OEMS Region 6

Regional Mass Casualty Incident (MCI) Plan

2026

Approved- ODEMSA Board of Directors- March 18, 2026

Old Dominion EMS Alliance
7818 E. Parham Road, Suite 911
Richmond, VA 23294
www.ODEMSA.vaems.net

Table of Contents

Introduction

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

EMS efforts in a multiple or mass casualty incident will begin with the first arriving unit and expand to meet the needs of the incident. The first arriving unit should establish Incident Command. After establishing Incident Command, the unit is responsible for assessing scene safety, conducting a scene size-up and sending that information to the Emergency Communications/911 Center, establishing the triage and treatment areas, and beginning to triage victims.

The three priorities of incident management are:

1. Life Safety
2. Incident Stabilization
3. Property Conservation/Incident Mitigation

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

In most multiple or mass casualty incidents (MCIs), the following ICS functions/positions should be staffed: incident command, staging area, extrication, triage, treatment, transportation, and safety officer. In a small scale incident, one person may assume more than one function, (i.e., triage and treatment may be done by the same person or transportation and staging may be handled by the same person). In a larger incident, the Incident or Unified Commander may establish a Medical Group or Medical Branch to oversee some or all of the above functions.

Larger agencies may be capable of managing greater numbers of patients without mutual aid whereas other agencies may need mutual aid resources from several jurisdictions to manage an incident of the same magnitude.
Success of the MCI Plan depends upon effective cooperation, organization and planning among health care professionals and administrators in hospitals and out-of-hospital agencies, state and local government representatives, and individuals and/or organizations associated with disaster-related support agencies in the planning district(s) and related jurisdictions which comprise the region.

The MCI Plan will be reviewed each year by the MCI Committee, referencing the MCI Plan Memorandum of Understanding. Updated copies will be provided by ODEMSA.

Purpose

- To provide a standardized action plan assisting in the coordination and/or management of any regional EMS mutual aid response to a MCI.
- To provide an effective utilization of the various human and material resources from various jurisdictions involved in a regional mutual aid EMS response or MCI that affects a part or the entire region.
- To maximize the number of survivors in mass casualty situations.

The goal of the ODEMSA/Central Virginia Mass Casualty Incident Plan, as stated in the accompanying Memorandum of Understanding, is to prepare on a regional basis for an interoperable response by prehospital and hospital agencies to effectively and safely manage a Mass Casualty Incident (MCI).

This Response Guide, as most recently amended, will serve as the basis for out-of-hospital and in-hospital response under the ODEMSA/Central Virginia MCI Plan (hereafter referred to as the MCI Plan) Success of the MCI Plan depends upon effective cooperation, organization and planning among all stakeholders in the planning districts which comprise the ODEMSA Region.

The ODEMSA MCI Plan may be employed in the following circumstances:

- An MCI is of such magnitude that it overwhelms the resources of the jurisdiction having authority.
- The MCI is multi-jurisdictional and overwhelms the resources of one or more of these jurisdictions.

Scope

This Plan standardizes operations during multiple and mass casualty incidents. It is intended to be an “all hazards” plan to meet the needs of any multiple or mass casualty incident regardless of what caused the incident. If necessary, these procedures can be modified based on the number of patients, the cause or severity of injuries, and special circumstances involved in the incident. The initial response will be determined by the number of patients. Accordingly, the plan provides the framework for organizing the pre-hospital and hospital response systems to effectively respond to and assist in managing patients generated in any MCI situation in the ODEMSA region.

Authority & References

The Old Dominion EMS Alliance is one of eleven Regional EMS Councils established within the Code of Virginia, § 32.1-111.11. Created in 1980, ODEMSA is charged "with the development and implementation of an efficient and effective regional emergency medical services delivery system" to include the regional coordination of emergency medical disaster planning and response. ODEMSA is defined as the 9,000 square mile region made up of Virginia Planning Districts 13, 14, 15, and 19.

General Considerations and Assumptions

All agencies and other identities and/or jurisdictions will operate during an MCI under the National Incident Management System (NIMS).

The resources needed to mitigate multiple simultaneous incidents are dependent on the size and complexity of the incidents as well as their location. Expected mutual aid resources may not be available or may be significantly delayed. Providers should be prepared to sustain their patients for long periods of time. Non-traditional modes of transportation and alternate patient transport destinations should be considered.

Health Care Facility Considerations

Predetermined guidelines and the proximity and capabilities of appropriate health care facilities will be the primary considerations of MCI Patient Distribution Center and the Regional Healthcare Coordination Center when designating the health care facilities to which patients are sent during any local or regional emergency situation resulting in the activation of the MCI Plan. The healthcare facility Incident Commander, or designee, of a facility that needs to evacuate or emergently relocate patients from their facility should go through their local jurisdiction.

Local Assumptions

Jurisdictions with resource needs beyond their pre-established mutual aid agreements shall go through the Virginia Department of Emergency Management.

Courtesy Call Notifications

Any locality that incurs an incident or event that generates enough patients from a single event or incident to classify a Type V or Type IV MCI shall make a courtesy call to the Regional PDC to notify them of the event/incident so that coordination can be preempted if needed. This is especially important if all the patients are being transported to the same hospital or free-standing emergency center.

The Regional PDC shall call the affected hospital or free-standing emergency center to advise them of the inbound patients.

Concept of MCI Response and Regional Activation Structure

Types of MCI(s)

Mass Casualty Incidents are classified by types similar to the NIMS typing matrix:

- **Type I-** 100 patients and greater
- **Type II-** 50 to 99 patients
- **Type III-** 25 to 49 patients
- **Type IV-** 10 to 24 patients
- **Type V-** 5 to 9 patients

Authority for Plan Activation

The following individuals shall have the authority to activate the MCI plan:

- The Incident Commander, or designee, at the scene of an MCI, usually via the local ECC.
- The jurisdictional Emergency Manager, or designee, of a political subdivision having authority for the management of the incident.

Activation of the MCI Plan – Role of the Public Safety Answering Point

Upon notification from the scene Incident Commander to activate the regional MCI plan, the local PSAP should activate the pre-hospital component of the MCI plan through established internal procedures and mutual aid agreements. When making mutual aid requests for ambulances or other equipment, the PSAP shall emphasize that these resources are being requested in response to activation of the regional MCI plan.

In the early stages of an incident, the incident commander (or designee) may direct the local PSAP to contact MCI Patient Distribution Center with early initial information.

Activation and Role of MCI Patient Distribution Center, the Regional Healthcare Coordination Center, and Hospitals

MCI Patient Distribution Center

Dial 1-800-276-0683, option 1

MCI Patient Distribution Center shall activate for all declared MCIs in the ODEMSA region. VCU Health System will serve as primary MCI Patient Distribution Center for the ODEMSA region. CJW Chippenham Medical Center, Southside Medical Center, and ODEMSA shall be the designated backup MCI Patient Distribution Center hospitals/alliance. VCU Medical Center may temporarily designate the other agencies as primary MCI Patient Distribution Center for any appropriate reason, including better communications, better or closer geographical location to the MCI scene, or because of any other reason that would be in the best interest of patient care.

During declared MCIs, MCI Patient Distribution Center shall activate the Regional Healthcare Coordination Center. During large scale incidents (Type III MCI and larger), MCI Patient Distribution Center will collaborate with the Regional Healthcare Coordination Center (RHCC).

MCI Patient Distribution Center will be responsible for patient destination recommendations of MCI patients to receiving hospitals. With larger MCI events, it may be necessary to streamline destination recommendations for non-MCI-related patients in order to not overwhelm facilities. During type III or larger MCI events, MCI Patient Distribution Center should be contacted to coordinate all transport destinations, including non-MCI transports, in order to achieve coordination and minimize impact to agencies. This may be guided through the use of hospital sectors, as noted in Annex C.
On-line medical direction will likely be impacted during an MCI.

In the absence of on-line medical direction, out-of-hospital adult and pediatric patient care will be in accordance with the responding agencies' Prehospital Patient Care Protocols, as most recently amended and approved by the respective Operational Medical Director.

MCI Patient Distribution Center shall assist with patient destination assignments, taking into consideration the required level of care, the capabilities of the receiving facility, and proximity to the patient location.

MCI Patient Distribution Center is activated by calling **1-800-276-0683 option 1.**

Local PSAPs or the scene incident commander should be prepared to provide the following information:

- Lead Agency Name
- Exact location of the incident
- Locality name
- Point of contact and callback number
- Type of incident/patient generator (explosion, major car accident, chemical fire, etc.)
- Total number of patients to include number of Red-, Yellow-, and Green-tagged patients (if known).

Regional Healthcare Coordination Center (RHCC)

Dial 1-800-276-0683 option 0

Via a memorandum of understanding with the Central Virginia Healthcare Coalition (CVHC), each acute care hospital in the ODEMSA region coordinates their emergency response and recovery operations with the Regional Healthcare Coordination Center (RHCC) through activation of the Regional Hospital Emergency Operations Plan (RHEOP). The RHCC may be activated 24 hours a day by calling **1-800-276-0683 option 0**.

During MCIs, the Regional Healthcare Coordination Center shall activate in support of CVHC hospitals and MCI Patient Distribution Center. MCI Patient Distribution Center is responsible for activating the RHCC.

The Central Virginia RHCC shall be responsible for:

- Activation of the Regional Hospital Emergency Operations Plan
- Incident alerting of all CVHC hospitals.
- Obtaining real-time emergency department bed availability / mass casualty capabilities from CVHC hospitals to support the confirmation and vetting of patient destination decisions.
- Establishing communications with MCI Patient Distribution Center.
- Providing ongoing situational awareness updates regarding the MCI to all CVHC hospitals.
- Alerting and notification of public health response partners.
- Coordinating the entry of all MCI patients into the VHASS Patient Tracking system.
- Requesting activation of the 2-1-1 Virginia Patient Locator call center for the purpose of family reunification at healthcare facilities.
- Coordinating with other RHCCs in the state for inter-region patient placement, as needed.

Due to the magnitude of an incident(s) it may become necessary to relocate large numbers of patients into or out of the ODEMSA region. Patient movement between regions within

the Commonwealth of Virginia should be coordinated by the Regional Healthcare Coordination Center. Movement of patients outside of the Commonwealth of Virginia should be performed in accordance with the Central Virginia National Disaster Medical Systems (NDMS) Operations Plan.

Healthcare Facilities

Upon notification of an MCI, healthcare facilities shall indicate their emergency department mass casualty capabilities (the number of Red-, Yellow-, and Green-tagged patients that could be seen in the next 30 minutes) in the Virginia Healthcare Alerting & Status System. This information will be used to recommend patient destination decisions. Hospitals should make every attempt to report this information within 10 minutes of MCI notification.

Representatives of participating hospitals will establish Hospital Triage Categories and Mutual Aid Capability tables to support the first wave concept (first 30 minutes after an event has been identified) to be used in the absence of real-time bed availability data. These tables will be reviewed annually. The numbers and types of patients which member hospitals will be prepared to receive are suggested in predetermined Hospital Triage Levels and Mutual Aid Capability table – found in the Annex section of this plan.

Hospitals will be responsible for providing definitive patient care to the levels of their capabilities during and after the incident. Any change in the operational status or capabilities of a hospital during an MCI should be immediately reported to the RHCC.

Prehospital Roles and Responsibilities

Transportation of patients under the MCI Plan during an incident will be done by licensed prehospital EMS agencies guided by the Incident Commander or designee.

Units and personnel involved in mutual aid response to a regional MCI will be dispatched through the responding agency's PSAP.

***No agency or personnel will self-dispatch*.** Agencies or personnel shall respond as designated within their locality or agency's emergency operations plan.

Each prehospital agency will operate under their Operation Medical Director's (OMD) purview using their agency's protocols. Documentation will be done on an accepted Virginia Prehospital Patient Care Report and/or the Virginia Triage Tag.

Ideally, the personnel responding to an MCI will carry photo-identification, documentation of certification, and proof of affiliation.

Any agency or other entity responding to an MCI will be responsible for maintaining all medical and operational documentation. Documentation, both operational and medical, will be made readily available to the Incident Commander, or their designee.

The numbers and types of patients which member hospitals will be prepared to receive are suggested in predetermined Hospital Triage Levels and Mutual Aid Capability table – found in the Annex section of this plan.

Decision Making Authority
Agencies or personnel shall respond as designated within their locality or agency's emergency operations plan.

Response Procedures

Local Emergency Operations Plans
Each jurisdiction shall develop and implement, as part of their state-mandated Emergency Operations Plan as outlined in § 44-146.19, Letter E.

EMS Needs Outside of MCI
This MCI Plan assumes all licensed EMS agencies will respond to mutual aid requests for resources based on their home locality's dispatch protocols and operational procedures. No agency or other responder shall violate the policies, directives, rules, or other governing documents of their agency or jurisdiction.

Special Resources Response
If an agency requires additional resources beyond its capabilities (e.g. Technical Rescue Operations, Hazardous Materials, Health and Medical Emergency Response Team (HMERT), or Air Medical Operations), contact the Virginia Department of Emergency Management Emergency Operations Center at (804) 674-2400 or 1-800-468-8892.

Fatalities and Mass Fatalities Incidents
The Code of Virginia details the Chief Medical Examiner's responsibility for medical investigation of out-of-hospital deaths in the Commonwealth of Virginia.

It is critical that the Medical Examiner's Office be notified as early as possible in any mass casualty incident which involves fatalities.

Communication

EMS-to-Hospital Communication
Cellular or Radio (HEAR) communication will remain the primary method of EMS-to-Hospital communication during an MCI. Other radio communication options available to assist in facilitating the MCI response include the Statewide EMS Mutual Aid Frequency (155.205 MHz) and the UHF Med Channels. The Hospital Emergency Administrative Radio (HEAR) VHF frequency is (155.340 MHz). The alternate HEAR (Hospital to Hospital) frequency is (155.280 MHz).

Demobilization
Utilizing the NIMS model, the Incident Commander or his designee will develop a demobilization plan. Included within the demobilization plan is the notification of Patient Distribution Center that Incident is terminated and that operations may return to normal. Patient Distribution Center will then make notifications to all receiving facilities.

Training and Exercise

Training is an important part of the MCI process. Agencies need to recognize the importance of understanding the overall components of your MCI Plan. Jurisdictions should conduct regular training and exercise in accordance with The ***Homeland Security Exercise and Evaluation Program*** (***HSEEP***). Training exercise events should include scenarios involving diverse populations to include: children and adults with functional and access needs. More information can be found at ***https://hseep.dhs.gov***

Plan Maintenance

MCI Committee

The Central Virginia MCI Committee is a working Committee of the Old Dominion EMS Alliance. It is made up of representatives of the hospital and prehospital components that render emergency medical care in Planning Districts 13, 14, 15 and 19.

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

Revisions and Amendments to the Plan

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

Revisions and/or amendments will be acted upon by the Committee no sooner than 45 days, and not longer than 120 days, after all signatories have been notified of the proposed changes and have had an opportunity to respond.

Revisions and/or amendments to the Plan will require the approval of the pre-determined quorum of the MCI Committee, as outlined in the MCI Committee By-Laws, in order to be enacted.

Glossary of Terms

E.M.S. Provider: Any person "responsible for the direct provision of EMS in a given medical emergency" as described in the Code of Virginia.

Health Care Facility: For the purposes of this plan, this is any acute care hospital or freestanding emergency department.

Health Care Facility Evacuation (Evacuation): An event resulting in the need to evacuate any number of patients from a health care facility.

Host Jurisdiction or Jurisdiction Having Authority: The jurisdiction to which the incident “belongs” - the jurisdiction responsible for the planning, response, recovery and mitigation of the incident or event.

Incident Command System: ICS is a fundamental form of management established in a standard format. It represents organizational "best practices" It allows responders to meet the needs of incidents of any kind or size by:

- Allowing personnel from a variety of agencies to meld rapidly into a common management structure.
- Providing logistical and administrative support to operational staff.
- Avoiding duplication of efforts thereby reducing costs.
- Ensuring the safety of all stakeholders.

ICS consists of procedures for controlling personnel, facilities, equipment, and communications. It is a system designed to be used or applied from the time an incident occurs until the requirement for management and operations no longer exists.

Mass Casualty Incident (MCI): Sometimes called a Multiple-Casualty Incident, an MCI is an incident or event resulting from man-made or natural causes which results in illness and/or injuries which exceed the capabilities of a hospital, locality, jurisdiction and/or region.

M.C.I. Patient Distribution Center (PDC): The medical facility, designated by the hospital community, which provides overall medical direction of the MCI or Evacuation according to predetermined guidelines for the distribution of patients throughout the healthcare community.

National Incident Management System (NIMS): provides a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment. This document is NIMS compliant as directed by Presidential Directive # 5. NIMS Components include:

- Preparedness
- Communications and Information Management

- Resource Management
- Command and Management (ICS)
- Ongoing Management and Maintenance

Patient: A patient is someone who was injured by the Patient Generator and requires care.

Patient Generator (PG): PG is the hazard, action or situation that creates patient volume. *Patient Volume (casualties) = Human Vulnerability x Patient Generator.* There are two kinds of PG's:

Static: The PG is inactive and no further casualties are expected. Examples: bleacher collapse, auto into the crowd, etc.

Dynamic: Situation where the PG is still active and may have to be mitigated before care begins. Examples: Active shooter, environmental, flu epidemic, etc.

Prehospital EMS Agency: Any agency licensed by the Commonwealth of Virginia to render prehospital emergency care and provide emergency transportation for sick and/or injured people as described in the Code of Virginia.

Regional Healthcare Coordination Center (RHCC): The RHCC is the emergency operations arm of the Central Virginia Healthcare Coalition. It is responsible for coordinating the emergency response and recovery activities of healthcare facilities in the ODEMSA region.

Victim: A victim is someone that may have been exposed to the Patient Generator but has no injury.

Virginia Triage System: The Triage system adopted by the Virginia Office of EMS where patients are assessed and evaluated on the basis of the severity of injuries and assigned emergency treatment priorities.

PSAP: Public Safety Answering Point, this is the receiving body i.e dispatch for 911 initiations.

Central Region First Wave Capabilities

Acute Care Hospital Name	Locality	Red	Yellow	Green
Bon Secours Memorial Regional Medical Center	Hanover	4	6	12
Bon Secours Richmond Community Hospital	Richmond City	1	3	5
Bon Secours Southern VA Medical Center	Emporia	1	1	3
Bon Secours Southside Medical Center	Petersburg	2	4	6
Bon Secours St. Francis Medical Center	Chesterfield	1	4	6
Bon Secours St. Mary's Hospital	Henrico	3	6	12
Centra Southside Community Hospital	Prince Edward Co	2	4	10
HCA Chippenham Hospital	Richmond City	6	12	36
HCA Henrico Doctors' Hospital	Henrico	3	8	20
HCA Johnston Willis Medical Center	Chesterfield	2	6	20
HCA Parham Doctors' Hospital	Henrico	1	3	10
HCA Retreat Doctors' Hospital	Richmond City	1	3	10
HCA TriCities Hospital (Former JRH)	Hopewell	3	6	12
Richmond Veterans Affairs Hospital	Richmond City	1	4	7
Sentara Halifax Regional Hospital	South Boston	1	2	8
VCU Children's Tower	Richmond City	4	4	8
VCU Health Community Memorial Hospital	Mecklenburg Co	1	3	5
VCU Medical Center	Richmond City	6	12	36
Free Standing Emergency Center				
Bon Secours Chester Emergency Center	Chesterfield	0	0	5
Bon Secours Colonial Heights Emergency Center	Colonial Heights	0	0	5
Bon Secours Short Pump Emergency Department	Henrico	0	0	5
Bon Secours Westchester Emergency Center	Chesterfield	0	0	5
HCA Hanover Emergency Center	Hanover	0	0	5
HCA Prince George ER (Former Tri-Cities ED)	Prince George	0	0	5
HCA Swift Creek Free Standing Emergency Room	Chesterfield	0	0	15
VCU Health New Kent Emergency Center	New Kent	0	0	5
	Totals	**43**	**91**	**276**

Specialty Patient Distribution

Pediatric Patient Capabilities

	VCU Health System	Chippenham Hospital	St. Mary's Hospital
Total Pediatric Beds	48	15	20
First Wave Pediatric (20%)	**10**	**3**	**4**

Burn Patient Capabilities *(Adult and Pediatric)*

	VCU Health System	Chippenham Hospital	St. Mary's Hospital
Total Burn Unit Beds	16	8	0
First Wave Burn (20%)	**4**	**2**	**0**