be self-sufficient for at least 72-hours.
  - Personnel must have ICS 100, ICS 200, and Basic MCI Field Operations Training.
  - 1 Strike Team Leader with the STL–Ambulance Course (8 Hours), and at least one year of experience.

Individual Ambulances (Ground)

- ALS (Type II):
  - 1 paramedic + 1 EMT-Basic or higher.
  - Can be deployed to cover 12 or 24-hour periods.
  - Capable of transporting 2 patients.

- BLS (Type IV):
  - 2 EMT-Basics or higher on each ambulance.
  - Can be deployed to cover 12 or 24-hour periods.
  - Capable of transporting 2 patients.

- Other (As Requested):
  - Non-transporting emergency medical response with BLS or ALS equipment and supplies.

Air Ambulance (Fixed-Wing)

- Critical Care (Type II):
  - Pilot, 2 paramedics (or 1 paramedic & 1 nurse or physician)
  - IFR capable
  - Able to transport one patient
  - Able to deploy a medical team, and MICU equipment (ventilator, infusion pump, medications, blood, etc)

- BLS (Type IV):
  - Pilot, 1 paramedic
  - Able to transport one patient
  - ALS ambulance equipment.

Air Ambulance (Rotary-Wing)

- ALS (Type II):
  - 1 pilot, and 2 paramedics (or 1 paramedic and 1 nurse or physician)
  - Capable of transporting two patients
  - VFR, IFR + Night Operations
  - Ability to deploy a medical team; MICU equipment (ventilators, infusion pumps, medications, blood, etc).

- ALS (Type III):
  - 1 pilot, and 2 paramedics (or 1 paramedic and 1 nurse or physician)
  - Capable of transporting one patient
  - VFR + Night Operations
  - Ability to deploy a medical team; MICU equipment (ventilators, infusion pumps, medications, blood, etc).

EQUIPMENT RECCOMENDATIONS FOR DEPLOYMENT

Personal

- Clothing appropriate for the climate, extra uniforms, socks, and underwear
- Safety boots
- Potable water for 3 days
- Meals Ready to Eat (MREs)
- Personal medications
- Toiletries and other personal items as needed, sunscreen, and bug spray
- Sleeping bag
- Hearing protection (ear plugs)
- Photo ID, department identification, EMT certification, and petty cash

Ambulance / Other Apparatus

- Equipment and supplies to meet minimum scope of practice as determined by DHS EMS & TS
- Maps for impacted area (e.g. Thomas Brother Pacific NW Map)
- Communications equipment
- Capability to purchase fuel locally
- 20 patient care reports, or approved patient log
- 50 disaster triage tags
- 2 pair work gloves, safety helmets, and dust-proof goggles
- 20 HEPA masks
- 2 Flashlights or headlamps, with spare batteries

Team Leader Logistical Supplies

- Maps for impacted areas (e.g. Thomas Brother Pacific NW Map)
- Laptop with charger
- Portable GPS
- Communication equipment capable of communicating with the team en route and at the incident: Cellular phone, satellite phone, radios, extra batteries, chargers, etc.
- MREs (Quantity sufficient enough to support the team for three days)
- Portable water
- 50 triage tags
- 2 helmets and work gloves
- 2 flashlights with spare batteries
- ICS forms and Team Leader Kit
- 100 Patient care reports and logs

Tab G-5 SUPERVISING PHYSICIANS AND PROTOCOLS

It is important to note that Scope of Practice is a legal definition for each level of education and certification granted. This is significantly different from the "Standard of Care" which defines the expected care to be provided within a given Scope of Practice. The standard of care may vary widely based upon local circumstances, nature of the emergency, and available resources.

Emergency Medical Services personnel may not exceed their medical scope of practice as defined by Oregon Administrative Rule 333.265, unless expressly permitted in very select circumstances.

Agencies and EMT's making themselves available under this plan are responsible for understanding and abiding by their home protocols. DHS EMS & TS may develop a standard equipment and medication list for units responding as a part of the plan. This list may limit the range of home protocols that would otherwise be used.

11.4 Tab G-6 MOU between OPHD and Oregon DMAT

11.5 Tab G-7 SOP: Statewide Asset Inventory for Transport Agencies, Non-Transport Agencies, Hospitals, Clinic Facilities, and Supporting Agencies

Region 1									
HRSA Regional Coordinator		Email	City			Phone			
	Kathy Richer								
County	**Agency**	**Address**	**City**	**Zip**	**Contact Person**	**Phone**	**Type**	**Resources**	**#**
Clapsop	Knappa Fire District	43114 Hillcrest Loop	Astoria	97103	Randolph Pedersen	(503) 458-6610	Fire	BLS/ILS	1
	Medix Ambulance Service	2325 SE Dolphin Ave	Warrenton	97146	JD Fuiten	(503) 861-1990	Private	ALS/BLS	7
	Seaside Volunteer F& R	150 South Lincoln	Seaside	97138	Robert Link	(503) 738-5420	Fire	ALS/BLS	1
Clackamas	American Medical Response	7915 SE Lake Rd	Milwaukie	97222	Philip Moyer	(503) 659-8892	Private	ALS/BLS	19
	Canby Fire District	PO Box 909	Canby	97013	Ted Kunze	(503) 266-5851	Fire	ALS/BLS	3
	Lake Oswego Fire Dept.	PO Box 369	Lake Oswego	97034	Daniel Semrad	(503) 635-0275	Fire	ALS/BLS	1
	Molalla Ambulance Service	PO Box 65	Molalla	97038	Vince Stafford	(503) 829-2200	Fire	ALS	2
Columbia	Clatskanie Rural FPD	PO Box 807	Clatskanie	97016	Richard Long	(503) 728-2025	Fire	ALS/BLS	2
	Mist-Birkenfeld Rural FPD	12525 Hwy. 202	Mist	97016	David Crawford	(503) 755-2710	Fire	BLS/ILS	2
	Rainier Rural Fire PD	PO Box 1055	Rainier	97048	Terry Grice	(503) 556-3672	Fire	ALS/BLS	2
	Scappoose Rural Fire PD	PO Box 625	Scappoose	97056	Glenda Collins	(503) 543-5026	Fire	ALS/BLS	3
	St. Helens Rurl Fire Dist.	270 Columbia Blvd.	St. Helens	97051	Brian Burright	(503) 397-2990	Fire	ALS/BLS	4
Multnomah	American Medical Response	PO Box 15339	Portland	97293	Randall Lauer	(503) 231-6300	Private	ALS/BLS	55
	Life Flight Network	2801 N. Gantenbein Ave	Portland	97227	Michael Griffiths	(503) 678-0206	Private	ALS	2
	Portland Bureau Fire	5 SE Madison Sr	Portland	97214	John Bisenius	(503) 823-3700	Fire	ALS/BLS	9
Tillamook	Tillamook Ambulance	1000 Third St.	Tillamook	97141	CW Hasseltine	(503) 815-2369	Hospital	ALS/BLS	6
Washington	Lifeguard Air Ambulance	PO Box 91430	Portland	97291	Roger Kelsay	(503) 640-2927	Private	ALS	9
	Metro West Ambulance	PO Box 1635	Hillsboro	97123	JD Fuiten	(503) 648-6658	Private	ALS	16
Region 2									
HRSA Regional Coordinator		**Email**	**City**			**Phone**			
	Ann Steeves	asteeves@samhealth.o	Corvallis	97330		(541) 768-6323			
County	**Agency**	**Address**	**City**	**Zip**	**Contact Person**	**Phone**	**Type**	**Resources**	**#**
Benton	Corvallis Fire Department	400 NW Harrison Blvd	Corvallis	97330	William Bauscher	(541) 757-6938	Fire	ALS	5
Linn	Albany Fire Department	PO Box 490	Albany	97321	Mark Bambach	(541)917-7700	Fire	ALS	5
	Lebanon Fire District	1050 W Oak St.	Lebanon	97355	Dan Woodson	(541) 451-1901	Fire	ALS/BLS	4
	Lyons Ambulance Service	PO Box 179	Lyons	97358	Charles Rollins	(503) 859-2410	Fire	ALS	2
	Sweet Home Fire Dept.	1099 Long St.	Sweet Home	97386	Douglas Emmert	(541) 367-5882	Fire	ALS	4
Lincoln	Central Oregon Coast F&R	PO Box 505	Waldport	97394	Derrick Claussen	(541)563-3190	Fire	ALS/BLS	2
	Pacific West Ambulance	PO Box 1635	Hillsboro	97123	JD Fuiten	(503)693-3217	Private	ALS	9
	South Lincoln Ambulance	PO Box 31	Yachats	97498	Frankie Petrick	(541)547-4257	Volunteer	ALS/BLS	1
Marion	Idanha-Detroit Fire Dist.	PO Drawer B	Detroit	97342	Jennifer Park	(541) 854-3238	Fire	BLS	2
	Jefferson RFPD	PO Box 911	Jefferson	97352	Scott Shepherd	(541) 327-2822	Fire	ALS/BLS	2
	Keizer Fire District	661 Chemawa Rd NE	Keizer	97303	Randy Jackson	(503) 390-1045	Fire	ALS/BLS	3
	Marion County Fire Dist. #1	300 Cordon Rd. NE	Salem	97301	Kevin Henson	(503) 588-6530	Fire	ALS/BLS	4
	Oregon State Hospital	2600 Center St. NE	Salem	97310	Cathy Piercy	(503) 945-2800	Hospital	BLS	1
	Rural Metro		Salem	97301	Greg Klopfenstein	(50309132-7798	Private	ALS/BLS	

	Salem Fire Dept.	2742 25th St. SE	Salem	97302	Michael Heffner	(503) 588-6238	Fire	ALS/BLS	8
	Santiam Memorial Hospital	1403 N Tenth Ave.	Stayton	97383	Genny Baldwin	(503) 769-2175	Hospital	ALS	5
	St. Paul Volunteer Fire	PO Box 144	St. Paul	97137	Brian Lee	(503) 633-4602	Fire	ALS/BLS	2
	Turner Fire District	PO Box 10	Turner	97392	Kevin Henson	(503) 743-2190	Fire	ALS/BLS	2
	Woodburn Ambulance	PO Box 584	Woodburn	97071	Shawn Baird	(503) 982-4699	Private	ALS	5
Polk	Dallas Ambulance Service	PO Box 67	Dallas	97338	Todd Brumfield	(503) 623-2338	Municipal	ALS/BLS	3
	Polk County Fire Dist. #1	1800 Monmouth St.	Independence	97351	Jason Crain	(503) 838-1510	Fire	ALS	3
Yamhill	McMinnville Fire Dept.	175 E First Dept.	McMinnville	97128	Jay Lilly	(503) 434-7305	Fire	ALS/BLS	4
	Newberg Fire Department	414 E. Second St.	Newberg	97132	Frank Douglas	(503) 537-1230	Fire	ALS/BLS	5
	Sheridan Fire District	PO Box 67	Sheridan	97378	Terry Nye	(503) 843-2467	Fire	ALS/BLS	2
	Willamina Fire District	PO Box 887	Willamina	97396	Gary Brooks	(503) 876-2004	Fire	ALS/BLS	3
Region 3									
HRSA Regional Coordinator		Email	City			Phone			
	Tracy DePew	HRSA@co.douglas.or.us	Roseburg			(541) 784-5696			
County	**Agency**	**Address**	**City**	**Zip**	**Contact Person**	**Phone**	**Type**	**Resources**	**#**
Coos	Bay Cities Ambulance	PO Box 575	Coos Bay	97420	JD Fuiten	(541) 269-1155	Private	ALS/BLS	6
	Coquille Valley Ambulance	3 rd & Alder	Coquille	97423	David Waddington	(541) 396-2232	Municipal	ALS/BLS	2
	Myrtle Point Ambulance	424 5th Street	Myrtle Point	97458	Miriam Brown	(541) 572-2993	Municipal	ALS/BLS	2
	Powers Volunteer Fire Dept.	PO Box 250	Powers	97466	Laurel Dudley	(541) 439-2411	Fire	BLS	2
Douglas	Douglas County FD # 2	1400 Buckhorn Rd	Roseburg	97470	Joel King	(541) 673-5503	Fire	ALS	3
	Drain Rural Fire District	PO Box 277	Drain	97435	James Thomas	(541) 8836-2282	Fire	ALS/BLS	4
	Glendale Ambulance	PO Box 495	Glendale	97442	Toni Kimple	(541) 832-2900	Health Dis	ALS/BLS	2
	Glide Rural FPD	O Box 446	Glide	97443	Debora Dean	(541) 496-0224	Fire	ALS/BLS	2
	Lower Umpqua EMS	600 Ranch Rd.	Reedsport	97467	Kevin Van Syoc	(541) 271-2171	Hospital	ALS	2
	MedCom Ambulance Auth.	774 SE Rose St.	Roseburg	97470	Greg Marler	(541) 677-9159	Municipal	ALS	7
	Sutherlin Fire Dept.	PO Box 459	Sutherlin	97479	Tom Wells	(541) 459-1394	Fire	ALS/BLS	2
	Winston-Dillard FD # 5	PO Box 1779	Winston	97496	Kenny McGinnis	(541) 679-8721	Fire	ALS/BLS	3
Lane	Eugene Fire & EMS	1705 West 2nd	Eugene	97402	JoAnna Kamppi	(541) 682-7104	Fire	ALS/BLS	9
	Lane Rural Fire/Rescue	29999 Hallett St	Eugene	97402	Bill Bass	(541) 688-1770	Fire	ALS/BLS	2
	Medical Transportation Serv	335 Mill St	Eugene	97401	Lynn Walter	(541) 342-3003	Private	BLS	2
	Oakridge Fire Dept.	PO Box 385	Oakridge	97463	Mark Sundin	(541) 782-2416	Fire	ALS/BLS	3
	South Lane Rural Fire	233 Harrison Ave	Cottage Grove	97424		(541) 942-4493	Fire	ALS/BLS	3
	Springfield Fire & Life Safety	225 N Fifth St.	Springfield	97477	Dennis Murphy	(541) 726-3737	Fire	ALS/BLS	5
	Western Lane Ambulance	PO Box 2690	Florence	97439	Henry Hanf	(541) 997-9614	Municipal	ALS	5
Region 5									
HRSA Regional Coordinator		Email	City			Phone			
	Beth DePew								
County	**Agency**	**Address**	**City**	**Zip**	**Contact Person**	**Phone**	**Type**	**Resources**	**#**
Curry	Cal-Ore Life Flight	PO Box 1986	Brookings	97415	Daniel Brattain	(541) 469-7911	Private	ALS/BLS	9
	Port Orford Community Amb	PO Box 582	Port Orford	97465	Curtis Brown	(541) 332-9035	Volunteer	BLS/ILS	2

Jackson	Ashland Fire & Rescue	455 Siskiyou Blvd	Ashland	97520	Keith Woodley	(541) 482-2770	Fire	ALS/BLS	5
	Jackson County FD # 3	8333 Agate Rd	White City	97503	Rod Edwards	(541) 826-7100	Fire	ALS/BLS	3
	Jackson County FD # 5	716 S. Pacific Hwy	Talent	97540	Dan Marshall	(541) 535-4222	Fire	ALS/BLS	2
	Mercy Flights, Inc	3650 Biddle Rd. # 14	Medford	97504	Kenneth Parsons	(541) 779-6552	Private	ALS/BLS	18
	Rogue River RFPD	PO Box 1170	Rogue River	97537	Gregory Winfrey	(541) 582-4411	Fire	ALS	3
	Southern Oregon Skyways	3650 Biddle Rd. #17	Medford	97504	Monte George	(541) 779-5445	Private	ALS	2
	Superior Air Charter	3650 Biddle Rd. # 18	Medford	97504		(541) 772-5660	Private	ALS	1
	Timberland Logging	PO Box 370	Ashland	97520		(541) 488-2880	Private	ALS	2
Josephine	American Medical Response	PO Box 1915	Grants Pass	97528	Dave Matthews	(541) 474-6303	Private	ALS/BLS	9
Klamath	Basin Volunteer Ambulance	PO Box 284	Malin	97632	Raymond Struve	(541) 798-5175	Health	ALS/BLS	4
	Bly Ambulance	PO Box 87	Bly	97622	Rhonda Vickerman	(541) 353-2604	Volunteer	BLS/ILS	1
	Bonanza Ambulance	PO Box 363	Bonanza	97623	Robert Collom	(541) 545-6705	Volunteer	ALS/BLS	1
	Chemult RFPD	PO Box 28	Chemult	97731	Nancy Mort	(541) 365-2255	Fire	BLS/ILS	2
	Chiloquin Volunteer Amb	PO Box 342	Chiloquin	97624	Carole Franzen	(541) 783-3131	Volunteer	ALS/BLS	2
	Crescent RFPD	PO Box 230	Crescent	97733	Berry Petznick	(541) 433-2466	Fire	ALS/BLS	2
	Harriman RFPD	25600 Rocky Pt. Rd.	Klamath Falls	97601	Larry Renicker	(541) 356-2205	Fire	BLS/ILS	2
	Keno Fire Dept. Ambulance	PO Box 10	Keno	97627	John Ketchum	(541) 884-3062	Fire	ALS/BLS	2
	Klamath County Fire Dist. #1	143 North Broad St.	Klamath Falls	97601	David Penicook	(541) 885-2056	Fire	ALS/BLS	7
	Klamath County Fire Dist. #4	4042 Balsam Drive	Klamath Falls	97601	Daniel Selby	(541) 884-1670	Fire	ALS/BLS	1
	Mid-County Ambulance	PO Box 99	Sprague River	97639	Patricia Ellison	(541) 533-2400	Volunteer	ALS/BLS	1
Region 6									
HRSA Regional Coordinator		Email	City			Phone			
	Pete Kinsley								
County	**Agency**	**Address**	**City**	**Zip**	**Contact Person**	**Phone**	**Type**	**Resources**	**#**
Gilliam	Arlington Volunteer FD	PO Box 105	Arlington	97812	Connie Anderson	(541) 454-2887	Health Dis	BLS/ILS	2
	South Gilliam County Amb	PO Box 85	Condon	97923	Karen Jones	(541) 384-2061	Health Dis	BLS/ILS	2
Hood River	Cascade Locks Ambulance	PO Box 308	Cascade Locks	97014	Carl Zerfing	(541) 374-8510	Fire	ALS/BLS	1
	Hood River Ambulance	PO Box 27	Hood River	97031	Gregory Simpson	(541) 386-3939	Fire	ALS	3
	Parkdale RFPD	PO Box 40	Parkdale	97041	Ty Erikson	(541) 352-6092	Fire	ALS/BLS	2
Sherman	Rufus Volunteer Ambulance	PO Box 235	Rufus	97050	Randall Absolon	(541) 739-2222	Volunteer	BLS	1
	Sherman County Ambulance	PO Box 365	Moro	97039	Mike McArthur	(541) 565-3100	Municipal	BLS/ILS	2
Wasco	Dufur Vounteer Ambulance	PO Box 145	Dufur	97021	Jalan Van Nice	(541) 469-2349	Municipal	BLS/ILS	1
	Mid-Columbia Fire & Rescue	1400 W. 8th St.	The Dalles	97058	Joseph Riichardson	(541) 296-9445	Fire	ALS/BLS	4
	Southern Wasco County Amb	PO Box 125	Maupin	97037	Sherry Holliday	(541) 395-2571	Volunteer	BLS	2
Region 7									
HRSA Regional Coordinator		Email	City			Phone			
	Marty Betsch								
County	**Agency**	**Address**	**City**	**Zip**	**Contact Person**	**Phone**	**Type**	**Resources**	**#**
Crook	Prineville Fire Dept.	500 N. Belknap	Prineville	97754	Elizabeth Morgan	(541) 447-5011	Fire	ALS/BLS	3
	Rager Emergency Services	171759 Rageor Rd.	Paulina	97751	Eugene Skrine	(541) 477-6900	Volunteer	BLS	1

Deschutes	Air Life of Oregon	2500 NE Neff Rd	Bend	97701	Vern Bartley	(541) 385-6305	Hospital	ALS	3
	Bend Fire Dept.	5 NW Minnesota Ave	Bend	97701	A. William Roberts	(541) 388-5533	Fire	ALS/BLS	5
	Black Butte Ranch RFPD	PO Box 8190	Balck Butte	97759	Gordon Rowat	(541) 595-2288	Fire	ALS/BLS	2
	LaPine Rural Fire PD	PO Box 10	LaPine	97739	James Court	(541) 536-295	Fire	ALS	3
	Redmond Fire Dept.	341 NW Douglas Ave	Redmond	97756	Dave Pickhardt	(541) 04-5000	Fire	ALS/BLS	3
	Sisters-Camp Sherman RFPD	PO Box 1509	Sisters	97759	Taylor Roberts	(541) 5549-0771	Fire	ALS/BLS	3
	Sunriver Fire Dept.	PO Box 3278	Sunriver	97707	Patrick McGinnis	(541) 593-8622	Fire	ALS/BLS	2
Grant	Blue Mountain Hosp. Vol.	170 Ford Rd.	John Day	97845	TR Hilton	(541) 575-1311	Hospital	ALS/BLS	7
Jefferson	Crooked River Ranch RFPD	7000 SW Shad Rd.	Crooked River	97760		(541) 923-6776	Fire	ALS/BLS	2
	Jefferson County EMS	PO Box 265	Madras	97741		(541) 475-7476	Health Dis	ALS/BLS	5
	Warm Springs Fire & Safety	PO Box C	Warm Springs	97761		(541) 553-16334	Fire	ALS/BLS	4
Harney	Harney District EMS	557 W Washington	Burns	97720	Timothy Peck	(541) 573-3686	Health	ALS	3
Lake	Lakeview Disaster Unit	PO Box 1007	Lareview	97630	Susan Suba	(541) 947-2504	Volunteer	ALS/BLS	3
	North Lake County EMS	PO Box 423	Christmas Valley	97641	William Jarmin	(541) 576-2759	Volunteer	ALS/BLS	2
	Paisley Disaster Unit	PO Box 208	Paisley	97636	James Overton	(541) 943-3342	Voluneer	ALS/BLS	2
	Silver Lake	PO Box 96	Silver Lake	97638	Juanita Nelson	(541) 576-2555	Fire	BLS/ILS	2
Wheeler	Fossil Volunteer Ambulance	PO Box 467	Fossil	97830	Jeanne Burch	(541) 763-2698	Municipal	BLS	1
	Mitchell Ambulance Service	PO Box 97	Mitchell	97750	Annette Wornell	(541) 462-3366	Municipal	BLS	1
	Spray Volunteer Ambulance	PO Box 234	Spray	97874	Bob Parkhurst	(541) 468-2395	Volunteer	ILS	2

Region 9									
HRSA Regional Coordinator		**Email**	**City**			**Phone**			
	Donna Hanna								
County	**Agency**	**Address**	**City**	**Zip**	**Contact Person**	**Phone**	**Type**	**Resources**	**#**
Baker	Baker City Fire Dept.	1616 Second St.	Baker City	97814	Bill Smith	(541) 523-3711	Fire	ALS/BLS	3
	Eagle Valley Ambulance	PO Box 334	Richland	97870	Patricia Matheson	(541) 893-6632	Volunteer	BLS/ILS	1
	Halfway-Oxbow Ambulance	PO Box 647	Halfway	97834	Chuck Peterson	(541) 742-5023	Volunteer	ALS/BLS	2
	Huntington Volunteer Fire	PO Box 369	Huntington	97907	Eric Bronson	(541) 869-2201	Fire	BLS/ILS	1
Mallheur	Jordan Valley Ambulance	PO Box 345	Jordan Valley	97910	Stanley Tschida	(541) 586-2563	Volunteer	BLS/ILS	2
	Nyssa Ambulance Service	14 S. Third St.	Nyssa	97913	Alicia Shell	(541) 372-2264	Municipal	BLS/ILS	2
	Treasure Valley Paramedics	PO Box 278	Ontario	97914	Kerry Nyce	(541) 823-8000	Private	ALS/BLS	3
	Vale Ambulance Service	252 "B" St. West	Vale	97918	Heather Collins	(541) 473- 3796	Municipal	BLS/ILS	2
Morrow	Morrow County Ambulance	PO Box 9	Heppner	97836	Carl Lauritsen	(541) 676-9133	Health	ALS/BLS	6
	Portland General Electric	PO Box 499	Boardman	97818	Robert Conner	(503) 464-8000	Industrial	BLS/ILS	1
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	Hermiston Fire & Emergency	330 S. 1st	Hermiston	97838	Steven Frazier	(541) 567-8822	Fire	ALS/BLS	4
	Milton-Freewater EMS	PO Box 356	MiltonFreewater	97862	Louis Heidenrich	(541) 938-7146	Fire	ALS/BLS	2
	Pendleton Fire & Ambulance	911 SW Court Ave	Pendleton	97801	Bill Gilliland	(541) 276-1442	Fire	ALS	4
	Umatilla Ambulance Service	PO Box 456	Umatilla	97882	Michael Roxbury	(541) 922-3718	Fire	ALS/BLS	2
Union	Elgin Ambulance Service	PO Box 128	Elgin	97827	Joe Garlitz	(541) 437-2253	Volunteer	BLS/ILS	1
	Grande Ronde Hospital	PO Box 3290	LaGrande	97850	Debi Akera	(541) 963-8421	Hospital	ALS	3

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11.6 Tab G-8 Examples of Local and Regional EMS Plans

Mass Medical Transportation Plan

Conceptual Framework

Oregon Healthcare Preparedness Region 1

Developed by: Tualatin Valley Fire & Rescue
September, 2006

Oregon Healthcare Preparedness Region 1
Mass Medical Transportation Plan
Conceptual Framework

September, 2006

Introduction and Purpose:

This draft conceptual framework was commissioned by Oregon Healthcare Preparedness (OHP) Region 1 and developed by Tualatin Valley Fire and Rescue. The intent of this document is to provide a conceptual framework from which to develop the Region's Mass Medical Transportation Plan (MMTP). It is a tool to be utilized as a starting point from which to craft a MMTP. The Region 1's MMTP is intended to: a) establish standardized definitions and terminology, b) serve as a mechanism for the controlled and coordinated deployment of EMS resources, c) facilitate command and control of EMS resources at the scene and d) integrate with existing and developing Public Health, EMS, fire service and Emergency Management coordination and command structures. When completed, the MMTP will include the following:

1 preplanned definitions and terminology
2 standardized access criteria and procedures
3 communications plan
4 operational plan
5 oversight and technical support
6 event and plan review

Strategic Concept and Assumptions:

The MMTP is based on the Incident Command System (ICS)/National Incident Management System (NIMS). The success of ICS/NIMS in incident management is predicated on standardized preplanning, standardized communications/terminology and a standardized operational/command structure. Utilizing the ICS/NIMS structure, EMS providers will be smoothly incorporated into ongoing and/or expanding events. Upon adoption of the MMTP, EMS will have known pre-established roles and responsibilities in the response to major mass casualty health events.

Region 1's MMTP is proposed to be an extension of existing local mutual aid plans in order to develop a well-ordered network of mutual aid for the region. Escalation of Medical Mutual Aid is depicted in the following diagram:

Escalation of Medical Mutual Aid

Agency Mutual Aid

↓

County ASA Mutual Aid

↓

Regional Mass Medical Transportation Plan

↓

Oregon EMS Mobilization Plan (To be developed by the State)

It is assumed that other Healthcare Preparedness Regions will develop locally-appropriate plans for mass medical transport utilizing ICS structure; thus, the MMTP of adjacent

regions will interface, facilitating the access and utilization of EMS resources from both regions.

It is also assumed that the State will establish a state-wide ambulance surge capacity plan with standards that will effectively integrate the MMTPs developed by the various Healthcare Preparedness Regions.

PREPLANNED DEFINITIONS AND STANDARDS:

EMS's ICS Application:
The purpose behind ICS is to make available, to allow access, and to facilitate the effective utilization of EMS resources. Standardization of definitions and terminology become extremely important when resources are coming from a variety of sources. The ability to quickly and effectively communicate resource needs is critical. At this time in the state of Oregon, EMS resources have not been defined for this purpose beyond a foot note reference to "ambulances" and "medic units" in the Standardized Cost Schedule in the Oregon State Fire Marshall's (OSFM's) Fire Service Mobilization Plan. The Federal Emergency Management Agency (FEMA) has developed resource typing definitions for EMS. Unfortunately, some of the definitions and terminology is not appropriate or is inadequate in providing the clarity and detail need to be functional with Oregon EMS resources. A decision will need be made whether to or how to use the FEMA definitions with clarifying verbiage.

At this time the following functional definitions are being recommended for Region 1's MMTP:

ALS Ambulance: An ALS ambulance is a transporting ambulance staffed with a minimum of one EMT-P or EMT-I and one EMT-B
Ambulance: as defined in ORS 682 and OAR 333-255
EMT-P (Paramedic): as defined in OAR 333-265
EMT-I (Intermediate): as defined in OAR 333-265
EMT-B (Basic): as defined in OAR 333-265

BLS Ambulance: A BLS ambulance is a transporting ambulance staffed with a minimum of two EMT-Bs
Ambulance: as defined in ORS 682 and OAR 333-255
EMT-B (Basic): as defined in OAR 333-265

Air Ambulance - Fixed Wing or Rotor Wing: An aircraft (fixed or rotor wing) staffed with appropriately trained EMT, Nurse, Physician Assistant or Physician and pilot
Air Ambulance: as defined in ORS 682 and OAR 333-255 Medical Personnel: as defined by their respective state regulatory body

Medical Crew: Is a single resource of medical personnel defined by need. A Medical Crew will consist of five EMTs of any level. Specific request may be made for the

crew to consist of ALS personnel (EMT-P or EMT-I) or to include an emergency physician(s) and/or emergency nurse(s) as dictated by the event.

Medical Personnel: as defined by their respective state regulatory body

Crew / Strike Team / Task Force Leader: Is an experienced EMT (any level) with advanced ICS training (beyond ICS 200) who has completed an EMS Strike Team Leader Course (to be developed or adopted based on California's, 16 hour, Strike Team Leader – Ambulance Course) and has been designated a Crew Leader, Strike Team Leader or Task Force Leader by their agency.

(see: *Crew/Strike Team/Task Force Leader Role and Responsibilities* at the end of this section)

The following operational resource designations are being recommended for Region 1's MMTP:

Single Resources: A specific Crew (team) of individuals with an identified Crew Leader (supervisor) to be used at an event

Medical Crew will be the common EMS single resource designation requested. It will generally be composed of 5 EMTs (any level) but may be specified to be ALS or BLS. Specific request may also be made to include emergency physicians and/or emergency nurses.

Strike Teams:

A specific combination of same kind and type resources with common communications and a Strike Team Leader

ALS Ambulance Strike Team will consist of 5 ALS ambulances and an ambulance strike team leader with own vehicle **BLS Ambulance Strike Team** will consist of 5 BLS ambulances and an ambulance strike team leader with own vehicle

Task Force: A combination of mixed resources assembled for a particular tactical need with common communications and a Task Force Leader

Medical Task Force will be the common EMS task force designation requested. It will generally be composed of a combination of ALS ambulances, BLS ambulances, air ambulance and/or medical crews. The specific composition will be determined by the tactical need.

All of the definitions, designations and concepts presented in this conceptual framework document are easily assimilated into the ICS/NIMS structure and operations. However the role and responsibilities of an EMS Crew, Strike Team or Task Force Leader are new and unique at this time. For Region 1's MMTP, the following position description is recommended for EMS operations: Crew / Strike Team / Task Force Leader Role and Responsibilities:

1 Assuring the safety and condition of personnel and equipment.

2 Coordinating the movement of the personnel and equipment traveling to and returning from an incident.

3 Supervising the operational deployment of the team at the incident, as directed by the Division/Group Supervisor, Operations Section Chief, or Incident Commander.
4 Maintaining familiarity with personnel and equipment operations, including assembly, response, and direct actions of assigned units, keeping the team accounted for at all times.
5 Contacting appropriate Incident personnel with problems encountered regarding the incident, including mechanical, operational, or logistical issues.
6 Ensuring vehicles have adequate communications capability prior to assignment.
7 Maintaining positive public relations during the incident.
8 Prior to deployment understand mission duration, special circumstances, reporting location and contact information.
9 Ensuring completion and submission of ICS documents for timekeeping and Demobilization (ICS Form 214).

An ICS/EMS leadership position requires the ability and experience to support, manage, coordinate, and direct the actions of EMS resources in a wide variety of operational situations and environments. This also includes administrative duties such as maintaining required records, and ensuring the logistical needs of assigned personnel are met for the duration of the activation of the team.

Qualifications and Training Requirements for Personnel:
Aside from their respective clinical education and requirements, operating in an ICS/NIMS environment requires ICS specific training. ICS training allows EMS providers to function safely and effectively within a multidisciplinary ICS structure coordinated through the use of a common command structure and standardized terminology.

All Responders:

Required:

ICS 100 and ICS 200 Courses Hazardous Materials First Responder Awareness Level Training Clinical Status: In good standing with certifying or licensing body 1 year clinical experience approval of provider agency

Recommended:

ICS 300 and ICS 400 Courses Basic MCI Field Operations Course (CA program – develop OR program) WMD Awareness Course Hazardous Materials First Responder Operations Level Training

Crew / Strike Team / Task Force Leader:

Required:

ICS 100, ICS 200, ICS 300 and ICS 400 Courses EMS Strike Team Leader's Course (to be developed or adopted based on California's, 16 hour, Strike Team Leader – Ambulance Course) Hazardous Materials First Responder Operations Level Training Basic MCI Field Operations Course (CA program – develop OR program) Critical Incident Stress Management Course (CISM) Clinical Status: In good standing with certifying or licensing body 3 years clinical experience 1 year in a leadership role in emergency service environment approval of provider agency

Recommended:
Additional ICS Courses
WMD Awareness Course

Equipment Requirements:
The following lists are derived from pre-existing lists. These lists will be revisited when the State develops a statewide ambulance surge capacity plan with defined minimal standards. Regional standards may be established provided they meet or exceed state minimums.

Personnel: EMS personnel participating in an event under Region 1's MMTP are expected to perform in extreme clinical and environmental conditions. EMS personnel need to be physically and emotionally fit to operate under these conditions. Home agencies should give consideration to a staff member's fitness for this type of duty in making responses assignments.

☐ - extra uniform, socks & underwear
☐ - clothing appropriate for climate
☐ - raingear
☐ - reflective vest/jacket
☐ - safety gear: helmet, turn-outs, gloves and boots (as appropriate)
☐ - hearing protection (ear plugs)
☐ - sunglasses
☐ - sunscreen
☐ - DEET
☐ - 1-qt. water bottle/canteen with potable water (minimum)
☐ - personal MREs and/or energy snacks
☐ - toiletries and other personal items as needed
☐ - toilet paper
☐ - sleeping bag
☐ - photo I.D. and petty cash
☐ - personal medicines and medical history documentation
☐ - approval of home agency

Ambulance: Ambulances shall be equipped and supplied as set forth in OAR 333-255 and appropriate to accommodate the level of care (paramedic, intermediate or basic) to be rendered. The following additional requirements must be met by units responding under Region 1's MMTP:

☐ - a current Oregon state road atlas or mapping equivalent
☐ - communication capabilities (tbd – see Communications section below)
☐ - credit cards and/or petty cash (for fuel and supplies as needed)
-25 patient care reports (PCRs)
-25 disaster triage tags

☐ - 25 Oregon Trauma System identification bracelets
-2 pair work gloves
-2 safety helmet with dust-proof safety goggles

-4 HEPA masks and 4 dust filters
-2 flashlights or headlamps (rechargeable or with extra batteries)

Air Ambulance - Fixed Wing or Rotor Wing:
Air ambulances shall be equipped and supplied as set forth in OAR 333-255. Air ambulances should be prepared to run multiple and back to back missions. Preplanning for alternate fueling and liquid oxygen resupply should be in place. Aircraft, crew and equipment should be able to accommodation various mission types such as scene, rendezvous, shuttles, and long and short distance transfers.

☐ - a current Oregon state road atlas or mapping equivalent
☐ - communication capabilities (tbd – see Communications section below)
☐ - credit cards and/or petty cash (for fuel and supplies as needed)
-25 patient care reports (PCRs)
-25 disaster triage tags

☐ - 25 Oregon Trauma System identification bracelets

Strike Team / Task Force Leader Command Vehicle: Command vehicles operating under Region 1's MMTP should be emergency response capable vehicles and equipped to not only lead but to provide a level of support to the team or forces medical assignment. (This vehicle may be, but need not be an ambulance.)
☐ - a current Oregon state road atlas or mapping equivalent
☐ - compass
-communication capabilities (tbd – see Communications section below)

☐ - credit cards and/or petty cash (for fuel and supplies as needed)
-cell phone, batteries and charger

☐ - appropriate extra batteries and/or chargers (medical/operational/communications)
☐ - 2 sleeping bags
☐ - 36 MREs
-potable water
-100 disaster triage tags

☐ - 100 patient care reports (PCRs)
☐ - 100 Oregon Trauma System identification bracelets
-ICS forms & Strike Team leader kit
-2 helmets
-2 pairs work gloves

☐ - 2 flashlights or headlamps (rechargeable or with extra batteries)
☐ - personal pack with contents as described above

Medical Crew Transportation or Operational Equipment and Vehicle: The equipment and vehicle required for a medical crew will be dictated by the nature and assignment of

the crew. Crews operating under the Region 1's MMTP are expected to be able to transport themselves and their equipment for the duration of their assignment. If the vehicle is for transport of personnel only, it need not have Code 3 capabilities but should have official markings and ongoing communication capabilities (not portables or cell phones without charging capabilities while mobile).

☐ - a current Oregon state road atlas or mapping equivalent

☐ - compass

-communication capabilities (tbd – see Communications section below)

☐ - credit cards and/or petty cash (for fuel and supplies as needed)

-cell phone, batteries and charger

☐ - 45 MREs

-potable water

☐ - appropriate and adequate safety equipment for every member of crew

☐ - 2 flashlights or headlamps (rechargeable or with extra batteries)

Treatment Guidelines and Medical Command:

All EMS personnel responding under the Region's MMTP are authorized to function at their level of clinical certification or licensure. The medical care render by EMS personnel is to be within their prescribed scope of practice, utilizing treatment guidelines, policies and procedures as set forth by their home agency and its Medical Director. Medical command and online medical control remain with the provider's home medical direction resources. With the prior permission of their home Medical Director, EMS personnel may accept direct or local online medical direction within their scope of practice.

At no time are EMS personnel allowed to exceed or extend their standard scope of practice. This is regardless of any direction or instruction received while responding to, on scene or in any way participating in an event under Region 1's MMTP.

Communication Requirements and Concept

Concept: Communication is essential to the management and functioning of EMS operations. Communications is the most common point of failure in major multi-agency events. Failure often results from hardware limitations, and process and application issues. The operating environment and status of the existing communication systems have to be assumed as unknowns. There is a need for redundancies and contingency plans to assure the availability of effective and reliable EMS communications regardless of the environment. Operational environments will range from an intact communications infrastructure to collapsed or non-existent infrastructure. As such the expectation will be for a communication system with interface capabilities as well as the ability to operate completely independent of the preexistent system.

Requirements:

Units or teams responding under the MMTP must have the following communications

capabilities to effectively and efficiently integrate into the operating ICS structure:

☐ - base communications: to home agency/dispatch for unit status and unit support
☐ - functional communications: within Team/Force for internal functional purposes - operational communications: at event for contacts within the ICS structure

Interoperability Resources The following have been identified as potential resources for EMS communications interoperability. Interim and long-term solutions need to be explored.

☐ - gateway device technology / cross band repeaters
☐ - UASI/CBRNE mobile units with VHF repeaters (UASI = urban area security initiative) (CBRNE = chemical/biological/radiological/nuclear/explosive)
☐ - HEAR System (155.340)
(HEAR = hospital emergency alert radio system)

☐ - State EMS Channels (150.775 and 150.790)
☐ - Regional Hospital/OHSU
☐ - HospCap Program
☐ - OHP Region 1's "Health Coordinating System"
☐ - OHP Region 1 Interoperability/Mutual Aid Communications Plan
☐ - Mountain Wave Emergency Communications

Status: There is substantive work underway at this time to establish a common communications system for effectively managing medical resources in a major event in Region 1. There are multiple systems under development by various agencies at the state, regional, and local levels. There are gaps in the EMS portion of the system as well as a number of complex technical issues that need to be resolved.

OPERATIONAL PLAN:

OHP Region 1's MMTP has been structured under a standard ICS framework. Standardization allows EMS and EMS resources to seamlessly integrate or interface with any other ICS structure. EMS becomes a functional component of the response in either a public health or public safety event. Under the MMTP EMS resources will operate under the lead agency's ICS structure: public health, emergency management or fire service.

The MMTP as presented here is in a parallel format of the significant action steps in implementing an ICS plan:

Activation of Plan: There is no activation required to access regional level resources. Once Region 1's resource documents have been developed and executed by appropriate agencies and the MMTP plan adopted, the Region 1 MMTP will be considered to be active. When the Region 1's MMTP is in place, resources can be accessed via local dispatch centers utilizing existing mutual aid resource requesting processes. With the MMTP the entire complement of EMS mutual aid resources in Region 1 will be available to the incident commander (IC). There is no authorization or activation process required to utilize regional resources.

Ordering Resources: Resource ordering within the region is no different than requesting local agency mutual aid resources. The request is made through the host agency's normal processes utilizing their local dispatch center. The MMTP extends the resources available to that agency to those in OHP Region 1. All local 911 dispatch centers within Region 1 will have information and access to all EMS mutual aid resources in Region 1. The logistics to this may vary by dispatch center. This procurement process is used until all of Region 1's mutual aid resources have been utilized. At the point at which it is determined that resources beyond those of Region 1 (and dependent on geographic location, neighboring agency mutual aid resources outside Region 1) steps should be taken to activate or mobilize resources on a statewide level.

Response to the Event: Response under the MMTP is immediate as it would be for any local request for mutual aid resources. The destination and reporting-in instructions will come as part of the request/dispatch communiqué and will be dependent on the level of ICS structure in place at the time of the request. Responding resources should be aware that the ICS structure may have or be evolving and should adapt as appropriate. At the MMTP level of response, resources may be requested as individual mutual aid resources or by their ICS/NIMS designation or category. Even though there has not been a state level mobilization, resources requested under their ICS designation (i.e., "ambulance strike team") are to act and respond as they would under a state level mobilization, adapting as appropriate (i.e., no pre-response paperwork or pre-response authorization, no ERC check-in, communication and orders may be directly with the IC, etc.). While response of crews, strike teams and task forces is expected to be immediate and appropriate adaptations made; team leaders are expected to complete their pre-response actions and duties to insure that their team is safe and prepared to respond.

Extended Events: As the MMTP is a regional based response, responding units will remain within a reasonable distance from their base of operations. Home agencies should anticipate and be prepared to provide or arrange for support to their unit(s) in the field. As the event develops and the ICS structure evolves a certain amount of logistical support will likely be established over time. However, it should not be counted on or depended on – contingency plans should be in place. Alternate fueling sources and ongoing oxygen re-supply will be essential, with specific attention being given to narcotics, incident specific medications and routine disposable supplies (i.e., oxygen masks/cannulas, gloves, linens, etc.). Early and consistent monitoring of personnel for length of duty assignments will be left to home agencies. With personnel safety being primary, consideration needs to be given to type and intensity of assignment as well as uninterrupted sleep/rest time. For regional operations under the MMTP the maximum duty assignment is 48 hours followed by 12 hours off-duty. 48 hours is the maximum, shorter duty assignments are encouraged to insure personnel and patient safety.

Demobilization: There will be no formal demobilization process at the regional level. Units deployed to the event remain a committed resource until formally released. Transporting units upon completion of their task report back in to their appropriate point of contact within the Operations Section of the prevailing ICS structure. Units will be reassigned or sent to the staging area. As the event deescalates resources will be released upon the direction of the IC. Once released, units are to report their status to

their home agencies and then come under their authority for returning directions.

Reimbursement: Response to a MMTP event is based on mutual aid. Aid is based on the mutual agreement to be available and respond as requested. The agreement is considered to be in-like-kind compensation for response to an event. Reimbursement for treatment and transportation of patients may be sought from the patient, patient's insurance or third party payor by agencies providing such services under the MMTP. Actions and activities related to billing for services are the sole responsibility of the home agency; and any reimbursement received becomes the property of the home agency which provided the service.

Post Event Review: All responses under Region 1's MMTP are to be reviewed for educational and ongoing program revisions and improvements. Facilitation of the post event review is the responsibility of the host agency. All agencies who responded to the event, the incident management team and other appropriate participating organizations (hospitals, dispatch, fire, law enforcement, etc.) should be invited to attend. The review process is to be objective and constructive identifying areas for improvement and potential solutions. The goal is to collaboratively enhance the effectiveness and safety of future responses under the MMTP. A written report with the findings and recommendations of the review process will be provided to OHP Region 1 and the State EMS Office.

List of Attachments:

A. Problems/Issues/Concerns Identified in Plan Development Process

B. Recommendations Identified in Plan Development Process

C. Contacts Made in Plan Development Process

D. Applicable Statutes and Rules

E. Additional Contacts for Establishing Plan (Phase 2)

F. Compilation of Tasks and Comments during Document Development

G. Sample Mutual Aid Agreement Verbiage

H. Sample Data Sheets:

I. Specific Event Type Considerations CBRNE Isolation / Decontamination Clinical/Medical Requirements Specific Natural and Weather Events

J. Specific Resources Available within or to OHP Region 1 Disaster Push Packs Pharmaceutical Caches Panda Team (Oregon Health Sciences University) Mobile Surgical Transport Team (Emanuel Legacy Hospital) ALS Engines MCI Response Trailers (Tillamook Fire District) DMAT Resources UASI Resources Oregon National Guard US Coast Guard

K. OHP Regions/ATAB Map

L. OHP Region 1 Hospital Map

Problems/Issues Concerns Identified in Plan Development Process

Oregon Healthcare Preparedness Region 1
Interview Response: Problem / Issue / Concern

Comment:

funding mechanism / funding source need enabling legislation / authority to participate in mutual aid & be paid Providers still need to meet ASA plan req's -will work with them to manage

No radio comm from coast to Ptld cell capable is there a need to -some do and some don't

Credentialing

Liability

Pvt ambulance: who do they take direction from? County/fd/ic/hosp?

post incident: money flows to public.... Mechanism to pay pvts

$ for transport?

$ for "other" services

what would our dispatch be asked to do?

what level would county be willing to allow them to drop to?

Prioritization of Amb Utilization: 1. Event, 2. ongoing 911 -non-emergency transfers stop -authority to prioritize and manage responses

Allocation of resources: home rule and home coverage will be issues Governance Structure & Authority will be key resupply / fueling / meals / accommodations need to be worked out resource and resupply for amb O2 /IV / fuel communications: on 800 sys role of wheelchair/stretcher vehicles Mix meds & Tx protocols -med director buy in -who's and what rules apply Plan adoption: State? Co EMS? Sup Physicians?

who provides the resupply? liability coverage: provider organizations (govt cap at $250K) use of FD rescues and other non-licensed ambulances no tort protection credentialing requirements use of home protocols is assumed? communications

Make sure crews understand structure and role -don't do ICS regularly training, edu and drills will be important communications: use VFH/800 patch single point of contact: will be managing scene vs managing resources need someone who can handle that A-Z Standardized terminology will be important: ie Strike Team of Amb Common Communications Channel: OR EMS Channel or Fire Marshalls major resources in Ptld urban center -what will be available to them political buy in to support rurals.... Communications and real-time information/status from field

political networking

technology networking

training and skills

challenge will be in the different organizational structures working together

Funding for responses will be a challenge

Agreement on activation std & requirements

Communications -Freq Stds

Call to Strike team time

considered urban due to proximity -actually more rural

Isolation -TH approx 1 hr any direction Hwy closures common

22K resident population 60K on weekends
60% of homes owned by people out of county... Ptld epidemic will come to Tillamook
mass casualty plan is related but different -not clear demarcations
need to have regional and state level coordination
coordination and communication between PS & EM is essential need to know resources and activities during event
no formal intercounty mutual aid plans in place
indemnification of private companies
payment/reimbursement of private companies -prearranged contracts
need State plan for infrastructure
need to preplan for interface and overlap with casualty collection points/MCI-plan / Mass care plan
Portions of Yamhill County, including Newberg Hospital are in ATAB 1, should Newberg Hospital be included in OHP Region 1 plans

Recommendations Identified in Plan Development Process

Oregon Healthcare Preparedness Region 1 Interview Response: Recommendation

Comment:

HospCap Program can provide event tracking and info up on the web can get info direct from scene Clark Co Resources: EMS & 2 hospitals Ambulance Service Plans could be beefed up to accommodate some needs Involve supervising physicians on front end -its their people... command and control issues / flow of pt and resources in their community Direction from County -should require 1 phone call only Needs to include: 1. Resource Typing, 2. Pre-Planning & 3. Infrastructure DMAT & NDMS are alternate destinations for transports Edu, training and joint exercise will be important suspend all non-emergency operations changes to staffing req? expectation levels? county's adj protocols/contract req as appropriate AMR Seattle BLS operation, can send 30 amb in 2 hrs (90% BLS) Use BLS with ALS First Responders track deep water ports Maintain scope at Reg 1 -some state issues beyond our control keep broad on ICS not FS plan -PH more aligned with Emerg Mgmt New bus system -JD's?
include MCI Trailers in (Tillamook FD has 50 pt ALS trailer)
Clarify Scope: Keep scope focused on transportation plan & transport related resources

remove ALS engines -maintain medical crews

specifically include/address airmedical resources -may not have normal role and destinations
include PSAP functions as well -not just dispatch, info access and

disbursement point as well, need access/integration with IC
Logistics: support functions need to spelled out... (LOX for airmedical)

Contacts Made in Plan Development Process

Contact List - Ambulance Surge Capacity Project

Contact List - Ambulance Surge Capacity Project

Last Name First Name Organization

Arana Jeanne

Kit Bangs (Christopher) Bates Brannon

Bernsten Christine Betsch Marty Billstrom David Boxman Larry Burright Brain Bybee Anne Collins Bill Dargan Steve DePew Beth DePew Tracy DesJardins Ryan Ernie Lesley Fietin JD Fuller Dave Hamilton Larry Hampton Kelly Hanna Don Harguth Vicki Hawks Rob Higginson Grant Jones Patrick Jui Jon Kelly Pat Kingsley Pete Lauer Randy LeSage Paul Lohner Brian McDaniels Larry Moyer Phil Mullins Duane Murphy Ken Oxman Gary Palmer Bob Porter Scott Richer Kathryn Roncanto Rocco Simpson Randy Steeves Anne Stevens Mark Swanson Eric

Oregon State EMS Office

OHSU – MRH
Portland Fire Bureau
NW Oregon Health Preparedness Organization, Region 1
Oregon Health Preparedness Region 7
Mountain Wave
MetroWest
Columbia River Fire & Rescue
CA EMS Authority
Multnomah County EMS
Washington County EMS
Oregon Health Preparedness Region 5
Oregon Health Preparedness Region 3
Clackamas County Dept. of Communications (C-COM)
Mountain Wave
MetroWest
AMR Clark County
Tillamook Hospital – Amb
ODOT-EMS
Oregon Health Preparedness Region 9
Columbia Co Emerg Mgr
Portland Fire Bureau
DHS-Community Health
Bureau of Emergency Communications
Multnomah County EMS
Tillamook Fire Department
Region 6 Coordinator
AMR Multnomah County
TVF&R
AMR Washington County
Clackamas County EMS
AMR Clackamas County
Medix Ambulance/MetroWest
Oregon Emergency Management

Multnomah County Health Dept
Mid-Columbia Fire & Rescue
Washington County Emerg Mgr
NW Oregon Health Preparedness Organization, Region 1
AMR Multnomah County
OSFM
Oregon Health Preparedness Region 2
TVF&R
Tillamook County Emergency Communications District

Applicable Statues and Rules:

Oregon Revised Statutes:

190.000	Intergovernmental Cooperation
190.410	Interstate Cooperation
401.043	Interstate Emergency and Disaster Assistance Compact
401.055	Powers of Governor
401.260	Oregon Emergency Management
401.305	Powers of Local Governments
401.651	Emergency Healthcare Services
431.600	Emergency Medical Service and Trauma Systems
476.510	Emergency Conflagration Act
682.000	Ambulance Services and Emergency Medical Personnel

Oregon Adminstrative Rules:

333-250 Ambulance Service Licensing
333-255 Ambulance Licensing
333-260 Ambulance Service Areas
333-265 Emergency Medical Technicians
847-035 Scope of Practice for Emergency Medical Technicians (regulated by the Oregon Board of Medical Examiners)

Additional Contacts for Establishing Plan (Phase 2)

Phase 2 Contacts

Organization:
All OHP Region 1 Transport Providers

x All OHP

Region 1 Non-transport Providers

x All OHP

Region 1 Dispatch Centers x All OHP Region 1 Hospitals x All OHP Region 1 County EMS Office/Managers Emergency Managers x All OHP Region 1 Emergency Managers x All OHP

Region 1 Public Health Officers x All OHP Region 1 Fire Defense Board Chiefs x All OHP Region 1 Nontraditional Transport Providers x x All OHP Region 1 Port Authorities, Airports and Transit Districts x x All OHP Region HRSA Grant Coordinators x x State EMS Office (Grant Higginson, MD) x State Fire Marshalls Office (Randy Simons) x State Police (Gary Withers) x State Office of Emergency Management (Ken Murphy) x State DOT (Kelly Hampton) AMR Seattle BLS Division (via Dave Fuller) x US Coast Guard Group / Air Station Astoria x Oregon Department of Military - Fort Rilea x Oregon Department of Military -1042nd Air Ambulance (503-584-3980) x State Interoperability Executive Council (SIEC) [via Marla Rae] x ICS Expert: Ross Rutschman (MFD) x Emergency Management Expert: Jeff Rubin (TVFR) x Communications Interoperability: John Ingrao CRFPD No 1 (ACU 1,000) x

OHP Region 1 MMTP Draft Conceptual Framework
Compilation of Tasks and Comments during Document Development

Medical Direction:
TASK: establish and facilitate this process… will require Med Dir education

Ordering Resources:
TASK: A regional level mutual aid agreement must be developed
TASK: Will need to be developed along with a maintenance procedure (access information)
TASK: Standardized as well as center specific logistics will need to be developed
TASK: Parameters and guidelines for this need to be collaboratively established (resources outside Reg 1)
COMMENT: to be defined in next section (activation at state level)

Response to an Event:
TASK: be sure this is included in Dispatch portion of plan (specific content of dispatch)
COMMENT: Is this a safe statement to be making, given the follow up parenthetical comment and next regular sentence? (adapting as appropriate)

Extended Events:
COMMENT: With proximity is rotation of units a realistic option? What does this do the IC or resource management/staging unit…
COMMENT: note differentiation of units vs staff – which does occur… (rotation of resources)
TASK: some guidelines or recommendations for regional events excerpted from the pending state's plan should be referenced (needs to be consistent / needs to be able to interface)
COMMENT: this is a Jon standard – need to be affirmed or adjusted by provider agencies (48 hr max)

Demobilization:
TASK: this will need to be a formalized process with a clear delineation as to the transfer of authority
COMMENT: confirm when transfer of authority occurs for Mutual Aid and Conflagration

Reimbursement:
TASK: have legal counsel review or provide verbiage which are appropriate and effective in both legal and legislative arenas (mutual aid concept)
COMMENT: confirm with legal that there is no "conflict of interest" here (fee for services rendered)
TASK: have legal counsel review or provide verbiage which are appropriate and effective in both legal and

legislative arenas (responsibility of billing)
TASK: have legal counsel review or provide verbiage which are appropriate and effective in both legal and legislative arenas (reimbursement funds)

Post Event Review:
TASK: develop language and process which affords QI protection of process and conclusions
TASK: establish formal parameters and expectations
TASK: parameters will need to be established which meet both QI and risk management process and protection requirements

Sample Mutual Aid Agreement Verbiage:

I. Oregon Fire Service Mobilization Plan
II. California Disaster and Civil Defense Master Mutual Aid Agreement
III. Inter-Regional Cooperative Agreement for Emergency Medical and Health Disaster Assistance

I. Oregon Fire Service Mobilization Plan

MODEL MUTUAL AID AGREEMENT

(Model only; may be revised to meet local needs)

1.0 INTRODUCTION

WHEREAS, certain disasters have the potential of outstripping the capacity of any community to effectively protect life and property,

WHEREAS, the parties desire to combine and coordinate their resources for responses to disasters occurring in their jurisdictions,

NOW, THEREFORE, under the authority of ORS Chapter 190, it is agreed between the parties as follows:

This Agreement shall be effective on the date signed by all parties, and shall be effective as to each additional party as provided in Section 18 of this Agreement, and is entered into for the purpose of securing to each party periodic emergency assistance for response to emergencies resulting from any cause.

2.0 AUTHORITY

This Agreement is entered into under the authority granted to the parties by their respective charters and/or Oregon Revised Statutes (ORS). Further, ORS 190.010 authorizes units of local government to enter into written agreements with any other units of local government for the purpose of any and all functions and activities that the parties to the agreement, its officers or agencies, have authority to perform, and ORS 190.010 authorizes units of state and local governments to enter into agreements with each other to cooperate in the performance of their duties. Additionally, ORS

Chapters 453, 476 and 401 authorize the State Fire Marshal and the Administrator of the Oregon Emergency Management to develop comprehensive statewide plans for the protection of life and property during disasters. This Agreement is intended to be consistent with, and supportive of, such state contingency plans.

3.0 SCOPE OF AGREEMENT

This Agreement, being in conformance with the *Oregon Fire Service Mass Medical Transportation Plan –Conceptual Framework Oregon Healthcare Preparedness Region 1 21 Mobilization Plan* as adopted by the State Fire Marshal, shall include the following types and kinds of mutual aid assistance, and operating terms and conditions.

3.1 TYPE OF EQUIPMENT AND PERSONNEL. The parties hereto agree to provide to all other parties to this Agreement personnel and equipment as described in Attachment "A" which is incorporated herein by this reference. Further, the parties hereto recognize and agree that such personnel and equipment shall be periodically unavailable under this Agreement due to normal operating requirements. However, when any significant change occurs to the available equipment and/or personnel which shall last more than thirty (30) days, the party experiencing such change shall notify all other parties to this Agreement.

3.2 GOOD FAITH. Each of the parties hereto agrees to attempt to furnish to a requesting party such assistance as the requesting party may deem reasonable and necessary to successfully abate an emergency in the requesting party's jurisdiction. Provided, however, that the party to whom the request is made shall have sole discretion to refuse such request if sending such assistance may lead to an unreasonable reduction in the level of protection within its jurisdiction, and provided further that a state or local agency may refuse a request for assistance if necessary to comply with any limitations on the use of dedicated funds by that agency.

3.3 DISPATCHING. It is agreed by the parties hereto that mutual aid assistance, when to be sent, shall be dispatched promptly and that first response by the jurisdiction requesting assistance shall not be a prerequisite to a request for assistance under this Agreement.

3.4 SUPERVISION. When personnel and/or equipment are furnished under this Agreement, the agency having incident command responsibility for the incident shall have overall supervision of mutual aid personnel and equipment during the period such incident is still in progress. Provided, however, when officers from the requesting jurisdiction have not arrived at the scene of the incident, the commanding officer of the jurisdiction arriving first to provide mutual aid

assistance shall be in command of the incident until relieved. Further, "supervision" as used in this section refers to conduct of the mission. Each person participating in the mission remains an employee of that person's employing agency and is subject to the personnel policies solely of that employing agency.

4.0 WAIVERS

4.1 GENERAL WAIVERS. Each party to this Agreement waives all claims against all other parties to this Agreement for compensation for any loss, damage, personal injury, or death occurring to personnel and/or equipment as a consequence of the performance of this Agreement.

4.2 HOLD HARMLESS. Any requesting party shall, to the extent permitted by any applicable constitutional or Tort Claims Act limitation, save and hold harmless any responding party against any and all claims or actions brought against the responding party, arising out of the responding party's efforts, except to the extent that such claims or actions arise out of any willful misconduct or grossly negligent action on the part of the responding party.

4.3 WORKERS' COMPENSATION. Each party to this Agreement agrees to provide workers' compensation insurance coverage to each of its employees and volunteers, and responding under this agreement recognizes that although overall incident command supervision will usually be provided by the jurisdiction in which the incident occurs, supervision of individual employees will be provided by their regular supervisors. The intent of this provision is to prevent the creation of "special employer" relationships under Oregon workers' compensation law.

2 **REFUSALS TO PERFORM**

This is a mutual aid agreement and it is assumed that all available assistance will generally be provided. Nothing, however, in this Agreement shall be construed to prevent a party to whom a request for assistance is made from refusing to respond when that is appropriate in its sole determination.

In addition, any responding party may refuse to perform any specific task when, in the sole determination of the responding party's commanding officer, response would create an unreasonable risk of danger to the responding party's employees and/or equipment or any third party.

6.0 COMPENSATION

The parties agree that the personnel and equipment available under this agreement are roughly equivalent and agree that the availability and provision of such constitute consideration under this agreement.

7.0 TERMINATION

Any party hereto may terminate this Agreement at any time by giving thirty (30) days' notice of the intention to do so to any and all other parties. Such notice shall be sent to the governing body of the other parties and a copy thereof to the chief of the department of the parties notified. This agreement will remain in effect

so long as there are at least two parties remaining.

EXTRA JURISDICTIONAL OPERATING AUTHORITY
COST RECOVERY

The parties hereto recognize and agree that ORS Chapters 190, 453, and 476 extend the powers and authorities of the parties herein beyond their regular jurisdictions when operating under this Agreement.

The parties hereto agree that any cost recovery actions brought by responding jurisdictions under this Agreement against third parties shall be coordinated by the jurisdiction in which the incident giving rise to the response occurred

10.0 RETIREMENT SYSTEM STATUS

The parties hereto recognize and agree that under this Agreement public employee retirement benefits and social security benefits accrue in the manner prescribed by the employee's regular employment and are the responsibility of the regular employer as if the employee were performing the employee's regular duties. No additional benefits arise due to participation in assistance under this Agreement.

11.0 ASSIGNMENTS/SUBCONTRACTS

Except as expressly provided herein, the parties hereto recognize and agree not to assign, sell, transfer, subcontract or sublet rights, or delegate responsibilities under this Agreement, in whole or in part, without the prior written approval of the other parties hereto.

12.0 SUCCESSORS IN INTEREST

The provisions of this Agreement shall be binding upon and inure to the benefit of all other parties to the Agreement and the respective successors and assigns.

13.0 COMPLIANCE WITH GOVERNMENT REGULATIONS

Each party to this Agreement agrees to comply with federal, state and local laws, codes, regulations, and ordinances applicable to the work performed under this Agreement.

14.0 FORCE MAJEURE

No party to this Agreement shall be held responsible for delay or default caused by fires, riots, acts of God and/or war which is beyond the reasonable control of the parties.

15.0 SEVERABILITY

If any provision of this Agreement is declared by a court having jurisdiction to be illegal or in conflict with any law, the validity of the remaining terms and provisions shall not be affected; the rights and obligations of the parties shall be construed and enforced as if the Agreement did not contain the particular provision held to be invalid.

16.0 AMENDMENTS

The terms and conditions of this Agreement shall not be waived, altered, modified, supplemented, or amended in any manner whatsoever without prior written approval of the parties hereto.

17.0 DISPUTE RESOLUTION

This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon as interpreted by the Oregon courts. However, the parties may attempt to resolve any dispute arising under this Agreement by any appropriate means of dispute resolution, except binding arbitration.

18.0 SIGNATURES

The undersigned warrant and represent that they are duty authorized to bind the agency represented by the undersigned as a party to this Agreement, and that the agency represented by the undersigned as a party to this Agreement, and that the agency represented by the undersigned is authorized to participate in and carry out the functions required by this Agreement.

All signatures shall be executed in counterparts, using the form appearing on the next page hereto or another substantially in that form.

SIGNATURE PAGE FOR MUTUAL AID AGREEMENT

PARTICIPATING AGENCY

NAME AND TITLE

SIGNATURE

DATE

PARTICIPATING AGENCY

NAME AND TITLE

SIGNATURE

DATE

[Add signature blocks as needed]

II. California Disaster and Civil Defense Master Mutual Aid Agreement

CALIFORNIA DISASTER AND CIVIL DEFENSE MASTER MUTUAL AID AGREEMENT

This agreement made and entered into by and between STATE OF CALIFORNIA, its various departments and agencies, and the various political subdivisions, municipal corporations, and other public agencies of the State of California;

WITNESSETH:

WHEREAS, It is necessary that all of the resources and facilities of the State, its various departments and agencies, and all its political subdivisions, municipal corporations, and other public agencies be made available to prevent and combat the effect of disasters which may result from such calamities as flood, fire, earthquake, pestilence, war, sabotage, and riot; and

WHEREAS, It is desirable that each of the parties hereto should voluntarily aid and assist each other in the event that a disaster should occur, by the interchange of services and facilities, including, but not limited to, fire, police, medical and health, communication, and transportation services and facilities, to cope with the problems of rescue, relief, evacuation, rehabilitation, and reconstruction which would arise in the event of a disaster; and

WHEREAS, It is necessary and desirable that a cooperative agreement be executed for the interchange of such mutual aid on a local, countywide, regional, statewide, and interstate basis;

NOW, THEREFORE, IT IS HEREBY AGREED by and between each and all of the parties hereto as follows:

(1) Each party shall develop a plan providing for the effective mobilization of all its resources and facilities, both public and private, to cope with any type of disaster.

(2) Each party agrees to furnish resources and facilities and to render services to each and every other party to this agreement to prevent and combat any type of disaster in accordance with duly adopted mutual aid operational plans, whether heretofore or hereafter adopted, detailing the method and manner by which such resources, facilities, and services are to be made available and furnished, which operational plans may include provisions for training and testing to make such mutual aid effective; provided, however, that no party shall be required to deplete unreasonably its own resources, facilities, and services in furnishing such mutual aid.

(3) It is expressly understood that this agreement and the operational plans adopted pursuant thereto shall not supplant existing agreements between some of the parties hereto providing for the exchange or furnishing of certain types of facilities and services on a reimbursable, exchange, or other basis, but that the mutual aid extended under this agreement and the operational plans adopted pursuant thereto, shall be

without reimbursement unless otherwise expressly provided for by the parties to this agreement or as provided in Sections 1541, 1586, and 1587, Military and Veterans Code; and that such mutual aid is intended to be available in the event of a disaster of such magnitude that it is, or is likely to be beyond the control of a single party and requires the combined forces of several or all of the parties to this agreement to combat.

(4) It is expressly understood that the mutual aid extended under this agreement and the operational plans adopted pursuant thereto shall be available and furnished in all cases of local peril or emergency and in all cases of which a **State of Extreme Emergency** has been proclaimed.

(5) It is expressly understood that any mutual aid extended under this agreement and the operational plans adopted pursuant thereto, is furnished in accordance with the "California Disaster Act" and other applicable provisions of law, and except as otherwise provided by law that: "The responsible local official in whose jurisdiction an incident requiring mutual aid has occurred shall remain in charge at such incident including the direction of such personnel and equipment provided him through the operation of such mutual aid plans." (Sec. 1564, Military and Veterans Code.)

(6) It is expressly understood that when and as the State of California enters into mutual aid agreements with other states and the Federal Government that the parties to this agreement shall abide by such mutual aid agreements in accordance with law.

(7) Upon approval or execution of this agreement by the parties hereto all mutual aid operational plans heretofore approved by the State Disaster Council, or its predecessors, and in effect as to some of the parties hereto, shall remain in full force and effect as to them until the same may be amended, revised, or modified. Additional mutual aid operational plans and amendments, revisions, or modifications of existing or hereafter adopted mutual aid operational plans, shall be adopted as follows:

(a) Countywide and local mutual aid operational plans shall be developed by the parties thereto and are operative as between the parties in accordance with the provisions of such operational plans. Such operational plans shall be submitted to the State Disaster Council for approval. The State Disaster Council shall notify each party to such operational plans of its approval, and shall also send copies of such operational plans to other parties to this agreement who did not participate in such operational plans and who are in the same area and affected by such operational plans. Such operational plans shall be operative as to such other parties 20 days after receipt thereof unless within that time the party by resolution of notice given to the State Disaster Council, in the same manner as notice of termination of participation of this agreement, declines to participate in the particular operational plan.

(b) Statewide and regional mutual aid operational plans shall be approved by the State Disaster Council and copies thereof shall forthwith be sent to each and every party affected by such operational plans. Such operational plans shall be operative as to the parties affected thereby 20 days after receipt thereof unless within that time the party by resolution or notice given to the State Disaster Council, in the same manner as notice of termination of participation in this agreement, declines to participate in the particular operational plan.

(c) The declination of one or more of the parties to participate in a particular operational plan or any amendment, revision, or modification thereof, shall not affect the operation of this agreement and the other operational plans adopted pursuant thereto.

(d) Any party may at any time by resolution or notice given to the State Disaster Council, in the same manner as notice of termination of participation in this agreement, decline to participate in any particular operational plan, which declination shall become effective 20 days after filing with the State Disaster Council.

(e) The State Disaster Council shall send copies of all operational plans to those state departments and agencies designated by the Governor. The Governor may, upon behalf of any department or agency, give notice that such department or agency declines to participate in a particular operational plan.

(f) The State Disaster Council, in sending copies of operational plans and other notices and information to the parties to this agreement, shall send copies to the Governor and any department or agency head designated by him; the chairman of the board of supervisors, the clerk of the board of supervisors, and County Disaster Council, and any other officer designated by a county; the mayor, the clerk of the city council, the City Disaster Council, and any other officer designated by a city; the executive head, the clerk of the governing body, or other officer of other political subdivisions and public agencies as designated by such parties.

(g) This agreement shall become effective as to each party when approved or executed by the party, and shall remain operative and effective as between each and every party that has heretofore or hereafter approved or executed this agreement, until participation in this agreement is terminated by the party. The termination by one or more of the parties of its participation in this agreement shall not affect the operation of this agreement as between the other parties thereto. Upon approval or execution of this agreement the State Disaster Council shall send copies of all approved and existing mutual aid operational plans affecting such party which shall become operative as to such party 20 days after receipt thereof unless within that time the party by resolution or notice given to the State Disaster Council, in the same manner as notice of

termination of participation in this agreement, declines to participate in any particular operational plan. The State Disaster Council shall keep every party currently advised of who the other parties to this agreement are and whether any of them has declined to participate in any particular operational plan.

(9) Approval or execution of this agreement shall be as follows:

(a) The Governor shall execute a copy of this agreement on behalf of the State of California and the various departments and agencies thereof. Upon execution by the Governor a signed copy shall forthwith be filed with the State Disaster Council.

(b) Counties, cities, and other political subdivisions and public agencies having a legislative or governing body shall by resolution approve and agree to abide by this agreement, which may be designated as "CALIFORNIA DISASTER AND CIVIL DEFENSE MASTER MUTUAL AID AGREEMENT." Upon adoption of such a resolution, a certified copy thereof shall forthwith be filed with the State Disaster Council.

(c) The executive head of those political subdivisions and public agencies having no legislative or governing body shall execute a copy of this agreement and forthwith file a signed copy with the State Disaster Council.

(10) Termination of participation in this agreement may be effected by any party as follows:

(a) The Governor, upon behalf of the State and its various departments and agencies, and the executive head of those political subdivisions and public agencies having no legislative or governing body, shall file a written notice of termination of participation in this agreement with the State Disaster Council and this agreement is terminated as to such party 20 days after the filing of such notice.

(b) Counties, cities, and other political subdivisions and public agencies having a legislative or governing body shall by resolution give notice of termination of participation in this agreement and file a certified copy of such resolution with the State Disaster Council, and this agreement is terminated as to such party 20 days after filing of such resolution.

IN WITNESS WHEREOF this agreement has been executed and approved and is effective and operative as to each of the parties as herein provided.

/signed/
EARL WARREN
GOVERNOR
On behalf of the State of California and all its Departments and Agencies

ATTEST:

/signed/
FRANK M. JORDA
Secretary of State

November 15, 1950

(GREAT SEAL)

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NOTE:

There are references in the foregoing agreement to the California Disaster Act, State Disaster Council, and various sections of the Military and Veterans Code.

Effective November 23, 1970, by enactment of Chapter 1454, Statutes 1970, the California Disaster Act (Section 1500 ff., Military and Veterans Code) was superseded by the California Emergency Services Act (Sections 8550 ff., Government Code), and the State Disaster Council was superseded by the California Emergency Council.

Section 8668 of the California Emergency Services Act provides:

(a) Any disaster council previously accredited, the State Civil Defense and Disaster Plan, the State Emergency Resources Management Plan, the State Fire Disaster Plan, the State Law Enforcement Mutual Aid Plan, all previously approved civil defense plans, all mutual aid agreements, and all documents and agreements existing as of the effective date of this chapter, shall remain in full force and effect until revised, amended, or revoked in accordance with the provisions of this chapter.

In addition, Section 8561 of the new act specifically provides:

"Master Mutual Aid Agreement" means the California Disaster and Civil Defense Master Mutual Aid Agreement, made and entered into by and between the State of California, its various departments and agencies, and the various political subdivisions of the state, to facilitate implementation of the purposes of this chapter.

Substantially the same provisions as previously contained in Sections 1541, 1564, 1586 and 1587 of the Military and

III. Inter-Regional Cooperative Agreement for Emergency Medical and Health Disaster Assistance

INTER-REGION COOPERATIVE AGREEMENT FOR

EMERGENCY MEDICAL AND HEALTH DISASTER ASSISTANCE

CONTRACT #_____

This Agreement is made and entered into by and between the signatory Counties of the State Office of Emergency Services (OES) Mutual Aid Region I and Region VI.

WHEREAS, there exists a great potential for a medical/health calamity capable of producing mass casualties that overwhelm local ability to contain and control; and

WHEREAS, in preparation for this threat, the signatories of this document, singularly and severally, agree to assist any participating County consistent with the OES Region I and Region VI Medical Health Mutual Aid Plans and the Standardized Emergency Management System by providing such assistance as possible without compromising each County's own jurisdiction's medical/health responsibility; and

WHEREAS, the OES Region I and Region VI Disaster Medical/Health Coordinators, selected in accordance with the OES Region I and Region VI Medical Mutual Aid Plan, are responsible for regional coordination of medical/health mutual aid within OES Region I and Region VI when so requested by an affected County of Region I or VI; and

WHEREAS, each County is desirous of providing to the others a reasonable and reciprocal exchange of emergency medical and health services where appropriate; and

WHEREAS, this Agreement is made and entered into by and between the Counties for those agencies within their respective jurisdictions, both public and private, capable of providing emergency medical and health support; and

WHEREAS, each County has emergency medical personnel, equipment, and supplies which can be made available, in the spirit of cooperation, under this Agreement; and

WHEREAS, each County enters into this Agreement for the prudent use and reimbursement of emergency medical and health services including, but not limited to, personnel, equipment, and supplies utilized in assisting any party participating in this Agreement.

NOW Therefore, it is agreed as follows:

□ 1. The Operational Area Medical/Health Coordinators, the Health Officers, or authorized designee from the affected County within OES Region I or Region VI □ may request emergency medical health services through the OES Region I or Region VI Disaster Medical/Health Coordination System in accordance with the Region Plan and the Standardized Emergency Management System.

2 Parties to this Agreement shall be financially responsible for those emergency medical and health personnel and supplies which they request. In responding to the request of an affected County identified in this Agreement or to the region as a whole, each of the assisting Counties shall provide emergency medical and health assistance to the extent it is

reasonably available and to meet the needs of the requesting County.

3 Financial responsibility of the requesting parties to this Agreement shall be limited to costs for personnel, supplies, and equipment confirmed by their request for assistance. Accurate records and documents related to mutual aid requests hereunder shall be maintained by both the parties that provide and request mutual aid assistance.

4 Release or reassignment of mutual aid, personnel, supplies, and equipment between the Counties in OES Region I and Region VI, shall be coordinated through the requesting region.

5 Details as to amounts and types of assistance available, methods of dispatching same, communications during the mutual aid event, training programs and procedures, and the names of persons authorized to send and receive such requests, together with lists of equipment and personnel which may be utilized, shall be developed by the Health Officers of each County. Such details shall be provided to the signatories of this document.

6 The requesting County is the controlling authority for use of emergency medical and health within its jurisdiction. In those instances where the assisting operational area providers arrive on scene before the jurisdictional area, the assisting personnel will take the necessary action dictated by the situation.

7 Within one hundred eighty days (180) following its provision of services and supplies for a disaster or calamity, an assisting County shall present its billing and a precise accounting of its costs for the incident to the requesting County. The requesting County shall pay this billing within ninety (90) days of its receipt unless other arrangements are made between the assisting and requesting Counties.

8 Any party to this Agreement may terminate its participation in this Agreement upon ninety (90) days advance written notice to the other parties.

□ 9. The requesting County agrees to indemnify and hold harmless the assisting County and their authorized agents, officers, volunteers and employees against any and all claims or actions arising from the requesting County's negligent acts

□ or omissions and for any costs or expenses incurred by the assisting County or requesting County on account of any claim thereof. The assisting County agrees to indemnify and hold harmless the requesting County and their authorized agents, officers, volunteers and employees against any and all claims or actions arising from the assisting County's negligent acts or omissions on account of any claim thereof.

□ 10. The body of this Agreement expresses all understandings of the parties concerning all matters covered and shall constitute the total Agreement, whether by written or verbal understanding of the parties, their officers, agents or employees.

□ No change or revision shall be valid unless made in the form of a written amendment to this Agreement which is formally approved and executed by all the participating parties.

9 This Agreement shall in no way affect or have any bearing on any preexisting mutual aid contracts between any of the Counties for fire and rescue services. To the extent an inconsistency exists between such contract and this Agreement, the former shall control and prevail.

10 This Agreement does not relieve any of the Counties from the necessity and obligation of using its own resources for furnishing emergency medical and rescue services within any part of its own jurisdiction. An assisting County's response to a request for assistance will be dependent upon the existing emergency conditions with its own jurisdiction and the status of its resources.

11 This Agreement shall not be construed as, or deemed to be an agreement for the benefit of anyone not a party hereto, and anyone who is not a party hereto shall not have a right of action hereunder for any cause whatsoever.

12 Notices hereunder shall be sent by first class mail, return receipt requested, to the Operational Area Disaster Medical Health Coordinator who represents the various signatory agencies.

IN WITNESS WHEREOF, the Board of Supervisors of each County has caused this Agreement to be subscribed on their behalf by their respective duly authorized officers, on the day, month, and year noted.

Sample Data Sheets:

I. Transport Agencies by County
II. Non-Transport Agencies by County
III. EMT by Work County
IV. Ambulance Surge Resources by County

Note: These data sheets have been developed from data provided by the State EMS Office. The data has not been scrubbed or validated, but is reflective of the information which is available and data sheets which can be developed.

Transport Agencies by County

Type	Agency	City	County
Transport	Canby Fire District Ambulance Service	Canby	CLAC
Transport	Clackamas County Fire District #1	Milwaukie	CLAC
Transport	Lake Oswego Fire Department	Lake Oswego	CLAC
Transport	Molalla Ambulance Service	Molalla	CLAC
Transport	Noble Ambulance	Clackamas	CLAC
Transport	Knappa Fire District	Astoria	CLAT
Transport	Medix Ambulance Service, Inc.	Warrenton	CLAT
Transport	Seaside Volunteer Fire & Rescue	Seaside	CLAT
Transport	Clatskanie Rural Fire Protection District	Clatskanie	COLU
Transport	Columbia River Fire and Rescue	St. Helens	COLU
Transport	Mist-Birkenfeld Rural Fire Protection District	Mist	COLU
Transport	Scappoose Rural Fire Protection District	Scappoose	COLU
Transport	American Medical Response Northwest, Inc.	Portland	MULT
Transport	Community Ambulance	Portland	MULT
Transport	Life Flight Network	Portland	MULT
Transport	Tillamook Ambulance	Tillamook	TILL
Transport	Lifeguard Air Ambulance	Portland	WASH
Transport	Metro West Ambulance	Hillsboro	WASH
Transport	Tualatin Valley Fire and Rescue	Aloha	WASH

Non-Transport Agencies by County			
Type	Agency	City	County
Non-Transport	Blue Heron Paper Company	Oregon City	CLAC
Non-Transport	Boring RFPD	Boring	CLAC
Non-Transport	Clackamas Community College	Oregon City	CLAC
Non-Transport	Clackamas County Sheriff	Oregon City	CLAC
Non-Transport	Clarkes RFPD #68	Beavercreek	CLAC
Non-Transport	Colton RFPD	Colton	CLAC
Non-Transport	Estacada RFPD	Estacada	CLAC
Non-Transport	Gladstone Fire Department	Gladstone	CLAC
Non-Transport	Hoodland RFPD #74	Welches	CLAC

Non-Transport	Mt. Hood Ski Bowl	Government Camp	CLAC
Non-Transport	Mt. Hood Ski Patrol	Government Camp	CLAC
Non-Transport	Oregon City Fire Department	Oregon City	CLAC
Non-Transport	Pacific Northwest Search and Rescue, Inc.	Oregon City	CLAC
Non-Transport	Portland Oregon Temple	Lake Oswego	CLAC
Non-Transport	Sandy RFPD #72	Sandy	CLAC
Non-Transport	Simpson Paper Company	West Linn	CLAC
Non-Transport	Timberline Professional Ski Patrol	Timberline	CLAC
Non-Transport	Upper Clackamas River EMT Team	Estacada	CLAC
Non-Transport	West Linn Fire Department	West Linn	CLAC
Non-Transport	Astoria Fire Department	Astoria	CLAT
Non-Transport	Brownsmead RFPD	Astoria	CLAT
Non-Transport	Cannon Beach RFPD	Cannon Beach	CLAT
Non-Transport	Clatsop Community College	Astoria	CLAT
Non-Transport	Clatsop County Sheriff	Astoria	CLAT
Non-Transport	Elsie-Vinemaple RFPD	Seaside	CLAT
Non-Transport	Fort James -Wauna Mill	Clatskanie	CLAT
Non-Transport	Gearhart Volunteer Fire Department	Gearhart	CLAT
Non-Transport	Hamlet RFPD	Seaside	CLAT
Non-Transport	John Day-Fernhill RFPD	Astoria	CLAT
Non-Transport	Lewis & Clark RFPD	Astoria	CLAT
Non-Transport	Olney Walluski Fire District #35	Astoria	CLAT
Non-Transport	Warrenton Fire Department	Warrenton	CLAT
Non-Transport	Westport-Wauna RFPD	Westport	CLAT
Non-Transport	Columbia County Sheriff	St. Helens	COLU
Non-Transport	Vernonia Fire Department -EMS	Vernonia	COLU
Non-Transport	304th RQS/DOPJ (Bldg 315)	Portland	MULT
Non-Transport	Assist Ambulance Services	Portland	MULT
Non-Transport	ATREC	Troutdale	MULT
Non-Transport	Boeing -Portland	Portland	MULT

Non-Transport	Bonneville Lock and Dam Project	Cascade Locks	MULT
Non-Transport	Boydston Metal Works, Inc.	Portland	MULT
Non-Transport	ESCO Corporation	Portland	MULT
Non-Transport	Federal Bureau of Investigation	Portland	MULT
Non-Transport	Foursquare Northwest Men's Retreat	Portland	MULT
Non-Transport	Gresham Fire Department	Gresham	MULT
Non-Transport	Hooper Detox Center	Portland	MULT
Non-Transport	Medicraft Services	Corbett	MULT
Non-Transport	Metro Washington Park Zoo	Portland	MULT
Non-Transport	Metropolitan Exposition -Recreation Commission	Portland	MULT
Non-Transport	Mountain Wave Emergency Communications, Inc.	Portland	MULT
Non-Transport	Mt Hood Meadows Pro Ski Patrol	Gresham	MULT
Non-Transport	Mt. Hood Community College	Gresham	MULT
Non-Transport	Multnomah County EMS	Portland	MULT
Non-Transport	Multnomah County RFPD #14	Corbett	MULT
Non-Transport	Multnomah County RFPD #20	Portland	MULT
Non-Transport	Multnomah County Sheriff	Portland	MULT
Non-Transport	Nabi Biomedical	Gresham	MULT
Non-Transport	Oregon Arena Corporation	Portland	MULT
Non-Transport	Oregon Emergency Medical Services	Portland	MULT
Non-Transport	Port of Portland -Airport Fire Dpartment	Portland	MULT
Non-Transport	Portland ANG Base Fire Department	Portland	MULT
Non-Transport	Portland Bureau of Fire, Rescue and Emergency Services	Portland	MULT
Non-Transport	Portland Community College	Portland	MULT
Non-Transport	Portland Mountain Rescue	Portland	MULT
Non-Transport	Reynolds Metals	Troutdale	MULT
Non-Transport	Sauvie Island Volunteer RFPD #30j	Portland	MULT
Non-Transport	Sports Car Club of America -Oregon Region	Portland	MULT
Non-Transport	The Becker Company	Portland	MULT
Non-Transport	US Coast Guard Auxiliary/Northwest Medivac	Aloha	MULT
Non-Transport	Veterans Affairs Medical Center	Portland	MULT
Non-Transport	Bay City Fire Department	Bay City	TILL
Non-Transport	Garibaldi Fire Department	Garibaldi	TILL
Non-Transport	Manzanita Dept of Public Safety	Manzanita	TILL
Non-Transport	Nehalem Volunteer Fire Department	Nehalem	TILL
Non-Transport	Nestucca RFPD	Cloverdale	TILL
Non-Transport	Netarts-Oceanside RFPD	Netarts	TILL
Non-Transport	Oceanside RFPD	Oceanside	TILL
Non-Transport	Rockaway Fire Department	Rockaway Beach	TILL
Non-Transport	Tillamook Bay Community College	Tillamook	TILL
Non-Transport	Tillamook County Sheriff	Tillamook	TILL
Non-Transport	Tillamook Fire District	Tillamook	TILL
Non-Transport	Twin Rocks Friends Camp	Rockaway Beach	TILL

Non-Transport	Wheeler Fire Department	Wheeler	TILL
Non-Transport	Allied Systems Company	Sherwood	WASH
Non-Transport	Banks Fire District #13	Banks	WASH
Non-Transport	College of Emergency Services	Beaverton	WASH
Non-Transport	Cornelius Fire Department	Cornelius	WASH
Non-Transport	Forest Grove Fire Department	Forest Grove	WASH
Non-Transport	Gaston RFPD	Gaston	WASH
Non-Transport	GE Interlogix	Tualatin	WASH
Non-Transport	Hillsboro Fire Department	Hillsboro	WASH
Non-Transport	Intel Corporation	Hillsboro	WASH
Non-Transport	Northwest Medical Teams	Portland	WASH
Non-Transport	OHSU/OIT Paramedic Program	Sherwood	WASH
Non-Transport	Tactical Negotiations Team (TNT)	Hillsboro	WASH
Non-Transport	Tualatin Police Dept.	Tualatin	WASH
Non-Transport	Washington County RFPD #2	North Plains	WASH
Non-Transport	Washington County Search and Rescue	Hillsboro	WASH

EMTs by Work County

Work County:	Agency:	EMT LEVEL B	I	P	Grand Total
CLACKAMAS	Blue Heron Paper Company	5	3		8
	Boring RFPD	17	29	6	52
	Canby Fire District #62	19	4	15	38
	City of Lake Oswego	12	10	24	46
	Clackamas County Fire District #1	42	30	98	170
	Colton RFPD	4	3	2	9
	Estacada RFPD	7	16	5	28
	Gladstone Fire Department	11	12	5	28
	Hoodland RFPD #74	19	10	9	38
	Molalla Rural Fire Protection District #	24	17	8	49
	Mt. Hood Ski Bowl	1			1
	Mt. Hood Ski Patrol	5		2	7
	Noble Ambulance, Inc.	5	1		6
	Pacific Northwest Search and Rescue, Inc	4	1		5
	Sandy RFPD	14	14	8	36
	Timberline Professional Ski Patrol	5	1		6
	Upper Clackamas River EMT Team	2			2
CLACKAMAS Total		**196**	**151**	**182**	**529**
CLATSOP	Cannon Beach RFPD	8	7		15
	City of Astoria	4	4	1	9
	City of Seaside	5	5		10
	Elsie-Vinemaple RFPD	1	1	1	3
	Fort James -Wauna Mill	4	1		5
	Gearhart Volunteer Fire Department	3	3		6
	Knappa-Svensen-Burnside Rural Fire Dist	5	5	3	13
	Lewis & Clark RFPD	3	1		4
	Medix Ambulance Service, Inc.	6	9	11	26
	Warrenton Fire Department	2	3		5

	Westport-Wauna RFPD	1			1
CLATSOP Total		**42**	**39**	**16**	**97**
COLUMBIA	Clatskanie Rural Fire Protection District	11	3	6	20
	Columbia River Fire and Rescue	21	4	25	50
	Mist-Birkenfeld Rural Fire Protection Di	7	5		12
	Scappoose Rural Fire Protection District	6	5	10	21
	Vernonia Rural Fire Protection District			2	2
COLUMBIA Total		**45**	**17**	**43**	**105**
MULTNOMAH	304th RQS/DOPJ (Bldg 315)			4	4
	All Terrain Rescue, Education and Consul			5	5
	American Medical Response Northwest	54	45	200	299
	City of Gresham	21	12	42	75
	City of Portland	496	7	151	654
	Dept of Human Services	1		5	6
	Emanuel Hospital & Health Center			10	10
	Hooper Detox Center	12	3	2	17
	Medicraft Services	1		1	2
	Metropolitan Exposition -Recreation Com	2	1	1	4
	Multnomah County EMS			2	2
	Multnomah County RFPD #14	8	1	4	13
	Nabi Biomedical	1			1
	Port of Portland -Airport Fire Department	19		10	29
	Portland ANG Base Fire Department	17			17
	Portland Community College		3	5	8
	Portland Mountain Rescue	3			3
	SAPA, Inc.		1		1
	Sauvie Island Volunteer RFPD #30j	5	1		6
	Sports Car Club of America-Oregon Reg.	4			4
	US Coast Guard Auxiliary/Northwest		1		1
MULTNOMAH Total		**644**	**75**	**442**	1161

TILLAMOOK	Manzanita Volunteer Fire Department	3			3
	Nestucca RFPD	7			7
	Netarts-Oceanside RFPD	3	1		4
	Tillamook County General Hospital	5	4	22	31
	Tillamook Fire District	5	2		7
TILLAMOOK Total		**23**	**7**	**22**	**52**
WASHINGTON	Banks Fire District #13	3	13	1	17
	College of Emergency Services		1	4	5
	Cornelius Fire Department	5	5	1	11
	Forest Grove Fire Department	11	7	8	26
	Gaston RFPD	4	3		7
	Hillsboro Fire Department	31	29	17	77
	Metro West Ambulance, Inc.	59	13	72	144
	Northwwest Medical Teams	1	2	1	4
	OHSU/OIT Paramedic Program	1		12	13
	Tualatin Police Services	1			1
	Tualatin Valley Fire and Rescue	170	11	181	362
	Washington County RFPD #2	11	8	2	21
WASHINGTON Total		**297**	**92**	**299**	**688**
Grand Total		**1247**	**381**	**1004**	**2632**

Ambulance Surge Resources By County:

County:	Resource Type:	Contact Information:

Clackamas

Regulatory Clackamas County EMS
Hospitals Kaiser Sunnyside Meridian Park Providence Milwaukie Willamette Falls
Dispatch Centers Clackamas Communications American Medical Response
Ambulance Transportation Providers American Medical Response Canby Fire Protection District Lake Oswego Fire Department Molalla Ambulance District
EMS First Responders NonTraditional Transportation Resources

Clatsup

Regulatory
Hospitals

Providence Seaside Hospital Dispatch Centers Ambulance Transportation Providers EMS First Responders NonTraditional Transportation Resources

Columbia

Regulatory
Hospitals

None Dispatch Centers Ambulance Transportation Providers EMS First Responders NonTraditional Transportation Resources

Multnomah

Regulatory Multnomah County EMS
Hospitals Adventist Medical Center Doernbecher Children's Hospital Emanuael Good Samaritan Mt Hood Medical Center Oregon Health Science University Providence Shriners Veterans Woodland Park
Dispatch Centers Portland Bureau of Emergency Communications American Medical Response Lake Oswego Communications Regional Hospital / UHSU
Ambulance Transportation Providers American Medical Response Community Ambulance
EMS First Responders NonTraditional Transportation Resources

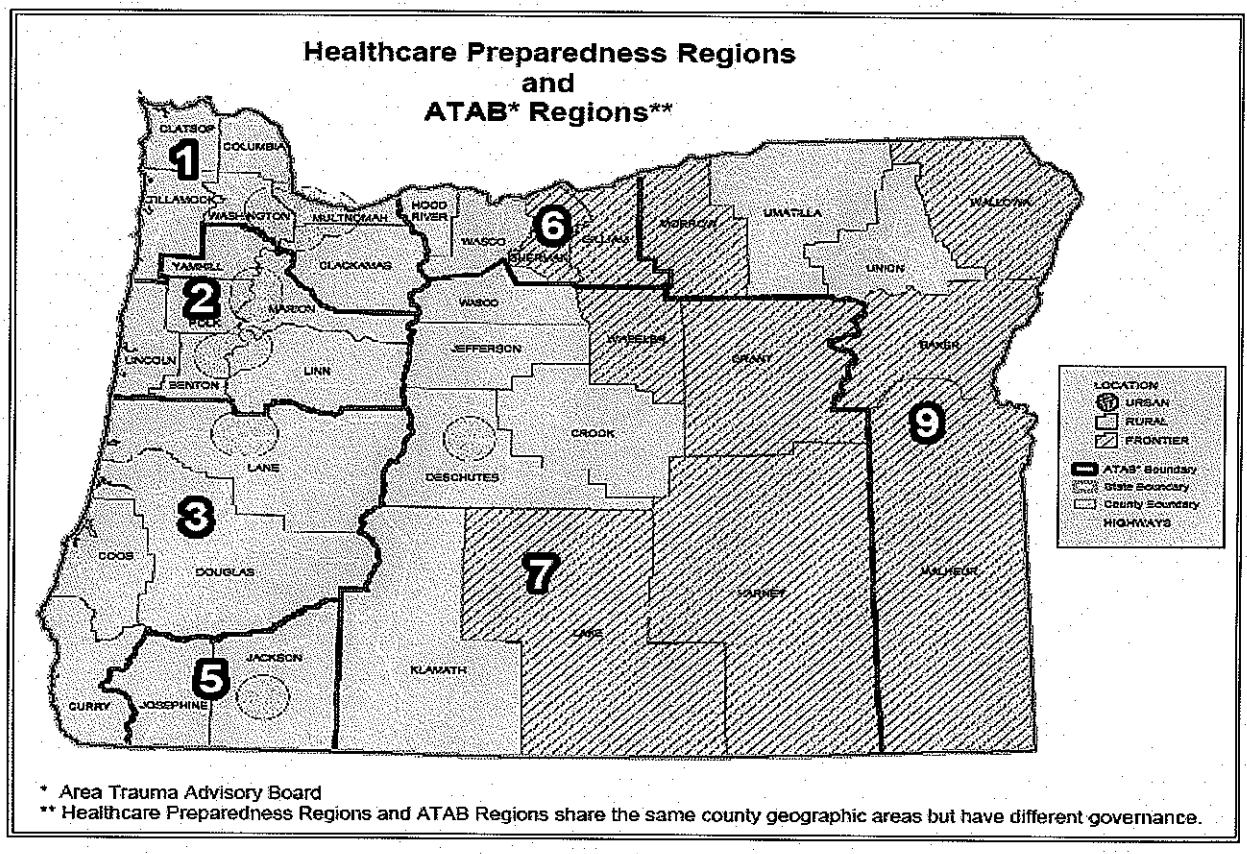
Tillamook

Regulatory
Hospitals
Tillamook General Hospital
Dispatch Centers
Ambulance Transportation Providers
Tillamook General Hospital
EMS First Responders
NonTraditional Transportation Resources

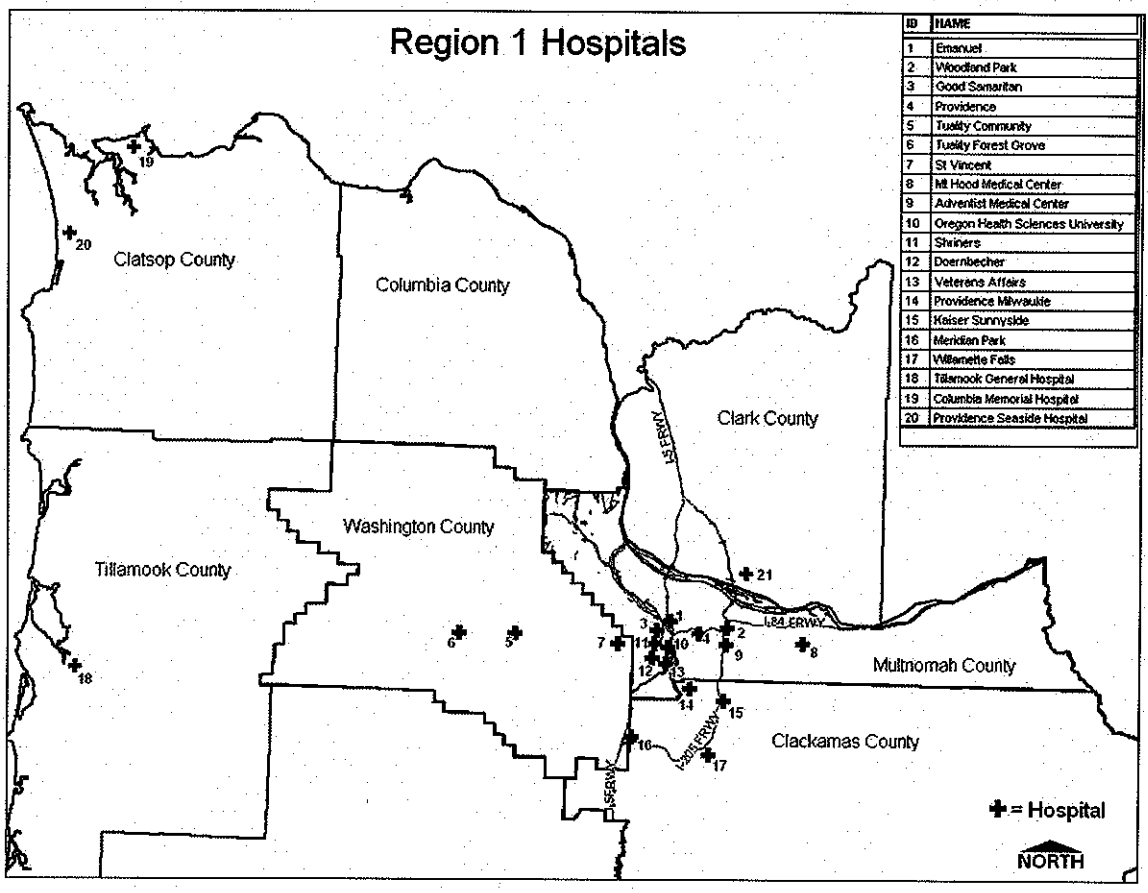
Washington

Regulatory
Washington County EMS
Hospitals
St. Vincent
Tuality
Tuality Forest Grove
Dispatch Centers
Ambulance Transportation Providers
MetroWest Ambulance

OHP Regions/ATAB Map



OHP Region 1 Hospital Map



ID	NAME
1	Emanuel
2	Woodland Park
3	Good Samaritan
4	Providence
5	Tuality Community
6	Tuality Forest Grove
7	St Vincent
8	Mt Hood Medical Center
9	Adventist Medical Center
10	Oregon Health Sciences University
11	Shriners
12	Doernbecher
13	Veterans Affairs
14	Providence Milwaukie
15	Kaiser Sunnyside
16	Meridian Park
17	Willamette Falls
18	Tillamook General Hospital
19	Columbia Memorial Hospital
20	Providence Seaside Hospital

ANNEX

EMERGENCY MEDICAL SERVICE (EMS) RESOURCE MANAGEMENT

I. PURPOSE

The purpose of this annex is to establish a comprehensive Emergency Medical Service (EMS) resource management plan for use during major emergencies and disasters within Washington County. Adoption of the process provided in this annex, combined with commitment to a formal staffing pattern, should allow for:

- Effective deployment and management of local, mutual aid, and other EMS resources
- An orderly transition from management of smaller incidents to larger ones
- Maintaining the roles and responsibilities of the Washington County Emergency Medical Services Office in ambulance resource management
- Identifying and maintaining the roles and responsibilities of the county's designated ambulance service provider

II. SITUATION AND ASSUMPTIONS

A. Situation

1. Washington County is subject to emergency or disaster circumstances that could occur locally or be part of a regional or national crisis. Large-scale incidents have the potential for generating emergency medical service resource demands beyond the capacity of local EMS providers. Incidents such as major earthquakes, airline crashes, HazMat releases, terrorism, and others can generate significant numbers of victims requiring emergency medical service (i.e., pre-hospital care and transport).

2. Washington County has designated a private ambulance company to provide paramedic level emergency medical transport services.

3. The ambulance service provider maintains a fleet of ambulances and staffs between 5 and 15 ambulances depending on the day of the week and time of day. Each ambulance is Advance Life Support (ALS) capable and has a staff of two with at least one

paramedic on board. The ambulance service provider also operates a fleet of wheel chair vehicles. Each wheel chair vehicle has a staff of one individual that has some level of medical training.

4. The Washington County Senior EMS Coordinator is the individual responsible for operational oversight of the ambulance provider.

5. The Washington County EMS Office coordinates all types of ambulance service within the county. The EMS Office is responsible for maintaining ambulance resource inventories, developing mutual aid agreements and procedures for the transfer and dispatch of ambulance resources, and coordinating with other ambulance providers.

6. Ambulance service in neighboring counties is provided by both public and private providers. Those providers may be available to respond into Washington County, however, there are no existing mutual aid agreements for their services. If called to assist, they typically provide the requested transport and handle the operational and administrative (e.g., billing) matters associated with the call.

7. Several fire service agencies within the county operate rescue vehicles that are equipped and configured to provide emergency medical transport. These units are Advanced Life Support (ALS), Intermediate Life Support (ILS), or Basic Life Support (BLS) staffed depending on the jurisdiction.

8. All front line fire apparatus staffed by Tualatin Valley Fire and Rescue (TVF&R) and Hillsboro Fire are ALS equipped and staffed with paramedics. Their volunteer staffed apparatus are BLS capable. The first out apparatus from Forest Grove Fire is ALS capable while the remaining are BLS capable. Other fire agency (Cornelius Fire, Banks Fire, Gaston Fire, and Washington County District #2) apparatus are Intermediated Life Support (ILS) or Basic Life Support (BLS) capable.

9. TVF&R, Forest Grove, and Hillsboro Fire have fulltime EMS coordinators. These individuals oversee their agency EMS operations, monitor compliance with adopted protocols, coordinate program delivery, and assist with development of new EMS plans and procedures.

10. All agencies providing EMS have a physician advisor designated as the Supervising Physician. The Supervising Physician prescribes

medical protocols that govern the delivery of emergency medical (i.e., pre-hospital) care by the staff of the organization they serve.

11. The county's fire service agencies provide mutual aid services and the Washington County Fire Defense Board, which represents the county's fire service agencies, has county-to-county mutual aid agreements with most of the surrounding counties. Several of the fire agencies in the surrounding counties provide emergency transport services in their respective areas and can respond into Washington County on a mutual aid basis.

12. Air ambulance services are provided by Lifeflight Network, LLC, a private company operating out of Portland. The company operates two helicopters which are capable of transporting one patient each. One of the helicopters is typically based at Portland-Hillsboro Airport (HIO) and the other at Aurora State Airport (UAO). Lifeflight's primary mission is to transport trauma patients to appropriate area hospitals. During a major emergency, they could also be used for inter-hospital patient transfer and evacuation of patients from local hospitals to locations out of the metropolitan area.

13. Daily EMS operations are governed by a number of regional and local protocols/ practices that enhance the delivery and coordination of emergency medical care. The protocols/practices include:

    - Regional Mass Casualty Incident (MCI) Protocol – A protocol outlining standard triage, treatment, transport, and medical communications procedures for mass casualty incidents (i.e., those with 10 or more patients) in Clackamas, Multnomah, and Washington counties.
    - Regional Hospital – A hospital in the Portland metropolitan area responsible for coordinating patient destination during MCI and other emergency situations. This function is performed by Oregon Health Sciences University using the "HOSCAP" talk group on the 800 MHz radio system.
    - Trauma Communications Control (TCC) – An entity that coordinates patients entered into the trauma system. This coordination includes the relay of patient information and hospital coordination from Life Flight.
    - Ambulance Diversion Guidelines – A protocol for diverting ambulances to alternate hospitals when one or more of the hospitals stops accepting emergency patients. When most of the hospitals close and go to "divert" status, the region

implements a zone management process. The county's contract ambulance service provider serves as Zone Manager for Washington County and Meridian Park Hospital. The Zone Manager then oversees the patient destination process within the zone.

- Medical Resource Hospital (MRH) – A hospital in the Portland metropolitan area that provides physician access to en route ambulances for medical and other related advice. Oregon Health Sciences University serves as the Medical Resource Hospital for Multnomah and Clackamas counties. Physician access in Washington County is handled directly through each Washington County hospital including Meridian Park Hospital.

14. On a daily basis, emergency medical service calls are received and "triaged" by the Washington County Consolidated Communications Agency (WCCCA), which provides 9-1-1 call-taking and dispatch services for the county's fire and law enforcement agencies. A fire resource is dispatched on all medical calls. Calls requiring (or potentially requiring) emergency transport services are also relayed to the private ambulance service provider's ambulance communications center. The ambulance communications center identifies and dispatches an appropriate resource based on their location identified by automatic vehicle locator (AVL). In any case where the private ambulance service cannot provide transport in a time prescribed by Washington County Administrative Rule fire-based rescue vehicles can be used for emergency transport.

15. WCCCA maintains a major emergency operations guideline that is used to facilitate dispatch during major emergencies. When that guideline is implemented, WCCCA may discontinue triaging medical calls from a transport perspective and transfer that responsibility to the private ambulance provider.

16. The Washington County Emergency Medical Service (EMS) Office also maintains a guideline for coordination of ambulance resources in emergency situations. The county's Senior EMS Coordinator can activate the guideline whenever resource demands require and/or when other incident related impacts (e.g., road conditions, hospital conditions, etc.) warrant.

17. Regardless of whose guidelines are activated, the following procedures can be implemented as the situation warrants:
    - Transfer of medical call transport triage to the private

ambulance service
- Use of modified triage guidelines
- Ambulance diversions (e.g., to nearest hospital)
- Use of private ambulance mutual aid
- Use of public agency transport resources

18. The county's ambulance service provider operates its own VHF high-band radio system that it uses to dispatch and manage its ambulance resources. The ambulance control center and the provider's emergency transport ambulances are also equipped with 800 MHz public safety radios to coordinate with WCCCA, other public safety responders, and hospitals throughout the region.

19. During catastrophic and other major emergencies creating extraordinary EMS system demands, non-traditional service delivery methods may be required. Alternative facilities staffed by a combination of professional EMS providers, other emergency responders, and volunteers may be needed for the pre-hospital treatment of patients. Disaster field hospitals, medical care points, casualty collection points, or other similar facilities may be established by local EMS, hospital, and medical reserve personnel and by federal Disaster Medical Assistance Teams (DMAT).

B. Assumptions

1. Shortages in Washington County emergency medical service resources will occur quickly in any extended or widespread emergency or disaster. A countywide disaster will likely affect road systems, utilities, communication systems, and other infrastructure, as well as affecting the lives and families of many EMS personnel.

2. Support from state and federal agencies will be available upon request once local resource capacity has been exceeded or when that capacity is near exhaustion. The interval between request and arrival of state resources will likely be 4-24 hours, and for federal resources 12-72 hours.

3. Spontaneous volunteers will be present to help perform essential tasks including assistance with first aid and non-technical support at mass casualty scenes.

III. CONCEPT OF OPERATIONS

A. Definitions

Ambulance: Any privately or publicly owned motor vehicle, aircraft or marine craft staffed and equipped at the paramedic, intermediate, or basic level that is regularly provided or offered to be provided for the emergency transportation of persons suffering from illness, injury, or disability.

Coordinator: The Senior Emergency Medical Services Coordinator or the person designated by the Board of County Commissioners to administer and enforce the provisions of this chapter, or the senior coordinator's delegate or designee.

Disaster Operations: Public safety incident response and resource management when centralized communications (i.e., 9-1-1 phone system and 800 MHz radio system) are not functioning.

Emergency Medical Services or EMS: Pre-hospital functions and services that are required to prepare for and respond to medical emergencies, including transport, treatment, communications, evaluation, and public education.

Major Emergency Operations: Public safety incident response and resource management protocol implemented when resource demand exceeds system capacity and incident prioritization is necessary, but centralized communications are operational.

Mass Casualty Incident: Any incident involving, or potentially involving, multiple patients as defined in the Regional Mass Casualty Incident Protocol.

B. General

The Washington County Emergency Medical Service system consists of personnel, equipment and supplies that are focused on the provision of pre-hospital care to accident victims and others in need of emergency medical service. The system includes public and private field responders trained at the paramedic, EMT-Intermediate, EMT-Basic, or first responder levels, EMS program coordinators at two of the county's fire service agencies, physician advisors/supervisors who work with public and private EMS organizations to develop and manage treatment protocols, private ambulances staffed and equipped to provide emergency transport, fire agency based rescue vehicles that are capable of providing emergency transport, a private air ambulance service, and a County Emergency Medical Service Office that oversees the county's contract for emergency medical transport services.

Management of the county's EMS resources involves private personnel and equipment operating under contract, public personnel and equipment, separate (public and private) dispatch facilities and communications equipment, and considerable oversight. EMS personnel and equipment must be licensed or certified for specific functions and must comply with numerous regulatory and procedural requirements.

On a daily basis, the public and private systems operate separately, but in a coordinated manner. Calls for emergency medical service come into the 9-1-1 center (WCCCA). They are triaged according to agency protocols and appropriate resources are dispatched. For medical calls, WCCCA dispatches fire-based EMS resources, relays the call information to the private ambulance service provider (electronically), and makes a radio call for dispatch of ambulance resources to the ambulance provider over the 800 MHz system. The ambulance service provider then dispatches appropriate resources using the company radio. Fire-based rescue vehicles are used for emergency transport when the ambulance service provider cannot provide transport in a prescribed time period.

During major emergencies and disasters, the EMS system must adapt rapidly to the incident circumstances and operate in a highly coordinated manner to:

- Minimize loss of life, subsequent disability and human suffering by ensuring timely and coordinated EMS response, to include evacuation of severely ill and injured patients;
- Coordinate the procurement, allocation, and distribution of medical personnel, equipment, supplies, communications, and other resources;
- Provide a system for management of pertinent information required for effective incident response and recovery, and to ensure information coordination with other involved disciplines and jurisdictions.

1. Major Field Operations

   During mass casualty incidents and other emergencies where the EMS system is not overwhelmed, EMS operations will be handled in accordance with the existing regional MCI protocol and other standard protocols/procedures.

2. Expanded Dispatch Operations

   a. As the tempo of fire-based EMS activity (i.e., calls for emergency medical service) increases, regardless of

emergency medical transport activity, WCCCA or the fire service can implement expanded dispatch operations in accordance with their respective policies (for WCCCA, the Major Emergency Dispatch Guidelines 3.4.9 and Expanded Fire Dispatch 3.4.20 and for the fire service, the Washington County Fire Resource Management Plan). Expanded dispatch involves the use of a fire agency incident management team to assist WCCCA with management of fire resources countywide. This involves both move-ups for coverage and the pursuit of both internal and external mutual aid resources to respond to incident-related activity.

b. As the tempo of ambulance (i.e., emergency medical transport) operations increases and the private provider's ability to respond is restricted, the county EMS Coordinator is notified and begins active monitoring of the situation. If the situation is protracted, the EMS Coordinator can operate from the ambulance control center and assist the private provider with acquisition of additional transport resources. Fire agencies are allowed to use their own resources for emergency medical transport under these circumstances if certain criteria are met.

3. Major Emergency Operations

a. WCCCA's major emergency guideline is activated when demand for resources exceeds system capacity and incident prioritization becomes necessary. Incidents are prioritized as;

- 1 – Life Safety,
- 2 – Unknown Life Safety, or
- 3 – Property/Environment only

and resources are dispatched accordingly. Single resources are dispatched in lieu of the multiple resources that are typically dispatched in normal operations. WCCCA will turn over ambulance triage responsibilities to the private ambulance provider under these circumstances. The county Emergency Operations Center (EOC) will be activated and response resources will be strategically managed from within the Operations Section of the EOC.

b. The ambulance service provider's emergency guideline is activated by the county EMS Coordinator when fire-based EMS resources are delayed or unavailable to respond, when

weather or other conditions significantly impede the ambulance provider's ability to transport patients to area hospitals in accordance with normal protocols, or when the ambulance provider has insufficient resources and incident prioritization is required. If the reason for activation of the guideline involves resource shortage and incident prioritization, the county EMS Coordinator will operate from the ambulance control center and assist the private provider with acquisition of additional transport resources.

c. WCCCA's major emergency guideline and the ambulance service provider's emergency guideline may be activated independently. Fire resources may be drawn down by a large wildland fire without significant impact on emergency medical transport. Conversely, a severe winter storm may significantly impact emergency medical transport without draining fire-based EMS resource capabilities.

d. Regardless of the status of emergency guideline implementation, if the county EOC is activated and the Incident Commander or Operations Section Chief believes staffing the EMS function is necessary for effective management of EMS resources, the county EMS Coordinator will staff the EMS Branch (or the EMS Group under the Fire Branch, as determined by the Ops Chief). Concurrently, the county Fire Defense Board will staff the Fire Branch as outlined in the Fire Resource Management Annex to this Plan.

e. During major emergency operations, transportation of patients to designated trauma centers may be suspended according to established protocols.

f. Depending on the nature and magnitude of the event triggering use of major emergency guidelines, alternative treatment facilities may be required in the field. The use of disaster field hospitals, medical care points, casualty collection points, or other similar facilities will be coordinated from the county EOC. Creative coordination and application of transport resources may also be required. Formation of ambulance strike teams, use of non-standard transport resources, and other appropriate measures will also be coordinated from the county EOC.

g. If the event triggering use of the major emergency operations guidelines is a public health emergency, the agency

physician supervisors may need to coordinate with the Washington County Public Health Officer for strategic (countywide) or tactical (on scene) alterations to adopted treatment protocols.

4. Disaster Operations

   a. Under disaster operations, where centralized public safety communications (i.e., 9-1-1 phone system and 800 MHz radio system) are not functioning, all agencies, including the private ambulance service provider, act independently to identify and respond to calls.

   b. The county EOC will be activated when disaster operations are implemented. In this situation, the fire agencies, the county EMS Coordinator, and the private ambulance provider will coordinate efforts from within the Operations Section of the county EOC.

   c. Various options for resource management will be considered under these circumstances. Ambulances may be staged at fire stations to maximize coordination with fire-based EMS resources or fire/EMS task forces may be formed to work in specific geographic areas.

5. Coordination with the State

   Except where state or federal agencies have authority to respond directly to local government needs/requests (e.g., military commanders supporting search and rescue activities), all requests for state or federal resource support will originate from or be forwarded though the county EOC.

6. Washington County EMS Coordinator Authority

   Staffing the ambulance operations function (i.e., EMS Branch or Group) in the county EOC neither diminishes nor supplants the Coordinator's responsibility and authority with respect to ambulance coordination, but serves to facilitate overall resource management and integration with other county operations and EMS resource providers.

IV. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

A. General

Activation of the county EOC may result from a variety of circumstances including a major fire, mass casualty incident, flooding, earthquake, or civil disturbance. Because EMS personnel and equipment play a major role in almost any type of emergency requiring EOC activation, it is important that a framework be in place for the various EMS resource providers to coordinate and maximize the use of those resources.

The EOC Incident Commander and EOC staff will manage resources provided by all county departments whenever the county EOC is activated for emergencies or disasters. The county EOC will provide strategic direction for all county resources. The county EOC will also serve as the clearinghouse for resource requests from county departments and local governments, coordinate with other responding organizations, and arrange for state and federal resource support if warranted.

The county EMS Coordinator, working in cooperation with the contract ambulance service provider, the county's fire service agencies, and the EOC Command and General staffs, will provide strategic direction for EMS resources within the county.

The EMS function in the EOC will normally be filled by the county EMS Coordinator. If the EMS Coordinator is unable to fill this role, it will be filled by one of the Fire EMS Coordinators or a supervisor from the contract ambulance service provider.

B. Task Assignments

1. County EOC Staff

a. Coordinate with the EMS function manager in the Operations Section, when staffed, to prioritize EMS resource needs and formulate and implement strategic resource management goals for EMS resources assigned to the incident (Incident Commander, Command, and General Staff).

b. Coordinate ambulance transport operations with the county EMS Coordinator when the EMS function is not staffed in the EOC (Incident Commander, General Staff). When the EMS function is staffed in the EOC, assign private ambulance resources in accordance with strategic resource management goals and incident priority guidelines.

c. Monitor the status of incidents occurring within the county, as well as incidents outside the county, that may generate a

request for EMS resources (Planning and Operations Sections).

d. Monitor the resource status of all EMS providers in the county (Planning and Operations Sections).

e. Coordinate resource support for all county EMS providers (Logistics, Operations, and Planning Sections).

f. Coordinate strategic EMS resource management actions with other responding organizations, e.g., other private ambulance providers and hospitals (Liaison Officer, Incident Commander, and Operations Section).

g. Document EMS resource (public and private) utilization and cost information (Finance Section).

C. County Emergency Medical Services Coordinator

1. Provide input into formulation of strategic EMS resource management goals particularly as they apply to the contract ambulance service provider.

2. Staff the EMS function in the county EOC in accordance with this plan.

3. Provide reference information and supplemental staff as needed, (i.e., Situation Status (SitStat) and Resource Status (ReStat) in the Planning Section), to assist in tracking the status of EMS resources.

4. Assign private ambulance resources in accordance with incident prioritization guidelines during expanded ambulance dispatch operations.

5. Coordinate EMS resource management in cooperation with fire-based EMS resource providers in the county EOC.

D. County Fire Service Agencies

1. Provide input into formulation of strategic EMS resource management goals as they apply to agency personnel and equipment.

2. Assign agency EMS coordinators to the EMS function in the county EOC if the circumstances dictate and agency operations permit.

3. Provide reference information and supplemental staff as needed, (i.e., Situation Status (SitStat) and Resource Status (ReStat) in the Planning Section), to assist in tracking the status of EMS resources.

4. Assign agency EMS resources in accordance with strategic resource management goals and incident prioritization guidelines.

5. Coordinate EMS resource management in cooperation with the county EMS Coordinator in the county EOC.

E. Contract Ambulance Service Provider

1. Assure staffing of all available/necessary transport equipment.

2. Assist with staffing of the EMS function in the county EOC as requested by the county EMS Coordinator.

3. Track resource utilization and costs in accordance with the current county contract.

V. DIRECTION AND CONTROL

A. The Board of County Commissioners provides overall guidance for the management of county resources.

B. In their capacity as the incident Policy Group, the County Administrator and department heads provide strategic direction to the Incident Commander regarding management of county resources, availability of funds for resource acquisition, and support to other jurisdictions. They keep the county commissioners informed of resource requirements and funding issues, and are responsible for continued oversight of day-to-day county government functions.

C. Priorities for allocation of EMS resources are established by the county EOC Incident Commander based on input received from the county EMS Coordinator, county EMS resource providers, the EOC Command and General Staff, and the Policy Group.

D. Tactical control of EMS resources (public and private) is exercised by the agency, organization, or incident commander to which they are assigned. Administrative control of the resources is maintained by the parent organization.

VI. ADMINISTRATION AND LOGISTICS

A. Administration

1. EMS resources (personnel and equipment) are available through a number of sources:

   a. The contract ambulance service provider and the county's fire service agencies (equipment and personnel)

   b. County-to-county fire mutual aid agreements (equipment and personnel)

   c. Private ambulance service providers in neighboring counties (equipment and personnel)

   d. Oregon Office of Emergency Management (access to state fire and health resources, access to local government resources in other counties, access to state-to-state mutual aid resources, and access to federal resources)

2. The EOC Cost, Time, and Procurement Units will track the utilization of EMS resources requested by the county EOC for incident documentation and possible cost recovery purposes.

B. Logistics

1. Resources assigned to an agency or organization are supported by that agency/organization.

2. Resources tactically assigned to another organization in charge of a large incident are typically supported by the incident management team in command of that incident.

3. In other circumstances, the county may need to provide shelter, feeding, and other support for out-of-county resources working incidents in the county.

4. EMS personnel assigned to the EOC are supported by the county.

VII. ANNEX DEVELOPMENT AND MAINTENANCE

The Washington County Emergency Medical Services Office maintains this annex in cooperation with the Washington County Emergency Management Office, the county's fire service agencies, and private EMS resource providers.

VIII. REFERENCES

A. Regional Mass Casualty Incident Protocol

B. Greater Portland Metropolitan Area Hospitals and Ambulance Providers Ambulance Diversion Guidelines, Revised July 11, 2002

C. Agreement for Emergency Ambulance Services (for Washington County)

D. Washington County Consolidated Communications Agency Operations Directive 3.4.9, *Dispatch, Major Emergency Guidelines* (revised), 8/30/05

E. Ambulance Diversion Guidelines

TABS

A – EMS Position Checklists

TAB A

EMS Position Checklists

Checklist for Expanded Ambulance Dispatch

Expanded Dispatch Functions in Support of Major Incidents

- ❑ Provide support to the Ambulance Control Center
- ❑ Maintain countywide ambulance resource status, including incoming mutual aid or other emergency transport resources
- ❑ Maintain countywide EMS incident situation status
- ❑ Acquire/coordinate logistical support for incident (as requested) and incoming mutual aid and other emergency transport resources
- ❑ Coordinate with the county EOC (if activated)
- ❑ Coordinate with local hospitals, the county Public Health Officer, and other EMS resource providers

Checklist for EMS Function in the County EOC

EOC Functions in Support of Major Incidents

- ❑ Maintain countywide EMS resource status, including status of incoming mutual aid and other EMS resources
- ❑ Maintain countywide EMS incident situation status including impacts on EMS resource providers
- ❑ Prioritize EMS resource needs and develop strategy for application of EMS resources countywide
- ❑ Acquire additional needed resources from adjacent Fire Defense Districts, other ambulance providers, and/or the state
- ❑ Acquire/coordinate logistical support for incident and incoming out-of-county resources
- ❑ Coordinate with local hospitals, physician supervisors, the county Public Health Officer, other EMS resource providers, and state ECC (as appropriate)
- ❑ Redistribute resources as incident activity and priorities dictate
- ❑ Release resources as incident activity warrants
- ❑ Circulate global changes in treatment or transport protocols specific to incident

EOC Operations Section (EMS Branch or Group)

- ❑ Prioritize EMS resource needs and develop strategy for application of EMS resources countywide
- ❑ Acquire additional needed resources from adjacent Fire Defense Districts, other ambulance providers, and/or the state
- ❑ Acquire/coordinate logistical support for incident and incoming out-of-county resources
- ❑ Activate alternate treatment facilities such as casualty collection points or medical care points (as necessary)
- ❑ Coordinate and/or support relocation of patients from damaged or untenable healthcare facilities
- ❑ Coordinate with local hospitals, physician supervisors, the county Public Health Officer, other EMS resource providers, and state ECC (as appropriate)
- ❑ Redistribute resources as incident activity and priorities dictate
- ❑ Release resources as incident activity warrants
- ❑ In consultation with the Planning Section Chief, the county Fire Defense Board Chief, and the ambulance service provider, ensure adequate staffing for the EMS function in Operations and the EMS SitStat/ReStat functions in Planning

Checklist for Activation and Staffing the EMS Function in the County EOC

- ❑ Check in at EOC sign-in, and with Operations Section Chief
- ❑ Obtain a situation status briefing from best source (e.g., Fire Dispatch, Planning Section Chief, Operations Section Chief) as determined by incident
- ❑ Advise the on-scene Incident Commander(s), WCCCA, Ambulance Control Center, and/or other local EOCs, as appropriate, that the EMS function is staffed
- ❑ Evaluate potential duration of incident
- ❑ Assess EMS resource requirements/demands
- ❑ Assess the status of EMS resources countywide
- ❑ Formulate a strategy for application of EMS resources countywide
- ❑ Coordinate with the EOC IC, county Emergency Management, and the state for requesting out-of-county resources
- ❑ Coordinate activation of alternative treatment facilities when needed
- ❑ Prioritize EMS resource needs and initiate actions to acquire additional resources as needed
- ❑ Evaluate and fill EMS staffing needs within the Planning Section
- ❑ Assist the Ambulance Control Center with resource assignments and prioritizing incidents
- ❑ Ensure that support requests received by dispatch and the Ambulance Control Center from incident scenes are routed appropriately:
  - o If other local EOCs are activated, they may support their resources with additional assistance requested through the county EOC as needed
  - o If only the county EOC is activated, support will be coordinated between the Operations and Logistics Sections
- ❑ In cooperation with the Planning Section, brief the EOC IC and/or Operations Section Chief on the EMS situation and resource status, priorities and strategy
- ❑ Brief the Public Information Officer on relevant EMS incident and resource information
- ❑ Keep local EMS resource providers informed of the countywide EMS situation
- ❑ For incidents expected to be of long duration, initiate arrangements for relief of EMS personnel in both the Operations and Planning Sections