



ATTACHMENT G: EMERGENCY MEDICAL SYSTEMS / AMBULANCE DEPLOYMENT PLAN

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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 significant events beyond the scope of local resources. 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 Emergency Medical Services (EMS) medical preparedness and response to significant events, the ultimate goal of preventing unnecessary suffering and loss of life may be achieved.

This plan clearly delineates the need for a coordinated, well-defined response to significant events beyond the scope of local resources by EMS resources. Furthermore, new and unique threats facing the state and nation have created significant challenges for emergency responders that may require specialized training and equipment for effective mitigation that would best be accomplished in a well-coordinated manner.

To provide the best possible organized response during a significant event, it is urgent to move forward in developing a unified system that combines the State's many EMS resources from within the volunteer and career Emergency Medical Services; fire-based ambulance services, third service based ambulance services, commercial (private) ambulance services, and hospital-based ambulance services. The development of the Oregon Emergency Medical Services and Ambulance Deployment Plan (EMS & ADP) is intended to serve as the mechanism for such a unified response.

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 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 functions outlined within.

Emergency Support Function 8 (ESF 8) Health and Medical Services, Attachment G to Annex F, which is part of the State of Oregon Emergency Management Plan.

2 PURPOSE AND AUTHORITIES

2.1 Purpose

The purpose of the EMS & ADP 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 EMS resources are available to respond to significant events throughout Oregon.

The primary mission of the EMS & ADP is to provide needed EMS resources and incident management support, if requested, to areas impacted by a significant event whose own resources may be overwhelmed by the emergency. Ambulance personnel are an extremely valuable service delivery resource in a large-scale response: medical triage, on-scene medical care, transportation to hospitals, care at alternate medical treatment sites, shelter medical care, etc. This disaster medical response system would provide supplemental ambulances and personnel to “impacted areas” whose resources are overwhelmed.

The EMS & ADP is organized and managed such that all members will understand their role in an operation. The EMS & ADP will adopt and adhere, when possible, to the principles of the National Incident Management System (NIMS). Leadership members will be thoroughly trained to provide the necessary leadership roles for successful mitigation of events. The EMS & ADP will utilize an accountability system for all deployments and activities. All movement of staff and equipment will be authorized.

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 patients 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 emergency medical responders, and licensing ambulances services in Oregon. Additionally, they provide coordination to the State Trauma System. During a significant 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 incidents will focus on provider safety and protecting human health.

A variety of events 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 & Ambulance Deployment Plan (EMS & ADP). 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 not recognized as an authorized response.

Significant events 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, EMS personnel may work for multiple agencies, and an individual entity may be required to operate below typical staffing levels.

State and local agencies will have response roles in a significant 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 assistance 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 may provide and or 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 National Incident Management Systems (NIMS), 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 incidents.

4 CONCEPT OF OPERATIONS

4.1 Notification

DHS EMS & TS may receive notification of a significant event 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). 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 and quantity of assets needed, via the local Public Safety Answering Point (PSAP) or appropriate Emergency Manager. An ambulance deployment should be requested by asset description (Ambulance Strike Team, Task Force, and/or optional deployment resources).

Meeting 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 or region liaison position in the State ECC.
 - County or region 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 will assign task numbers to the ambulance deployment team members. ESF 8 in conjunction with ESF 4 & 9 will coordinate the ambulance deployment formation and deployment. A determination must be made for “Regular Deployment”, or for a “Rapid Activation,” based upon the resource request.
 - Ambulance deployment resources should be acquired from one or more unaffected geographical counties. ESF 8 will

assign the duty of Ambulance Strike Team leader and Ambulance Task Force leader to previously approved and qualified personnel.

- ESF 8 will contact County or region 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 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 meeting 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 response time).
 - 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 shall develop an internal procedure to assure 24-hour availability in the event of a significant incident. This will include procedures for multi-directional communication within and outside of DHS.

EMS & TS will work with county or regional emergency managers, or designees, to establish and maintain a list of pre-identified resources, including personnel and equipment. Resource lists should be accessible to EMS & TS, ESF 8 at the State EOC, and the PHEP Duty Officer.

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 (AOC). The SME may be from a range of personnel within or external to 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.
- Activate specialty overhead team as applicable.

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 provide victim identification and mortuary services. 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 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

The OPHD Agency Operating Center (AOC) is responsible for patient tracking, distribution, and hospital notification during a significant event.

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 significant event by providing regulatory systems that will assure access to quality emergency care for victims of such events is necessary.

Pre-event:

- Establish and maintain necessary regulatory framework to implement this plan.
- Assure an integrated statewide ambulance system.
 - Ensure statewide mutual aid agreements exist
 - Develop a statewide asset list of licensed ambulances, personnel, and strike team units
 - Identify specialty resources (i.e. watercraft, four-wheel drive ambulances, bariatric ambulances)
 - Ensure interoperative communications
 - Develop an adequate surge plan
 - Ensure continual ambulance strike team availability by developing predetermined lists of qualified county or regional assets.
- Develop list of subject matter experts able to serve on an incident management overhead team.
- 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. Interface with EMS to verify asset capabilities, and to ensure a coordinated prehospital response.

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 local 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 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 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

Ambulance deployment training for EMS responders should be conducted on a regular basis. Training materials may be requested from DHS EMS & TS.

Specific Training: Triage may be required during a significant event. A common triage system may enhance the effectiveness of mutual aid responders. 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 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 testing this plan shall be conducted with scenarios based upon potential significant events in Oregon. Exercises should be conducted in various regions throughout the state. Hazards may include, but are not limited to:

- Tsunami
- Earthquake
- Windstorms
- Severe flooding
- Temperature extremes
- Mass poisoning
- Major transportation related accidents including aircraft or highway vehicles
- Accidental radiation release

After an exercise, or an actual significant event, 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 update the EMS & ADP to reflect 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 & ADP was developed by DHS EMS & TS. It will be updated periodically. All changes or updates will be made available via EMS & Trauma Systems website.

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

Oregon Statewide Communications Interoperability Plan

10 ACRONYMS AND GLOSSARY

10.1 Acronyms

AAR	After Action Report
ADP	Ambulance Deployment Plan
ALS	Advanced Life Support
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
HAN	Health Alert Network
HAZMAT	Hazardous Materials
HHS	U.S. Department of Health and Human Services
HOSCAP	Hospital Capacity Website
HRSA	Health Resources and Services Administration
ICS	Incident Command System
IMT	Incident Management Team
LHD	Local Health Department
MCI	Mass Casualty Incident
MRE	Meal Ready to Eat
OARs	Oregon Administrative Rules
OR- DMAT	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 Overhead Team: Command level personnel with advanced training in ICS, ambulance operations, and deployment.

Ambulance Strike Team (AST): Five (5) licensed ambulances, staffed by EMTs, 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 meeting area or other designated location and coordinate their response to and efforts during, an incident.

Ambulance Task Force (ATF): Any combination of transport capable units, staffed with emergency responders, 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 meeting area or other designated location and coordinate their response to, and efforts during, an incident.

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.

Hospital Capacity Website (HOSCAP): Internet / web based platform used to communicate hospital capacity. <https://oregonhospitals.org>

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.

Region: Areas following established Area Trauma Advisory Board boundaries.

Single Resource: Individual ambulances, equipment, or specific personnel that may be requested to support an 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.

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).

11.2 Tab G-2 CHEMPACK

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

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 revisions of this plan may be necessary to conform with the Statewide Communications Interoperability 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 Federal Communications Commission. When possible, every EMS 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.

DHS EMS & TS shall set designate four statewide VHF frequencies for use as part of the Ambulance Deployment Plan.

- Air to Ground designated frequency is 155.160 - 25 units statewide license
- Ground to Ground, Operations 1 designated frequency is 150.775 --3000 units statewide license
- Ground to Ground, Operation 2 designated frequency is 150.790 ---3000 units statewide license
- Incident Command designated frequency is 155.175 - 25 unit statewide license

Ambulance Strike Teams, Task Forces, and individual assets should be equipped with VHF radios containing the identified statewide 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: Agencies may 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.

The following statewide VHF frequencies have been designated for use as part of the Ambulance Deployment Plan.

- Air to Ground designated frequency is 155.160 - 25 units statewide license
- Ground to Ground, Operations 1 designated frequency is 150.775 --3000 units statewide license
- Ground to Ground, Operation 2 designated frequency is 150.790 ---3000 units statewide license
- Incident Command designated frequency is 155.175 - 25 unit statewide license

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 or region is responsible for developing Ambulance Strike Teams, Ambulance Task Forces, and / or 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 or regional emergency managers.

The county or regional 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 be documented and tracked by the sending county or region. In addition, it is imperative that personnel arrive on scene of an event 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 possible that some regions in Oregon will not be able to commit to this 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. It is recognized that Oregon’s limited resources may limit strict NIMS compliance when establishing teams. Each is to have a designated, trained leader and common radio communications. The most common use of pre-identified teams will be for incidents requiring a rapid response, particularly those designated “Rapid Activation”. All of the required deployment documentation should be compiled and maintained by the county or regional emergency manager, or designee, in advance.

Pre-Staged Resources: Based on the forecast of an imminent event, it may be necessary to stage resources in advance, to better position them geographically for a timely response. That decision will be made with the concurrence of the State EOC, and the ESF 4 and 9 representatives. Once a mission has been tasked, the resources shall be prepared for deployment and sent to an 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

EMS agencies may identify and train personnel to participate on an Ambulance Strike Team / Task Force. DHS EMS & TS, 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 kit (GO PACK) 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 meeting point designated by ESF 8, to meet with ST/TF Leaders. At the meeting point, the ST/TF Leader will be responsible for the following:

- 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.
- Identifying a travel radio frequency for en route communications.
- Conducting a checklist to ensure ST/TF readiness and equipment availability.

- Notifying the ESF 8 of their status and response time to the incident site/staging area.

If an ambulance unit is unable to continue 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 further instruction.

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 event 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 an event may also be difficult. 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 a 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 primary 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 incident 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 completed. 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 or region Coordinator is responsible for collecting all documentation relative to the disaster incident

from each department deployed. The County or region Coordinator will compile the documentation and identify eligible reimbursement in accordance with current FEMA guidelines.

The county or regional 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).

NIMS Resource: Ambulance Task Force

	Supervisor	Ambulances
Type I	1	5 Type I Ambulances Capable of transporting 10 litter pat.
Type II	1	5 Type II Ambulances Capable of transporting 10 litter pat.
Type III	1	5 Type III Ambulances Capable of transporting 10 litter pat.
Type IV	1	5 Type IV Ambulances Capable of transporting 10 litter pat.

Any Combination of ambulances, within span of control, with common communications and a leader. This resource typing is used to distinguish between a Task Force of Ambulances and an Emergency Medical Task Force (any combination of resources).

NIMS Resource: Ambulance Strike Team

	Ambulances	Personnel	Supplies
Supervisor	Must have own vehicle with communications		Go-Pack
Type I	5 ALS- Capable of transporting 10 litter pts.	ICS 100 & 200, Basic MCI Field Operations (8 hours) Strike Team Leader- Ambulance Course 1 yr. experience in a related field	Go-Pack Equipment & Supplies to meet minimum scope of practice (ALS)
Type II	5 ALS - Capable of transporting 10 litter pts.	ICS 300, HazMat FRO Course WMD Awareness Course 3 years EMS experience	Go-Pack Equipment & Supplies to meet minimum scope of practice (ALS)
Type III	5 BLS - Capable of transporting 10 litter pts.		Go-Pack Equipment & Supplies to meet minimum scope of practice (BLS)
Type IV	5 BLS - Capable of transporting 10 litter pts.		Go-Pack Equipment & Supplies to meet minimum scope of practice (BLS)

An **Ambulance Strike Team** is a group of five ambulances of the same type with common communications and a leader. It provides for an operational grouping of ambulances complete with supervisory element for organization command and control. The strike team may be all ALS or all BLS. Support elements needed include fuel, security, resupply of medical supplies, and support for a minimum of 11 personnel. Temperature control support may be required for medical supplies in some environments. Vehicle maintenance support required.

EQUIPMENT RECCOMENDATIONS FOR DEPLOYMENT (GO PACK)

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

- 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
- 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 event, and available resources.

Emergency responders deployed as part of a team are responsible for understanding and abiding by their home protocols, under the authority of their primary supervising physician or medical director.

Emergency responders not deployed as part of a team will need to have their competency verified with the local supervising physician or designee prior to providing patient care. Such assets may function as members of the hosting organization, following respective local protocols. Individual assets may require just-in-time training on unfamiliar protocols (i.e. medications). Individual assets should be paired with a local asset whenever possible.

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.

Emergency Medical Services personnel may not exceed their medical scope of practice as defined by Oregon Administrative Rule 333.265.

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

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