ANNEX H

HEALTH & MEDICAL SERVICES

TRAUMA SERVICE AREA D
Counties of Brown, Callahan, Coleman, Comanche, Eastland, Fisher, Haskell, Jones, Knox, Mitchell, Nolan, Runnels (North), Shackelford, Stephens, Stonewall, Taylor, Throckmorton

Comanche County
Cities of Comanche, De Leon and Gustine

Ver 1
9/03

APPROVAL & IMPLEMENTATION

Annex H

Health & Medical services

This annex is hereby approved for implementation and supercedes all previous editions.

_________________________________ _________________________
Signature Comanche County Judge Date

_________________________________ _________________________
Signature EMC Date

RECORD OF CHANGES

Annex H

Health & Medical Services

Change #	Date of Change	Entered By	Date Entered
01	**11-01-2004**	**Raymond Helberg**	**11-01-04**
02	**9-20-2006**	**Helberg**	

ANNEX H

HEALTH & MEDICAL SERVICES

I. AUTHORITY

See Basic Plan, Section I.

Texas Code of Criminal Procedure, Part 1, Chapter 49, Inquests on Dead Bodies.

II. PURPOSE

The purpose of this annex is to outline the local organization, operational concepts, responsibilities, and procedures to accomplish coordinated public health and medical services to reduce death and injury during emergency situations and restore essential health and medical services within a disaster area.

III. EXPLANATION OF TERMS

A. Acronyms

ARC	American Red Cross
DDC	Disaster District Committee
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Services Team
DSHS	Department of State Health Services
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operations or Operating Center
FEMA	Federal Emergency Management Agency
ICP	Incident Command Post
ICS	Incident Command System
NDMS	National Disaster Medical System
NIMS	National Incident Management System
PIO	Public Information Officer
SOPs	Standard Operating Procedures

B. Definitions

1. Disaster Medical Assistance Team. A team of volunteer medical professionals and support personnel equipped with deployable equipment and supplies that can move quickly to a disaster area and provide medical care.

2. Disaster Mortuary Services Team. A team of mortuary service and medical personnel that provide mortuary and victim identification services following major or catastrophic disasters.
3. National Disaster Medical System. A nation-wide mutual aid network consisting of federal agencies, businesses, and other organizations that coordinates disaster medical response, patient evacuation, and definitive medical care. At the federal level, it is a partnership between Department of Health and Human Services, the Department of Defense, the Department of Veterans Affairs, and FEMA. Non-federal participants include major pharmaceutical companies and hospital suppliers, the national Foundation for Mortuary Care, and certain international disaster response and health organizations.

4. Special Needs Individuals/Groups. Includes the elderly, medically fragile, mentally and/or physically challenged or handicapped, individuals with mental illness, and the developmentally delayed. These groups may need specially trained health care providers to care for them, special facilities equipped to meet their needs, and require specialized vehicles and equipment for transport. This population requires specialized assistance in meeting daily needs and may need special assistance during emergency situations.

IV. SITUATION & ASSUMPTIONS

A. Situation

1. As outlined in section IV.A and Figure 1 in the Basic Plan, our area is vulnerable to a number of hazards. These hazards could result in the evacuation, destruction of or damage to homes and businesses, loss of personal property, disruption of food distribution and utility services, serious health risks, and other situations that adversely affect the daily life of our citizens.

2. Emergency situations could result in the loss of water supply, wastewater, and solid waste disposal services, creating potential health hazards.

3. Hospitals, nursing homes, ambulatory care centers, pharmacies, and other facilities for medical/health care and special needs populations may be damaged or destroyed in major emergency situations.

4. Health and medical facilities that survive emergency situations with little or no damage may be unable to operate normally because of a lack of utilities or because staff are unable to report for duty as a result of personal injuries or damage to communications and transportation systems.

5. Medical and health care facilities that remain in operation and have the necessary utilities and staff could be overwhelmed by the “walking wounded” and seriously injured victims transported to facilities in the aftermath of a disaster.

6. Uninjured persons who require frequent medications such as insulin and antihypertensive drugs, or regular medical treatment, such as dialysis, may have difficulty in obtaining these medications and treatments in the aftermath of an emergency situation due to damage to pharmacies and treatment facilities and disruptions caused by loss of utilities and damage to transportation systems.

7. Use of nuclear, chemical or biological weapons of mass destruction could produce a large number of injuries/illnesses requiring specialized treatment that could overwhelm the local and state health and medical system.

8. Emergency responders, victims, and others who are affected by emergency situations may experience stress, anxiety, and display other physical and psychological symptoms that may adversely impinge on their daily lives. In some cases, disaster mental health services may be needed during response operations.

B. Assumptions

1. Although many health-related problems are associated with disasters, there is an adequate local capability to meet most emergency situations for a short period of time.

2. Public and private medical, health, and mortuary services resources located in our region will be available for use during emergency situations; however, these resources may be adversely impacted by the emergency.

3. If hospitals and nursing homes are damaged, it may be necessary to relocate significant numbers of patients to other comparable facilities elsewhere.

4. Disruption of sanitation services and facilities, loss of power, and the concentration of people in shelters may increase the potential for disease and injury.

5. Damage to chemical plants, sewer lines and water distribution systems, and secondary hazards such as fires could result in toxic environmental and public health hazards that pose a threat to response personnel and the general public. This includes exposure to hazardous chemicals, biologicals, radiological substances, and contaminated water supplies, crops, livestock, and food products.

6. The public will require guidance on how to avoid health hazards caused by the disaster or arising from its effects.

7. Some types of emergency situations, including tornadoes, fires, and floods) may affect a large proportion of our region, making it difficult to obtain mutual aid from the usual sources.

8. State, and possibly federal, assistance will be available, upon request, to supplement local health and medical resources.

V. CONCEPT OF OPERATIONS

A. General

1. This government will provide a consistent approach to the effective management of actual or potential public health or medical situations to ensure the health and welfare of its citizens operating under the principles and protocols outlined in the National Incident Management System (NIMS).

2. The Texas Department of State Health Services is the agency primarily responsible for the day-to-day provision of many health and medical services for our region. This department also serves as the Health Authority for our region.

3. This annex is based upon the concept that the emergency functions of the public health, medical, and mortuary services will generally parallel their normal day-to-day functions. To the extent possible, the same personnel and material resources will be employed in both cases. Some day-to-day functions that do not contribute directly to the emergency operation may be suspended for the duration of the emergency and the resources that would normally be committed to those functions will be redirected to the accomplishment of emergency tasks.

4. Provisions must be made for the following:

   a. Establishment of a medical command post at the disaster site.
   b. Coordinating health & medical response team efforts.
   c. Triage of the injured, if appropriate.
   d. Medical care and transport for the injured.
   e. Identification, transportation, and disposition of the deceased.
   f. Holding and treatment areas for the injured.
   g. Isolating, decontaminating, and treating victims of hazardous materials or infectious diseases, as needed.
   h. Identifying hazardous materials or infectious diseases, controlling their spread, and reporting their presence to the appropriate state or federal health or environmental authorities.
   i. Issuing health & medical advisories to the public on such issues as drinking water precautions, waste disposal, the need for immunizations, and food protection techniques.
   j. Conducting health inspections of congregate care and emergency feeding facilities.

B. Mental Health Services

1. Appropriate disaster mental health services need to be made available for disaster victims, survivors, bystanders, responders and their families, and other community caregivers during response and recovery operations. Services may include crisis counseling, critical incident stress management, information and referral to other services, and education about normal, predictable reactions to a disaster experience and how to cope with them.

2. Information on disaster mental health services procedures can be found in Annex O (Human Services).

C. Medical Services

1. Ambulance and Transportation

   a. All ambulances and emergency rescue vehicles serving in our region will be equipped with International Field Triage Tags and shall contain at all times, those essential items as specified by the Texas Department of State Health Services (DSHS) Bureau of Emergency Management.

b. Upon notification of an emergency situation, the appropriate ambulance service will dispatch the necessary units to the scene.

c. The Senior EMT or paramedic who first arrives on the scene will:

1) Survey the disaster scene.
2) Report to the Incident Commander and establish a triage area.
3) Institute a preliminary screening of casualties and begin stabilizing and transporting those most critically injured.
4) Record the number of casualties transported and their destination.

d. If the emergency situation warrants, the EMT/paramedic will request, through the Incident Commander, those additional ambulances are sent to the scene.

e. Upon arrival of the EMS Control Officer or Triage Officer, all ambulance service personnel will place themselves at his/her disposal and will follow their directions in regard to casualty movement.

f. The senior EMT/paramedic will report to the Triage Officer and inform the Triage Officer as to what procedures have begun, the location of the triage area, the number of casualties, and the number transported.

g. The EMS Transportation Officer, during the course of the disaster, will provide the ambulance personnel with information relative to situation and/or existing capabilities at the various medical treatment facilities.

2. Triage

a. It is the responsibility of the first EMT/paramedic who arrives on the scene to institute triage, confer with the nearest emergency department physician, and to implement actions that may be required by the situation.

b. If it is apparent that there will be mass casualties, the nearest hospital with emergency facilities and others with suitable facilities will be notified.

c. The EMS Chief or a designated Control Officer shall respond to the scene during a medical disaster and shall act as liaison between the on-scene commander and EMS. This individual shall be in charge of patient care, triage, transportation and all EMS personnel. This person is responsible for the formal declaration of a medical disaster.

d. The Triage Officer shall respond immediately to the scene of a local disaster. This person is in charge of sorting patients to establish priority of treatment and transportation. This person is also in charge of the care of patients awaiting transportation.

e. The EMS Transportation Officer is in charge of all ambulances and directs the loading and transportation of patients. This person acts as liaison with the field and the hospitals.

f. Registered Nurses and Paramedics employed with local ambulance services and capable of providing advanced life support ~~of~~ in the field will respond immediately to the disaster site. They will work with the Triage Officer and apply their skills as required to disaster victims.

g. Equipment and medication for administrating advanced life support to trauma victims will be transported to the scene by the assigned rescue unit. Additional supplies (as available) will be obtained from local hospitals upon request. The closest facility will be notified first. Appendix 3.

h. Triage Priorities – Patients with certain conditions or injuries have priority for transportation and treatment over others. An outline of these conditions are as follows:

1) Red Category – First Priority, most urgent

(a) Airway and breathing difficulties
(b) Uncontrolled or suspected severe bleeding
(c) Shock
(d) Open chest or abdominal wounds
(e) Severe head injuries

2) Yellow Category – Second Priority, Urgent

(a) Burns
(b) Major or multiple fractures
(c) Back injuries with or without spinal damages

3) Green Category – Third Priority, Non-urgent

Transportation and treatment is required for minor injuries (but not necessarily by EMS personnel), minor fractures, or other injuries of a minor nature.

4) Black Category – Deceased, Non-urgent

D. Mortuary Services

1. Law enforcement is responsible for investigating deaths that are not due to natural causes or that do not occur in the presence of an attending physician. Justices of the Peace/Medical Examiners are responsible for determining cause of death, authorizing requiring autopsies to determine the cause of death, authorizing forensic investigations to identify unidentified bodies, and authorizing removal of bodies from incident sites.

2. When it appears that an incident involves fatalities, the Incident Commander shall request the Communications Center/Dispatch Office make notifications to the Justice of the Peace/Medical Examiner and law enforcement and request that they respond to the scene.

3. Law enforcement or the Justice of the Peace/Medical Examiner shall arrange for the transportation of bodies requiring autopsy or identification to morgues or suitable examination facilities. When mass fatalities have occurred, it may be necessary to

establish a temporary morgue and holding facilities and obtain additional mortuary service assistance.

4. Funeral homes will collect bodies of victims from the scene and from hospitals, morgues, and other locations and arrange with next of kin for the disposition of remains.

E. Medical and Mortuary Assistance

1. Texas Department of State Health Services (DSHS). As DSHS functions as the local Health Authority, it can request additional health and medical assistance needed in emergency situations from its parent department through organizational channels.

2. Disaster Medical Assistance Team (DMAT)

   a. As noted previously, DMAT is a group of volunteer medical professionals and support personnel equipped with supplies and equipment that can be moved quickly to a disaster area and provide medical care. DMATs are a part of the National Disaster Medical System (NDMS). The DMAT concept involves using volunteer medical professionals to provide emergency services to victims of disasters. Each DMAT is an independent, self-sufficient team that can be deployed within a matter of hours and can set up and continue operations at the disaster site for up to 72 hours with no additional supplies or personnel. The 72-hour period allows federal support, including medical supplies, food, water, and any other commodity required by the DMAT to arrive.

   b. TX-1 DMAT is a federal and state response asset based in Texas. TX-1 DMAT can be activated by the State to respond to emergency events that may not be severe enough to warrant a federal response. Working closely with TDH, TX-1 DMAT can serve as a state-level responder to major emergencies and disasters that require additional medical response resource.

3. Disaster Mortuary Services Team (DMORT)

   The Texas DMORT provides mortuary and victim identification services following major or catastrophic disasters. The team is comprised of volunteer professionals from the mortuary and funeral industries.

F. Damage Assessment

1. Casualty Information. The Health Authority has primary responsibility for gathering information concerning injuries and fatalities resulting from emergencies and disasters. Since accurate information concerning casualties is essential in identifying required levels of medical support, information of this type must be forwarded to Health Officer in the EOC as soon as it is available to support requests for assistance and for inclusion in required reports.

2. Water Supply Systems. In cooperation with County/City Public Works, DSHS has responsibility for evaluating damage to water treatment facilities following disaster occurrences. Because of system vulnerability to numerous forms of contamination and because of the impact which prolonged shutdown of water treatment facilities could have on public health and welfare, it is essential that rapid and accurate assessments of

damage be completed. Accurate timely estimates for required repairs will permit the DSHS and the city/county Health Department to identify appropriate interim measures such as rationing, expedient water treatment, or construction of temporary water delivery systems.

3. Wastewater Systems. Wastewater treatment facilities are vulnerable to disaster-related interruptions and their unavailability can have a major impact on the community's health and well being. The TNRCC, in cooperation with Public Works, has a responsibility for evaluating damage to those facilities, as well as advising local officials concerning expedient sanitation practices, which may be required in the affected areas.

4. Medical Facilities. The Health Authority has primary responsibility for evaluating damage sustained by medical facilities in a disaster area. The hospitals and nursing homes in each county/city will provide support in this activity. The facility administrator or his/her designee will gather initial damage reports and identify which patients must be removed pending repairs. This data will be provided to Texas Department of State Health Services for the Health Authority's use.

G. Requesting External Assistance.

If health and medical problems resulting from an emergency situation cannot be resolved with local resources those obtained pursuant to inter-local agreements, or resources obtained by the Resource Management staff in the EOC, the Health Authority may request additional medical or mortuary assistance through TDH channels. Requests for other types of assistance to support emergency operations should be made by the County Judge to the DDC Chairperson in Disaster District 4B (Note: Hospitals within the region are located in 4 disaster districts [5A, 4B, Sub 4B, 6A]. The DDC Chairperson for DD 4B will coordinate activities between the districts). Cities must request from their county before requesting assistance from the State.

H. Activities By Phases of Emergency Management

1. Mitigation:

    a. Educate the public and give immunizations.
    b. Promote and encourage the use of the blood donation program.
    c. Conduct specialized training (e.g. hazmat, decontamination, WMD etc.).
    d. Conduct epidemic intelligence, evaluation, presentation, and detection of communicable diseases.
    e. Conduct normal public health awareness programs.

2. Preparedness:

    a. Maintain adequate medical supplies. Appendix 4
    b. Coordinate with county/city officials to ensure water quality.
    c. Coordinate with county/city officials to provide safe waste disposal.
    d. Review emergency plans for laboratory activities regarding examination of food and water, diagnostic tests, and identification, registration and disposal of the deceased.
    e. Train and exercise personnel

3. Response:

a. Communicate status to Regional facility.
b. Communicate status to closest facility.
c. Conduct disease control operations.
d. Ensure that supplies of potable water are available.
e. Conduct environmental health activities regarding waste disposal, refuse, food and water control, and vector control.
f. Begin the collection of vital statistics.

4. Recovery:

a. Compile health reports for state and federal officials.
b. Identify potential and/or continuing hazards affecting public health
c. Distribute appropriate guidance for the prevention of the harmful effects of the hazard.
d. Continue to collect vital statistics.

VI. ORGANIZATION & ASSIGNMENT REPONSIBILITIES

A. Organization

1. Our normal emergency organization, described in Section VI.A of the Basic Plan and depicted in Attachment 3 to that Plan, supported by TDH staff, will plan and carry out health and medical operations during emergency situations.

2. Texas Department of State Health Services Region 2 functions as the local Health Authority. The Health Authority has primary responsibility for the health and medical services function and shall provide public health and medical services during emergency situations. Local government may designate a local health professional as Health and Medical Liaison to coordinate local planning and emergency support with DSHS. The liaison shall serve as a member of the EOC staff.

3. Upon receipt of official notification of an actual or potential emergency condition, it is the responsibility of the Health Authority to receive and evaluate all requests for health and medical assistance and to disseminate such notification to all appropriate public health, medical, and mortuary services.

B. Assignment of Responsibilities

1. General

All agencies/organizations assigned to provide health and medical services support are responsible for the following:

a. Designating and training representatives of their agency, to include NIMS and ICS training.
b. nd training representatives of their agency.
c. Ensuring that appropriate SOPs are developed and maintained.

d. Maintaining current notification procedures to insure trained personnel are available for extended emergency duty in the EOC and, as needed, in the field.
e. Maintaining a current emergency preparedness/response inventory.
f. Participating in Mutual Aid Agreements within the region.
g. Adopting and maintaining an ICS approach to emergency management.

2. Emergency Functions

   Under the County/City Emergency Management Plan, the Health Authority has primary responsibility to provide the following services in response to emergency situations:

   a. Essential medical, surgical, and hospital care and treatment for persons whose illnesses or injuries are a result of a disaster or where care and treatment are complicated by a disaster.
   b. Public health protection for the affected population.
   c. Mortuary and vital records services.
   d. Damage assessment for public health & medical facilities and systems.

3. To ensure that these services are available as needed, various medical and public health services have been assigned primary or support responsibility for specific activities. Those activities, and the services responsible for their accomplishment, are summarized below.

C. Task Assignments

1. The Health and Medical Liaison will:

   a. Assist in local planning for emergency and medical services by conducting liaison with TDH.
   b. During emergencies, coordinate with DSHS regarding local health and medical service needs.

2. The Health Authority will:

   a. Coordinate emergency health and medical activities from the EOC when that facility is activated.
   b. Rapidly assess health and medical needs.
   c. Oversee and coordinate the efforts of local health and medical organizations activated for an emergency, assess their needs, help them obtain additional resources, and ensure that necessary services are provided.
   d. Ensure that emergency medical teams responding to a disaster site establish a medical command post.
   e. Coordinate with neighboring community health and medical organizations on matters related to assistance from other jurisdictions
   f. Coordinate state and federal officials regarding state and federal assistance.
   g. Coordinate with incoming response units, such as DMAT, and screen individual health and medical volunteers.
   h. Ensure that positive identification and proof of licensure is obtained from all volunteers.

i. Coordinate the location, procurement, screening, and allocation of health and medical supplies and resources, including human resources, required to support health and medical operations.
j. Provide, through the PIO, information to the news media on casualties and instructions to the public on dealing with public health problems.
k. Coordinate the provision of laboratory services required in support of emergency health and medical services.
l. Coordinate immunization campaigns or quarantines, if required.
m. Coordinate inspection of foodstuffs, water, drugs, and other consumables that were exposed to the hazard.
n. Coordinate inspection of damaged buildings for health hazards.
o. Coordinate with animal control agencies to dispose of dead animals.
p. Coordinate the implementation of measures to prevent or control disease vectors such as flies, mosquitoes, and rodents.
q. Establish preventive health services, including control of communicable diseases such as influenza, particularly in shelters.
r. Monitor food handling and sanitation in emergency facilities.

3. Emergency Medical Services will:

   a. Respond to the scene with appropriate emergency medical personnel and equipment.
   b. Upon arrival at the scene, assume an appropriate role in the ICS. If ICS has not been established, initiate it and report to the EOC.
   c. Triage, stabilize, treat, and transport the injured.
   d. Coordinate with local and regional hospitals to ensure casualties are transported to the appropriate facilities.
   e. Establish and maintain field communications and coordination with other responding emergency teams (medical, fire, police, public works, etc.) and radio and/or telephone communications with hospitals, as appropriate.
   f. Direct the activities of private, volunteer, and other emergency medical units, and of bystander volunteers, as needed.
   g. Evacuate patients from affected hospitals and nursing homes, if needed.

4. Hospitals will:

   a. Implement internal and/or external disaster plans.
   b. Advise the Health and medical services staff in the EOC of conditions at the facility and the number and type of available beds.
   c. Establish and maintain field and inter-facility medical communications.
   d. Provide medical guidance, as needed, to EMS.
   e. Coordinate with EMS, other facilities, and any medical response personnel at the scene to ensure the following is accomplished:
      1) Casualties are transported to the appropriate medical facility.
      2) Patients are distributed to and among hospitals both inside and outside the area based on severity and types of injuries, time and mode of transport, capability to treat, and bed capacity.
      3) Take into account special designations such as trauma centers and burn centers.
      4) Consider the use of clinics to treat less than acute illnesses and injuries.

f. Coordinate with local emergency responders to isolate and decontaminate incoming patients, if needed, to avoid the spread of chemical or bacterial agents to other patients and staff.
g. Coordinate with other hospitals and with EMS on the evacuation of affected hospitals, if necessary. Evacuation provisions should specify where the patients are to be taken.
h. Depending on the situation, deploy medical personnel, supplies, and equipment to the disaster site(s) or retain them at the hospital for incoming patients.
i. Establish and staff a reception and support center at each hospital for the relatives and friends of disaster victims who may converge there in search of their loved ones.
j. Provide patient identification information to the American Red Cross upon request.

5. The Mental Health Authority will:

Ensure that appropriate mental health services are available for disaster victims, survivors, bystanders, responders and their families, and other community caregivers during response and recovery operations. Information on disaster mental health services procedures can be found in Annex O (Human Services).

6. The Justice(s) of the Peace will:

a. Conduct inquests for the deceased and prepared death certificates.
b. Order or conduct autopsies if necessary to determine cause of death.
c. Order or conduct forensic investigations to identify unidentified bodies.
d. Authorize removal of bodies from incident sites to the morgue or mortuary facilities.
e. Provide information through the PIO to the news media for the dissemination of public advisories, as needed.

7. Law Enforcement will:

a. Upon request, provide security for medical facilities.
b. Conduct investigations of deaths not due to natural causes.
c. Locate and notify next of kin.

8. Mortuary Services will:

a. Provide for the collection and care of human remains.
b. Establish temporary holding facilities and morgue sites, if required.
c. Coordinate, as necessary, with emergency health and medical services.

9. The Public Works Department will:

a. Inspect damaged medical facilities.
b. Make temporary repairs to medical facilities.

10. The Utility Companies will:

Coordinate in restoring utility service to key medical facilities.

11. The Public Information Office (PIO) will:

Disseminate emergency public information provided by health and medical officials. The Health Officer has primary responsibility for coordination of health & medical information intended for release through public media during emergency operations, with support provided by those public health and medical services responsible for particular aspects of the response. Additional information on emergency public information procedures can be found in Annex I (Emergency Public Information).

VII. DIRECTION & CONTROL

A. General

1. The Health Authority shall direct and coordinate the efforts of local health and medical services, agencies, and organizations during major emergencies and disasters requiring a coordinated response.

2. Routine health and medical services operations may continue during less severe emergency situations. Direction and control of such operations will be by those that normally direct and control day-to-day health and medical activities.

3. External agencies providing health and medical support during emergencies are expected to conform to the general guidance provided by our senior decision-makers and carry out mission assignments directed by the Incident Commander or the EOC. However, organized response units will normally work under the immediate control of their own supervisors.

B. Incident Command System – EOC Interface

If both the EOC and an ICP are operating, the Incident Commander and the EOC must agree upon a specific division of responsibilities for emergency response activities to avoid duplication of effort as well as conflicting guidance and direction. The EOC and the ICP must maintain a regular two-way information flow. A general division of responsibilities between the ICP and the EOC that can be used as a basis for more specific agreement is provided in Section V of Annex N, Direction & Control.

C. Disaster Area Medical Coordination

1. In emergency situations involving significant damage to medical facilities, each facility shall be responsible for determining its overall status and compiling a consolidated list of resources or services needed to restore vital functions. Each operating unit will report its status and needs to a single contact point designated by the facility. This facility contact should consolidate the data provided and report it to the Health and Medical liaison in the EOC.

2. The Health and Medical liaison must be prepared to receive the consolidated requests and channel various elements of those requests to those local health and medical facilities as well as other departments, agencies, and organizations that can best respond. Requests for resources that cannot be obtained through normal sources of supply or through mutual aid by health and medical facilities outside the local area should be identified to the Resource Management staff in the EOC for action.

D. Line of Succession

To ensure continuity of health and medical activities during threatened or actual disasters, the following line of succession is established for the Health Officer

1. The County Health Officer (Appendix 3)

2. County Judge

3. Department of Public Service

VIII. READINESS LEVELS

A. Level 4: Normal Conditions:

1. Review and update plans and related SOPs.
2. Review assignment of all personnel.
3. Coordinate with local private industries on related activities.
4. Maintain a list of health & medical resources (see Annex M).
5. Maintain and periodically test equipment.
6. Conduct appropriate training, drills, and exercises.
7. Develop tentative task assignments and identify potential resource shortfalls.
8. Establish a liaison with all private health & medical facilities.

B. Level 3: Increased Readiness:

1. Check readiness of health and medical equipment, supplies, and facilities.
2. Correct any deficiencies in equipment and facilities.
3. Check readiness of equipment, supplies, and facilities.
4. Correct shortages of essential supplies and equipment.
5. Update incident notification and staff recall rosters.
6. Notify key personnel of possible emergency operations.
7. Review procedures for relocating patients and determine the availability of required specialized equipment if evacuation of health & medical facilities may be required.

C. Level 2: High Readiness:

1. Alert personnel to the possibility of emergency duty.
2. Place selected personnel and equipment on standby.
3. Identify personnel to staff the EOC and ICP if those facilities are activated.

D. Level 1: Maximum Readiness:

1. Mobilize health and medical resources to include personnel and equipment.
2. Dispatch health and medical representative(s) to the EOC when activated.
3. Dispatch health and medical resources as directed.

IX ADMINISTRATION & SUPPORT

A. Reporting

1. In addition to reports that may be required by their parent organizations, health & medical elements participating in emergency operations should provide appropriate situation reports to the Incident Commander, or if an incident command operation has not been established, to the Health and Medical liaison in the EOC. The Incident Commander will forward periodic reports to the EOC.

2. Pertinent information from all sources will be incorporated into the Initial Emergency Report and the periodic Situation Report that is prepared and disseminated to key officials, other affected jurisdictions, and state agencies during major emergency operations. The essential elements of information for the Initial Emergency Report and the Situation Report are outlined in Appendices 2 and 3 to Annex N, Direction and Control.

B. Maintenance and Preservation of Records

1. Maintenance of Records. Health and medical operational records generated during an emergency will be collected and filed in an orderly manner. This is so a record of events is preserved for use in determining the possible recovery of emergency operations expenses, response costs, settling claims, assessing the effectiveness of operations, and updating emergency plans and procedures.

2. Documentation of Costs. Expenses incurred in carrying out health and medical services for certain hazards, such as radiological accidents or hazardous materials incidents, may be recoverable from the responsible party. Hence, all departments and agencies will maintain records of personnel and equipment used and supplies consumed during large-scale health and medical operations.

3. Preservation of Records. Vital health & medical records should be protected from the effects of a disaster to the maximum extent possible. Should records be damaged during an emergency situation, professional assistance for preserving and restoring those records should be obtained as soon as possible

C. Post Incident Review

For large-scale emergencies and disasters, the County Judge shall organize and conduct a review of emergency operations by those tasked in this annex in accordance with the guidance provided in Section IX. E of the Basic Plan. The purpose of this review is to identify needed improvements in this annex, procedures, facilities, and equipment. Health and medical services that participated in the emergency operations that are being reviewed should participate in the post-incident review.

D. Exercises

Local drills, tabletop exercises, functional exercises, and full-scale exercises based on the hazards faced by our region should periodically include health and medical services operations. Additional drills and exercises may be conducted by various agencies and services for the purpose of developing and testing abilities to make effective health and medical response to various types of emergencies.

E. Resources

1. A list of local health & medical facilities is provided in Appendix 1.
2. The distribution list for this annex is provided in Appendix 2.
3. A first to notify list is provided in Appendix 3.
4. A recommended equipment list and goal plan is provided in Appendix 4.
5. The Mutual Aid agreement for the region is provided in Appendix 5.
6. Participants in the Mutual Aid agreement are listed in Appendix 6.
7. A list of deployable health and medical response resources is provided in Annex M, Resource Management.

X. ANNEX DEVELOPMENT & MAINTENANCE

A. The Regional Healthcare Committee is responsible for developing this annex. The EMC will maintain and review this annex..

B. This annex will be revised annually and updated in accordance with the schedule outlined in Section X of the Basic Plan.

C. Departments and agencies assigned responsibilities in this annex are responsible for developing and maintaining SOPs covering those responsibilities.

XI. REFERENCES

A. Annex H (Health & Medical Services) to the *State of Texas Emergency Management Plan*.

B. Texas Department of Health (TDH) website: www.tdh.state.tx.us. www.dshs.state.tx.us.

C. DSHS Public Health Region website: www.tdh.state.tx.us/brlho/regions.html. This site contains information on the counties served by the 11 TDH Public Health Regions.

APPENDICES

Appendix 1 .... Local Health & Medical Facilities

Appendix 2 ……………………………………………………………………….Distri bution List

Appendix 3…………………………………………………………………......First to Notify List

Appendix 4………………………………………………Recommended Equipment and Goal Plan

Appendix 5………………………………………………………………….Mutual Aid Agreement

Appendix 6……………………………………………….....Participants in th e Mutual Aid Agreement

Appendix 7…………………………………………………………………...Regional Facility Map

LOCAL HEALTH & MEDICAL FACILITIES

1. **Hospitals**
2. **Clinics**
3. **Nursing Homes**

County	Hospitals	Clinics	Nursing Homes
BROWN	Brownwood Regional Medical Center 1501 Burnet Box 760 Brownwood, TX 76801 Phone: 325-646-8541	Hearth of Texas Foot Care 103A South Park Drive Brownwood, TX 76801 Phone: 325-646-0715	Cross Country Healthcare 1514 Indian Creek Drive Brownwood, TX 76801 Phone: 325-646-6529
		One Source 919 Early Blvd. Early, TX 76802 Phone: 325-643-3010	Bangs Nursing Home 1105 Fitzgerald PO Box 10 Bangs, TX 76828 Phone: 325-752-6321
		Central Texas Rural Clinic and Central Texas Woman's Clinic 2410 Crocket Drive Brownwood, TX 76801 Phone: 325-643-5167	Brownwood Nursing and Rehabilitation 101 Miller Drive Brownwood, TX 76801 Phone: 325-643-9555
		The Heart Center 1501 Burnet Drive Brownwood, TX 76801 Phone: 325-649-3000	Oak Ridge Manor 2501 Morris Sheppard Brownwood, TX 76801 Phone: 325-643-2746
		Veteran's Clinic 2600 Memorial Park Drive Brownwood, TX 76801 Phone: 325-641-0568	Songbird Lodge 2500 Songbird Circle Brownwood, TX 76801 Phone: 325-646-4750
			Twilight Nursing Home 205 S. West PO Box 130 Bangs, TX 76823 Phone: 325-752-6322
CALLAHAN	NONE	Baird Family Clinic 140 W. 5th Street PO Box 816 Baird, TX 79504 Phone: 325-854-1741	Baird Canterbury Villa 224 E. 6th Street Baird, TX 79504 Phone: 325-854-1429
		One Source Health Center 109 NE 9th Cross Plains, TX 76443 Phone: 254-725-7106	Clyde Nursing Center 806 Stephens Street Clyde, TX 79510 Phone: 254-725-7106
COLEMAN	Coleman Community Medical Center 310 S. Pecos Street Coleman, TX 76834 Phone: 325-625-2135	Coleman Medical Assistance 310 S. Pecos Street Coleman, TX 76834 Phone: 325-625-3533	Coleman Health Center 2713 S. Commercial Coleman, TX 76834 Phone: 325-625-4105
COMANCHE	Comanche County Medical Center Comanche, TX 76442 Phone: 352-356-5241	Doctors Medical Clinic Hwy 16 Comanche 76442 Phone: 254-893-3509	Canterbury Villa of DeLeon 809 East Navarro Ave. DeLeon, TX 76444 Phone: 254-893-2075

COMANCHE (CONT)			DeLeon Nursing Home 205 E. Ayers DeLeon, TX 76444 Phone: 254-893-2011
		CrossTimbers Health Clinic 1009 S. Ball Park Loop DeLeon, TX 76444 Phone: 254-893-5895	Western Hills Healthcare Residence 400 Old Sidney Road Comanche, TX 76442 Phone: 325-356-2571
		Pino A.E. Clinic 224 N. Texas DeLeon, TX 76444 Phone: 254-893-2097	The White Stone Community 100 Alamo Drive Comanche, TX 76442 Phone: 325-356-9303
		Family Medical Clinic 101 West Mill Ave. Comanche, TX 76442 Phone: 325-356-7537	
		Doctors Medical Clinic 105 Valley Forge Comanche, TX 76442 Phone: 325-356-5595	
		Byrd, Richard W. Clinic 201 Valley Forge Comanche, TX 76442 Phone: 325-356-5595	
EASTLAND	Eastland Memorial Hospital 304 S. Daugherty St. PO Box 897 Eastland, TX 76448 Phone: 254-629-2601	B&W Clinic 400 S. Plummer Eastland, TX 76448 Phone: 254-629-1744	Eastland Healthcare 1405 W. Commerce Eastland, TX 76448 Phone: 254-629-2686
		Family Health Clinic 500 W. Plummer Eastland, TX 76448 Phone: 254-629-3971	Valley View Nursing Home 700 S. Ostrom Eastland, TX 76448 Phone: 254-629-1779
		William F. Simpson, D.O. 921 W. Main Eastland, TX 76448 Phone: 254-629-3971	Canterbury Villa 1404 Front Street Cisco, TX 76437 Phone: 254-442-4202
		Hugh H. Wilson, M.D. 203 S. Daugherty Eastland, TX 76448 Phone: 254-629-3200	Ranger Health Care Center 460 W. Main Ranger, TX 76470 Phone: 254-647-3111
		Eastland Community Healthcare Center 404 W. Commerce Eastland, TX 76448 Phone: 254-629-8889	Heritage Manor 600 W. Roosevelt Gorman, TX 76454 Phone: 254-734-2202
		Cisco Medical Clinic 1621 Hwy 80 West PO Box 764 Cisco, TX 76437 Phone: 254-442-3951	Rising Star Nursing Center 411 N. Miller Rising Star, TX 76471 Phone: 254-643-2691
		Walnut Street Clinic 200 Walnut Street Ranger, TX 76470 Phone: 254-647-1182	

		One Source Health Center 902 W. College PO Box 250 Rising Star, TX 76471 Phone: 254-643-3141	
FISHER	Fisher County Hospital District Drawer F Rotan, TX 79546 Phone: 915-735-2256	Clear Fork Health Center Drawer L Rotan, TX 79546 Phone: 325-735-2211	NONE
		Roby Rural Health Clinic PO Box 66 Roby, TX 79543 Phone: 325-776-2500	
		Rotan Health Center 715 E. 5th Rotan, TX 79546 Phone: 325-735-2233	
HASKELL	Haskell Memorial Hospital One Avenue N PO Box 1117 Haskell, TX 79521 Phone: 940-864-2621	Cadenhead Rural Health Clini PO Box 938 Haskell, TX 79521 Phone: 940-864-2636	Rice Springs Care Home 1302 N. 1st Haskell, TX 79521 Phone: 940-864-2652
		Hospital Clinic 1400 S. 1st Haskell, TX 79521 Phone: 940-864-8513	Haskell Health Care Center 1504 N. 1st Haskell, TX 79521 Phone: 940-864-8518
JONES	Anson General Hospital 101 Avenue J Anson, TX 79501 Phone: 915-823-3231	Hamlin Medical Clinic 350 NW Ave. F Hamlin, TX 79520 Phone: 325-576-3611	Holiday Lodge Healthcare Center 425 SW Ave. F Hamlin, TX 79520 Phone: 325-576-3643
	Hamlin Memorial Hospital PO Box 400 Hamlin, TX 79520 Phone: 915-576-3646	Anson Family Wellness Clinic 215 N. Ave. J Anson, TX 79501 Phone: 325-823-3209	Valley View Care Center 101 Liberty Lane Anson, TX 79501 Phone: 325-823-2141
	Stamford Memorial Hospital PO Box 911 Stamford, TX 79553 Phone: 915-773-2725	Kapu Medical Clinic PO Box 391 Anson, TX 79501 Phone: 325-823-3296	Anson Care Center 125 Ave. J Anson, TX 79501 Phone: 325-823-3471
			Memorial Health Clinic 1303 Mabee Drive Stamford, TX 79553 Phone: 325-773-5733
			Teakwood Manor Nursing Home PO Box 232 Stamford, TX 79553 Phone: 325-773-3671
KNOX	Knox County Hospital PO Box 608 Knox City, TX 70529 Phone: 940-657-3535	Knox County Hospital Clinic PO Box 488 Knox City, TX 79529 Phone: 940-657-3906	Brazos Valley Care Home 605 Ave. F Knox City, TX 79529 Phone: 940-658-3543
		Munday Clinic 131 S. Munday Ave. Munday, TX 76371 Phone: 940-422-5271	

MITCHELL	Mitchell County Hospital 1543 Chestnut Street Colorado City, TX 79512 Phone: 915-728-3431	Family Medical Associates 505 Chestnut Colorado City, TX 79512 Phone: 325-728-2693	Kristie Lee Manor 1941 Chestnut Colorado City, TX 79512 Phone: 325-728-5247
			Valley Fair Lodge 1541 Chestnut Colorado City, TX 79512 Phone: 325-728-2634
NOLAN	Rolling Plains Memorial Hospital PO Box 690 Sweetwater, TX 79556 Phone: 915-235-1701	Rolling Plains Rural Health Care 201 E. Arizona Sweetwater, TX 79556 Phone: 325-235-8641	Sweetwater Health Care 1600 Josephine Sweetwater, TX 79556 Phone: 325-236-6653
			Nolan Nursing and Rehab PO Box 1369 Sweetwater, TX 79556 Phone: 325-235-5417
			Roscoe Health Care PO Box 519 Roscoe, TX 79545 Phone: 325-766-3374
RUNNELS	North Runnels Hospital PO Box 185 Winters, TX 79567 Phone: 915-754-4553	NRH Clinic 7771 East Hwy 153 Winters, TX 79567 Phone: 325-754-1317	Senior Citizens 506 Van Ness Winters, TX 79567 Phone: 325-754-4566
			Our House (Assisted Living) 616 East Truitt Winters, TX 79567 Phone: 325-754-5083
SHACKELFORD	NONE	Rural Care Clinic 450 Kenshalo Albany, TX Phone: 915-762-3661	NONE
		Shackelford Behavioral Health Services 715 Pate Street Albany, TX Phone: 915-762-3147	
STEPHENS	Stephens Memorial Hospital 200 S. Geneva Breckenridge, TX 76424 Phone: 254-559-2241	Breckenridge Family Clinic 103 S. Hartford Ave. Breckenridge, TX 76424 Phone: 254-559-3363	Colonial Ridge Nursing Home 103 Sage Drive Breckenridge, TX 76424 Phone: 254-559-3302
		Family Care Clinic 101 S. Hartford Ste. B Breckenridge, TX 76424 Phone: 254-559-1595	Villa Haven Nursing Home 300 S. Jackson Breckenridge, TX 76424 Phone: 254-559-3386
		Breckenridge Medical Clinic 207 S. Geneva Street Breckenridge, TX 76424 Phone: 254-559-5094	
		Cynthia Perry 101 S. Hartford, Ste. A Breckenridge, TX 76424 Phone: 254-559-5094	
		Dwight J Nichols, M.D. 201 S. Geneva St. Breckenridge, TX 76424 Phone: 254-559-7575	

		MHMR – Betty Hardwick Center 1612 W. Walker Breckenridge, TX 76424 Phone: 254-522-3490	
		James Cawley, M.D. 1822 B. West Walker Breckenridge, TX 76424 Phone: 254-559-1393	
STONEWALL	Stonewall Memorial Hospital PO Box C Aspermont, TX 79502 Phone: 940-989-3551	Stonewall Rural Health Clinic 821 N. Broadway Aspermont, TX 79502 Phone: 940-989-2875	Gibson Care Center 1000 N. Broadway PO Box 567 Aspermont, TX 79502 Phone: 940-989-3526
TAYLOR	Abilene Regional Medical Center 6250 Highway 83-84 Abilene, TX 79601 Phone: 915-695-9900	Abilene Healthcare and Injury Clinic 1290 S. Willis Ste. 101 Abilene, TX 79605 Phone: 325-677-4589	Abilene Convalescent Center 2630 Old Anson Rd Abilene, TX 79603 Phone: 325-673-5101
	Hendrick Medical Center 1242 North 19th Street Abilene, TX 79601 Phone: 915-670-2000	Aids Resources of Rural Texas 190 Woodlawn Abilene, TX 79603 Phone: 325-645-2437	Mesa Springs Healthcare Center 7171 Buffalo Gap Abilene, TX 79606 Phone: 325-692-8080
		Abilene Integrative Medical Center 3900 N. 1st Abilene, TX 79603 Phone: 325-676-0749	Northern Oaks Nursing and Rehab Center 2722 Old Anson Rd Abilene, TX 79603 Phone: 325-676-1677
		Hendrick Express Care 4009 Ridgemont Abilene, TX 79606 Phone: 325-690-1500	Sears Methodist Center 3202 S. Willis Abilene, TX 79605 Phone: 325-692-6145
		Hendrick Family Health Center 1857 Pine Abilene, TX 79601 Phone: 325-670-2678	Spring Season Nursing and Rehab 725 Medical Drive Abilene, TX 79601 Phone: 325-672-3236
		Minor Emergency Clinic 3101 S. 27th Abilene, TX 79605 Phone: 325-695-5440	Chisholm House 1450 E. North 10th Abilene, TX 79601 Phone: 325-670-0961
		Walk In Care Clinic 560 Judge Ely Abilene, TX 79601 Phone: 325-677-4904	
THROCKMORTON	Throckmorton County Memorial Hospital 802 N. Minter Throckmorton, TX 76483 Phone: 940-849-2151	Throckmorton Clinic 802 N. Minter Throckmorton, TX 76483 Phone: 940-849-2471	Throckmorton Healthcare Center 1000 Minter Throckmorton, TX 76483 Phone: 940-849-2861

NOTE: THIS LIST IS NOT ALL INCLUSIVE. THERE MAY BE OTHER HEALTHCARE RESOURCES AVAILABLE WITHIN EACH COUNTY.

DISTRIBUTION LIST

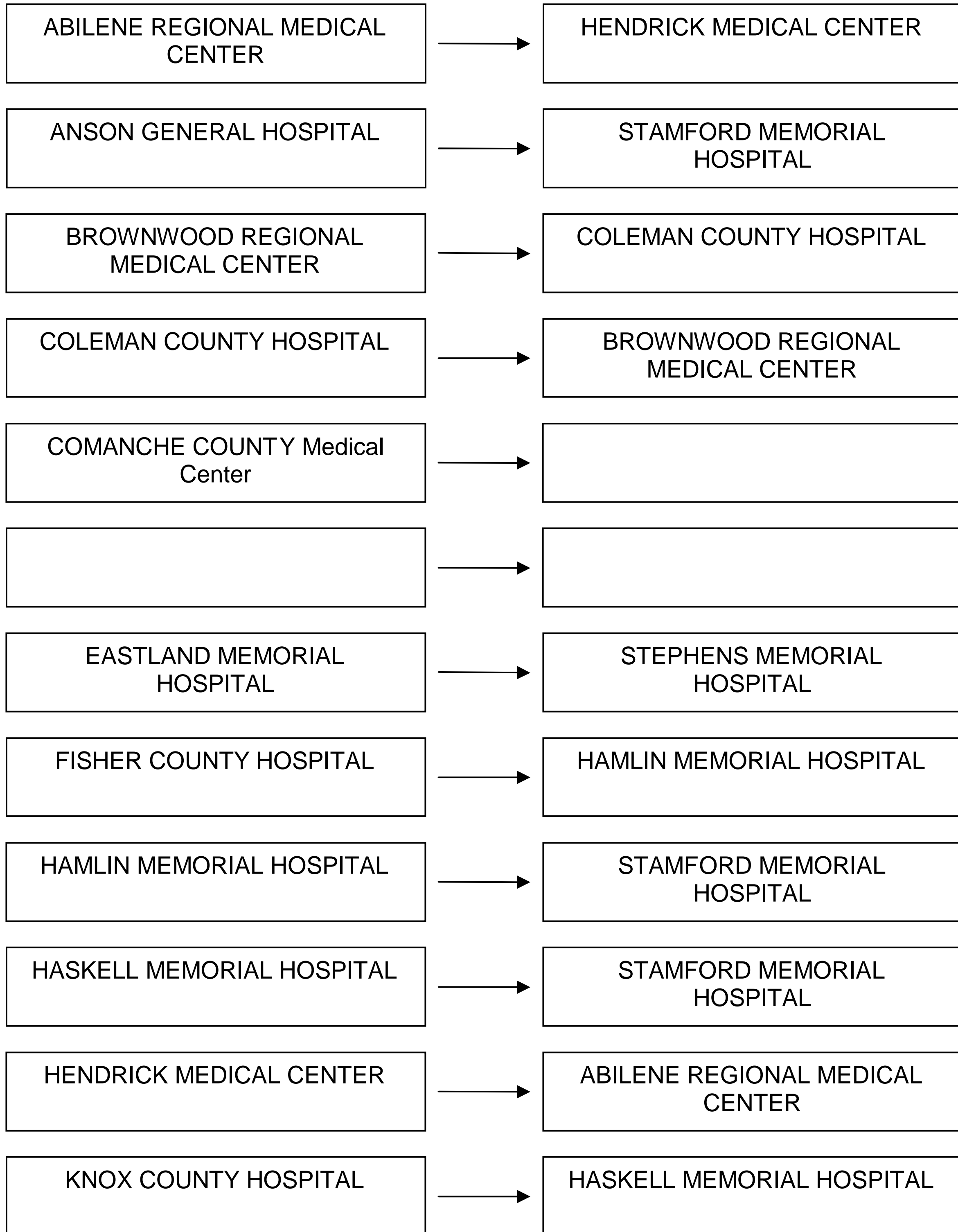
Brown County Judge
Brownwood Mayor
Brownwood Regional Medical Center
Callahan County Judge
Coleman County Judge
Coleman Mayor
Coleman County Medical Center
Comanche County Judge
Comanche Mayor
DeLeon Mayor
Comanche County Hospital District
Eastland County Judge
Eastland Mayor
Eastland Memorial Hospital
Fisher County Judge
Rotan Mayor
Fisher County Hospital District
Haskell County Judge
Haskell Mayor
Haskell Memorial Hospital
Jones County Judge
Hamlin Mayor
Anson Mayor
Stamford Mayor
Anson General Hospital
Hamlin Memorial Hospital
Stamford Memorial Hospital
Knox County Judge
Knox City Mayor
Knox County Hospital
Mitchell County Judge
Colorado City Mayor
Mitchell County Hospital
Nolan County Judge
Winters Mayor
North Runnels Hospital
Shackelford County Judge
Albany Mayor
Stephens County Judge
Breckenridge Mayor
Stephens Memorial Hospital
Stonewall County Judge
Aspermont Mayor
Stonewall Memorial Hospital
Taylor County Judge
Abilene Mayor
Abilene Regional Medical Center
Hendricks Medical Center

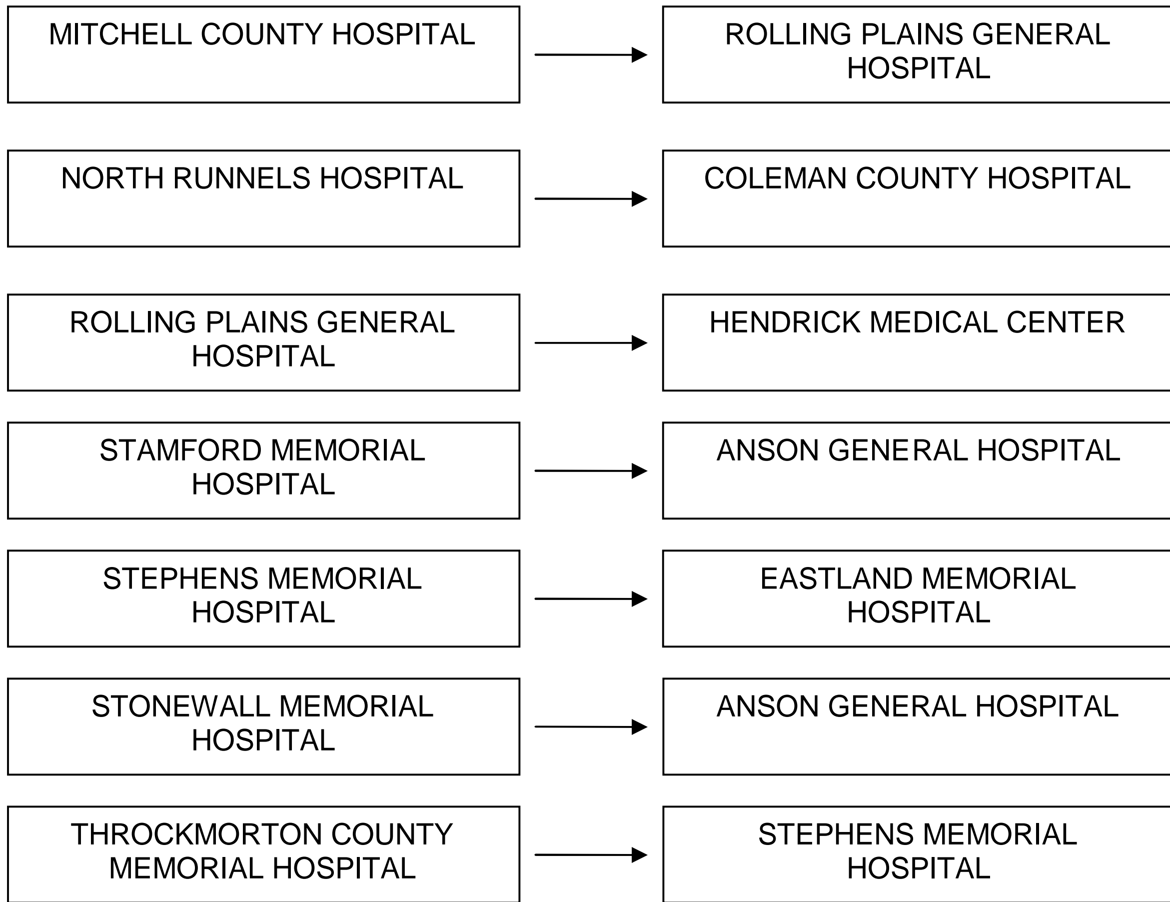
Throckmorton County Judge

Throckmorton Mayor

Throckmorton County Memorial Hospital

NOTIFICATION LIST




MITCHELL COUNTY HOSPITAL
ROLLING PLAINS GENERAL HOSPITAL
NORTH RUNNELS HOSPITAL
COLEMAN COUNTY HOSPITAL
ROLLING PLAINS GENERAL HOSPITAL
HENDRICK MEDICAL CENTER
STAMFORD MEMORIAL HOSPITAL
ANSON GENERAL HOSPITAL
STEPHENS MEMORIAL HOSPITAL
EASTLAND MEMORIAL HOSPITAL
STONEWALL MEMORIAL HOSPITAL
ANSON GENERAL HOSPITAL
THROCKMORTON COUNTY MEMORIAL HOSPITAL
STEPHENS MEMORIAL HOSPITAL

	TRAUMA	BIOLOGICAL	CHEMICAL	RADIOLOGICAL	NOTES
HOSPITAL CATEGORY **TRAUMA LEVEL III**	**Meets state guidelines for Level III facility – provides stabilization and limited operative care for isolated injuries, refers majority of multiple trauma to trauma center** Planning Goal: 50 patients requiring care, 15 admits, 8 criticals	Able to triage all patients. Plans to refer airborne precautions patients in place, able to hospitalize other categories of infectious patients Planning Goal: admit/cohort 15 patients (airborne precautions), 8 criticals	Maintains PPE for personnel, able to decon 5-24 patients per hour with call-in of additional staff or public safety augmentation. Planning Goal: provide decon/treatment to 20 persons, plan supplemental assistance for above this number.	G-M counter(s) available in hospital, trained personnel available on call. Plans for consultation with RSO or health physicist. Planning goal: screen 20 persons	HEICS or compatible incident management system in place. Communication capability with regional hospitals and EMS required. Must be prepared to triage / screen more than this number of casualties.

TRAUMA

See attached guidance on stock items and following notes/items:

- Triage tags, numbered
- Rapid assessment sheets for walking wounded
- Consider additional burn supplies (e.g.: burn sheets, specialized dressings)
- Assure adequate bag-valve and endotracheal tubes to provide for anticipated numbers of victims that may require temporary hand ventiliaton (e.g.: consider 10 bag/valve devices)
- May wish to consider 3-5 day supply (based on usual use) of those supplies on formulary lists (see final pages) applicable to your institution.

BIOLOGICAL

- Adequate supplies of N95 and barrier precautions to protect ED / and other clinic staff and staff to care for up to 10 cohorted patients hospitalized for 72hrs. Assume masks may be used for duration of shift, barrier gowns and gloves disposed of unless working in cohort care area. Surgical masks should be used on patients.
- Supplies to fit-test additional employees if rapid program required to implement N95 protection.
- Doxycycline sufficient to prophylax all hospital employees and patients.
- Consider other additional antibiotics / antivirals including pediatric patients.

OTHER

- Satellite phone, radio equipment
- Vests, clipboards, portable radios, and other HEICS equipment
- EOC equipment including computer access, fax, additional phone lines, phones, etc.
- Transport ventilators and portable monitors may be considered but are not a priority. Available equipment from crash carts, etc. should be inventoried and used during a disaster.

CHEMICAL

- Stock crystalline atropine adequate to care for 50 victims at 5mg/pt and have compounding protocols available
- Stock crystalline 2PAM if desired
- Stock Mark 1 kits and ready-for-use atropine and 2PAM as desired
- Stock sodium thiosulfate adequate for 12.5g/pt for 10-25 victims
- Consider stocking sodium nitrite
- Consider additional supplies of proparacaine, benzodiazepines, paralytics
- Stock bag-valve devices (10) in addition to usual supplies
- Stock additional 7.5 and 7.0 endotracheal tubes total 10
- Stock additional oxygen tubing and masks as per trauma
- Chemical PPE 4-6 sets and trained staff available on site or via call-in or outside support within 20 minutes (operations level). Should have staff trained to conduct directed patient self-decontamination (e.g.: talk ambulatory patients through process for safe distance or via loudspeaker) at all times (awareness level)
- Decontamination facilities sufficient for 5-25 pts. / hour and associated supplies (towels, gowns, belongings bags)

RADIOLOGIC

- G-M counters similar to Ludlum Model 3 with pancake probe and mR/h scale available in facililty (at least one)
- Civil defense or other qualitative meters may be considered for ED use
- Radiation dosimeter badges for all staff involved in assessment and decontamination
- Consider other forms of dosimetry
- SSKI at least one bottle at each facility (several qtt = adult dose qd)

MEDICAL/SURGICAL AND PPE SUPPLIES BY TYPE AND CATEGORY OF HOSPITAL EMERGENCY SERVICES

	TRAUMA	BIOLOGIC	CHEMICAL	RADIOLOGIC	NOTES
HOSPITAL CATEGORY **TRAUMA LEVEL IV**	Meets TDH guidelines for Level 4 facility – provides stabilization and referral of trauma patients to definitive care facility. Planning Goal: 25 patients requiring medical care, 8 admits, 4 criticals	Triage and refers patients requiring critical care / airborne precautions. Limited capacity to hospitalize other categories of infected patients. Planning Goal: Admit/cohort 8 patients with airborne precautions, 4 critical.	Maintains PPE or has agreements with local fire department/staff to provide decon for up to 5 patients per hour. Planning Goal: Provide decon/treatment to 5 persons, plan for supplemental assistance for above this number.	Agreements in place for evaluation, detection, and referral of patients with radiologic contamination. Planning Goal: Provide qualitative screening with community partners to 5 patients.	HEICS or compatible incident management system in place. Communication capability with regional hospital and EMS required. Must be prepared to triage/screen more than this number of casualties.

TRAUMA

See attached guidance on stock items and following notes/items:

- Triage tags, numbered
- Rapid assessment sheets for walking wounded
- Consider additional burn supplies (e.g.: burn sheets, specialized dressings)
- Assure adequate bag-valve and endotracheal tubes to provide for anticipated numbers of victims that may require temporary hand ventilation (e.g.: consider 5 spare bag/valves)
- May wish to consider 3-5d supply (based on usual use) of those supplies on formulary lists (see final pages) applicable to your institution.

BIOLOGIC

- Adequate supplies of N95 and barrier precautions to protect ED / other clinic staff and staff to care for up to 5 cohorted patients hospitalized for 72h. Assume masks may be used for duration of shift, barrier gowns and gloves disposed of unless working in cohort care area.
- Surgical masks for patients.
- Supplies to rapidly fit-test additional employees if rapid program required to implement N95 protection
- Doxycycline sufficient to prophylax all hospital employees and patients
- Consider additional antibiotics, antivirals, suspension preparations, pediatric preparations, etc.

CHEMICAL

- Consider atropine 1mg/ml sufficient for 10-25 casualties at 5mg/pt or crystalline stocks if compounding available.
- Consider stocking cyanide antidote kit or provide sodium thiosulfate 12.5g vials per patient, up to 10 patients.
- Provide chemical PPE as indicated by hospital capabilities, suggest minimum of 2-3 sets and at least some hospital personnel trained to provide decontamination that can be called in as needed (operations level) and capability for staff to talk patients through ambulatory self-decontamination from a safe distance (awareness level)
- Decontamination facilities sufficient for up to 5 patients per hour.

RADIOLOGIC

- Consider G-M counters similar to Ludlum Model 3 with pancake probe and mR/h scale or civil defense/other qualitative meters or other community resources
- Consider dosimetry badges or other forms of dosimetry
- SSKI at least one bottle at each facility (sever qtt = adult dose qd)

OTHER

- Satellite phone, radio equipment
- Vests, clipboards, portable radios, and other HEICS equipment
- EOC equipment including computer access, fax, additional phone lines, phones, etc.
- Transport ventilators and portable monitors may be considered but are not a priority. Available equipment from crash carts should be inventoried and used during a disaster.

CORE DISASTER FORMULARY

Instruments/ Equipment
BP Cuffs, Disposable
BP Manometer
Batteries – AA, AAA, D, C
Artificial Resuscitator Bag (BVM) 10% Child, 5% Infant

Sharps, NDL/Syringes
10cc Needless Syringes
60cc Needless Syringes
3cc 23G 1" Safety syringes
3cc 22G 1 ½ " Safety syringes
TB/insulin syringes
Blunt Plastic Cannula
Luer Lock Cannula
18G 1 ½ " Safety Needles
20G 1" Safety Needles
Sharps container
IV Start Catheter (20, 18, 16, 14g)
Butterfly 23GA and 25GA
25G 1.5" needles for injections

ED/Surgical Supplies
Scalpels plastic with attached #11 blade
Suture sets
Irrigations sets (zerowet, canon system, etc.)
Thoracotomy tray
Peritoneal lavage tray
Chest tubes (12, 24, 28, 36)
Chest drainage system
Sterile towels and sheets
Burn sheets/dressings
Sterile basins
Skin stapler
Consider additional stocking of Surgical trays (lap, amputation, major procedure, thoracic, etc.) by OR/central supply

Irrigation Solutions
Normal Saline irrigation solution 2000cc

IV Access/Supplies
IV Start kits / supplies
Micro drip tubing
Adult drip tubing
Blood administration tubing
Disposable IV pressure bag
IV pump tubing
Arterial line tubing (if capable)
Central vein catheter kit

IV Solutions
NS 1000cc
Long Arm Board
Short Arm Board
Stopcock

Dressings
Vaseline – impregnated dressings
2x2 sponges sterile
ABD pads
4x4 dressings/sponges sterile
Self adhering dressings (tegaderm)
4" roller guaze / kerlix
2" roller guaze
Sterile cotton applicators
2" porous first aid tape
3" porous first aid tape
3" foam tape
Adhesive bandages
1" paper tape
Bacitracin ointment

Linen
Disposable Sheets
Disposable Pillows
Disposable Pillow Covers

GU
Foley catheters and urometers
Urine multistix

Hand Hygiene
Providine/iodine scrub brushes
PCMX scrub brushes
(1 box per 100 casualties)

Patient Personal Care Supplies
Bath basin
Emesis basin
Facial tissues
Bedpan
Urinal
Belonging bag
Regular soap
Disposable / other gowns
Paper/cloth towels

Musculoskeletal
Bandage scissors
Slings (medium and large)
Cervical collars (small and medium)
Knee immobilizers
Ankle immobilizers
Crutches
Splints:
Fiberglass pre-padded 3, 4, 5 inch
Plaster impregnated 4, 5 inch rolls
Plaster 5x35 inch sheets
Roller bandages 3 and 6 inch

Respiratory System Supplies
ABG kits
Nasal airways 6.5, 7.0, 7.5
Oral airways 3, 4, 5
Oxygen cannulas
Oxygen masks
Neb sets
Yankauer Suction tips
Suction kit/cup 14F x 22
ET tubes 6, 7, 7.5
Cook over needle cath for chest decompression / needle ventilation
Shiley 4-6 trach
Cricothyrotomy tray
End-tidal CO2 detector
Esophageal detection device

Miscellaneous
Sterile lubricant
Alcohol wipes
Povodine/iodine swab sticks
Povodine/iodine bottle
Hydrogen peroxide
Tongue depressors
Garbage liners
Blood glucose testing supplies
Waterproof markers
Body bags (25 per 100 casualties)
Blank labels / tags
Bottled drinking water
Monitoring electrodes
Sat probes
Restraints – wrist , waist
Flashlights

Common Medications
Ancef / other antibiotics
Morphine
Local anesthetic
Benzodiazepines
Paralytics, sedatives
dT booster

PEDIATRIC FORMULARY

Instruments/Equipment Disposable BP Cuffs – Neonatal, Infant, Child, Small Adult Artificial Resuscitator Bag Masks Ped, Infant (BVM) Ent-tidal CO2 detector **Patient Personal Care Supplies** Diapers / wipes Pacifier Cotton balls Bottles / formula **Respiratory System Supplies** Oral Airway peds Oxygen Cannulas peds Oxygen masks peds ET tubes 4.0 – 6.0 Suction catheters 8F **ER / Trauma / Surgical Supplies** Facial suture tray / plastics tray Buretrol tubing 60 drops Chest tubes (8, 10, 12, 24)	**GI/GU System supplies** Feeding tubes (5, 8F) Foley catheters 8, 10, 12F **Sharps: NDL / Syringes** Bulb syringes Safety syringes (21, 25) Filter needles Catheter tip syringe 60cc Sharps container Luer lock Syringes 20cc, 60cc Syringes 1, 3, 5, 10cc **IV Access/Supplies** IV start kits Stopcock T-connector IV start catheter (22, 24) Arm board – infant, child IV Filters (.22 micron, 1.2 micron) Syringe pump tubing Micro drip tubing Pediatric central line kit Intraosseous needles	**IV Solutions** D5W NS 100cc **Musculoskeletal** Infant and child c –collar Small slings Small knee immobilizers Small crutches **Miscellaneous** Broselow tape (or similar dosing chart) Safety pins Dolls, books, stickers Pediatric sat probes Pediatric electrodes Rectal thermometer

TRAUMA SERVICE AREA D
MUTUAL AID AGREEMENT

This agreement is made and entered into as of ___________________, 2003 by and between nineteen hospitals located in the seventeen county trauma service area.

RECITALS

WHEREAS, this agreement is not a legally binding contract but rather this agreement signifies the belief and commitment of the undersigned hospitals that in the event of a disaster, the medical needs of the community will be best met if the undersigned hospitals cooperate with each other and coordinate their response efforts.

WHEREAS, the undersigned hospitals desire to set forth the basic tenants of a cooperative and coordinated response plan in the event of a disaster.

NOW THEREFORE, in consideration of the above recitals, the undersigned hospitals agree as follows:

ARTICLE I

COMMUNICATION BETWEEN THE UNDERSIGNED HOSPITALS DURING A DISASTER

The undersigned hospitals will:

1.1 Communicate and coordinate efforts to respond to a disaster via their Health and Medical liaison officers, public information officers, and/or incident commanders (CEO) primarily.

1.2 Receive alert information via the local dispatch regarding any disaster or special incid ent.

1.3 Communicate with each other's Emergency Operations Centers (EOC) by phone, fax, and/or email via the Regional notification system.

1.4 Utilize a Joint Public Information Center (JPIC) through Hendrick Medical Center during a disaster to allow their public relations personnel to communicate with each other and release consistent community and media educational / advisory messages. Each undersigned hospital should designate a Public Information Officer (PIO) who will be the hospital liaison with the JPIC.

Depending on the event, this may be coordinated through the Texas Department of Health and / or the Texas Division of Emergency Management. If Hendrick Medical Center is unable to assume responsibility, Abilene Regional Medical Center will ass ume this responsibility.

ARTICLE II

ONGOING COMMUNICATION ABSENT A DISASTER

The undersigned hospitals will:

2.1 Meet quarterly under the auspices of the Trauma Service Area D Regional Response System to discuss continued emergency response issues and coordination of response efforts.

2.2 Identify primary point-of-contact and back-up representatives for ongoing communication purposes. These individuals will be responsible for determining the distribution of information within their healthcare organizations.

ARTICLE III

FORCED EVACUATION OF AN UNDERSIGNED HOSPITAL

3.1 If a disaster affects an undersigned hospital(s) forcing partial or complete facility evacuation, the other undersigned hospitals agree to participate in the distribution of patients from the affected hospital, even if this requires activating emergency response plans at the receiving hospital.

3.2 In the event of an evacuation, Hendrick Medical Center will be the hospital point -of-contact to assist with organizing transportation for the evacuation and will distribute patients equitably to the unaffected undersigned hospitals.

3.3 The undersigned hospitals will assist with location of available hospital beds and transportation of patients.

3.4 In the event of an anticipated evacuation, transportation arrangements will be made in accordance with the affected hospital's usual and customary practice. County resource lists may be used by the affected undersigned hospital to help arrange transportation resources.

ARTICLE IV

RESPONSE WHEN THE NATIONAL DISASTER MEDICAL SYSTEM IS ACTIVATED

4.1 If the National Disaster Medical System (NDMS) is activated in response to a disaster, Hendrick Medical Center will determine bed availability and capability in the undersigned hospitals.

4.2 If patients are to be received from outside the area in response to the activation of the NDMS, these patients will be distributed according to the undersigned hospitals' bed capacity and capabilities. The undersigned hospitals will cooperate by accepting transfers in anticipation of arriving NDMS patients (for example, accept transfers from an undersigned hospital to increase that hospital's capacity to accept NDMS patients) if needed.

4.3 If the National Disaster Medical System is activated in response to a disaster in region, Hendrick Medical Center will obtain information from the undersigned hospitals regarding the number of patients that require transportation and will coordinate resources with support from the Texas Division of Emergency Management.

ARTICLE V

REPORTING BED CAPACITY AND CAPABILITY

5.1 The undersigned hospitals will notify Hendrick Medical Center to report the hospital's bed capacity, its capabilities and its Emergency Department's ability to receive patients.

5.2 Bed capacity and capabilities will include at a minimum: medical/surgical floor, monitored beds and ICU.

ARTICLE VI

AUXILIARY HOSPITAL AND CASUALTY COLLECTION LOCATION

6.1 An auxiliary hospital and/or casualty collection location may be required in the event a dis aster overwhelms the area hospital's capacity and capabilities.

6.2 If an auxiliary hospital and/or casualty collection location is required, Hendrick Medical Center will coordinate administration, staffing, and site operations.

6.3 The undersigned hos pitals may be asked to contribute volunteer staff to an auxiliary hospital or casualty collection location on an urgent basis, subject to availability.

6.4 If available, each undersigned hospital will provide teams within 24 hours to staff the auxiliary hospital or casualty collection area. Each team will be expected to care for a large volume of patients requiring ongoing austere medical care. A suggested team is 1 Physician and 2 RN/LVN. These teams will function as a unit at the auxiliary hospital o r casualty collection location.

6.5 Each undersigned hospital will plan to contribute 1 team for the first 48 hours. Staffing after 48 hours will involve at least some hospital staff, with outside agencies, retirees, and other alternative staff also being utilized to provide for ongoing care. Hendrick Medical Center will work with County and State resources as well as the hospitals to coordinate ongoing staffing.

ARTICLE VII

STAFF, MEDICAL SUPPLIES AND PHARMACUETICAL SUPPLIES IN THE EVENT OF A DISASTER

7.1 In the event of a disaster when patient care staff are in surplus at one of the undersigned hospitals and lacking at another, the undersigned hospital with the surplus will share staff to help assure that the available hospital beds in the area ar e adequately staffed during a disaster.

7.2 In an emergency, hospitals may be deluged with calls from volunteers, many of whom are physicians and nurses looking to help. Each facility will have a procedure to manage and verify the

credentials of professional staff who volunteer. Each facility will ensure minimum credentials by asking volunteers to show copies of their licenses and hospital ID badges, and then keep a record of who was cleared as well as their profession / specialty.

7.3 In the event that needed supplies are in surplus at one of the undersigned hospitals and lacking at another, the undersigned hospital with the surplus will share supplies to help ensure that patients in the area receive necessary treatment during a disaster.

7.4 The above staff and supply sharing will occur in cooperation between the incident commanders (CEOs) at the involved undersigned hospitals.

ARTICLE VIII

MISCELLANEOUS PROVISIONS

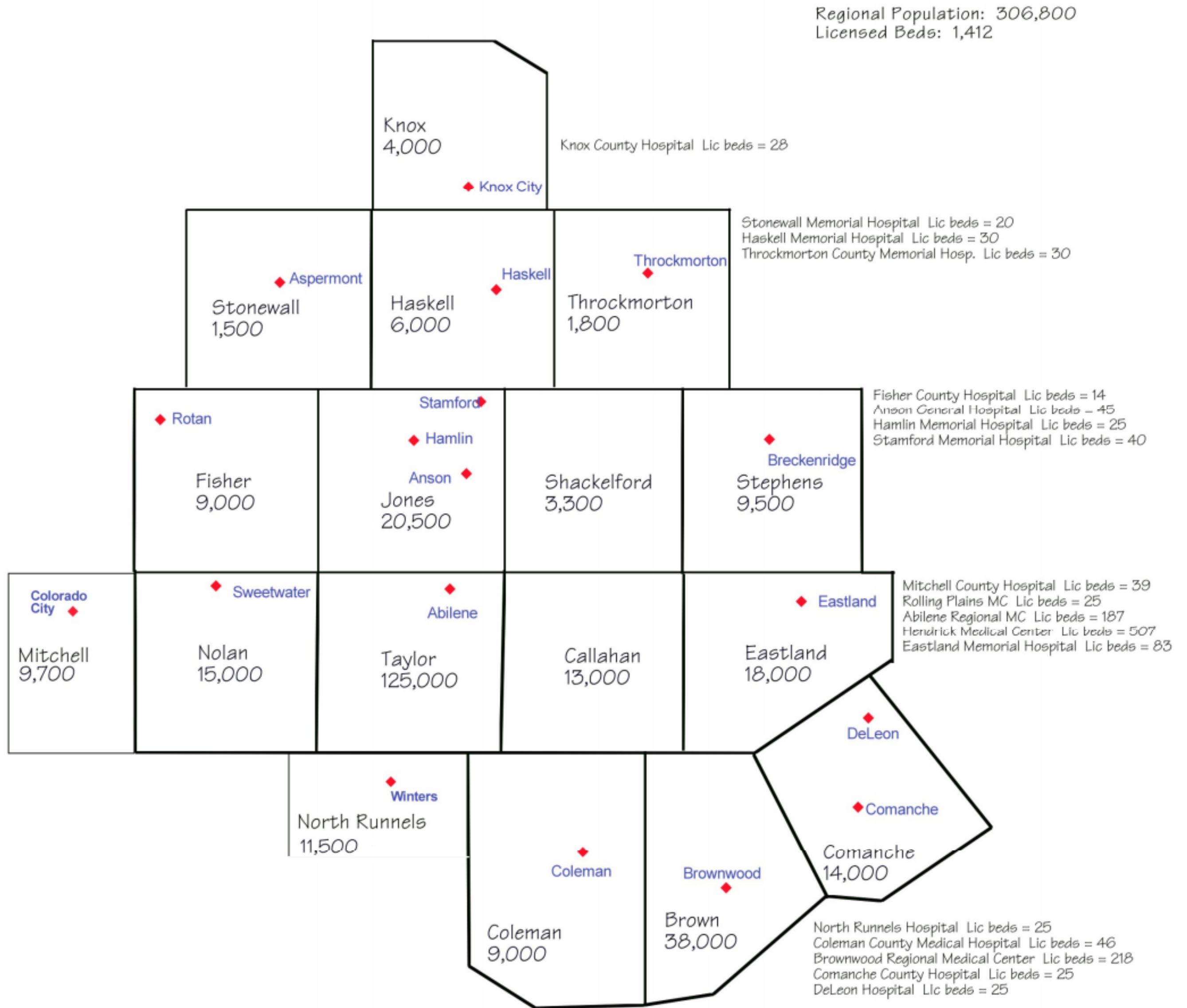
8.1 This agreement constitutes the entire agreement between the undersigned hospitals.

8.2 Amendments to this agreement must be in writing and signed by the participating hospitals.

8.3 An undersigned hospital may at anytime terminate its participation in the agreement by providing sixty-day (60) written notice to the regional representatives at each of the undersigned hospitals.

MUTUAL AID AGREEMENT PARTICIPANTS

Abilene Regional Medical Center
Anson General Hospital
Brownwood Regional Medical Center
Coleman County Hospital
Comanche County Hospital
DeLeon Hospital
Eastland Memorial Hospital
Fisher County Hospital
Hamlin Memorial Hospital
Haskell Memorial Hospital
Hendrick Medical Center
Knox County Hospital
Mitchell County Hospital
North Runnels Hospital
Rolling Plains General Hospital
Stamford Memorial Hospital
Stephens Memorial Hospital
Stonewall Memorial Hospital
Throckmorton County Memorial Hospital


TEXAS TRAUMA SERVICE AREA D
2001 ESTIMATED CENSUS AND FACILITY MAP
Regional Population: 306,800
Licensed Beds: 1,412
Knox
4,000
Knox City
Knox County Hospital Lic beds = 28
Stonewall Memorial Hospital Lic beds = 20
Haskell Memorial Hospital Lic beds = 30
Throckmorton County Memorial Hosp. Lic beds = 30
Aspermont
Stonewall
1,500
Haskell
Haskell
6,000
Throckmorton
Throckmorton
1,800
Fisher County Hospital Lic beds = 14
Anson General Hospital Lic beds = 45
Hamlin Memorial Hospital Lic beds = 25
Stamford Memorial Hospital Lic beds = 40
Rotan
Fisher
9,000
Stamford
Hamlin
Anson
Jones
20,500
Shackelford
3,300
Breckenridge
Stephens
9,500
Mitchell County Hospital Lic beds = 39
Rolling Plains MC Lic beds = 25
Abilene Regional MC Lic beds = 187
Hendrick Medical Center Lic beds = 507
Eastland Memorial Hospital Lic beds = 83
Colorado City
Mitchell
9,700
Sweetwater
Nolan
15,000
Abilene
Taylor
125,000
Callahan
13,000
Eastland
Eastland
18,000
DeLeon
Winters
North Runnels
11,500
Comanche
Comanche
14,000
Coleman
Brownwood
Coleman
9,000
Brown
38,000
North Runnels Hospital Lic beds = 25
Coleman County Medical Hospital Lic beds = 46
Brownwood Regional Medical Center Lic beds = 218
Comanche County Hospital Lic beds = 25
DeLeon Hospital Lic beds = 25