Regional Healthcare Preparedness Coalition

CMOC DIVISION 1

SETRAC

Catastrophic Medical Operations Center (CMOC) Regional Plan

January 14, 2019

Promulgation Statement

In 2012, The Regional Hospital Preparedness Council and the Southeast Texas Regional Advisory Council combined organizations and the Regional Hospital Preparedness Council evolved into the Regional Healthcare Preparedness Coalition (RHPC) and a standing Board Committee of the Southeast Texas Regional Advisory Council. The Southeast Texas Regional Advisory Council (SETRAC) has the authority and responsibility for coordination of medical operations in Southeast Texas during major special events, human-caused incidents, and natural disasters. This document provides planning and program guidance for implementing medical activities for the region under the Catastrophic Medical Operations Center (CMOC).

This plan has been developed in accordance with Comprehensive Preparedness Guidance (CPG) 101 and is intended to support local, regional, state, and/or federal operations requiring a coordinated medical response. The SETRAC Preparedness Director shall maintain this plan and will ensure its execution directly or through a delegation of authority. This plan is:

- the official operations source for the CMOC and medical agencies in the region;
- authorized by and promulgated under the authority contained by local, state, and federal statutes listed herein; and
- has obtained all appropriate authorities in the Southeast Texas region.

Approval and Implementation

The CMOC Regional Plan is effective upon the signature of the Preparedness Director for the Southeast Texas Regional Advisory Council (SETRAC) and shall supersede all previous versions.

This Plan and related Annexes will be reviewed and updated as required. Recommended changes shall be submitted to the Preparedness Director at SETRAC for consideration and approval. Minor changes identified as “pen and ink” revisions will be disseminated on a “Record of Change” document from the SETRAC. Any conceptual changes that modify existing activities or add new activities shall require the plan to be submitted for signature and recertification by the Preparedness Director.

If any portion of this Plan is held invalid by judicial or administrative ruling, such ruling shall not affect the validity of the remaining portions of the Plan.

Foreword

The overarching goal of this regional Catastrophic Medical Operations Center (CMOC) plan is to mitigate medical and healthcare consequences of any disaster affecting the Southeast Texas 25-County Region. This plan is a collaborative effort with input from the following entities:

- Regional Healthcare Preparedness Coalition (RHPC)
- Southeast Texas Regional Advisory Council (SETRAC)
- East Texas Gulf Coast Regional Advisory Council (RAC-R)
- Deep East Texas Regional Advisory Council (RAC-H)
- Emergency medical services (EMS) leaders
- Strategic National Stockpile coordinators
- Houston-Galveston Area Council (H-GAC)
- City, county and regional health department representatives
- Texas Department of State Health Services (DSHS)

The CMOC serves as a center for collecting and disseminating current information about medical and healthcare resources and needs (e.g., equipment, bed capacity, personnel, supplies), developing priority allocations, identification of patient transport locations, support of field operations, allocating and tracking disbursement of resources, and addressing other relevant medical and healthcare response matters. If authorized to activate, the CMOC may be given purchasing authority, which will allow it to directly procure the resources needed to support healthcare response and recovery operations.

History

In 1997, Houston was named one of the first Metropolitan Medical Response System (MMRS) cities in the nation. The focus of the MMRS program is to support the integration of emergency management, health, and medical systems into a coordinated response to mass casualty incidents caused by any hazard. By integrating these systems, communities should be better prepared to reduce the consequences of a mass-casualty incident during the incident's initial response period by having augmented existing local operational response system before an incident occurs.

To help achieve this goal, the first hospital planning group was formed. The Houston Fire Department identified eight hospitals strategically located around the city as mass-casualty receiving hospitals during such an incident. This initial group, known as the Hospital Receiving Group (HRG), identified planning priorities necessary to integrate as a system, including a common communications network, a healthcare planning template, common equipment and training, executive support, and mutual aid agreements.

The year 2001 saw rapid growth as well as significant challenges to healthcare response in the region. Tropical Storm Allison lingered over the Houston area, causing extensive flooding and subsequent evacuation or closure of several hospitals. Most of the flooding occurred in the

downtown and Texas Medical Center (TMC) areas. When the TMC hospitals were unable to accept patients, a devastating ripple effect occurred throughout the region as patients were diverted to other hospitals, and overcrowding resulted. Of concern was the fact that hospitals responded individually or within their own systems and that no formal coordinating entity existed to ensure patients received the care they needed and hospitals can provide that care.

Following the events of September 11, 2001, the HRG increased to include 12 more acute care agencies and developed a 50-member Community Hospital Subcommittee. These two groups later merged into one hospital planning group, the Houston Area Hospitals Emergency Management Collaborative (HAHEMC), with the unique needs of the healthcare system as its focus.

The Regional Hospital Preparedness Council (RHPC) officially formed in 2002 with the mission of providing collaborative planning and response to emergencies using a multidisciplinary approach and preserving the medical infrastructure of the region. The RHPC and other regional health and medical groups continued to discuss the need for a coordinating entity.

In 2005, despite the lack of a formal coordinating body at the time, the Houston region's medical response capability galvanized while responding to hurricanes Katrina and Rita. An ad hoc regional coordinating entity called the Disaster Unified Medical Command was formed and activated; it served as a precursor to today's CMOC. Since there was no formal plan, structure, or recognized authority, forming this entity constituted a leap of faith for hospitals, health officials, and emergency managers in the region; all the coordinating organizations were committed to the mission and success of the overall response, dedicated to serving the medical community.

In 2006, the first version of the CMOC plan was developed in accordance with standards for local emergency management plans developed by the Texas Division of Emergency Management pursuant to §418.043(a) of the Texas Government Code and in accordance with existing plans, mandates, and standard operating procedures of the City of Houston Office of Emergency Management (OEM) for infrastructure support purposes. The CMOC plan is applicable in all natural and manmade emergency situations affecting the area residents, staff, patients, family members, and visitors of the region.

This revision accounts for lessons learned from exercises, training, and real-world incidents, such as Hurricane Ike (2008), Tax Day Floods (2016), and Hurricane Harvey (2017).

Record of Changes

Change #	Change Description	Change Made By	Date
1	Throughout document where RHPC is listed as governing body of CMOC – change made to SETRAC	L. Upton	July 2012
2	Addition of TSA H into CMOC response region	L. Upton	September 2013
	Change from 4 Corridors to five Corridors to include TSA H		
	CMOC demographics updated to include TSA H		
3	CMOC Org Chart revised	L. Upton	May 2015
4	Associated Standard Operating Guides, Annexes and other Attachments added to the CMOC Regional Plan	L. Upton	June 2015
5	CMOC Plan operational considerations and other sections added and associated attachments updated across multiple Red Team Review meetings.	Tina Rose on behalf of Red Team Review	September 2018 - January 2019

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Introduction

Purpose

The purpose of this plan is to provide general guidelines for preparation, response, and recovery to natural and manmade incidents that endanger the patients, visitors, staff, and family members of medical healthcare agencies within the region. This plan describes how medical and healthcare agencies within the region collectively mitigate, prepare for, respond to, and recover from the effects of an emergency or disaster. It also addresses the types of services and resources that are provided in certain situations. This plan outlines methods for assisting the staff of healthcare agencies within the region to deal with effects of disasters. It does not replace local, county, or agency plans and procedures.

Scope

Any incident may cause a major emergency within the region with contingencies that will vary in severity, scope, and intensity. Devastation may be isolated and limited in one area and wide-ranging and extreme in another. Since incidents can occur in several locations simultaneously, planning efforts are made as general as possible so that latitude and flexibility is available in the application assumptions about the existence of specific resources and capabilities that are subject to change. Additionally, some variations in the implementation of concepts identified in this plan may be necessary to protect the health and safety of patients, staff, and medical infrastructure.

The healthcare agencies within the region are part of a regional healthcare coalition in Southeast Texas that includes Angelina, Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Tyler, Walker, Waller, and Wharton counties. Agencies in these counties have signed a memorandum of agreement (MOA) with SETRAC to plan, prepare for, and respond to a regional disaster in a cooperative fashion.

Regional Overview

Geography

The Catastrophic Medical Operation Center (CMOC) supports a region that is primarily comprised of 25 counties in three Trauma Service Areas: TSA Q, TSA R and TSA H. Historically, the CMOC has supported as many as 34 counties and two parishes in Louisiana. The CMOC can expand or contract as the situation dictates or as mission-tasked by the state of Texas, but the primary region is the 25-county footprint shown in **Error! Reference source not found.**.

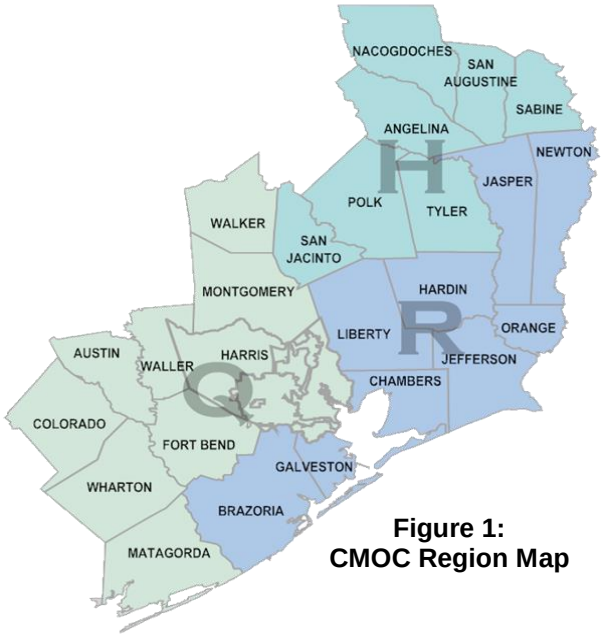


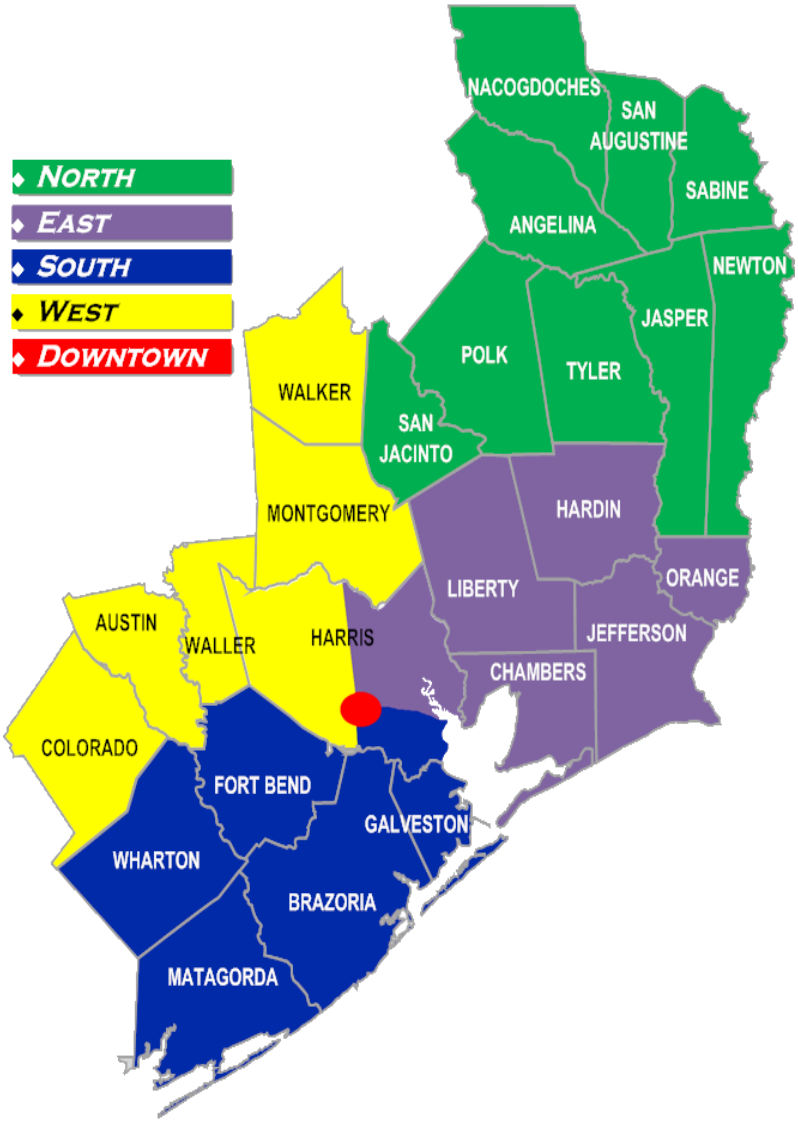
Figure 1: CMOC Region Map

CMOC Location

The primary physical location for level I operations of the CMOC is in the Harris County Office of Homeland Security and Emergency Management TRANSTAR building in the Emergency Operations Center (EOC). Back-up locations include the Houston Emergency Center (HEC), Fort Bend County Emergency Operation Center, or any potential impacted location in the 25 coalition counties. The CMOC serves as a coordinating entity for healthcare agencies within the region and is designed to coordinate medical care, patient evacuation, and medical resources throughout the region prior to or following a large-scale incident.

Corridors

The SETRAC regional footprint is divided geographically into the five corridors described below (the North, East, South, West, and Downtown Corridors):



- **North Corridor**

Includes the counties of: Nacogdoches, San Augustine, Sabine, Angelina, San Jacinto, Polk, Tyler, Jasper, and Newton.

- **East Corridor**

Includes the counties of: Hardin, Liberty, Chambers, Jefferson, Orange, and portions of Harris County that are outside Loop 610 and North of Hwy 225 and East of Hardy Toll Road.

- **South Corridor**

Includes counties of: Ft Bend, Brazoria, Matagorda, Wharton, Galveston, and portions of Harris County outside Loop 610 and East of 288 and South of Hwy 225.

- **West Corridor**

Includes counties of: Colorado, Austin, Waller, Montgomery, Walker and portions of Harris County outside Loop 610 and West of 288 up to Hardy Toll Road.

- **Downtown Corridor**

Includes City of Houston and Harris County within Loop 610.

Demographics

The CMOC coordinates resource requests for approximately 180+ hospitals and 900+ nursing homes serving 25 counties with more than 7.7 million people and 28 percent of the self-reported disability population. See Table 1 for population information for the region served by the CMOC.

Table 1: CMOC Region Population

County	2000	2010	2018
Angelina	86,771	86,162	87,805
Austin	23,590	28,417	29,786
Brazoria	241,767	313,166	362,457
Chambers	26,031	35,096	41,441
Colorado	20,390	20,874	21,232
Fort Bend	354,452	585,375	764,828
Galveston	250,158	291,309	335,036
Hardin	48,073	54,635	57,139
Harris	3,400,578	4,092,459	4,652,980
Jasper	35,604	35,710	35,561
Jefferson	252,051	252,273	256,299
Liberty	70,154	75,643	83,658
Matagorda	37,957	36,702	36,840
Montgomery	293,768	455,746	570,934
Nacogdoches	64,524	65,330	65,580
Newton	15,072	14,445	13,952
Orange	84,966	81,837	85,047
Polk	45,413	51,806	49,162
Sabine	10,835	10,879	10,461
San Augustine	8,865	9,685	8,253
San Jacinto	26,384	29,292	28,270
Tyler	21,766	22,289	21,539
Walker	61,758	67,861	72,245
Waller	32,663	43,205	51,307
Wharton	41,188	41,280	41,968
TOTAL	**5,290,220**	**6,526,033**	**7,783,780**

Hazard Profile

Disaster conditions could be a result of a variety of natural phenomena, such as hurricanes, floods (river and flash), winter storms, drought, and fires (urban, grass, and forest). In addition, the region is subject to a myriad of other disaster contingencies, such as transportation accidents involving chemicals and other hazardous materials, plant explosions, train derailments, pipeline ruptures, aircraft disasters, building or bridge collapses, sink holes, utility service disruptions, energy shortages, civil disturbances, terrorist incidents, or a combination of any of these. Please refer to county specific hazard mitigation plans and the detailed regional medical Hazard Vulnerability Analysis for further detail.[1]

Critical Assumptions

- SETRAC will activate the CMOC according to the CMOC Activation Standard Operating Procedure (see Activation Standard Operating Procedure).
- The CMOC may be activated as a precautionary measure for emergency situations that have the potential to escalate, impending disaster conditions, or when prolonged or catastrophic incidents cause widespread disruptions of daily life and have an adverse medical impact on those affected by these incidents.
- Within each jurisdiction, there exists a combination of emergency services and medical capabilities that are adequate to cope with normal emergencies. A normal emergency is considered to be any incident that can be addressed or handled with locally available resources. A basic premise of emergency planning is that incidents are generally handled at the lowest jurisdictional level possible. Each agency is responsible for incident management at that level.
- A disaster is considered to be something that cannot be addressed or handled with locally available resources.
- This region is at risk of various hazards that increase the likelihood of health and medical issues, loss of life, and extensive damage to property and the environment. Prolonged or catastrophic incidents cause widespread disruptions of day-to-day life and have an adverse impact on those affected by these incidents.
- It is the responsibility of officials under this plan to save lives, relieve human suffering, and sustain survivors.
- Each county, emergency medical services, and healthcare agencies must be prepared to address and provide comprehensive information on how human-caused incidents or natural disasters that directly impact area residents, patients, visitors, staff, and family members while being able to ensure immediate action on behalf of those most severely affected.
- Effective prediction and warning systems have been established that make it possible to anticipate certain disaster situations that may occur throughout the region.
- Each agency within the region will implement its specific, appropriate, and prudent plans and procedures when actually or potentially threatened by natural and/or manmade disasters.

[1] Each hospital is required to complete a hazard vulnerability analysis (HVA). In turn SETRAC integrates the HVA into a single regional HVA.

- During emergencies residents within the region may experience numerous health problems. Some of these problems are attributable to preexisting medical conditions complicated by the emergency while other problems may arise as a direct result of the incident.
- The increased number of area residents needing medical assistance may burden and/or overcome the health and medical infrastructure. This increase in demand may require a regional response and/or subsequent state and/or federal level of assistance.
- A catastrophic incident may cause widespread damage that the existing internal response capacity and capability of EMS and healthcare agencies are compromised or destroyed. During some emergencies, it may be necessary to evacuate patients and staff from the affected area(s) and/or healthcare agencies.
- Response actions will vary according to the specific conditions. Generally, these actions will follow a phase-in process based on the emergency type.
- When officials from an affected jurisdiction determine their own resources to be insufficient, assistance by response organizations from another jurisdiction is expected to supplement the efforts of the affected jurisdiction in an efficient, effective, and coordinated response.
- Continuity of Operations will be maintained and executed if the physical location of the CMOC is compromised.
- Healthcare agency staff involvement in planning, training, and exercising this CMOC Plan is essential for practicing mitigation efforts that emphasis preparedness, response, and recovery.

Activation

The CMOC may be activated by due to an incident of any cause as requested by incident command, including city, county, and state officials due to emerging public health threats that affect the medical infrastructure. The mission of the CMOC includes coordination of medical care and response resources for the affected area. SETRAC will activate the CMOC according to the CMOC Activation Standard Operating Procedure (see Appendix A).

Activation Sequence

The CMOC may be activated by many agencies, including the Department of State Health Services (DSHS), the Texas Division of Emergency Management (TDEM), and county or city OEMs to serve as the emergency medical component of Emergency Support Function (ESF) #8 in the Regional Health and Medical Operation Center (RHMOC) and the Multi-Agency Coordination Center (MACC), when activated. In accordance with guidelines from the National Incident Management System (NIMS), the CMOC follows the Incident Command System. Based on the need for additional resources and support, the CMOC may be activated by any of the following agencies:

- Local or Regional Public Health Authority
- Texas Department of Emergency Management (e.g. SOC, SMOC, DDC, etc.)
- City or County OEM/Emergency Management Coordinator (EMC)
- State or Regional DSHS

The following steps outline the CMOC activation from request to initial operations:

1. The requestor establishes the need for medical coordination and/or support based on an emergent or existing situation.
2. Notify SETRAC on-call duty officer at 281.822.4444 to request medical resources and/or support services.
3. The SETRAC determines CMOC activation level required based on information provided by the requestor and identifies/activates appropriate staffing levels.
4. Activated personnel will report to the CMOC or field location, as designated.
5. If not already established, the CMOC will work with the regional administrator to establish an incident in WebEOC.

Key Activation Steps

The activities need to be accomplished in response to a variety of hazards and emergency situations are listed below.

1. Identify and analyze the hazard or perceived threat to the medical infrastructure in the affected area.
2. Activate the CMOC to appropriate level.
3. Obtain and maintain a common operating picture.
4. Identify, prioritize, and coordinate the delivery of medical and healthcare needs and resources in the affected area.
5. Allocate healthcare and medical response resources based on need.
6. Coordinate public messaging with Public Information Officers (PIOs) in the authority having jurisdiction (AHJ), as needed.
7. Integrate and coordinate with the DDC/RHMOC.

CMOC Activation Levels

CMOC planners have also developed the following CMOC activation designations for readiness. Staffing, operations, and possible activating situations are described in Table 2):

Level 1: Full Activation

During an actual occurrence, the CMOC will implement actions to accomplish task assignments in accordance with applicable operational procedures. Notification will be issued to the healthcare agencies throughout the region that CMOC is operational. If the scope of the emergency expands to the point that agencies within the region have exhausted or are depleting internal response assets, the CMOC will assist with coordination of requests with the following agencies: local fire, law enforcement, EMS, public health, city and/or county emergency management offices, the Texas Department of Public Safety (DPS), Texas Division of Emergency Management (TDEM), the Texas Disaster District Committee (DDC), Texas Department of State Health Services (DSHS), the Federal Emergency Management Agency (FEMA), or other applicable agency.

Level 2: Partial Activation

When an emergency is imminent, all applicable protective action plans and procedures will be activated. This includes opening the CMOC as requested and implementing notification to healthcare agencies throughout the region. A process is in place for reporting ongoing incidents and assessing current factors and resources.

Level 3: Normal Operations

During normal conditions, primary emphasis will focus on awareness, readiness (i.e., planning, information, training, and exercising), and education. In addition, staff should complete training that is germane to applicable response activities. The agencies should conduct at least one annual exercise that includes testing disaster response with regional, city, and/or county agencies.

Table 2: Activation Levels and Support Examples[2]

	Level 1: Full Activation	Level 2: Partial Activation	Level 3: Normal Operations
Staffing	All positions in the CMOC will be staffed including liaisons and field operations	The CMOC Operations Chief and other positions (including liaisons and field operations), as required, will be staffed	SETRAC staff remain on call.
Operations	Ground operations, strike teams, task forces, and other resources will be activated	Resources readied; requested as needed	Normal daily operations; some resource requests can occur without an activation
Situation Example	Hurricane in Gulf of Mexico; terrorist attack resulting in a significant number of casualties	Including virtual activation, Significant weather affecting medical agencies; High Consequence Infectious Disease (HCID), localized mass casualty incident. Localized incident that could expand into a mass casualty situation or a special event, e.g., Super Bowl, Final Four	IV/supply shortages, MCI notifications, EMS coordination, and internal healthcare agency disaster not necessitating evacuation.

Concept of Operations

This CMOC plan applies to all disaster and emergency situations in the region that requires a coordinated regional medical response and may be activated as a precautionary measure, as needed for emergency situations that have the potential to escalate or for impending disaster conditions. Implementation of procedures will begin as soon as practical after the incident is predicted or occurs and the priority for all decisions will be life-saving measures. Transportation and placement of patients will be made based on the patient's need and the receiving agency's capacity and capability. This section emphasizes operational considerations during CMOC activations.

[2] Each situation requiring CMOC activation is different and needs will be evaluated individually by the CMOC Operations Chief on call. This table merely provides a scaled framework to assist in determining activation options.

Situational Awareness

SETRAC daily awareness initiatives, which includes alerts, notifications, preventive measures, and local trainings are critical aspects of the overall response strategy. Efforts will be made to foster individual involvement and to promote the idea of "neighbors helping neighbors" within the region. Effective agency-wide participation by administration, health and medical professionals, other staff, volunteers, outside healthcare and medical providers, and city/county emergency management personnel must be cultivated and sustained to ensure maximum protection of the patients, staff, and area residents.

Frequently communicated information may include the following situational awareness factors: evacuation areas, hospital closures, incident parameters, significant weather, the number of patients received, available bed capacity or specialty services/bed availability, fatalities, current guidelines regarding symptomatology and diagnosis, agency status, identified and/or ongoing threats, accessible routes/road conditions, and other recommendations.

External communications with a variety of entities is critical for continued functioning of the regional healthcare infrastructure, some of which may include:

- Texas state agencies;
- Regional healthcare agencies;
- City/County Departments of Health;
- City/County Office of Emergency Management (OEM);
- Various Operation Centers (e.g. SOC, SMOC, RHMOC, DDC); and
- Local agencies (e.g. Fire, EMS, Law Enforcement).

Information Sharing

Coordination of disaster intelligence may require identifying what types of essential elements of information (EEI) is needed, where the information is expected to come from, who will use the information, how the information will be shared and determining the appropriate format for providing the information along with the specific times when the information will be needed.

Tracking/Distributing Resources

When the CMOC is authorized to activate, it may be given purchasing authority, which will allow the CMOC to directly procure resources needed to support healthcare response and recovery operations. Potential tasks will include collecting, tracking, and disseminating current information about medical and healthcare resources needed (e.g., equipment, bed capacity, personnel, supplies), developing priority allocations, identification of patient transport locations, support of field operations, allocating and tracking disbursement of resources, and addressing other relevant medical and healthcare response matters.

Staging Operations

The staging and assignment of all medical assets should be coordinated by the CMOC to reduce duplication and maintain efficient operations.

Priority Allocations

To develop priority allocations of scarce resources and achieve redistribution of medical resources, it is essential that available options are understood and accepted by all stakeholders. The proper use of medical resources changes from one disaster to another. Proper resource allocation—whether it is people, supplies, transport vehicles, or available treatment modalities—must be coordinated and geared to providing the most care for the most individuals without regard to financial capabilities or deficiencies.

Surge Capacity

To create additional surge capacity within any medical system, there must be redistribution of medical care and resources within regional healthcare. The placement of individuals into healthcare agencies will be determined based on hospital capacity and on medical capability matched with the healthcare needs of patients. Long-term care agencies and specialty hospitals will be included in the surge capacity decision making. By using this approach, acute care agencies will not become overwhelmed with non-acute patients, and the most medically fragile individuals will be treated in the most appropriate agency, thereby eliminating the need for further transfer of a patient for appropriate or specialized care.

Evacuation/Relocation

When assistance is requested by a healthcare facility or Jurisdictional Health Authority (JHA) for evacuation of a hospital, nursing home, assisted living center, or other bedded healthcare facility, the CMOC will contact the evacuating facility's point of contact and request the following information:

1. Number of patients to be evacuated/relocated;
2. Name of facility accepting evacuated/relocated patients (if known or obtained); and
3. Environmental or other hazards associated with the need for evacuation.

The CMOC will assign the evacuating facility to one of the Corridor Coordinators as primary lead for the evacuation. The Coordinator will request a patient manifest from the evacuating facility. At a minimum, the manifest should include the patients':

1. First and last name(s);
2. Age and/or Date of Birth;
3. Chief complaint/diagnosis;
4. Supportive medical equipment to accompany the patient;
5. Other medical or physical considerations (e.g. infectious disease, immobility, orthopedic traction, IV medications for hemodynamic stability, O2, bariatric, etc.).

The Corridor Coordinators will take the additional steps outlined below, depending on if the evacuating facility has already designated a receiving facility to accept their patients or if the evacuating facility needs assistance identifying a designated receiving facility.

A. If the evacuating facility <u>does not have a receiving facility accepting their patients</u>, then the Corridor Coordinator will:

1. Review the patient manifest and identify receiving facilities based on bed availability, capability and capacity for the patient's needs.
2. Make telephone contact with the receiving hospital for patient manifest acceptance.
3. Obtain a point of contact from the receiving hospital and provide it to the evacuating hospital to call for formal transfer approval and the patient care report.
4. Once the receiving facility is confirmed for accepting the evacuating facility patients, then all steps below can be followed by the Corridor Coordinator.

B. If the evacuating facility <u>has a receiving facility already accepting their patients</u>, then the Corridor Coordinator will:

1. Review the patient manifest for
   a. transportation needs (e.g. paratransit vehicle, helicopter, Ambulance Bus (AmBus) ALS/BLS ambulance), and
   b. number of each asset needed to safely transport the patient(s).

   Note: For evacuations, patients may be "double loaded" in ambulances if safety and infectious disease considerations are ruled out.
2. Complete a <u>CMOC 213 General Message</u> form (see example 213s in Appendix C) then
   a. attach the form to the top of the patient manifest, and
   b. submit the evacuation packet to the Clinical Director for approval/review.
3. Upon approval, the Clinical Director will
   a. Input the evacuation mission into the CMOC Mission Task Board in WEBEOC and
   b. Route the request to the Transportation Sector of CMOC.
4. The Transportation Sector will
   a. determine the appropriate staging area and assets for the mission and
   b. assign the mission to the Staging Manager who will then assign the individual asset and update the Mission Task as "in-progress."
5. Upon successful transportation and care of the evacuated patient has been turned over to the receiving hospital, the transporting unit will notify the ambulance staging manager who will mark the Mission as "Complete."

Organization and Assignment of Responsibilities

The CMOC recognizes its unique role and responsibilities to the public and the medical community and will respond to community and national medical emergencies by providing coordination of regional assets, including transportation, medical surge capacity, notifications, updates, patient tracking, and agency requests for resources.

Each healthcare agency is responsible for developing and maintaining its own emergency management procedures. In addition to the coordination components listed above, the CMOC serves as a 'safety net' for healthcare agencies within the region when they are unable to execute their emergency operations plan.

Organization Chart

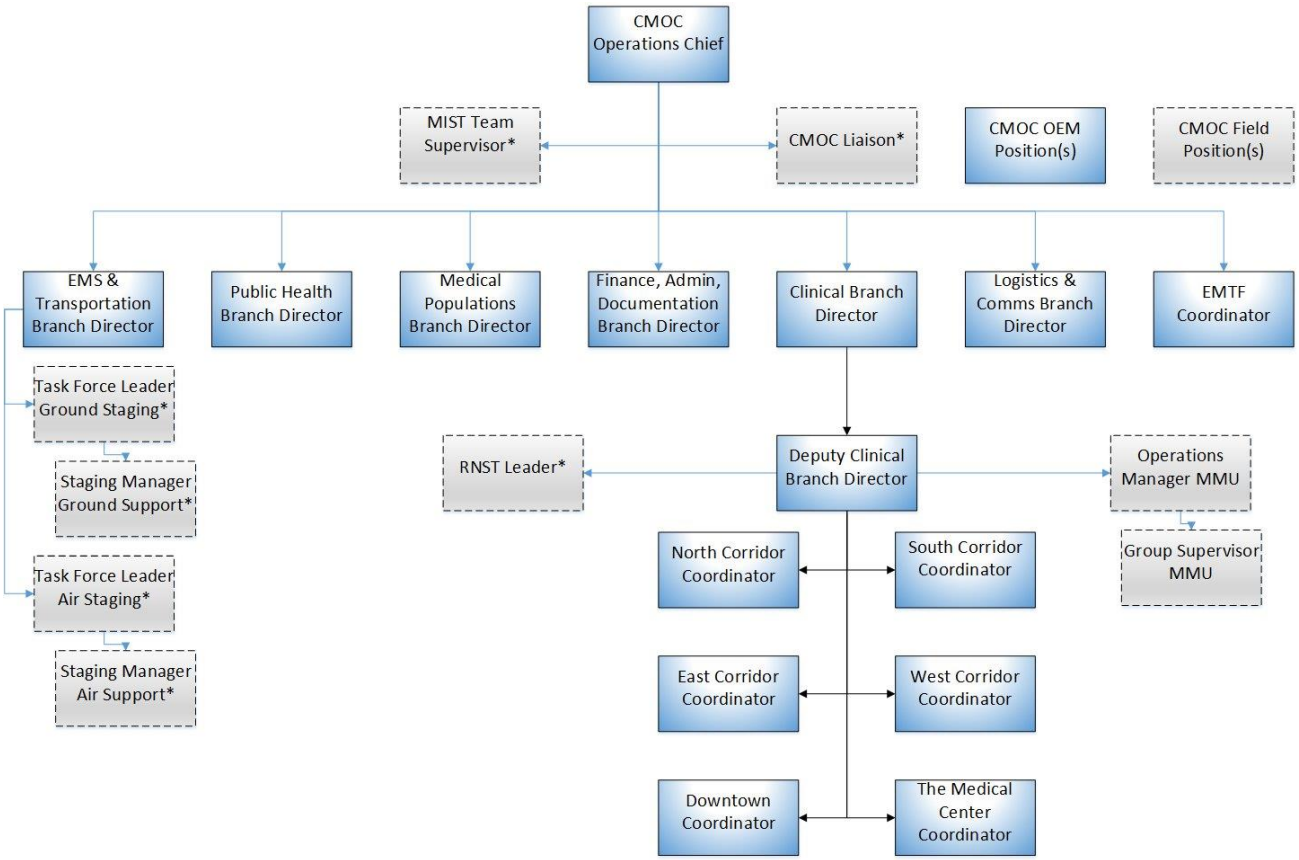


Figure 2: CMOC Organizational Chart

Position Responsibilities

All members of the CMOC team will collaborate in good faith to make decisions that are in the best interests of the region. Members will not consider their own agency or hospital affiliations when making any decisions. During full activation, the CMOC contains the positions portrayed in the CMOC organization chart along with some of the general responsibilities listed in Table 3.

Table 3: Responsibilities of CMOC Positions

Position	General Responsibilities
CMOC Operations Chief	▪ Develops the command structure that is necessary to carry out the objectives of the CMOC; ▪ Maintains overall command and control for the CMOC's activities; ▪ Briefs all members of the CMOC on the mission and objectives of the section and maintains a rotational schedule to provide 24-hour, 7-day coverage during the incident response; and ▪ Works with governing entities in the coordination of response to ensure that emergency incidents do not adversely affect the quality, capacity, and continuity of healthcare operations for the region. ▪ Maintains and submits situation reports of actions taken to the appropriate authority during a major disaster utilizing an incident command compliant format ▪ Acts as an advisor to Unified Command or Area Command during any declared emergency affecting the public with medical needs, emergency medical services, healthcare agencies, and response personnel within the affected area ▪ In the absence of the Joint Information Center, the Operations Chief will serve as the Public Information Officer for the CMOC.
Clinical Care Branch Director	▪ Serves concurrently as Deputy Operations Chief and oversees the Corridor Coordinators; ▪ Approves appropriate requests for supplies, missions, and other resources; and ▪ Works closely with EMS/Transportation Branch Director to ensure missions are completed.
Deputy Clinical Care Director	▪ Assists Clinical Care Director in position responsibilities; ▪ Assists and supports Corridor Coordinators in position responsibilities; ▪ Directly coordinates with MMU Supervisor (if activated); ▪ Assumes role of Clinical Care Director when Clinical Care Director serves as Operations Chief
Emergency Medical Services/Transportation Branch Director	▪ Coordinates transportation services and staging areas for the CMOC health and medical partners; ▪ Maintains situational awareness of field operations, including asset visibility; and ▪ Receives and routes requests for transportation to the appropriate field operators.
Logistics/Communications Branch Director	▪ Responsible for asset management, including inventory; ▪ Provides logistical and communications coordination for deployed resources to support medical operations; ▪ Receives and processes all CMOC resource requests.

Position	General Responsibilities
Finance, Administration, and Documentation Branch Director	▪ Responsible for financial documentation (e.g. purchase orders, receipts) completed during disaster activations; ▪ Gathers and collects all documentation developed and used during the incident response; ▪ Ensures all CMOC workers meet NIMS standards for EOC reimbursement requirements.
Public Health Branch Director	▪ Provides support and recommendations to the CMOC Operations Chief about vector control, epidemiology, or mass prophylaxis considerations in response to natural and biological incidents; ▪ Coordinates with the appropriate entities so that complete, accurate, and timely communication about life safety procedures, public health advisories, and other vital information is shared with the public within the affected region; and ▪ Collaborates with the Medical Populations Coordinator to support non-hospital healthcare providers (e.g., nursing homes, long-term care agencies, dialysis clinics, medical special needs shelters).
EMTF Coordinator	▪ Serves as the primary point-of-contact for the EMTF State Coordinating Organization (SCO); ▪ Provides support and management for all deployed teams under the EMTF Standard Operating Guide; ▪ Attend conference calls with state partners as needed to accomplish the mission; ▪ Facilitate tracking of deployed assets, staff, and documentation for financial reimbursement.
Medical Director Liaison	▪ Serves as a resource for the CMOC on clinical matters, as requested. ▪ Coordinates directly with the CMOC Operations Chief. ▪ Provides clinical expertise in their field
Corridor Coordinators	▪ Coordinate medical response requests for a hospital, group of hospitals, or a regional hospital corridor; ▪ Ensure needed supplies and other resources are routed to the appropriate location for the duration of the incident; ▪ Maintains situational awareness of healthcare agencies within the designated region; ▪ Coordinates with healthcare agencies to meet the transportation, reception, evacuation, and resource needs required to continue patient care services; ▪ Gathers information and clarifies the nature of requests for resources coming into the CMOC to streamline appropriate use of existing material; and ▪ Tracks patient movement within and outside the boundaries of the region.
TMC Liaison	▪ Liaison between all non-hospital facilities within the TMC complex; ▪ Coordinate response requests and ensures needed supplies are routed to the appropriate locations in the TMC area. ▪ Maintain situation awareness and coordinate with CMOC branches to meet their transportation, reception, evacuation, and resources/needs.

Position	General Responsibilities
Medical Populations Coordinator	▪ Coordinates medical response requests for non-hospital agencies (e.g., nursing homes, long-term care agencies, dialysis clinics, medical special needs shelters) providing patient care within the region; ▪ Ensures that needed supplies and other resources are routed to the appropriate location for the duration of the incident; ▪ Maintains situational awareness of non-hospital healthcare agencies within the designated region and coordinates to meet the transportation, reception, evacuation, and resource needs required to continue patient care services; and ▪ Gathers information and clarifies the nature of requests for resources coming into the CMOC to streamline appropriate use of existing resources.
MIST, MMU, Liaison, Staging (incident specific)	▪ * Incident Specific positions may be filled (e.g. Task Force Leaders, Strike Teams, Staging Managers, Air Ops, DDC Liaison, Family Assistance Center Liaison, Jurisdictional EOC Liaison, etc.).

Coordinating Partners

Coordinating with other government entities is essential for the CMOC in carrying out the incident mission. Examples of state and federal level departments that may support CMOC operations include:

- Regional Health and Medical Operations Center (RHMOC)
- Mutual Aid Associations (e.g. CIMA, Sabine Neches Chiefs)
- Texas Department of Public Safety
- Texas Division of Emergency Management (e.g. SOC, SMOC)
- Texas Military Department (e.g. State Guard)
- Texas Task Force 1
- Texas Department of State Health Services
- Texas Department of Health and Human Services Commission
- U.S. Coast Guard
- U.S. Health and Human Services

Private-sector organizations within the jurisdiction may assist with a wide variety of tasks based on their capabilities. They include emergency medical services, vendors, nongovernmental organizations, and volunteer agencies, as needed or requested.

Assistance from surrounding jurisdictions and supporting services is available through the execution of a memorandum of understanding (MOU) or a MOA.

Communications

During emergencies, the ability to communicate between healthcare agencies within the same areas and throughout the entire region will be critical. Communication strategies have been developed to allow healthcare agencies' EOCs to communicate with each other and each agency's local city and/or county EOC, as applicable.

Information Collection, Analysis, and Dissemination

During a disaster or emergency CMOC will coordinate medical essential/critical information. Disaster information managed by the CMOC is coordinated through representatives located within the center. These representatives collect information from, analyze information with, and disseminate information to counterparts in the field. These representatives also disseminate and analyze information within the CMOC that can be used to develop courses of action and manage response operations.

External communications within and between healthcare agencies and outside emergency organizations use existing communication systems. Community-wide or regional requests for assistance to medical emergencies will be communicated directly to the CMOC through any of the redundant means listed in the table below.

Table 4: Redundant Communication

Computer Software	▪ EMResource
	▪ EMTrack
	▪ SmartNotice
	▪ WebEOC
	▪ Email
Radio	▪ Land Mobile Radio (e.g. 700/800, Ham Radio, VHF, etc.)
Phone Networks	▪ Dedicated telephone lines
	▪ Land-line telephones or Fax machines
	▪ Cellular phones
	▪ Satellite phones
	▪ Public Safety LTE (e.g. First Net, GETS, etc.);

Notifications and Warnings

Warning(s) of a potential disaster may come from a variety of sources (e.g. local health departments, fire departments, law enforcement, etc.). SETRAC/CMOC will share open source information that could impact the normal or continued operations of healthcare and EMS agencies. Multiple sources are available to provide redundancy in the external notification system listed above.

Logistical Considerations

Establishing logistics services and support systems to all the organizational components involved in the incident is critical. Once established Logistics is responsible for all support requirements needed to facilitate effective and efficient incident operations to include transportation, supplies, equipment maintenance, fuel, food services, communications and information technology support, emergency responder medical services/support and accountability of all personnel and resources.

The CMOC should quickly identify what is currently available to support the operations and the broad categories of resources that will be required. The following considerations should be accomplished as soon as possible when operations are in progress:

- Determine and establish staging areas for air and ground apparatus, personnel, and equipment.
- Rapidly assess personnel and equipment requirements based on the situation need and type.
- Determine the appropriate resource request process.
- Assess incident location and determine distance, time, and possible delays en-route resources or equipment may have.
- Determine what services are on-site for the duration of operations and request resources and/or support activities to support operations.

Resource & Support Considerations	
Resources	• Apparatus • Specialized Teams • Personnel • Vessels • Helicopters
Support	• Area Security • Traffic Control • Administrative Facilities • Communications (Radios, Phone, Data) • Medical Support / Crew Rehab • Personal Protective Equipment • Toilet Facilities • Food and Water • Equipment Maintenance Support • Fuel • Shelter

Resource Requests

When the resources of local agencies are exhausted or when a needed capability does not exist within a local jurisdiction, the agencies will place requests for medical support to the CMOC. Any non-medical requests will be forwarded to the appropriate jurisdiction.

State and Federal Resources

The assignment of local, regional, state, and federal assets must be coordinated to provide the most efficient operation and cover the greatest area in a catastrophic incident or widespread natural disaster. All medical resources operating outside of their home jurisdictions should operate under the established incident command structure. CMOC will coordinate state and federal medical assets assigned to the CMOC in response to affected jurisdictions.

Competing Resources

During large scale incident(s), availability of resources can become a critical point of failure during operations. Multiple aspects of the response will be considered when critical resource needs may outweigh availability. For example, similar resources needed to support the ESF 4 (Firefighting), ESF 8 (Public Health and Medical Services), ESF 9 (Search and Rescue), and ESF 13 (Public Safety and Security). Resources will be allocated based on the greatest need and/or risk due to various factors (e.g. type of incident, proximity to an impending natural disaster, etc.). Coordinating these resource concerns with the County EOC, State DDC, and State SOC is imperative to ensuring continuity of operations and resource allocations to fulfill critical missions.

Staging Operations

When an incident is expanding to multiple operational periods and the UC/AHJ has requested CMOC assistance and resources a Base of Operations / Staging Area will need to be established in the AHJ, to better support operations. The staging specific location may be predetermined by the local jurisdiction prior to the arrival of resources. If a staging will be established the following factors should be considered:

- Travel distance to and from the operational worksite
- Transportation and access routes
- Terrain and elevation
- Facilities for personnel and cache sheltering
- Communications
- Safety/security
- Adequate space and available infrastructure including:
    - Equipment cache set-up and maintenance
    - Command Post
    - Medical treatment area
    - Food preparation and feeding area
    - Toilet and sanitation area
    - Helicopter landing zones (optional).

Rehabilitation, Reassignment, & Release

In addition to standard mission assignment demobilization procedures in a catastrophic disaster, CMOC resources may be reassigned to missions that are normally assigned to other resources. The logistics section will track and coordinate demobilization, rest, and/or redeployment with the appropriate parties, including the jurisdiction or agency that sent the resource.

The CMOC, in conjunction with appropriate state or local officials and agencies, will carefully assess the ability of a medical resource (e.g. personnel or equipment) that is already established and in operation to accept a tactical reassignment requiring a location change. It is incumbent upon the supervisory personnel to continually assess the physical and mental condition of their personnel and equipment status/readiness for continued operation. The following factors should be considered:

- Duration of operation already underway and its forecast completion
- Status of the medical and community infrastructure
- Re-establishment of the supply chain
- Local healthcare resources (EMS, hospitals, clinics, pharmacies, dialysis, etc.) are operational and can handle the demand for services
- Physical and mental condition of task force personnel
- Rest period in response to safety concerns

Reimbursement

The H-GAC 12-hour MOU provides that the local request within 12 hours is free, then according to the Texas Government Code (Chapter 418.1181) after 12 hours the requesting local or state jurisdiction will be billed for personnel hours and equipment to support the mission.

> "Texas Government Code Sec. 418.1181 - REIMBURSEMENT OF COSTS: REQUEST BY LOCAL GOVERNMENT ENTITY. (a) If a local government entity requests mutual aid assistance from another local government entity under the system that requires a response that exceeds 12 consecutive hours, the requesting local government entity shall reimburse the actual costs of providing mutual aid assistance to the responding local government entity, including costs for personnel, operation and maintenance of equipment, damaged equipment, food, lodging, and transportation, incurred by the responding local government entity in response to a request for reimbursement. Local government entities with a mutual aid agreement when the request for mutual aid assistance is made are subject to the agreement's terms of reimbursement, as provided by Section 418.111.

When mutual aid assistance will be provided for more than twelve (12) consecutive hours, the Requesting Party shall, prior to the expiration of the twelfth (12^{th}) hour, confirm in writing to the Responding Party that the Requesting Party desires continued mutual aid assistance from the Responding Party. Notwithstanding the above, if, due to the nature of the emergency, disaster, or other condition requiring mutual aid, the Requesting Party cannot confirm its request for continued mutual aid assistance before the expiration of the twelfth (12^{th}) hour, the written request must be sent as soon as practicable, but in all cases, within ninety (90) days of the verbal request. If a Party hereto requests mutual aid assistance that requires a response that exceeds twelve (12) consecutive hours, the Requesting Party shall reimburse the Responding Party its actual cost for providing mutual aid assistance to the Requesting Party after the first twelve (12) hours, including costs for

personnel, operation and maintenance of equipment, damaged equipment, food, lodging, and transportation, provided that, in no event shall the cost for a service or item be greater than the rate, as such rates are amended from time to time, set by the Federal Emergency Management Agency (FEMA) for the substantially same service or item. FEMA rates are available at http://www.fema.gov The Parties mutually agree that a Responding Party shall not be entitled to and will not seek reimbursement from a Requesting Party for either: (a) assistance provided that does not exceed twelve (12) consecutive hours or (b) for assistance provided during the initial twelve (12) hours of the response (See reimbursement packets in the Emergency Medical Task Force (EMTF) 6 Standard Operating Guide (SOG) for the additional requirements of the EMTF deployed assets).

Demobilization

The CMOC will develop a demobilization plan that considers the facility status', community infrastructure, continued medical resource needs, and healthcare agency repopulation that is approved by the mission tasking entity. The demobilization plan is approved by the CMOC Operations Chief and the requesting jurisdiction/entity. Once approved, SETRAC will demobilize the CMOC according to the following steps as a guide for a smooth demobilization process for all medical resources in the region (see Appendix B: Demobilization Standard Operating Procedures):

- The CMOC Operations Chief reviews and approves the CMOC demobilization plan.
- CMOC notifies staff, field personnel, and staging regarding tentative and final asset releases.
- The Staging and EMS/Transportation branches make sure all signatures are obtained and required documentation (e.g. ICS 221 Demob checklist) is submitted for demobilizing CMOC controlled assets in staging areas.
- The CMOC Operations Chief monitors the demobilization process of the CMOC staff, field personnel, and field assets and makes necessary adjustments to the process.
- The Logistics and Communications Branch Director ensures that nonexpendable property items are returned or accounted for prior to release.
- With oversight from the EMS/Transportation Branch and the Ambulance Staging Manager ensures vehicles receive a safety check prior to leaving the incident or staging area. Any deficiencies must be corrected before release of the asset.
- The Logistics and Communications Branch Director coordinates with staff and field operations to ensure all communications equipment is returned and accounted for.
- The Finance, Administration, and Documentation Branch Director ensures all personnel have returned to home base, all time sheets, ICS 214s, demobilization orders/packets and expenditures have been submitted for approval, and all purchase orders and task lists have been completed, canceled, or closed out.
- The Finance, Administration, and Documentation Branch Director is responsible for collecting all CMOC generated documents (e.g. notes, positions logs, P.O.s, STAR forms, etc.) and ensure safe storage, as required by government standard/statute.

Administration/Finance

This section outlines general policies for administering resources.

Agreements and Understandings

When a disaster overwhelms local government, requests may be made to neighboring jurisdictions, state agencies, and federal departments in accordance with mutual aid agreements. Outside assistance may be in the form of manpower, equipment, materials, and supplies for use by local officials and the affected community. All agreements will be formalized in writing, whenever possible, and signed by the proper officials. Copies of written agreements will be kept on file at the SETRAC offices – 1111 North Loop West Suite 160 Houston, Texas 77008.

Emergency Purchases

The CMOC Operations Chief has the authority to order any emergency purchases and/or authorize the contracting of any emergency services that might be required to fulfill the mission, as assigned. Because there is no provision in the regional budget to deal with a large emergency that might occur to tax limited resources, mutual aid agreements and procedures for requests for assistance from state and federal authorities are critical to the planning effort.

Records and Reports

All records of emergency managements meetings and emergency actions will be maintained at the SETRAC offices (1111 N Loop W # 160 Houston, Texas 77008). Responsibility for submitting reports to the Requesting Jurisdiction/Entity rests with the CMOC Operations Chief.

- The CMOC Finance, Administration, and Documentation Branch Director will maintain records of expenditures and obligations in emergency operations.
- Narrative- and log-type records or response actions to all emergencies will be maintained in accordance with law.

Plan Development and Maintenance

This plan is a cooperative effort among agencies within the SETRAC region. A copy of this plan is on file at in the state of Texas Department of Health and Human Services Emergency Preparedness Division offices and the Southeast Texas Regional Advisory Council office. An electronic version is placed on the SETRAC and UASI website in a password-protected location.

Maintenance Requirements

- The SETRAC Director of Preparedness will maintain, distribute, and update this plan. Revisions will reflect changes in procedures, improved methods, identified best practices, changes in availability of resources, and corrections of any deficiencies or omissions.
- The SETRAC will review and, if necessary, update this plan at least every 3 years. Revisions will reflect changes in procedures, improved methods, identified best practices, changes in availability of resources, and corrections of any deficiencies or omissions.
- Revisions will be forwarded to officials that appear on the record of distribution.
- Directors of supporting agencies have the responsibility of maintaining internal plans, SOPs, and resource data to ensure prompt and effective response to and recovery from disasters and emergency situations.

Review and Update

The CMOC plan will be reviewed at least every three years by representatives from the RHPC and SETRAC. SETRAC will establish a process for reviewing this plan. Changes should be made to the CMOC plan when the documents are no longer current. Changes to the CMOC plan may be needed when:

- hazard consequences or risk areas change;
- the concept of operations for emergencies changes;
- departments, agencies, or groups that perform emergency functions are reorganized and can no longer perform the emergency tasks laid out in planning documents;
- warning and communications systems change;
- additional emergency resources are obtained through acquisition or agreement or through the disposition of existing resources changes or when anticipated emergency resources are no longer available;
- a training exercise or an actual emergency reveals significant deficiencies in existing planning documents; or
- state/territorial or federal planning standards for the documents are revised.

Authorities and References

Legal Authority	
Federal	▪ The Robert T. Stafford Disaster Relief and Emergency Assistance, Public Law 93-288 as amended ▪ Other executive orders and acts pertaining to disasters enacted or to be enacted ▪ Public Employees Occupational Safety and Health Act regulations ▪ Emergency Planning and Community Right-to-Know Act, 42 U.S.C. Chapter 116 ▪ Emergency Management and Assistance, 44 CFR ▪ Homeland Security Presidential Directive (HSPD) 3, Advisory System ▪ HSPD-5, Management of Domestic Incidents ▪ PPD-8, National Preparedness ▪ National Incident Management System ▪ National Response Framework, FEMA, January 2008 ▪ National Strategy for Homeland Security
Regional	▪ RP57—relating to implementing recommendations from the Governor's Task Force on Evacuation, Transportation, and Logistics
State	▪ Section 418.043(a) of the Texas Government Code
Local	▪ Draft Joint Powers Agreement ▪ County emergency management plans (EMPs) ▪ Medical and healthcare agencies EMPs
Volunteer, Quasi-Governmental	▪ Act 58-4-1905, American National Red Cross Statement of Understanding, December 30, 1985 ▪ Mennonite Disaster Services—Agreement with the Federal Disaster Assistance Administration, 1974 ▪ Public Law 93-288
References	
Federal	▪ Comprehensive Preparedness Guide (CPG) 101: Producing Emergency Plans: A Guide for All-Hazard Emergency Operations Planning for State, Territorial, Local, and Tribal Governments, Federal Emergency Management Agency, Interim Version 1.0, August 1, 2008 ▪ Homeland Security Exercise and Evaluation Program (HSEEP), February 2013 ▪ National Incident Management System (NIMS), 2017 ▪ National Response Framework, FEMA, January 2008 ▪ Assistant Secretary Preparedness and Response (US Health and Human Services)
Regional	▪ Houston-Galveston Area Council Regional MOU/MAA ▪ Regional Multi-Agency Coordination Plan ▪ Regional Mass Fatality Management ConOps ▪ Regional Search and Rescue Plan
State	▪ State of Texas EMP ▪ Texas Disaster Medical System Overview ▪ Annex from State ESF #8
Local	▪ Local MOUs/MOAs and Inter-local agreement(s) ▪ Local plans

Appendix A: Activation Standard Operating Procedure

Introduction

The Catastrophic Medical Operations Center (CMOC) is a coordinating body that supports resource needs of healthcare agencies within Trauma Service Areas Q, R and H. The CMOC responds to community and national medical emergencies by facilitating the coordination of regional assets, including transportation, medical surge capacity, notifications, updates, patient tracking, and agency requests for resources.

Roles and Responsibilities

The CMOC may be activated when prolonged or catastrophic incidents cause widespread disruptions of daily life and have an adverse impact on those affected by these incidents. The CMOC may be activated due to a mass casualty incident of any cause as requested by the incident commander as well as by local cities and counties due to emerging threats to public health. The CMOC may also be activated for an exercise or other training, or to obtain situational awareness during large-scale, high-profile events.

Based on the need for additional resources and support, the CMOC may be activated by any of the following agencies[3]:

- Department of State Health Services (DSHS)
- Texas Division of Emergency Management (TDEM)
- County OEM/EMC
- City OEM/EMC
- Local Public Health Departments/Authorities

Critical Assumptions

- The CMOC must be able to activate quickly at any time day or night, operate around the clock, and deal effectively with emergency situations that range from minor to catastrophic.
- Local resources will be used to respond to emergency situations and, if needed, requests will be made for external assistance from other jurisdictions or from the state pursuant to inter-local agreements. Because it takes time to summon external assistance, it is essential for the local jurisdiction to be prepared to carry out an initial emergency response independently.
- CMOC objectives will be identified by the requesting entity's incident or unified command, except where state or federal law provides that a state or federal agency must take charge.
- Effective direction and control requires suitable agencies, equipment, guidelines, and trained personnel.

[3] Healthcare agencies must request activation through their county or city OEM and the department or agency requesting activation retains fiscal responsibility for the activation of the CMOC.

- The initial response to a disaster or emergency situation will focus on lifesaving and injury reduction activities followed by protection of property and the environment.
- The CMOC should be ready to relocate on short notice and to stand up at alternate agencies if circumstances dictate.
- The CMOC will not necessarily be staffed with the positions listed in the organization chart. Some positions may be activated but may operate from an alternate location that allows them to operate more effectively.

CMOC Activation

The following actions are intended to be general and not comprehensive. Each incident or request for action may vary in nature. These steps should provide the foundational steps for further development of this standard operating procedure (SOP).

The following steps outline the CMOC activation from request to initial operations:

- The requestor establishes the need for medical coordination and/or support based on an emergent or existing situation.
- Notify SETRAC on-call duty officer at 281.822.4444 to request medical resources and/or support services.
- The SETRAC determines CMOC activation level required based on information provided by the requestor and identifies/activates appropriate staffing levels.
- Activated personnel will report to the CMOC or field location, as designated.
- If not already established, the CMOC will work with the regional administrator to establish an incident in WebEOC.

CMOC Readiness Levels

Depending on the size and severity of the incident, CMOC planners have also developed the following designations for readiness (staffing, operations, and possible activating situations are described in Table 4).

Level 1: Full Activation

During an actual occurrence, the CMOC will implement actions to accomplish task assignments in accordance with applicable operational procedures. At this time, notification will be issued to the healthcare agencies throughout the region that CMOC is operational. If the scope of the emergency expands to the point that agencies within the region have exhausted or are depleting internal response assets, the CMOC will assist with coordination of requests with the following agencies: local fire, law enforcement, EMS, public health, city and/or county emergency management offices, the Texas Department of Public Safety (DPS), Texas Division of Emergency Management (TDEM), the Texas Disaster District Committee (DDC), Texas Department of State Health Services (DSHS), the Federal Emergency Management Agency (FEMA), or other applicable agency.

Level 2: Partial Activation

When an emergency is imminent, all applicable protective action plans and procedures will be activated. This includes opening the CMOC as requested and implementing notification to healthcare agencies throughout the region. A process is in place for reporting ongoing incidents and assessing current factors and resources.

Level 3: Normal Operations

During normal conditions, primary emphasis will focus on awareness, readiness (i.e., planning, information, training, and exercising), and education. In addition, staff should complete training that is germane to applicable response activities. The agencies should conduct at least one annual exercise that includes testing disaster response with regional, city, and/or county agencies.

Table 4: Activation Levels and Support Examples[4]

	Level 1: Full Activation	Level 2: Partial Activation	Level 3: Normal Operations
Staffing	All positions in the CMOC will be staffed including liaisons and field operations	The CMOC Operations Chief and other positions (including liaisons and field operations), as required, will be staffed	SETRAC staff remain on call.
Operations	Ground operations, strike teams, task forces, and other resources will be activated	Resources readied; requested as needed	Normal daily operations; some resource requests can occur without an activation
Situation Example	Hurricane in Gulf of Mexico; terrorist attack resulting in a significant number of casualties	Including virtual activation, Significant weather affecting medical agencies; High Consequence Infectious Disease (HCID), localized mass casualty incident. Localized incident that could expand into a mass casualty situation or a special event, e.g., Super Bowl, Final Four	IV/supply shortages, MCI notifications, EMS coordination, and internal healthcare agency disaster not necessitating evacuation.

[4] Each situation requiring CMOC activation is different and needs will be evaluated individually by the CMOC Operations Chief on call. This table merely provides a scaled framework to assist in determining activation options.

Appendix B: Demobilization Standard Operating Procedure

Introduction

This standard operating procedure (SOP) outlines the general roles and responsibilities, critical assumptions, organizational chart, general tasks to be performed, and authorities and references that can be used for demobilization of the Catastrophic Medical Operations Center (CMOC).

Roles and Responsibilities

The Logistics Branch Director will facilitate all resource releases from the CMOC after obtaining the concurrence of the CMOC Operations Chief. All resources assigned by the CMOC will be held at their respective operating center or staging areas during the time it takes to process them through the demobilization process.

No resources are to leave the CMOC or staging areas until authorized to do so. The Logistics Branch Director will coordinate with the EMS/Transportation Branch to provide ground transportation of released personnel and equipment. The Finance, Administration, and Documentation Branch Director (e.g. reimbursement packets, etc.)

Resource Demobilization

- Resources will not leave staging area(s) until authorized.
- No personnel will be released without having a minimum of 8 hours off shift, unless specifically approved by the CMOC Operations Chief.
- All resources must be able to arrive at their home base prior to 2200 (10 p.m.) unless specifically approved by the Incident Commander at each respective incident site.
- All assigned personnel will be briefed prior to leaving the CMOC.
- The EMS/Transportation and Finance, Administration, and Documentation Branch Director will be notified as soon as possible when surplus resources are to be deactivated.
- The Incident Action Plan (IAP) for the CMOC will include notifications regarding resources being deactivated or reassigned.
- Branch Directors are responsible for determining when assigned resources become surplus resources and for submitting tentative release lists to the Logistics Branch Director 12 to 24 hours prior to the estimated release date and time.

CMOC Demobilization

A Demobilization Plan is developed and approved by the CMOC Operations Chief and the requesting jurisdiction/entity. Once approved, the following steps should be used as a guide for a smooth demobilization process for all medical resources in the region:

- The CMOC Operations Chief reviews and approves the CMOC demobilization plan.
- CMOC notifies staff, field personnel, and staging regarding tentative and final asset releases.
- The Staging and EMS/Transportation branches make sure all signatures are obtained and required documentation (e.g. ICS 221 Demob checklist) is submitted for demobilizing CMOC controlled assets in staging areas.
- The CMOC Operations Chief monitors the demobilization process of the CMOC staff, field personnel, and field assets and makes necessary adjustments to the process.
- The Logistics and Communications Branch Director ensures that nonexpendable property items are returned or accounted for prior to release.
- With oversight from the EMS/Transportation Branch and the Ambulance Staging Manager ensures vehicles receive a safety check prior to leaving the incident or staging area. Any deficiencies must be corrected before release of the asset.
- The Logistics and Communications Branch Director coordinates with staff and field operations to ensure all communications equipment is returned and accounted for.
- The Finance, Administration, and Documentation Branch Director ensures all personnel have returned to home base, all time sheets, ICS 214s, demobilization orders/packets and expenditures have been submitted for approval, and all purchase orders and task lists have been completed, canceled, or closed out.
- The Finance, Administration, and Documentation Branch Director is responsible for collecting all CMOC generated documents (e.g. notes, positions logs, P.O.s, STAR forms, etc.) and ensure safe storage, as required by government standard/statute.

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Appendix C: CMOC 213 Form Examples

EXAMPLE (Facility Request)

CMOC 213 - GENERAL MESSAGE – EVACUATION/REPOPULATION		
TO: CMOC	POSITION: Transportation	
FROM: Sacred Heart Nursing Home	POSITION: DON	
MISSION: Facility evacuation	DATE: 01/01/2020	TIME: 0900

MESSAGE:

From: Sacred Heart Nursing Home
Address: 123 Bluebell Road
City, Texas 77000
POC: Sister Jones – 281-555-1212

To: CareWell Nursing Home
Address: 123 Angel Hwy
Far Away City, Texas 77001
POC: Jim Smith – 832-555-1212

Date/time Entered and Mission Number:	Signature:
01/01/2020 0900 Mission number E486	My name

Name(s), age, diagnosis/complaint/transport type:

27 patients to be transported at 1700 1/1/2010
MANIFEST ATTACHED – all patients can go directly to their assigned rooms.

DATE/TIME:	UPDATES:	SIGNATURE:
01/01/2020 1300	Remove Jim Jones from transport list – family picked him up	Name

EXAMPLE (Individual Request)

CMOC 213 - GENERAL MESSAGE – EVACUATION/REPOPULATION			
TO: CMOC		POSITION: Transportation	
FROM: Texas County OEM		POSITION: EMC	
SUBJECT: Individual evacuation		DATE: 01/01/2020	TIME: 0900
MESSAGE:			
From: Home Address: 123 Bluebell Road City, Texas 77000 POC: Sister Jones – 281-555-1212 To: Medical Shelter 1 Address: 123 Angel Hwy City, Texas 77001 POC: Chief Smith – 832-555-1212			
Date/time Entered and Mission Number: 01/01/2020 0900 Mission number E486		Signature: My name	
Name(s), age, diagnosis/complaint/transport type:			
James Jones – 87 y/o bedridden, on vent			
DATE/TIME:	UPDATES:		SIGNATURE:

CMOC 213 - GENERAL MESSAGE – EVACUATION/REPOPULATION		
TO:	POSITION:	
FROM:	POSITION:	
SUBJECT:	DATE:	TIME:
MESSAGE:		
From: Address: POC: To: Address: POC:		
Date/time Entered and Mission Number:	Signature:	
Name(s), age, diagnosis/complaint/transport type:		
DATE/TIME:	UPDATES:	SIGNATURE:

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Attachment 1: Regional Plan One-Pager

Catastrophic Medical Operation Center Plan (CMOC) And Associated Attachments

Plan Purpose

This plan provides guidelines for preparation, response, coordination, and recovery of medical infrastructure and components within the region. This plan has associated attachments that include the process for rapidly activating, coordinating, and mobilizing EMS resources throughout the region, as well as, coordinating regional emergency medical response to large-scale, no-notice incident(s).

Plan Owner

Owner: Southeast Texas Regional Advisory Council
Last Revised: January 2019
Contact: Lori Upton
Email: lori.upton@setrac.org
Phone: (281) 822-4450

Plan Triggers

1. When a scheduled event, natural disaster, or human-caused incident requires a coordinated whole-community medical response.
2. When the local jurisdiction affected has exceeded its capability and exhausted local mutual aid in response to a mass casualty incident and/or has few resources available.
3. When a single or multiple jurisdictions have been affected by an incident (e.g., IED) or multiple incident sites requiring coordinated emergency medical response.

Plan Activation

The CMOC may be activated by a number of agencies, including the Department of State Health Services (DSHS), Texas Division of Emergency Management (TDEM), and county or city offices of emergency management by calling the SETRAC 24/7 duty officer at (281) 822-4444.

Recommended Partners to Consider

Local (City/County)	Regional/State	Emergency Support Functions (Federal)
Texas Medical Center Healthcare Organizations Hospitals Public Health Departments Emergency Management Emergency Medical Services Fire Departments Law Enforcement Local Government Non-Governmental Organizations Non-Profit Organizations	Medical Reserve Corps Southeast Texas Regional Advisory Council Houston Galveston Area Council Texas Department of State Health Services Texas Division of Emergency Management Texas Department of Public Safety Texas Health and Human Services Texas Department of Assistive and Rehabilitative Services Texas State National Guard	☒ 1- Transportation ☒ 2- Communications ☒ 3-Public Works/Engineering ☒ 4-Firefighting ☒ 5-Info./Planning ☒ 6-Mass Care/Housing ☒ 7-Logistics/Resource Support ☒ 8-Public Health/Medical ☒ 9-Search And Rescue ☒ 10-Oil/HazMat Response ☐ 11- Agri/Natural Resources ☒ 12-Energy ☒ 13- Public Safety/Security ☒ 14- Long-Term Recovery ☐ 15- External Affairs

This plan can be accessed at: https://www.HoustonUASI.com

Catastrophic Medical Operation Center

- Medical resource requests and coordination
- Hospital Assessments
- Ambulance/EMS Coordination
- Patient Distribution/Tracking
- Highly Contagious Infectious Disease (HCID) transport
- Emergency Medical Task Force (EMTF) SOGs
- Hospital Medical Counter Measure Distribution
- Healthcare protocols & templates
- Medical Surge Management

Regional Epidemiology Coordination Plan	Outbreak surveillance and investigations; Laboratory testing, analysis, and results; HIPAA sharing between hospitals and epi; Distributing information to the public.
Regional Emergency Public Information Plan	Joint Information Center (JIC) activation; Coordinate public information across jurisdictions
Regional Search & Rescue	Coordinated SAR response. Examples: (Air, water, ground SAR)
Regional Mass Fatality	Victim accounting; Victim Identification; Fatality site management; Family Reception Center (FRC); Family Assistance Center (FAC); Morgue Operations; Human Remains
Regional Wildfire	Wildland/urban interface fires; Resource management and sharing protocols; Unified Command.
Texas Medical Center Response Guide	Staffing and Response Guidance
Coordination of Multiple Incident Sites	Multi-jurisdictional Unified Command (UC); Scene coordination and investigation between local, state, and federal partners.
Regional Interoperable Communications	Formal Network Operation Center notification; Multi-jurisdictional Radio Interoperability.
Regional Public Health Coordination	Regional Public Health Strategic Advisory Group (RPHSAG); Local Health Authority (LHA) / Local Health Department (LHD) recommendations for Strategic National Stockpile (SNS) Points of Dispensing (PODs); Alternate Care Sites (ACSs), and crisis standards of care.
Multi-Agency Coordination Center	Non-medical resource and mutual aid coordination; Multi-jurisdictional situational awareness.
City/County	When local resources are strained or exhausted any regional, state, and/or federal plans may be integrated to assist with the response.
State/Federal	There are Emergency Support Functions that may be integrated to assist with the response.

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Attachment 2: EMTF 6 Standard Operating Guidelines

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Attachment 3: Regional Emergency Medical Response ConOps

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Attachment 4: Regional Information Sharing Protocols

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Attachment 5: Healthcare Recovery Assessment

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Attachment 6: Hospital MCM Distribution Plan

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Attachment 7: Regional Ebola Transportation Ambulance Plan

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Attachment 8: Placeholder

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Attachment 9: Placeholder

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Attachment 10: Placeholder

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Emergency Medical Task Force Region 6

Standard Operating Guideline

Intra-regional response

SETRAC
11/01/2018

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The opinions, findings, and conclusions or recommendations expressed in this publication are those of the authors and do not necessarily reflect the views of the U.S. Department of Homeland Security, the Governor's Texas Division of Emergency Management, or any individual jurisdiction within the 25-county EMTF-6 region.

Implementation of this EMTF6 Regional SOG is coordinated by SETRAC.

For more information, call 281-822-4444.

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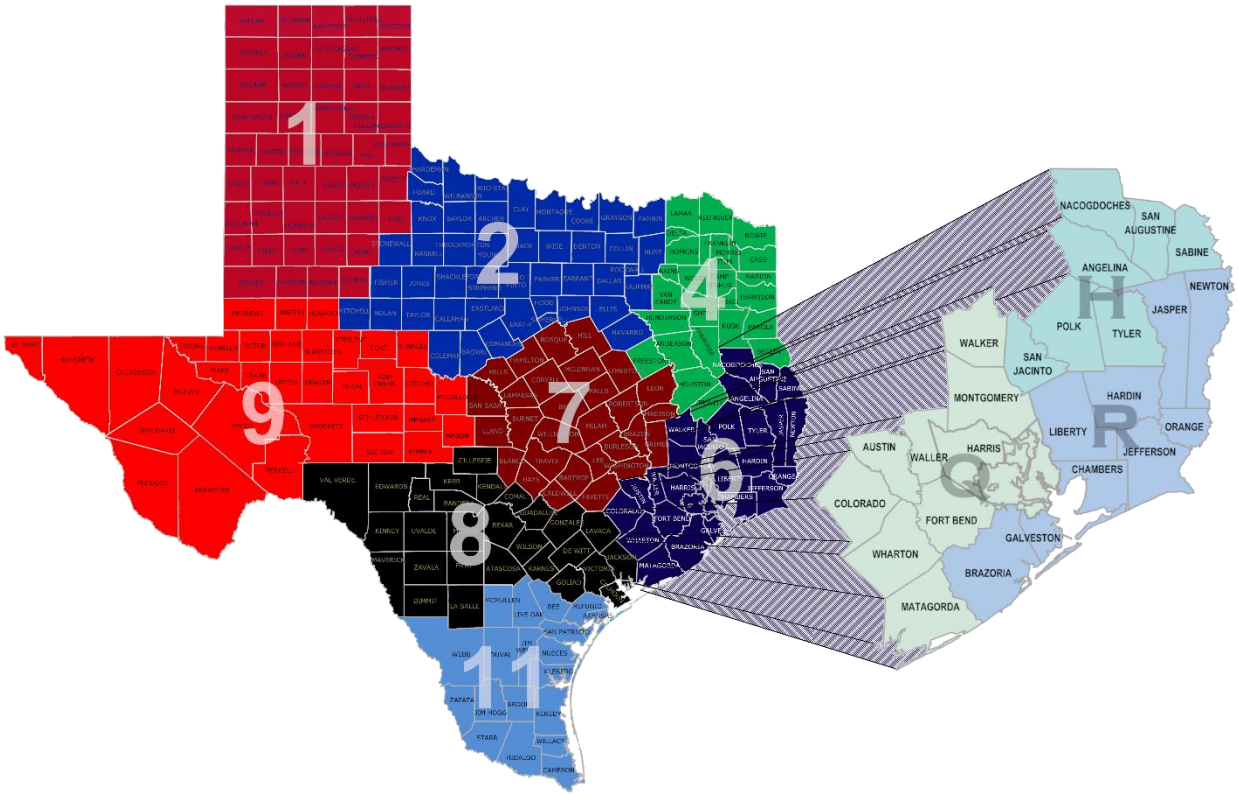
EMTF-6 Intra-Regional Deployment Operations

Scope

This Standard Operating Guideline (SOG) addresses the intra-regional, one or two operational period (<24 hours) mission profile for the Region 6 Emergency Medical Task Force (EMTF). Not addressed in this document is the extra-regional and/or multi-operational period mission profile.

The footprint supported by this plan is presented in Figure 1. The map in Figure 1 shows the 25 counties included in the EMTF-6 region. Nine of the counties are within TSA-Q; nine of the counties are within TSA-R; seven of the counties are within TSA-H.

Figure 1: EMTF-6 Region



Purpose

The EMTF-6 Regional SOG focuses exclusively on regional support and coordination for activation, notification, mobilization and deployment of regional medical resources.

This SOG is designed to provide guidelines for the resource response, incident management team structure and oversight, communications, and logistical support for each of the subcomponents of the EMTF, including Ambulance Strike Teams (AST), Nurse Strike Teams (RNST), AMBUS, Mobile Medical Unit (MMU), Ambulance Staging Management Teams (ASMT), Medical Incident Support Teams (MIST), and the Infectious Disease Response Unit (IDRU) team across the twenty-five counties of the EMTF of region six (6). Support Services for the TMORT and IDRU teams, still in a germinal stage, will be better

identified and included in future versions of this document. These strategies are developed to support local and regional jurisdictions and entities, as well as the Texas Department of State Health Services (DSHS) during large scale medical emergencies, evacuations, and other public health threats.

The intended audience for this SOG includes governmental and emergency response representatives from the 25 counties and various large cities within the EMTF-6 region the Catastrophic Medical Operations Center serves, non-governmental and private sector representatives, state governmental and emergency response representatives, and federal government representatives.

The EMTF-6 Regional SOG's primary purpose is to describe the process for rapidly activating and mobilizing medical resources throughout the region in response to large-scale events or incidents. The SOG is scalable and flexible and may be adapted to address the specific characteristics of the incident or jurisdiction affected.

The SOG does not supersede or exclude any existing jurisdictional or regional plans; rather, it places relevant plans in the context of a response to an incident within the region, during which time a series of regional plans (including Catastrophic Medical Operations, Multi-Agency Coordination) are activated. More specifically, it does not address local procedures for:

- Incident Command (IC)
- Local response activities
- Established mutual aid relationships and procedures at the local level
- Joint information and messaging through the Joint Information System (JIS)/Joint Information Center (JIC)
- Tactical operations on scene, including patient triage and transport, HAZMAT, and mass fatality management

Regional emergency medical response objectives:

- Obtain situational awareness of the event to deploy resources into the affected area

  The AHJ should initiate triage (S.T.A.R.T. is the standardized regional triage system)

  Join the developing IC structure at each incident site

  Notify area hospitals via EMResource.

  Implement EmTrack, the regional patient tracking system using appropriate technologies throughout the disaster continuum

  Transfer victims from search and rescue collection points to the triage area

  Identify routes of ingress and egress and establish staging areas for EMS units

  Implement and maintain accountability procedures for EMS personnel, equipment, and supplies.

  Coordinate with the CMOC for transfer from the treatment area to an appropriate health care facility based on capability and capacity

  Maintain visibility on the results from hazardous materials assessments.

- Establish an IC structure at health care facilities and redundant communications with the CMOC

  Identify hospital surge and morgue capacity

  Establish the linkage between law enforcement and medical care for the gathering of evidence and investigation

  Establish the demobilization process

Mission

The purpose of the Emergency Medical Task Force (EMTF) is to build alternate care capacity with an acute care medical focus, such as emergency medical transport, hospital surge staffing, and mobile medical units that could be deployed during a large mass-casualty event, significant regional incident, statewide disaster, a pandemic response or any other event that requires surge capacity and capability to augment the local or regional response by the healthcare delivery system.

The EMTF is structured as eight regions across Texas; region 6 comprises the following twenty-five counties: Angelina, Nacogdoches, Polk, Sabine, San Augustine, San Jacinto, Tyler, Brazoria, Chambers, Galveston, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Austin, Colorado, Fort Bend, Harris, Matagorda, Montgomery, Walker, Waller, and Wharton. The EMTF-6 comprises TSAs H, R, and Q.

- The EMTF MMU Component is to augment and support the needs of an impacted community with temporary healthcare infrastructure configured to the incident occurring.
- The EMTF AMBUS Component is to provide the capability for mass transportation and/or care to the sick and/or injured as well as responders across a variety of incidents that may threaten the health and safety of Texans and others.
- The EMTF Ambulance Strike Team Component is to provide supplemental medical transportation during large-scale patient movements or other special circumstances.
- The EMTF R.N. Strike Team component is to augment staffing of a hospital(s) in an affected jurisdiction.
- The EMTF IDRU (Infectious Disease Response Unit) is a team of Texas-credentialed, uniquely trained clinicians that, upon request, deploy to supplement the pre-hospital transport and care, as well as the in-hospital patient care of a patient experiencing a high consequence infectious disease (HCID).
- The MUR-C (Medical Unit Rehab Crew) is a highly trained Paramedic medical crew dedicated to the health and wellbeing of all incident responders, complete with a pharmacy cache, suturing and emergency dental capabilities, and prescription writing authority.
- The TMORT (Texas Mass Fatality Operations Response Team) is currently under development.

Critical Assumptions

To ensure consistency this SOG makes the following assumptions:

1. This document is to be considered a living document which may be updated from time to time as new information becomes available. The most current copy will be maintained by the EMTF-6 Coordinator and will be kept by the Southeast Texas Regional Advisory Council (SETRAC) and will be posted on the SETRAC website.
2. The term “region” or “regions” will be utilized throughout this document and refers to the EMTF regions as defined by the state. Instances where this does not apply will be noted as such.
3. The EMTF-6 response and operations will operate within the parameters set forth by SETRAC, in conjunction with the Catastrophic Medical Operations Center (CMOC).
4. The EMTF-6 teams will not “self-dispatch” or freelance. The EMTF-6 teams will activate upon the appropriate request from authorized personnel.
5. The EMTF-6 has identified, partnered with, and trained a public safety communications center with 24/7 operations, regarding EMTF-6’s deployment package. This center is Cypress Creek EMS Communications Center and will be referred to as the “Regional Communication Center” or “RCC”.
6. EMTF-6 has a primary contact phone number (281)822-4444), answerable 24/7, that has been publicized to the Regional and State’s disaster response entities, including but not limited to: DSHS, DDC, TDEM, OEMs, etc.
7. EMTF-6 has identified and implemented systems or technologies with redundancies, designed for the notification of deployment team members, from all participating agencies.
8. This EMTF-6 Team is developed and used in conjunction with local and county emergency management, hospital facilities, pre-hospital agencies, fire and law enforcement departments, industry, public health offices and/or other agencies with responsibility and authority for the incident.

9. Homeland Security Presidential Directive-5 (HSPD-5) provides a National Incident Management System (NIMS) through which all incident response agencies and assets are to be integrated and coordinated. EMTF-6 teams will be integrated into the Incident Command System (ICS) structure implemented by the requesting Authority Having Jurisdiction (AHJ).
10. Local and regional resources will be exhausted before requesting state and/or federal assistance. This SOG will be activated during the regional request phase of the process.
11. Regional response assets will be available immediately, but scene reporting times will vary depending upon location.
12. EMTF-6 will have pre-identified Emergency Medical Services (EMS) agencies for deployment as part of the EMTF's Ambulance Strike Team component.
13. Each Ambulance shall be licensed as an Ambulance by the Department of State Health Services to become a deployable asset and must maintain the license to remain deployable.
14. EMTF-6 will have executed appropriate MOA's with partnering agencies and personnel to allow for a State tasked mission.
15. Members of the R.N. Strike Team will be working in customary and familiar clinical environments.
16. The Sponsoring Entity shall continue to assume legal and financial responsibility of the personnel and equipment for the duration of activation or deployment.
17. Sponsoring Entity shall ensure that all personnel meet all licensing, training and certification requirements related to his/her particular profession and/or mission.
18. Sponsoring Entity shall ensure that all personnel are actively employed and engaged in the clinical specialty which they are assigned within the team.

Safety

All EMTF activities involve variables and unknowns which may have a substantial impact on the health and welfare of staff members. These potential risks require frequent identification, assessment, analysis, and planning to minimize their impact. Risks should be assessed based on the likelihood of occurrence and potential severity. When appropriate, a qualified person may fill the role of Safety Officer.

A survey should be conducted to determine basic needs (e.g., sleep/rest, food, and mental health support), as well as ensure post-incident medical monitoring of first responders. Consider critical incident stress management (CISM) teams, if applicable.

Requests for police escort during regional Convoy Operations should be submitted to the CMOC via the proper channels, who will work with the Authority Having Jurisdiction (AHJ) to provide the resource, if possible.

Command Operations

It is beyond the scope of this document to address all operational concerns of resources deployed as part of EMTF. However, the following general guidelines can be assumed to apply in most deployments.

Command Operations should be documented on appropriate ICS forms available if unable to utilize WebEOC. A 214 (unit log) should be completed by each unit for each operational period and provided

to the team leader. The team leader should also complete a 214 (unit log) for each operational period and submit is as a summary to the CMOC.

EMTF-6 Teams will follow an appropriate incident command system structure. Intervening levels of command may be inserted as incident scope affects the span of control. See Appendix D for a sample EMTF-6 and FEMA
ICS Organizational Chart.

As a part of any deployment, EMTF-6 team members should be prepared to perform a variety of missions, both in and out of the scope of normal daily operations. Concerns related to assigned missions should be forwarded to the team leader. At all times, it is the intention of the EMTF to "Be Helpful, Be Nice" in all interactions with the public as well as fellow responders and affected region stakeholders.

Logistical Support

Each of the components of the EMTF may have a support systems package which supports their respective missions. The supplies, equipment, staffing, and other provisions should be determined in advance, including Ambulance Staging Managers, CMOC Liaisons, Task Force Leaders, Ambulance Strike Team Leaders, Medical Incident Support Teams and appropriate SETRAC personnel.

Communications Support

Each of the components of the EMTF may have a communications package which supports their respective missions. The interoperable communication equipment and redundant systems have been determined in advance and can be adjusted during the incident.

The leadership assigned during each mission shall ensure that SETRAC personnel and EMTF6 teams have the communication support needed and will work with local, regional, and state agencies or Medical Operation Centers to satisfy additional needs or gaps during a regional response. See "Appendix E" for additional interoperable communications channels from the Texas Statewide Interoperability Channel Plan.

Table 2: EMTF-6 Default ICS-205

INCIDENT RADIO COMMUNICATIONS PLAN (ICS 205)

1. Incident Name:	2. Date/Time Prepared:	3. Operational Period:
SETRAC / EMTF6 Generic	Date:	Date From: *12/1/14* Date To: *12/1/15*
	Time:	Time From: *8:00* Time To: *17:00*

4. Basic Radio Channel Use:

Zone Grp.	Ch #	Function	Name/Trunked Radio System Talkgroup	Assignment (Div/Group/etc.)	RX Freq N or W	RX Tone/NAC	TX Freq N or W	TX Tone/NAC	Mode (A, D, or M)	Remarks
		Command	*VTAC14**		*159.4725*	*CSQ*	*159.4735*	*156.7*	*A*	
		Support/Logs	*VTAC12**		*154.4525*	*CSQ*	*154.4525*	*156.7*	*A*	
		Staging	*VTAC13**		*158.7375*	*CSQ*	*158.7375*	*156.7*	*A*	
		Travel	*VMED29**		*155.3475*	*CSQ*	*155.3475*	*156.7*	*A*	
		Air to Ground	*VFIRE25**		*154.2875*	*CSQ*	*154.2875*	*156.7*	*A*	
		MMU Clinical	*VTAC 11**		*151.1375*	*CSQ*	*151.1375*	*156.7*	*A*	
		MMU Logistics	*VTAC 12**		*154.4525*	*CSQ*	*154.4525*	*156.7*	*A*	
		MMU Pt Reports	*VMED 28**		*155.34*	*CSQ*	*155.34*	*156.7*	*A*	
		Security	*VLAW31**		*155.475*	*CSQ*	*155.475*	*156.7*	*A*	
		Fire	*VFIRE24**		*154.2725*	*CSQ*	*154.2725*	*156.7*	*A*	
		Travel	*MSAT/SETRAC1*							
		CypressCreek	*MSAT/Interagency*							

5. Special Instructions:

This 205 has been created as a "Generic" starting point if you do not have a Communications Plan at the start of an EMTF Incident (Primarily for an MMU activation).

****CMOC1,CMOC2, CMOC3, CMOC4, CMOC5, CMOC6 or CMOC Command 800mHx channels may be substituted, as necessary.***

SETRAC's communications resources include:

- Regional Communications Vehicle (RCV-Q)
- Mobile Communications Center (MCC-602 & MCC-603)
- Cache of Motorola CM-200 Mobile VHF radios
- Cache of Puxing Portable VHF radios
- Cache of Motorola XTS2500 Portable 800mHz radios
- Cache of Motorola APX6000 Portable 800mHz radios
- Cache of M-SAT (mobile satellite) push-to-talk units
- Internet Mi-Fi units
- VSAT units
- Motorola WAVE (in development)

Mutual Aid

"Texas Government Code Sec. 418.1181 - REIMBURSEMENT OF COSTS: REQUEST BY LOCAL GOVERNMENT ENTITY. (a) If a local government entity requests mutual aid assistance from another local government entity under the system that requires a response that exceeds 12 consecutive hours, the requesting local government entity shall reimburse the actual costs of providing mutual aid assistance to the responding local government entity, including costs for personnel, operation and maintenance of equipment, damaged equipment, food, lodging, and transportation, incurred by the responding local government entity in response to a request for reimbursement. Local government

entities with a mutual aid agreement when the request for mutual aid assistance is made are subject to the agreement's terms of reimbursement, as provided by Section 418.111.

(b) The requesting local government entity shall pay the reimbursement from available funds. If federal money is available to pay costs associated with the provision of mutual aid assistance, the requesting local government entity shall make the claim for the eligible costs of the responding local government entity on the requesting entity's subgrant application and shall disburse the federal share of the money to the responding local government entity, with sufficient local funds to cover the actual costs of the responding local government entity in providing assistance."

The EMTF6 SOG does not supersede or exclude any existing jurisdictional or regional plans or agreements.

Operational Support

The EMTF-6 is a regional asset under the SETRAC / CMOC, and as such the support and operations of any or all of the four EMTF components during activation will be provided under SETRAC/CMOC mission assignment. The following general guidelines can be assumed to apply in most deployments.

The teams will adhere to chain of command and will work collaboratively with the following agencies/organizations utilizing the National Incident Management System's (NIMS) chain of command.

- State Medical Operation Center (SMOC)
- Regional Mutual Aid
- Medical Operations Centers
- Public Health Regions, Local Health Authorities/Local Health Departments
- Disaster District Committees (DDCs)
- Local and County Emergency Operation Centers (EOCs)
- Incident Commanders

It may be necessary at times to "assign" a single resource or strike team under the command of either another responding agency or local jurisdiction. This neither relieves the EMTF members of their responsibility to the unit, nor does it remove the resource or strike team from the regional chain of command. Rather, it is an opportunity for close cooperation between the two entities in order to accomplish locally significant missions.

All other operational concerns and questions should be forwarded to the appropriate person in the SETRAC/CMOC Command structure.

Command and Control

EMTF-6 is first and foremost a local/regional asset and must coordinate with their local EOCs and MACCs for regional deployments. The leadership for the EMTF includes command, operational, and logistical authority for the personnel and assets assigned to that EMTF for the incident.

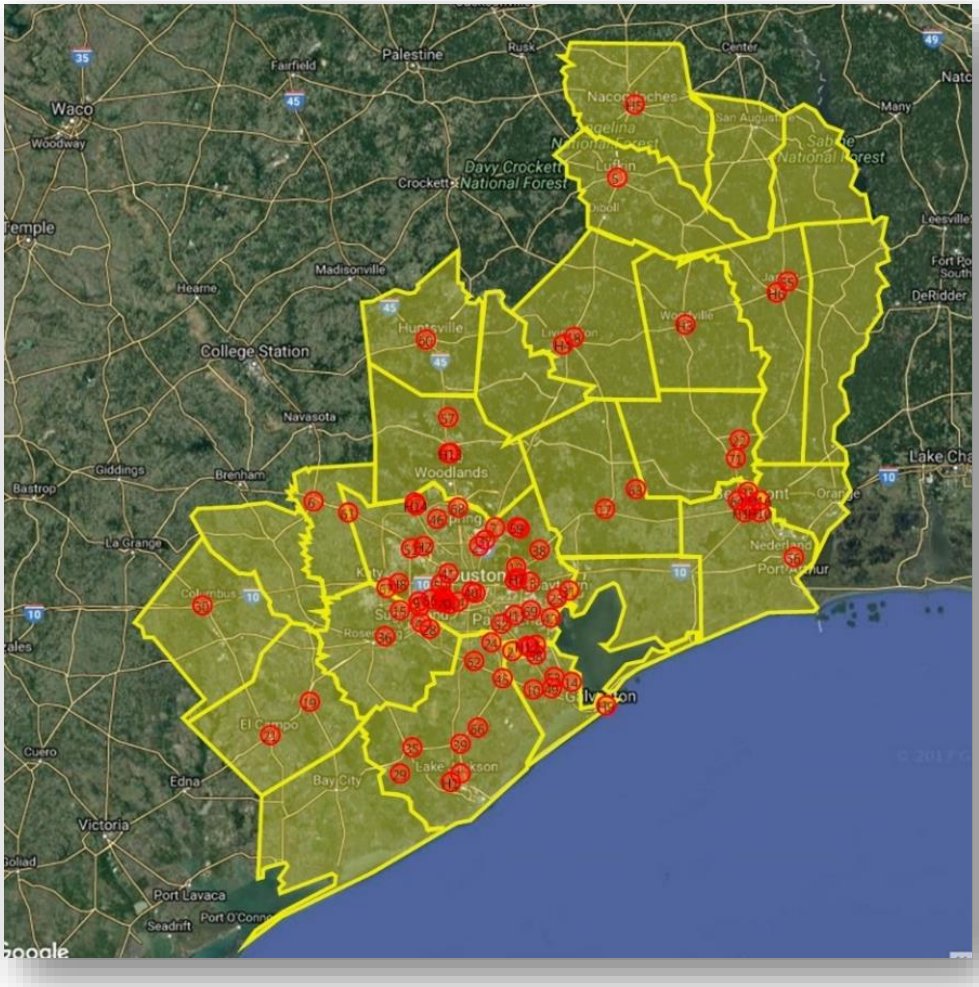
In a local event, the EMTF leadership will guarantee a unified command approach to successfully work with local jurisdictions of authority to coordinate the efforts of the EMTF teams with local responders.

In a regional tasking, the EMTF leadership understands that it is granted command, operational, and logistical authority of the EMTF at the discretion of the CMOC and the AHJ to support local, regional jurisdictions. Planning and operational decisions for the EMTF may be collaborative between the IMT, SOC, DSHS MACC, MOCs, DDCs, and/or other local responding agencies.

EMTF-6 Team Members

The EMTF-6 region has a pre-screened roster of persons agreed upon by both the sponsoring entity and the SETRAC/CMOC. EMTF-6 Region has developed a system of notification for these stakeholder agencies upon tasking from the CMOC. Following this notification, it will be the responsibility of the stakeholder agencies to activate personnel appropriate to the tasked mission. Stakeholder agencies, upon notification, are to report back to their EMTF Coordinator and/or CMOC with their personnel and asset information, current status and estimated time of arrival at their individual mustering point. The EMTF Coordinator will roster the teams so the information is available to the region. The EMTF-6 Team Application is detailed in Appendix K. See Figure 2 for EMTF-6 partnering entities, as of Dec 2016.

Figure 2: 2016 EMTF-6 MOA Entities



Activation

When the need for a regional mass casualty response is apparent, the local Emergency Operations Center (EOC), Incident Command Post (ICP), or a designated agency representative will request the EMTF-6 teams by contacting the Regional Communications Center (Cypress Creek EMS Communications Center / RCC) at (281)822-4444. The RCC will then notify the SETRAC/CMOC On-Call Duty Officer of the situation. The Duty Officer will notify appropriate SETRAC leadership, elevating the CMOC activation level, as needed.

The individual contacting the RCC to request EMTF-6 teams should be prepared to provide the following information:

- Incident type
- Incident location
- Estimated number of patients
- Complicating factors
- Resource requirements
- Staging area information
- IC/Point of Contact

Having this information will allow staff to determine what level of response is required. The following recommendations do not supersede local jurisdictional/agency mass casualty plans for additional resources. The SETRAC/CMOC on-call duty officer will consider requesting resources using the following MCI Levels:

Table 2: MCI Tier Levels with Suggested Resources

MCI Level	*# Immediate/Delayed Victims*	*Minimum Resources Requested*
Level 1	10-20	1 Ambulance Strike Team (5 ambulances); 6 First Responder Personnel
Level 2	20-50	2 Ambulance Strike Teams; 15 First Responder Personnel 1 AMBUS (optional); 2 MCI Trailers (optional)
Level 3	50-100	5 Ambulance Strike Teams; 30 First Responder Personnel 2 AMBUSES; MCI Trailers (optional); SETRAC RCV-Q (optional)
Level 4	100-250	10 Ambulance Strike Teams; 50 First Responder Personnel 2 AMBUSES; MCI Trailers; SETRAC RCV-Q Mobile Medical Unit (optional)
Level 5	250+	25 Ambulance Strike Teams; 100 First Responder Personnel 2 AMBUSES; 2 MCI Trailers; SETRAC RCV-Q; Mobile Medical Unit (optional)

Incident Component Notification

When the SETRAC and/or CMOC receives a request for EMTF assistance, the CMOC will consult with EMTF Coordinator to determine the most appropriate region and component to respond to the pending request. Utilizing the technology identified by the EMTF-6 (see Appendix F), a notification will promptly be broadcasted to appropriate EMTF-6 teams.

Activation of any of the four components of EMTF may trigger the elevation of the CMOC. EMTF-6 should pre-identify persons that are qualified to assume an EMTF leadership role. Other individuals that may be rostered for these leadership roles will be organized and activated through the CMOC.

The CMOC may assign specific EMTF leadership roles to the individuals that respond to the call out process.

Notification

A call for the EMTF team activation may lead to immediate mass-messaging sent through a Mass Notification System (i.e. SmartNotice; see Appendix F). SmartNotice is a mass notification internet-based program that will send and receive time-sensitive messages to a home, business, cell phone, email, hearing impaired devices or by text message. The notifications will adhere to the notification terminology detailed in Table 2.

Table 3: Notification Terminology

NAME	*ACTION*	*FISCAL IMPACT*	*SMA#? (state mission assignment)*
Awareness	Tell team members and staff that there is a possible incident that has occurred, Information only. No action requested.	NONE	NO
Standby	EMTF Coordinators will check availability of resources and may initiate conference calls.	NONE	NO
Alert	A request or the possibility of request for EMTF resources is imminent. The CMOC or SMOC will be responsible for Alert initiation. We will place names of team members in team member slots, EMTF resources should be ready for deployment, rental trucks rented, warehouse and other team leadership activated.	Yes, probably <$10,000.00 4 Suburbans $100.00/day 1 box truck $100.00 /day 10 personnel $40.00/per hour	YES
Activation	Call in all team personnel and necessary coordination center personnel. Deployment of personnel/assets through demobilization	YES, TBD by scope and typing	YES

Incident Report notification

The initial notification will be brief, informative and will provide situational awareness to the EMTF-6 throughout the region. The message can be developed using information provided by the responder on-scene and contains a description about what type of incident has occurred, where it occurred, and approximately how many immediate and delayed patients are present. The initial message serves as an alert to agencies throughout the region and gives leadership a chance to gauge readiness levels while the need for specific resources becomes apparent. The message will instruct recipients to stand by for additional messages containing specific resource requests.

The Incident Report may be sent to all agencies in the CMOC Region, regardless of whether they will be required to respond. In addition to fire and EMS agencies, message recipients may include Emergency Management personnel, CMOC command representatives, RACS Q, H, R and other partners that could participate in an expanding incident and response.

Resource Request notification(s)

The second notification sent should contain specific information about what resources are needed for incident response. Staff member(s) sending Resource Needs notification should work with applicable personnel to ensure that resource types and quantities are requested clearly and appropriately.

The RCC may utilize the mass notification polling function to identify the availability for assets. Upon receipt of the message, agencies can respond both affirmatively or negatively with their ability to send resources to the incident. Polling results will determine the need for additional mass notification requests.

Response to Resource Request notifications

EMTF-6 teams should follow the appropriate procedure to acknowledge the receipt of the mass-notification. EMTF-6 teams should provide their availability at (url) http://roster.setrac.org, or as otherwise directed by the notification message.

The decision of when to inform and request EMS personnel for regional response lies with individual response agencies. Some may choose to notify staff immediately, while others await confirmation of the exact quantity of personnel and equipment required.

Incident Update notification

The Incident Update notification provides a brief summary of developments that have occurred since the initial notification and may include clarifying facts or situational awareness relevant to first responders throughout the region. Additionally, the Incident Update should include a report on resource needs and the level to which requests have been fulfilled. After reading the Incident Update, recipients should have an indication of whether to stay on standby for potential mobilization and deployment.

Mobilization

EMTF-6 team mobilization[1] takes place at individual agencies. Though agencies belong to Strike Teams and are summoned accordingly, they do not physically meet with Strike Team partners before moving to the incident staging area. As soon as response staff and equipment are ready and given clearance by their agency, they mobilize to the staging area and report to local Incident/Unified Command. A "Level-3", regional resource staging area may be utilized, if appropriate. It is the goal of the EMTF to be an agile, rapid response force dedicated to the public health and safety of the citizens of the EMTF-6 region and Texas. In the following sections, timely, efficient, modular and prepackaged activations and deployments are the goal of the EMTF.

No contractual obligation or alteration of other contractual documents is implied by the following EMTF deployment time goals.

Mustering

EMTF-6 teams may utilize predetermined or ad hoc mustering points which will be determined upon activation. These sites are *not* considered base camps, rather a common meeting area for final deployment tasks to be completed. Geographical diversity is suggested to ensure the site selected by the team leader is in the direction of the deployment. EMTF teams may wish to select sites that are lit and allow overnight parking which is secured for cases where team members have arrived in their personal vehicles at the mustering point. This deployment model is, for various reasons, not ideal but may be the best option in some regions.

Once released from the mustering point, the team leader will be responsible for ensuring his assigned units arrive at the deployment staging area.

Travel

Travel by the EMTF will be accomplished in convoy style. The make-up of the EMTF convoy will be at the discretion of the team leader. Members should be aware that they may travel with mobile assets that have different performance profiles and may need to adjust their driving habits as a result. The key to safety in convoy is communication; the convoy team will maintain radio communications and, preferably, an activated GPS tracking app. The route to the deployment area will be at the discretion of the team leader, working in cooperation with in theatre and CMOC.

Teams should anticipate efficient travel. Stops for non-mission essential reasons are discouraged and should be at the discretion of the team leader. Units should travel at the best, safe speed of the slowest unit in the convoy. Road and weather safety should be considered by all.

[1] This SOG uses the term *mobilization,* rather than *deployment,* to describe the process by which resources are gathered and transported to a staging area. Under the National Incident Management System guidelines (NIMS), mobilization is defined as "the process and procedures used by all organizations – Federal, State, local, and tribal – for activating, assembling, and *transporting* all resources that have been requested to respond to or support an incident." - FEMA, *NIMS* (FEMA 501/Draft), 2007, p. 154.

Travel by the EMTF will be incident driven. Considering the distances, mission profile, infrastructure available in the deployment region and other factors, the EMTF-6 region may have multiple travel profiles planned. These can include but are not limited to: contingency contracts for rental vehicles, travel by air, travel with another EMTF Component (e.g., AST, AMBUS, etc.). Flexibility and an all hazard approach to planning is the recommendation for best mode of travel. If the EMTF Teams are to travel by ground, EMTF-6 may wish to plan for vehicles large enough to carry the entire team, with deployment equipment, and suitable to the deployment environment.

Individual EMTF strike teams should anticipate travel as a group and should plan to muster at a point determined when activated to ensure a coordinated arrival to the deployment as well as follow on travel and accommodations.

Demobilization

A strategy for demobilization of the regional assets should be developed at the time of mobilization. Criteria for making the determination that the asset is no longer necessary should be determined in advance. These types of determination factors may involve volume of utilization or benefit vs cost at the current time.

Demobilization may occur at the deployment staging area or regional mustering point according to the CMOC, Strike Team Leader and/or Task Force Leader's discretion. Demobilization will not occur directly from field assignments. Exceptions will be the discretion of the CMOC, Strike Team Leader and/or Task Force Leader. The Leader for each Strike Team will ensure that all persons in his/her care have a comprehensive demobilization briefing and ensure that all incident specific paperwork and forms are being completed appropriately. Travel from the deployment region during demobilization may be different than methods utilized in deployment and will be the discretion of the CMOC, Strike Team Leader and/or Task Force Leader.

The EMTF-6 region may utilize a Demobilization Checklist (Form ICS 221) for use by the Group Supervisors to ensure that appropriate documentation was completed during and after the deployment. The Demobilization process should include a "Hotwash" of observations for improvement and best practices to be included in the documentation packet submitted for reimbursement, if applicable.

R.N. Strike Team Composition

Each R.N. Strike Team will consist of five (5) licensed Registered Nurses of like specialization with one of which is designated as a Strike Team Leader. Given the operational profile of the R.N. Strike Teams, it is expected that existing technologies will provide each team with common communications between the team, other EMTF-6 components and/or the CMOC.

The composition of each team, based on specialty (ER, ICU, Medical/Surgical, Pediatric, etc.), may be limited by resources available to the EMTF-6 Region. As such, it is the guidance of this SOG that each of the R.N. Strike Teams be composed of personnel with appropriate care experience, though no rules

regarding the distribution of specialty is made. EMTF-6's distribution of specialty may be determined by resources available to the specific EMTF region.

RN's with unique specialty focus (Burn, Neurology, Neonatal, etc.) may all have high and specific value to the EMTF given the mission profile. However, due to the relative rarity and wide variety of specialties it is not the recommendation of this SOG to pre-roster entire strike teams of these personnel in the EMTF-6 region. Rather, personnel who hold these specialties may be included as Single Resources attached to the EMTF as part of the most appropriate component.

R.N. Strike Teams shall be assigned to a "like" department within a facility that is comparable, and within their skill set and competency to perform, to their specialty area.

Operations

It is beyond the scope of this document to discuss every aspect of operations as a hospital acute care provider. However, certain planning should be made clear. It is the expectation of the EMTF-6 that nurses on the R.N. Strike Team will operate as caregivers in a hospital environment familiar to them. While the working conditions and patient load are difficult to quantify in advance, it is not the intention of this EMTF component to work in austere or environmentally harsh conditions.

At the onset of operations in the deployment hospital, the R.N. Strike Team Leader should determine that facility's clinical scope for nursing staff and perform to that level, if it is within their training and competency (see Appendix G). The RNST members shall bring verifying documentation of their licensure/certifications, preferably on a digital memory device (e.g., thumbdrive).

The R.N. Strike Team Leader will be responsible for determining and communicating reporting structure for team members while on the unit, as well as command structure for personnel with regards to logistical support and assignments. The R.N. Strike Team Leader is responsible for accountability of the members of their team while either on or off duty.

Other working conditions should be consistent with those encountered in the everyday hospital environment. While 12-hour shifts are common, incidents that demand additional hospital staffing may request a member(s) of the R.N. Strike Team to work extended shifts. R.N. Strike Team members should use discretion when working longer than 12-hour periods and MUST have, at minimum, eight (8) hours of downtime within a 24-hour period.

Medical Records

Medical records will be recorded using the Host Facility's routine documentation method. In the event the RNST members are unable to use the facility's routine documentation method, the T-Sheet medical record system has been preplanned and can be put in place. Paper copies of a contact roster (patient list which include a unique identifier that could traced back to a patient but does not include HIPAA protected information) should be provided to the RNST Leader, ideally, at the end of each operational period or at least during demobilization, for all patient encounters.

The original patient care records will be maintained by the host agency.

Mobile Medical Unit

Scope of Care[2]

The following descriptions of the MMU's capability are guidelines only; no restrictions, no limitations, or promises of level of care are implied. Generally, the MMU will not have laboratory or radiology capability. In some cases, the MMU may be used for specific tasks, including:

Non-Critical Care Capability

The MMU may be used to assist in providing bed capacity for hospital relief. The staffing, supplies and equipment of an MMU result in a limited scope of care for hospital relief. The minimal scope of care includes:

- nursing care for stabilized internal medicine, trauma, orthopedic, and obstetric patients;
- medical workups and examinations;
- nursing care for special needs patients;
- ability to provide care for a variety of acuity levels while providing treatment, transfer or discharge;
- preparation for transport for patients who require transfer to hospitals;
- the MMU does not provide surgical services.

If available, the equipment and supplies may allow for resuscitative intervention if needed in individual cases.

Emergent Care Capability

The MMU may be used to assist in providing acute or emergent care level of services for hospital relief. The staffing, supplies, and equipment of an MMU must be appropriately increased to provide such intensity of care. In rare instances when staffing, supplies, and infrastructure permit, the MMU may be configured to provide emergency intervention. The scope of care for such a configuration includes:

- Administration of intravenous medications and drips;
- Minimal short-term cardiac monitoring; and
- Minimal short-term ventilator support.

Isolation Capability

The MMU may provide support to isolation operations with the capability to evaluate and hold persons suspected of being either exposed to or affected by an agent requiring isolation. The MMU, with an appropriately configured isolation cache, equipped with staff, and provided with service support facilities enables:

- Holding and segregation of persons suspected or confirmed to have illness;
- Taking of biological samples for submission to local, State or Federal laboratories;
- Short-term isolation of patients pending transfer to a hospital isolation ward;

[2] The intent of the MMU is to provide "fast track" or "urgent care" style medical care for cases with rapid disposition. Mission specific objectives will be dependent on the requesting jurisdiction and/or DSHS tasking.

Staffing Framework

Staffing of the MMU is a critical task. For the optimal standards of a 16-bed MMU, Appendix H MMU Typing Document is provided for comparison with State-Mission-Assigned MMU deployments. It is expected that for rotational purposes, each EMTF region will roster at least one team with consideration for depth when needed for extended periods of operation.

Personnel Requirements

Enormous numbers of patients seeking treatment in excess of a region's bed capacity during a disaster, for any reason, will cause healthcare facilities to fill to capacity. Available in-region staff will also be fully engaged. EMTF-6 will, as part of its deployment package, identify the team required and deployable for MMU operation.

MMU Team Skill Mix

The MMU team is staffed to maximize the use of limited staffing resources, not only to provide for an expected large quantity of patients, but also to ensure sustainability while providing the highest quality care possible given the limited resources. The team skill mix should be appropriate to adequately care for the patients in the MMU facility within the scope of care planned.

MMU Staff Training

It is incumbent upon EMTF-6 to ensure that member agencies and deployment personnel are adequately prepared to perform at their highest level under the dynamic and often adverse circumstances faced in disaster medical operations. In order to facilitate this readiness, the EMTF-6 MMU team meets regularly for training and planning to ensure the highest level of preparedness for the EMTF MMU Component's all-hazard response.

MMU Staff Activation

EMTF-6 will have pre-screened teams approved for deployment. Rostering and staffing plans may be impacted by the resources available to the region during an incident. EMTF-6 region should have appropriate relationships with the facilities & agencies to contribute resources to the formation of the MMU team roster. It will be the responsibility of the stakeholder agencies to activate personnel appropriate to the tasked mission. Stakeholder agencies, upon notification, are to report back to their EMTF Coordinator with their personnel and asset information, current status and estimated time of arrival at their individual mustering point.

MMU Supervision

Unlike other components of the EMTF (Ambulance Strike Teams, Ambus, and RN Strike Teams) the MMU faces unique challenges related to its deployment and operation. Specifically, given the large and complex scope of most foreseeable mission profiles it is apparent that the MMU may require the greatest level of organizational support during the incident. Owing to span of control and other operational factors, elements of the EMTF's overarching support structure may need to be housed within the MMU command structure or those MMU specific positions may need to be filled uniquely for

the MMU. Internally, each MMU will follow an ICS structure for a public health or medical emergency and provide necessary operations as stated in the incident action plans (IAPs) for the specific incident.

To ensure organized operations through an incident command structure, the MMU and associated staff will have a clearly defined reporting structure integrated into the CMOC structure. This structure may be provided within the organization of the MMU, by an overarching support team, or by infrastructure from a authority having-jurisdiction (AHJ).

Consistent with the ICS, each staff position should receive a job action sheet (JAS), which is a simple checklist that describes the role, responsibility, and reporting structure of each position within the ICS structure. These forms should be prepared in advance of the incident for rapid distribution to participating staff on their arrival to the MMU.

Supplies and Equipment

The MMU is designed to rapidly surge healthcare capacity into an affected region. Owing to that mission, it is the recommendation of this SOG that supply caches be configured based on interventions to be performed, rather than in bulk caches. This will limit the set-up time required for the stocking of treatment areas in the MMU, thus shortening the deployment to open time as well as aid in demobilization and restocking.

MMU supplies may be broken out into categories of care, both to aid in par stocking levels (related to expected patient loads) and cache configuration. EMTF–6 utilizes the following categories:

- Admin
- Diagnostic
- Facility
- IV
- Med Admin
- Pt Supplies
- PPE
- Respiratory
- Specialty
- Wound Care

Communications

Mechanisms for internal communication between EMTF-6 MMU functional areas and associated staff may include at a minimum cellular, radio and satellite phone capability. In many cases portable two-way radios may be available and used.

Operational Support

Coordinated through CMOC Logistics, the MMU may require the following external support services:

- Waste disposal (routine and bio-hazard)
- Food / potable water for patients and staff
- Security
- Water
- Fuel
- Latrines and showers

- Mortuary
- Private space for staff should be available to include incident briefing and medical report areas as well as eating, sleeping, toilet, showering, and rest facilities apart from the general patient population.

Security

Physical security of the MMU staff, equipment and the facility is essential. Physical security points include the following:

- Entry and exit points to the area (e.g., the city block), if practicable.
- Access points to the building.
- High-risk or high-value areas within the building, such as the temporary morgue and pharmacy.

Patient Management

Based on the predetermined role of the MMU, patients may arrive either by private transportation or by ambulance. A receiving area for initial evaluation and registration should be in place and easily accessible for arriving patients.

A medical record system has been planned for and put in place on activation of the MMU. Every patient encounter will be documented using the medical record system planned for the MMU (T-System).

Preprinted order sheets and care plans may facilitate the management of patients, consistent with the planned role of the MMU. The EmTrack system for tracking patient location within the MMU or disposition after completion of treatment at the MMU will be utilized. This system strives to be interoperable with the State of Texas WebEOC ETN system.

The original patient care records will be maintained by the sponsoring entity or SETRAC. A copy of each patient care record may be submitted to the Department of State Health Services via the reimbursement packet for the incident, as applicable

Ambulance Strike Team Composition

Each ambulance strike team is five (5) ambulances under the direction of an Ambulance Strike Team Leader (ASTL) in a separate vehicle. The six (6) vehicles in the strike team (five (5) ambulances plus ASTL vehicle) must have common communications. This recommendation is met with the member agency compliance with the TICP (see Appendix E).

Specialty ambulances, (bariatric capable, Critical Care Transport (CCT), or Neonatal Transport units, etc.) may all have high and specific value to the EMTF, given the mission profile. However, due to the rarity and wide variation of capabilities of these types of apparatus, it is not the recommendation of this SOG to pool a "Specialty" Strike Team in place of a traditional one. Rather, these assets in the region may be included as Single Resources attached to the EMTF as part of the most appropriate component.

In a regional or state response affecting the EMTF-6 region, all ambulance assets will be coordinated under CMOC Transportation Director to the Ambulance Staging Manager(s).

Incident Component Staffing

EMTF-6 should have appropriate relationships with the region's EMS agencies to contribute resources to the formation of the AST roster. EMTF-6 will have, as noted in the planning assumptions, a system of notification for these stakeholder agencies upon tasking from the CMOC. Following this notification, it will be the responsibility of the stakeholder agencies to activate personnel appropriate to the tasked mission. Stakeholder agencies, upon notification, are to report back to the EMTF Coordinator with their personnel and asset information, current status and estimated time of arrival at their individual mustering point. The EMTF Coordinator will roster the teams in preparation of deployment.

Medical Records

Medical records will be recorded using the EMS agencies routine documentation method. Paper copies should be made available to the ASTL, ideally, at the end of each operational period or at least during demobilization, for all patient encounters.

The original patient care records will be maintained by the sponsoring entity or SETRAC. If applicable, a copy of each patient care record may be submitted to the Department of State Health Services via the reimbursement packet for the incident.

AMBUS Crew Composition

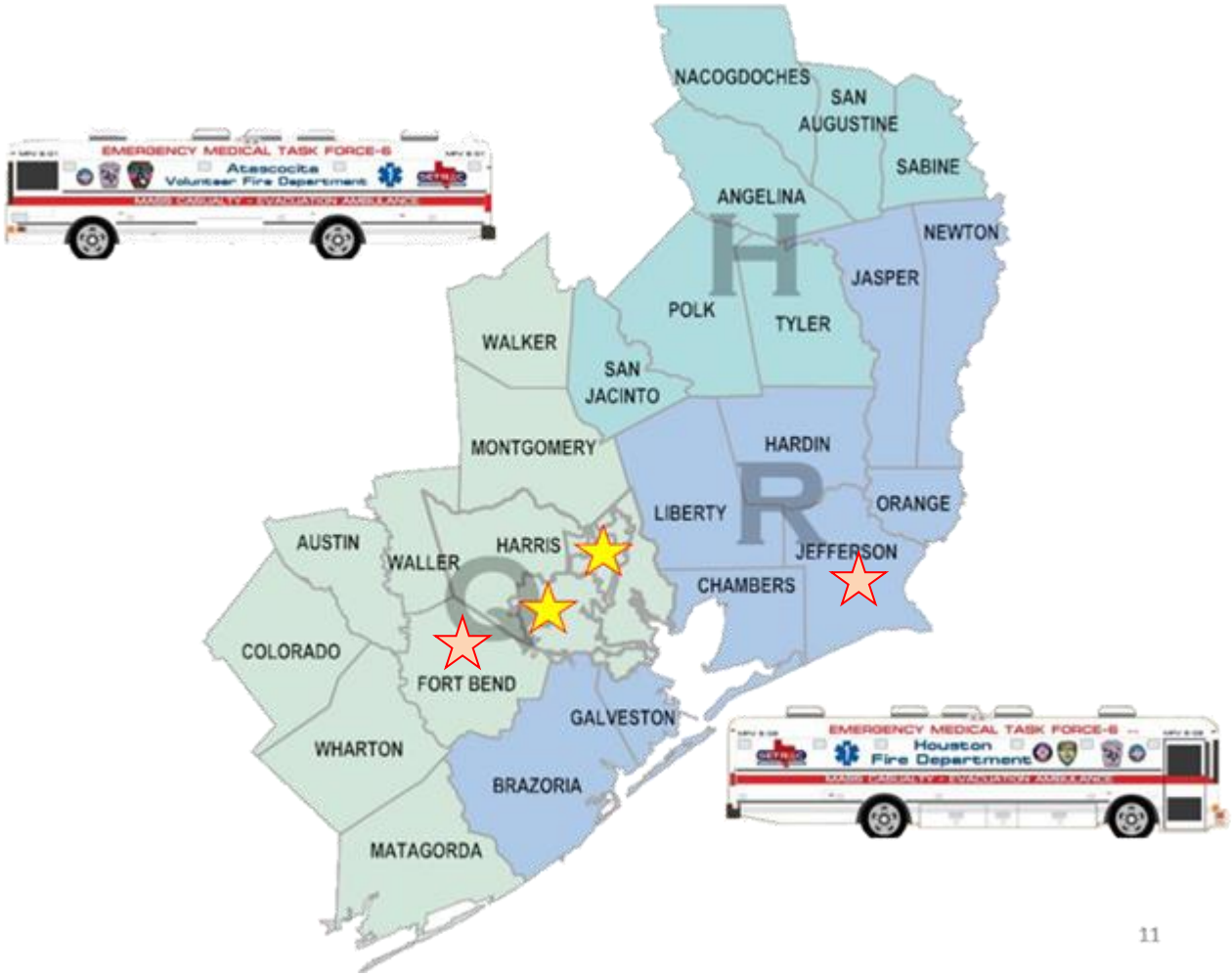
The TX-EMTF AMBUS is a TDMS Type-1 Medical Ambulance Bus, capable of providing advanced medical transportation services and additional capabilities during a large-scale disaster, mass casualty incidents, incident rehabilitation, point of dispensing and other appropriate missions. The AMBUS has a maximum capacity of twenty supine patients with six care providers on-board. See Appendix I for typing details.

The AMBUS shall be licensed as Specialty Emergency Medical Services Vehicle allowing for variances from the proscribed staffing levels set forth by DSHS for ambulances. At a minimum, this SOG recognizes that in some instances the Incident Commander (IC), based upon the incident, may alter staffing needs in special circumstances. See Appendix J for AMBUS request considerations.

EMTF-6 has two AMBUSes within its region. See Figure 3.

- MPV-601 – operated by Atascosita Fire Department; housed at Station 2, 4000 Atascosita Road, Humble, TX
- MPV-602 – operated by Houston Fire Department; housed at Station 8, 1919 Louisiana St, Houston, TX
- MPV-603 – Fort Bend County EMS (future; in progress)
- MPV-604 – Acadian Ambulance (future; in progress)

Figure 3: EMTF-6 AMBUS Locations



Incident Component Staffing Pool

EMTF-6 has relationships with the Houston Fire Department and the Atascocita Fire Department to house and operate the AMBUS. EMTF-6 has developed a system for notification of these stakeholder agencies upon tasking from the CMOC. Following this notification, it will be the responsibility of the stakeholder agencies to activate personnel appropriate to the tasked mission. Stakeholder agencies, upon notification, are to report back to the EMTF Coordinator with their personnel and asset information, current status and estimated time of arrival at their individual mustering point. The EMTF Coordinator will roster the teams in preparation for deployment.

Operations

AMBUSes will be deployed to various scenarios utilizing Appendix J as a guideline for deployment.

AMBUS deployments will follow an appropriate incident command system structure. Each AMBUS will have an "AMBUS Crew Boss" assigned to it. This position serves as a resource and operations expert of

the AMBUS itself. The AMBUS Crew Boss will report to an Ambulance Strike Team Leader and the Strike Team Leader in turn reports to the Ambulance Group Supervisor. Intervening levels of command may be inserted as incident scope affects the span of control.

At all times the AMBUS is subject to recall for higher priority missions.

All other operational concerns and questions should be forwarded to the appropriate person in the EMTF Command structure.

Medical Records

Medical records will be recorded using the EMS agencies routine documentation method. Paper copies should be made available to the ASTL, ideally, at the end of each operational period or at least during demobilization, for all patient encounters.

The original patient care records will be maintained by the sponsoring agency or the Lead RAC. A copy of each patient care record is to be submitted to the Department of State Health Services via the reimbursement packet for the incident.

Reimbursement Process

If applicable, the Sponsoring Entity will submit a completed Reimbursement Packet to the SETRAC Comptroller. All appropriate supporting documentation, including receipts, paycheck stubs, and ICS214, should accompany Reimbursement Packet for processing.

Documents

Updated documents, including the current EMTF Memorandum of Agreement, Typing Documents, Team Application, as well as this SOG, are available at setrac.org/emtf6 or by following this QR-code:

Appendix A: Index of Acronyms and Abbreviations

1.	AHJ	Authority Having Jurisdiction
2.	AMBUS	Ambulance Bus
3.	CMOC	Catastrophic Medical Operations Center
4.	DDC	Disaster District Chair/Committee
5.	DSHS	Department of State Health Services
6.	EmResource	A day-to-day crisis application hosted by Juvare
7.	EMTF	Emergency Medical Task Force
8.	EmTrack	Web-based application for tracking of evacuees, patients, associated property
9.	EMS	Emergency Medical Services
10.	ESF-8	Emergency Support Function 8 – Public Health & Medical
11.	EOC	Emergency Operations Center
12.	FOUO	For Official Use Only
13.	HAZMAT	Hazardous Materials
14.	HEC	Houston Emergency Center
15.	H-GAC	Houston-Galveston Area Council
16.	IAP	Incident Action Plan
17.	IC	Incident Command
18.	ICP	Incident Command Post
19.	ICS	Incident Command System
20.	IDRU	Infectious Disease Response Unit
21.	MACC	Multi-Agency Coordination Center
22.	MCI	Mass Casualty Incident
23.	MIST	Medical Incident Support Team
24.	MOA	Memorandum of Agreement
25.	MPV	Multiple Patient Vehicle
26.	NIMS	National Incident Management System
27.	PST-Q	Personnel Support Trailer-Q
28.	PSTT-Q	Personnel Support Tow Vehicle-Q
29.	RAC-H	Regional Advisory Council-H
30.	RAC-Q	Regional Advisory Council-Q
31.	RAC-R	Regional Advisory Council-R
32.	RITA	Regional Infectious Transportation Ambulance
33.	RCC	Regional Communication Center
34.	RCV-Q	Regional Communications Vehicle-Q
35.	RHPC	Regional Hospital Preparedness Council
36.	SMOC	State Medical Operation Center
37.	SOC	State Operations Center
38.	TDEM	Texas Division of Emergency Management
39.	TMORT	Texas Mass Fatality Operations Response Team
40.	TSA-H	Trauma Service Area-H
41.	TSA-Q	Trauma Service Area-Q
42.	TSA-R	Trauma Service Area-R
43.	WebEOC	Web-based Emergency Operations Center

Appendix B: Related Plans

The following is a non-inclusive list agency plans outlining their roles and responsibilities during a response to a no-notice mass casualty incident.

- Catastrophic Medical Operations Center (CMOC) Basic Plan
- Houston-Galveston Area Council (H-GAC) Multi-agency Coordination (MAC) Plan Annex
- Regional No-Notice Emergency Response CONOPS (Dec 2012)

The following organizations have policies and procedures detailing their response to mass casualty incidents.

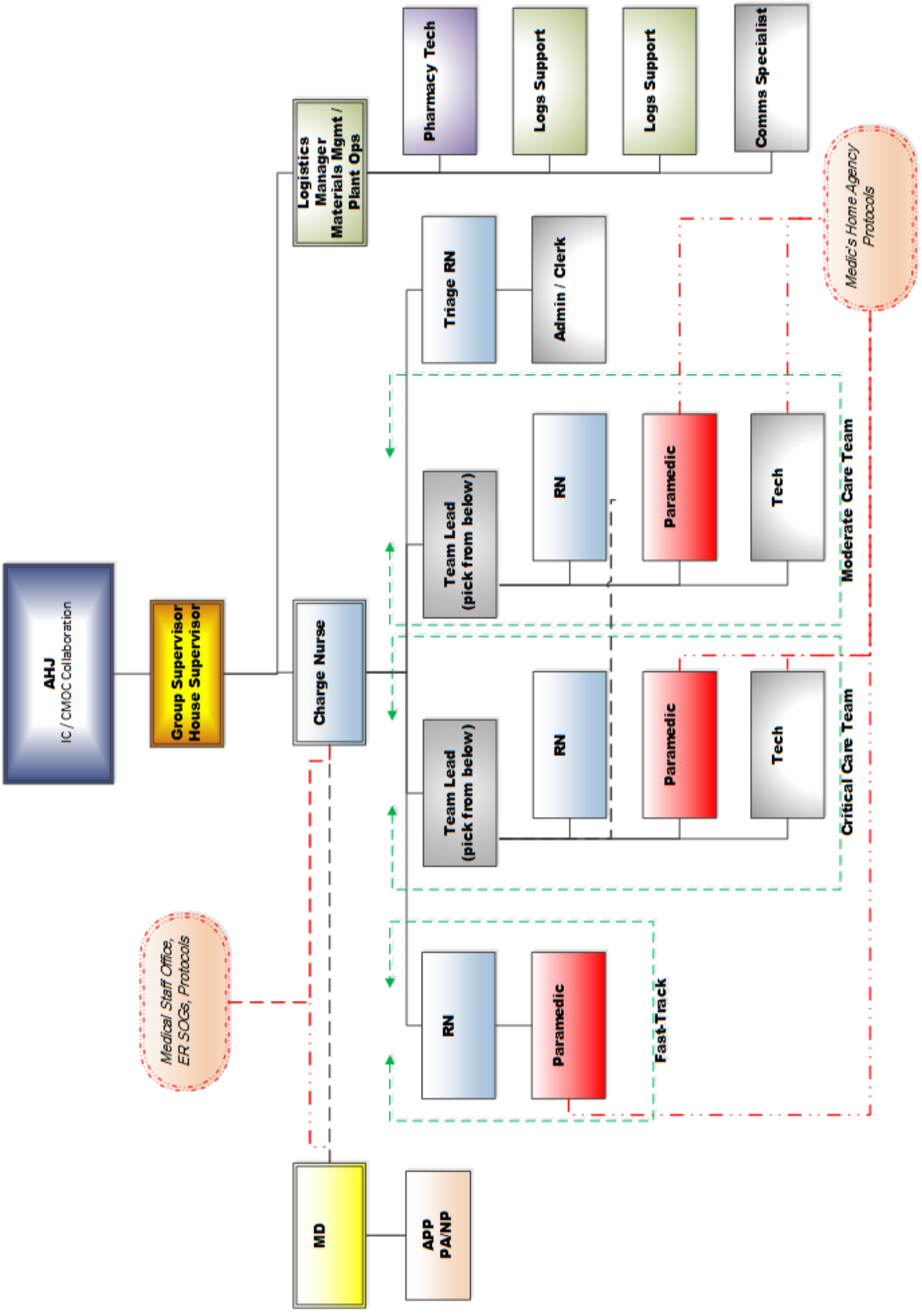
- SouthEast Texas Regional Advisory Council (SETRAC) maintains protocols and guidelines for triage, stabilization and transport activities in RAC-Q
- National Disaster Medical System (NDMS) - Federal resource from the Federal Emergency Management Agency (FEMA)
- Houston Metropolitan Medical Response System (HMMRS) - Mass casualty response system for the City of Houston
- Local EMS agencies/jurisdictions - Agencies are responsible for maintaining plans or procedures for response to mass casualty incidents in their jurisdictions.
- Local Treatment Centers - Mass casualty and surge planning is part of each hospital's Joint Commission on Accreditation of Hospitals review process

Appendix C – Deployment Equipment Guidelines (Go-Bag)

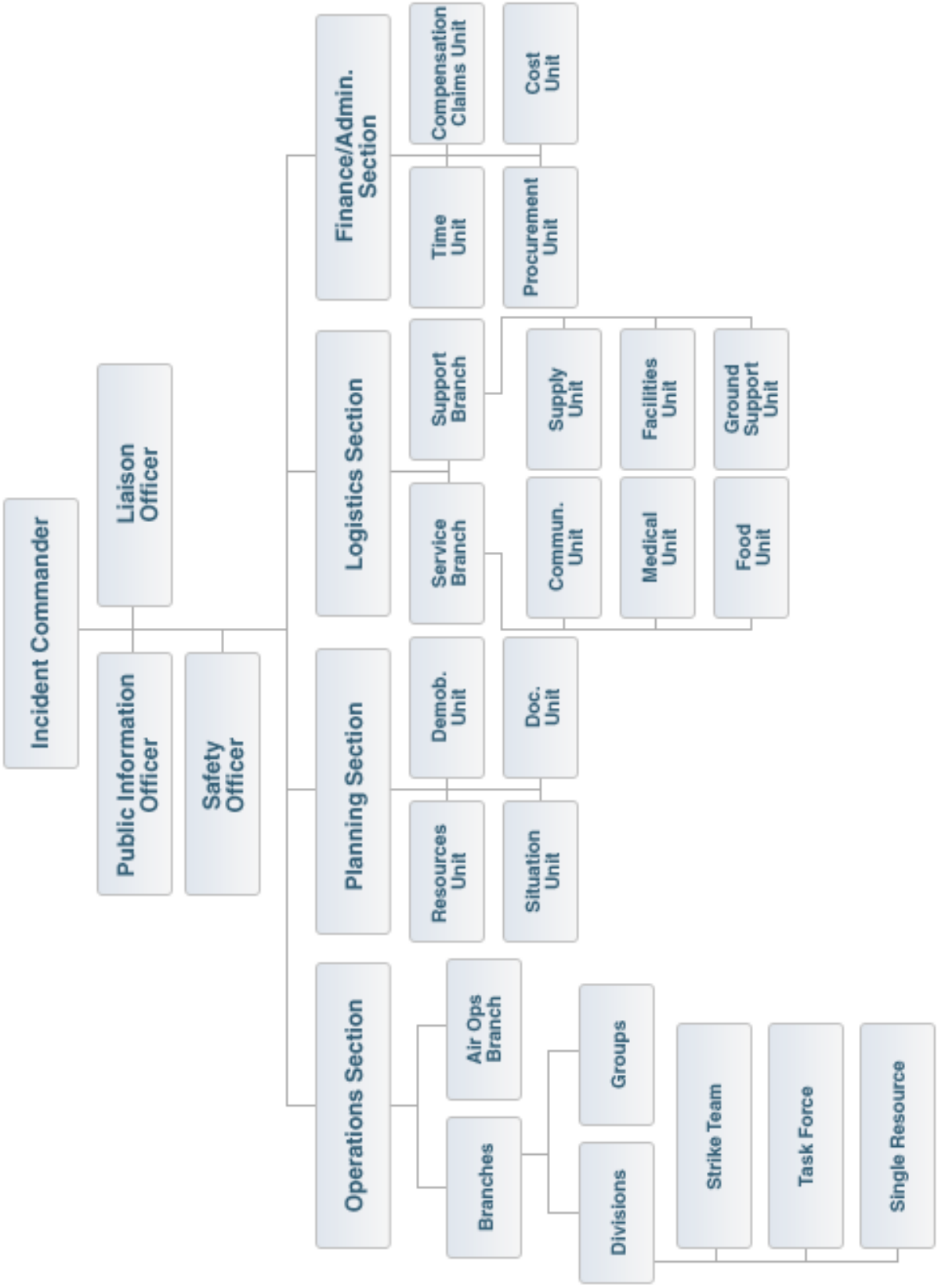
Item Description	Qty
Uniform/Scrub Shirts	5
Uniform/Scrub Pants	5
Undergarments	5
Work Shoes	1
Socks (pair)	7
Athletic Shoes	1
Mesh Laundry Bag	1
Parka / Rain Gear	1-2
Towel	1-2
Toiletries (keep in portable bag)	
T-Shirts	2
Cold Weather Gear	as needed
Large Ziplock Bags	Assorted
Baby Wipes	
Hand Sanitizer	
Woolite	
Snacks/Drink Mix/MREs	
Cards/Games	
Extra pair of glasses or extra contact lenses	
Sunscreen	
Lip balm with sunscreen	
Texas road map and map of deployment area	
Field guides (NIMS, ICS, public health emergencies, emergency response etc.)	
Feminine items (tampons, makeup etc.)	
Cash	$100.00
Prescription Medications	

*****All clothes should have name and/or initials in at least two places**

Appendix D: Sample EMTF-6 Organizational Chart



Sample ICS organization chart showing all parts of the Command and General Staffs. <emilms.fema.gov>



Appendix E: Texas Statewide Interoperability Channel Plan

Revised January 25, 2013 – page 19 and 31

VHF 150 MHz Narrowband Interoperability Channels (12.5 kHz)**

Emission Designators 11K2F3E, 11K3F3E, 11K2G2E

Mobile and Portable Configuration*					
Label	**Receive**	**Transmit**	**Station Class**	**CTCSS RX /TX**	**Use**
VCALL10	155.7525	155.7525	FBT / MO	CSQ / 156.7	Calling Channel
VTAC11	151.1375	151.1375	FBT / MO	CSQ / 156.7	Tactical Channel
VTAC12	154.4525	154.4525	FBT / MO	CSQ / 156.7	Tactical Channel
VTAC13	158.7375	158.7375	FBT / MO	CSQ / 156.7	Tactical Channel
VTAC14	159.4725	159.4725	FBT / MO	CSQ / 156.7	Tactical Channel
VFIRE21	154.2800	154.2800	FBT / MO	CSQ / 156.7	Tactical Channel
VFIRE22	154.2650	154.2650	FBT / MO	CSQ / 156.7	Tactical Channel
VFIRE23	154.2950	154.2950	FBT / MO	CSQ / 156.7	Tactical Channel
VFIRE24	154.2725	154.2725	FBT / MO	CSQ / 156.7	Tactical Channel
VFIRE25	154.2875	154.2875	FBT / MO	CSQ / 156.7	Tactical Channel
VFIRE26	154.3025	154.3025	FBT / MO	CSQ / 156.7	Tactical Channel (for Air-to-Ground with State/Federal Aircraft ONLY)
VMED28	155.3400	155.3400	FBT / MO	CSQ / 156.7	Tactical Channel (and for Air-to-Ground use)
VMED29	155.3475	155.3475	FBT / MO	CSQ / 156.7	Tactical Channel
VLAW31	155.4750	155.4750	FBT / MO	CSQ / 156.7	Tactical Channel
VLAW32	155.4825	155.4825	FBT / MO	CSQ / 156.7	Tactical Channel
TXCALL1D	154.9500	154.9500	FBT / MO	**156.7 / 156.7**	Mobile-to-Mobile Calling Channel
TXCALL2D	155.3700	155.3700	FBT / MO	**156.7 / 156.7**	PRI: Calling Channel for State/Federal Aircraft to/from a Base and SEC: VCALL10 backup

800 NPSPAC Interoperability Channels (20 kHz)

Emission Designator 20K0F3E

Label	**Receive**	**Transmit**	**Station Class**	**CTCSS RX/TX**	**Use**
8CALL90	851.0125	806.0125	FX1T / MO	CSQ / 156.7	Calling Channel (Repeater)
8CALL90D	851.0125	851.0125	FX1T / MO	CSQ / 156.7	Calling Channel (Direct)
8TAC91	851.5125	806.5125	FX1T / MO	CSQ / 156.7	Incident Temporary Repeater Channel
8TAC91D	851.5125	851.5125	FX1T / MO	CSQ / 156.7	Tactical Channel (Direct)
8TAC92	852.0125	807.0125	FX1T / MO	CSQ / 156.7	Incident Temporary Repeater Channel
8TAC92D	852.0125	852.0125	FX1T / MO	CSQ / 156.7	Tactical Channel (Direct)
8TAC93	852.5125	807.5125	FX1T / MO	CSQ / 156.7	Incident Temporary Repeater Channel
8TAC93D	852.5125	852.5125	FX1T / MO	CSQ / 156.7	Tactical Channel (Direct)
8TAC94	853.0125	808.0125	FX1T / MO	CSQ / 156.7	Incident Temporary Repeater Channel
8TAC94D	853.0125	853.0125	FX1T / MO	CSQ / 156.7	Tactical Channel (Direct)
8TAC95D ***	851.5500	851.5500	MO	CSQ / 156.7	Incident Control Channel (Direct)
8TAC96D ***	853.0500	853.0500	MO	CSQ / 156.7	Incident Control Channel (Direct)
8TAC97D ***	853.3500	853.3500	MO	CSQ / 156.7	Incident Control Channel (Direct)

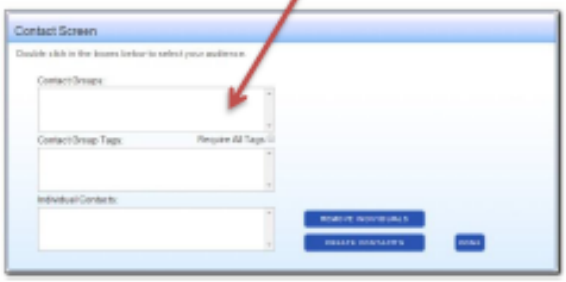
Appendix F – SmartNotice Directions

Go to https://login.smartnotice.net and log into the system with your assigned username and password.

From your Dashboard click **BUILD** to start the launch process.

Click **CONTACT** to add your group(s).

Double click in the Contact Group box to add the group(s) you need to add. Then click **DONE** when completed.



Click **Continue to Messages** to proceed after selecting your group(s)

Appendix G – RNST Checklist

Compentency/Skill	Self Eval: (CIRCLE)	Comments
ACLS	Yes/No/See Comments	
TNCC	Yes/No/See Comments	
ENPC/PALS	Yes/No/See Comments	
NRP	Yes/No/See Comments	
Haz Mat/Decon Team	Yes/No/See Comments	
Intubation/LMA	Yes/No/See Comments	
Arterial Blood Gases	Yes/No/See Comments	
Suturing	Yes/No/See Comments	
Blood Product Administration	Yes/No/See Comments	
Rapid Infusion	Yes/No/See Comments	
Chest Tubes	Yes/No/See Comments	
Thoracotomy Procedures	Yes/No/See Comments	
Cut Downs	Yes/No/See Comments	
Psychiatric (Close Obs) Care	Yes/No/See Comments	
Paricentesis	Yes/No/See Comments	
Biphasic Defibrillator	Yes/No/See Comments	
NGT/OGT/Lavage	Yes/No/See Comments	
Restraints	Yes/No/See Comments	
SANE trained	Yes/No/See Comments	
Core Measures (knowledge)	Yes/No/See Comments	
G-Tube/PEG/feedings & meds	Yes/No/See Comments	
Art Lines (placement and monitoring)	Yes/No/See Comments	
Central Lines (placement and care)	Yes/No/See Comments	
ICP Monitoring	Yes/No/See Comments	
Thrombolytics (Stroke and STEMI)	Yes/No/See Comments	
Immobilization/Splinting Procedures	Yes/No/See Comments	

NOTE: The intent of this skills checklist is to rapidly verify that the RN serving in a disaster scenario is aware of the skills allowed while serving in the assigned setting, during a disaster assignment.

Appendix H: TDMS TXEMTF MMU Typing Version Aug 2013

RESOURCE: Mobile Medical Unit - Sustained Operations (> 24 hours)
Emergency Medical Services (ESF #8); Command and Control

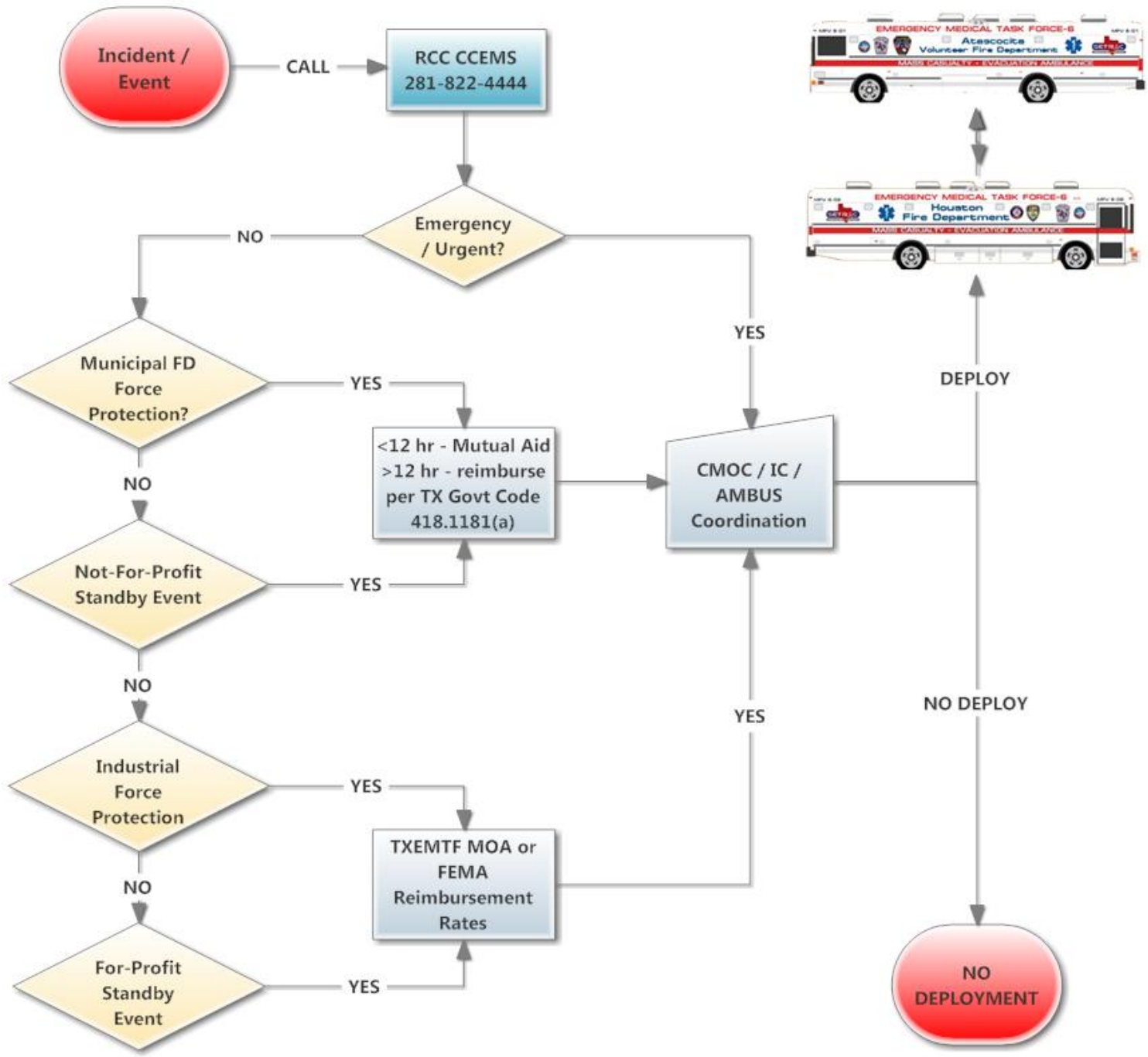
CATEGORY:		Type I (32+ Beds 24/7)	Type II (16-32 beds max)	Type III (8-12 Beds)	Type IV (6-8 Beds)	Type V Type IV w/o equipment
MINIMUM CAPABILITIES:						
Component	Metric					
Operational Usage		Replacement of ER that Is Off-Line Anticipated Significant Patient Surge Large Scale Community Disaster	Replacement of ER that Is Off-Line Anticipated Significant Patient Surge Large Scale Community Disaster	Alternate Care Center Special Events Medical Operations	Innoculation Clinic Minor Care Clinic First Responder Force Protection	Roving Shelter Support Force Protection
	Example	Joplin Tornado	Joplin Tornado	Planned Community Events -	Bastrop Wild Fire	FLDS In San Angelo
Personnel	Number of Personnel	35-person response	19-person response	10-person response	7-person response	7-person responseR
	Sustained Operations	(2) Operations Manager (1) Logistic Manager (1) Group Supervisor (2) MD (2) APP(Adv.Practice Professional) (10) Registered Nurse (2-Charge) (6) Paramedic (2) Pharmacy Tech (4) Tech (2) Admin/Clerk (3) Logistical Support ~~(1) Comm Tech~~	(1) Operations Manager (1) Logistic Manager (1) Group Supervisor (1) MD (1) APP(Adv.Practice Professional) (5) Registered Nurse (1-Charge) (3) Paramedic (1) Pharmacy Tech (2) Tech (1) Admin/Clerk (2) Logistical Support ~~(1) Comm Tech~~	(1) Operations Manager (1) Group Supervisor (1) MD (2) Registered Nurse (2) Paramedic (1) Tech (1) Admin/Clerk (1) Logistical Support	(1) Group Supervisor (2) APP(Adv.Practice Professional) (2) Registered Nurse (2) Paramedic	(1) Group Supervisor (2) APP(Adv.Practice Professional) (2) Registered Nurse (2) Paramedic
Operational Area	Parking and Support	40,000 sq ft Operations Area (200' x 200')	40,000 sq ft Operations Area (200' x 200')	22,500 sq ft Operations Area (150' x 150')	15,625+ sq ft Operations Area (125' x 125')	225+ sq ft Medical Eval Area (15' x 15')
Air Operations	Landing Zone	10,000 sq ft Operations Area (100' x 100')	10,000 sq ft Operations Area (100' x 100')	10,000 sq ft Operations Area (100' x 100')	None	None
	Sleeping Area	860 sq ft	860 sq ft	860 sq ft	175 sq ft	175 sq ft
Equipment	Support Trailer/Command Vehicles	(1) 53' MMU Trailer with Power, Internal Command Center and Climate Controlled with: (2) Awning(s) (2) 36' MMU Trailer with Power and Climate Control with: (2) 860 (2) Quad or Awning (or equivalent)	(1) 53' MMU Trailer with Power, Internal Command Center and Climate Controlled with: (2) Awning(s) (2) 36' MMU Trailer with Power and Climate Control with: (2) 860 (2) Quad or Awning (or equivalent)	(1) Type II or Type III "Mobile EOC" (2) 36' MMU Trailer with Power and Climate Control with: (2) 860s (1) Quad (1) Awning (or equivalent)	(1) 36' MMU Trailer with Power and climate Control with: (1) 860 (1) Quad or Awning (or equivalent)	None
	Tow Vehicles	(1) Semi/Tractor (with Driver)[1][1] (4) 1-Ton Truck [4][16] (3) 3/4 Ton Crew Cab Truck/Suburban [5][15] (2) Supply Truck [2][4]	(1) Semi/Tractor (with Driver)[1][1] (4) 1-Ton Truck [4][16] (2) 3/4 Ton Crew Cab Truck/Suburban [5][10] (2) Supply Truck [2][4]	(3) 1-ton Truck [4][12] (2) 3/4 Ton Crew Cab Trucks / Suburban [5][10] (1-2) Supply Truck(2) [2]-[4]	(1) 1-ton Truck [4][4] (1) 3/4 Ton Crew Cab Trucks / Suburban [5][5] (1) Supply Truck(2) [2]	(2) Suburban [5] [10]
	Travel Package	Minimum of: (3) Credit Card (10) GPS Units and area maps (10) Radio (pull from Comm pkg) (10) DIC - A/C Power Invertor (10) Cases of Water (3) Case of MREs	Minimum of: (3) Credit Card (10) GPS Units and area maps (10) Radio (pull from Comm pkg) (10) DIC - A/C Power Invertor (10) Cases of Water (3) Case of MREs	Minimum of: (2) Credit Card (7) GPS Units and area maps (7) Radio (pull from Comm pkg) (7) DIC - A/C Power Invertor (6) Cases of Water (2) Case of MREs	Minimum of: (1) Credit Card (3) GPS Units and area maps (3) Radio (pull from Comm pkg) (3) DIC - A/C Power Invertor (2) Cases of Water (1) Case of MREs	Minimum of: (1) Credit Card (2) GPS Units and area maps (2) Radio (pull from Comm pkg) (2) DIC - A/C Power Invertor (1) Cases of Water (1) Case of MREs
	Power Generation	(1) 125kw Generator (Type VI) (1) 60kw Generator (1) 6.5 kw Generator Capability to Provide Shoreline Power	(1) 125kw Generator (Type VI) (1) 60kw Generator (1) 6.5 kw Generator Capability to Provide Shoreline Power	(1) 60kw Generator (1) 6.5 kw Generator	(1) 60kw Generator (1) 6.5 kw Generator	(1) Honda 1000 watt Generator (1) Gas Can, 2 gallon
	All Terrain Mobility	(1) All Terrain Utility Vehicle	(1) All Terrain Utility Vehicle	(1) All Terrain Utility Vehicle	None	None

Appendix I: TDMS AMBUS Typing Document

Resource:		Medical Ambulance Bus				
Category:	Emergency Medical Services (ESF #8); Transportation		Kind:	Vehicle		
Minimum Capabilities:		Type I	Type II	Type III	Type IV	Type V
Component	Metric					
Overall Function	Primary Mission	Capable of providing advanced medical transportation services during a large scale disaster	Capable of providing advanced medical transportation services during a large scale disaster	Capable of providing advanced medical transportation services during a large scale disaster	Capable of providing basic medical transportation services during a large scale disaster	
	Alternate Mission	Capable of response to Mass Casualty Incidents utilizing Regional agreements	Capable of response to Mass Casualty Incidents utilizing Regional agreements	Additional capabilities for Incident Rehabilitation, Point of Dispensing and other Appropriate Missions		
	Alternate Mission	Additional capabilities for Incident Rehabilitation, Point of Dispensing and other Appropriate Missions	Additional capabilities for Incident Rehabilitation, Point of Dispensing and other Appropriate Missions			
Readiness	Dispatch Time*	Response Capable in < 10 minutes.	Response Capable in < 10 minutes.	Response Capable in < 2 hours.	Response Capable in < 6 hours.	
Capacity	Number of Patients	20 Litter Patients or 12 Seated Patients	12 Litter Patients	6 Litter Patients	25 Seated Patients	
	Number of Crew**	(1) Apparatus Operator (1) Command Position*** (4) Care Providers	(1) Apparatus Operator (4) Care Providers	(1) Apparatus Operator (2) Care Providers	(1) Apparatus Operator (2) Care Providers	
	Number of Accompanying Care Givers**	(4) Additional Passengers	(4) Additional Passengers	(4) Additional Passengers	(4) Additional Passengers	
Equipment	Vehicle Production	Custom vehicle with integrated electrical, oxygen and communication systems	Custom vehicle with after market electrical, oxygen and communication systems	Vehicle of opportunity that is augmented with bolt-on equipment and carry-on supplies	Vehicle of opportunity that is augmented with carry-on equipment and supplies	
	Emergency Warning Systems	Lighting and Audible warning system compliant with NFPA and KKK specifications	Lighting and Audible warning system compliant with NFPA and KKK specifications	No lighting or warning systems required.	No lighting or warning systems required.	
	On-board Power Generation	On-board generator capable of running all on-board equipment.	On-board generator capable of running critical equipment.	12V power system only	12V power system only	
	Oxygen Supply Systems	Integrated system capable of providing oxygen to all patients, including ventilator patients.	Aftermarket system capable of providing oxygen to all patients.	Portable bottles secured on the unit to provide low-flow oxygen for all occupants.		
	Climate Control Systems	A/C and Heat system capable of operation off on-board generator	A/C and Heat system capable of operation off on-board generator	On-Board Heat and A/C system available while unit is running.	On-Board Heat and A/C system available while unit is running.	
	Interior Storage	Integrated Equipment and Supply storage units to include refrigerated medications	Aftermarket Equipment and Supply storage units	Portable Equipment and Supply storage, to include hard cases, bags and shelving.	Carry-on Bags containing all patient care equipment and supplies.	
	Mounting Systems	At least two Stretcher Mounts Wheelchair mounting system	No rolling stretcher mounts Wheelchair mounting system	No rolling stretcher or wheelchair mounting systems	No rolling stretcher or wheelchair mounting systems	
Equipment	Operational Fuel Load	8 hours of Fuel	8 hours of Fuel	4 hours of Fuel	8 hours of Fuel	
	Deployment Duration	24 hour Operation*****	24 hour Operation*****	24 hour Operation*****	12 hour Operation	

Resource:		Medical Ambulance Bus				
Category:	Emergency Medical Services (ESF #8); Transportation		Kind:	Vehicle		
Minimum Capabilities:		Type I	Type II	Type III	Type IV	Type V
Component	Metric					
Commun-ications	Radio Systems****	Integrated with Local and Regional EMS and Fire Radio Systems (VHF, UHF, 700, 800 and/or 900)	Integrated with Local and Regional EMS and Fire Radio Systems (VHF, UHF, 700, 800 and/or 900)	Portable Radio on-board capable of integration with local and regional radio systems	Portable Radio on-board capable of integration with local and regional radio systems	
	Satellite Systems	Satellite Radio and Telephone System	Satellite Radio and Telephone System	Portable Satellite Radio and Telephone Package, if available.	Portable Satellite Radio and Telephone Package, if available.	
	Internet Connectivity	4G/3G Wireless Internet on board with wireless router.	4G/3G Wireless Internet on board with wireless router.	None required.	None required.	
	AVL/GPS Tracking	Active AVL and GPS Tracking	Active AVL and GPS Tracking	None required.	None required.	
Supplies	Level of Care	Critical Care Transport capable	Mobile Intensive Care capable	Advanced Life Support capable	Basic Life Support capable	
	Patient Monitoring	Patient Monitoring (NIBP, SPO2, EKG) for at least (12) patients with Central Monitoring Station.	Patient Monitoring (NIBP, SPO2, EKG) for at least (12) patients with Central Monitoring Station.	Patient Monitoring for at least (2) patients using portable monitors.	(1) Automated external defibrillator on board only	
	Medical Equipment Requirements (beyond ambulance licensure requirements)	Monitor/Defibrillator/Pacer (1) Medication Infusion Pumps (8) Transport Ventilator (4) End-Tidal CO2 detector (4) Immobilization Equipment (12) Traction Splints (2) Intubation / Medication Kits (2)	Monitor/Defibrillator/Pacer (1) Medication Infusion Pumps (8) Transport Ventilator (4) End-Tidal CO2 detector (4) Immobilization Equipment (12) Traction Splints (2) Intubation / Medication Kits (2)	Immobilization Equipment (4)	None required.	
Safety	Gas Monitoring	Four gas detector for oxygen, carbon monoxide, combustibles (LEL) and hydrogen sulfide.	Four gas detector for oxygen, carbon monoxide, combustibles (LEL) and hydrogen sulfide.	Carbon Monoxide detector minimum.	Monitoring organic to the bus.	
	PPE	Protective Equipment Carried on board for Each Crewmember******	Protective Equipment Carried on board for Each Crewmember*****	Protective Equipment Carried on board for Each Crewmember*****	Protective Equipment Carried on board for Each Crewmember*****	
	Vehicle Marking	Reflective Vehicle Markings per NFPA specifications.	Reflective Vehicle Markings per NFPA specifications.	None required.	None required.	
	Lighting	Scene lighting on all sides of the vehicle with additional lighting available at the loading/unloading area to the rear of the unit	Scene lighting on all sides of the vehicle with additional lighting available at the loading/unloading area to the rear of the unit	None required.	None required.	
Comments:	* - Includes time required for vehicle configuration, personnel response, supply/equipment loading and pre-movement inspection ** - Number of Crew and Number of Accompanying Care Givers is based on the number of physical seats with NFPA/KKK compliant restraint systems. *** - A dedicated seat/workstation for a team leader or communications technician.					

Appendix J: EMTF-6 AMBUS Request Flow



Appendix K: Available Regional Assets

Regional Medical Assets	
The following are regionally-owned assets that may be deployed in response to a mass-casualty incident in the CMOC region. Though they are stored throughout the region, the assets are owned by SETRAC who provides for maintenance, fuel, licensing, and requests reimbursement for asset use when they are deployed to state and federally declared emergencies.	
Regional Communications Vehicle (RCVQ)	RCVQ is a 48ft Frontline Command Vehicle. The truck provides a mobile solution for interoperable communications and redundant, load-balancing wired & wireless connectivity. Purchased and maintained by SETRAC; SETRAC is responsible for its maintenance, mobilization and deployment.
MCC-602 & MCC-603	MCC-602 & MCC-603 are 20ft enclosed trailers designed as a rapid-response unit for incidents requiring communication and technological interoperability. MCC-602 & MCC-603 are small but versatile and are equipped with phones, computers, internet and radios. They can be used as a free-standing ICP or EOC or provide support to existing facilities. MCC-602 is housed, maintained, mobilized and deployed by SETRAC; MCC-603 is housed, maintained, mobilized and deployed by Wharton County EMS.
Billeting Trailer (BLT – 1)	The Billeting Trailer provides response personnel a place to rest during deployments. Capable of supporting twelve (12) personnel, it has bunks, a kitchenette, laundry facilities, and a restroom/shower facility. It may also serve as a cargo hauler for ambulance staging equipment or other items needed for operations. BLT-1 is housed, maintained, mobilized and deployed by the SETRAC.
International Navistar 8600 6x4 (HST-1)	HST-1 is a tractor capable of towing via bumper, gooseneck or fifth-wheel. The International is housed, maintained, mobilized and deployed by the SETRAC.
GMC 5500 Tow Vehicle (PST-1)	PST-1 is a flatbed, bumper and gooseneck pulling truck with a 90-gallon supplemental fuel tank & pump. The GMC is housed, maintained, mobilized and deployed by the SETRAC.
Ford F450 Tow Vehicle (PST-2 / PST-4)	The F450 is a flatbed, bumper and gooseneck pulling truck. The Ford F450 is housed, maintained, mobilized and deployed by the SETRAC. SETRAC has two of these vehicles available.
Ford F-750 Crew Cab 4x2 Tow Vehicle (PST-3)	The F750 is a flatbed, bumper and gooseneck pulling truck. The Ford F450 is housed, maintained, mobilized and deployed by the SETRAC.
DPMU1	Disaster Portable Morgue Unit: 53’ refrigerated trailer with various deployable morgue components; temporary decedent storage
DPMU2, 3, & 4	Disaster Portable Morgue Unit: 24’ refrigerated trailer for temporary decedent storage
Water Purification Trailer	Deployable Water purification system capable of purifying 3100 gph of water. The water purification system MCC-603 is housed, maintained, mobilized and deployed by Harris County Emergency Corps.
DECON Trailer	Enclosed trailer capable of two-lanes, hot/cold water mass decontamination

Appendix L: EMTF-6 Team Application

EMTF Application - Please Print

NAME:

Last: _____ First: _____ Middle: _____

HOME ADDRESS:

Street: _____

City: _____ State: _____ ZIP: _____

PRIMARY CONTACT INFORMATION:

Mobile Phone: _____ Email 1: _____

Home Phone: _____ Email 2: _____

Work Phone: _____ Other: _____

SPONSORING ENTITY:

Agency Name:

_____

Address:

_____

City: _____ State: _____ ZIP: _____

Current Position: _____ Years of Experience: _____

Current Duties:

_____

SPONSORING AGENCY AUTHORIZATION

Department Head / Supervisor Name: _____

Office Phone: _____Email: _____

As an official representative of the sponsoring agency, I support the candidate becoming a member of the Texas Emergency Medical Task Force. I understand that, if selected, the candidate will represent their home agency during team trainings and meetings along with any local, regional or state deployments.

Signature: _____ Date: _____

Please notify me of: Team Training / Meetings *Yes* *No* Deployments *Yes* *No*

POSITION REQUEST

Mobile Medical Unit Team:

- ☐ MD
- ☐ PA
- ☐ Paramedic
- ☐ Pharmacy Tech
- ☐ Nurse Practitioner
- ☐ RN
- ☐ Tech / Clerk
- ☐ Logistics Specialist
- ☐ Other

RN STRIKE TEAM:RN Strike Team Leader

- ☐ ICU RN
- ☐ OR RN
- ☐ MED SURG RN
- ☐ ED RN
- ☐ NICU RN
- ☐ PEDI RN
- ☐ Other _____

REFERENCES:

Name	**Phone**
Relationship	**Years Known**

Name	**Phone**
Relationship	**Years Known**

Name	**Phone**
Relationship	**Years Known**

Has your employer agreed to support your membership with the Texas Emergency Medical Task Force?

Yes **No** **Not yet**

Do you have prior emergency response experience? **Yes** **No**

If yes, please provide details:

_____

_____

Do you understand that team trainings, as well as occasional work details, mobilization drills and quarterly meetings are required, and are you willing and able to attend these trainings?

Yes **Occasionally** **No**

Do you have employment responsibilities or other commitments that will hinder your ability to deploy without notice?

Yes **No**

If yes, explain:

_____

Are you willing to receive any and all immunizations? **Yes** **No**

If no, please explain:

_____

What knowledge, skills, abilities or experience do you have that you would like to have considered in the review of your initial membership application?

I attest that my answers are true and complete to the best of my knowledge.

If accepted as a member of the Texas Emergency Medical Task Force, I understand that any false or misleading information in my application or interview may result in my membership being terminated.

Signed: _____ Date: _____

Mail completed form to:

Southeast Texas Regional Advisory Council (SETRAC)
Attn: Mark Sastre, EMTF 6 Coordinator
1111 North Loop West Suite 200
Houston, Texas 77008
Fax: (281)822-4668
Email: mark.sastre@setrac.org

Please complete the check-list on the back page prior to turning in this form.

Application Check Sheet

Please submit this completed membership form as well as the other requested supporting documentation listed below. Any information that is omitted or incomplete will prevent formal membership processing.

- ☐ Department Head or Supervisor signature
- ☐ Resume (include a copy of your license / certification and certification cards)
- ☐ Create an account at https://www.texasdisastervolunteerregistry.org (select the organization "Emergency Medical Task Force -6", populate your license information)
- ☐ Current Immunization Records
- ☐ NIMS 700 & 200 Recommended (online training https://training.fema.gov/IS/NIMS.aspx)
- ☐ Other NIMS certificates

Requirements for selected members

First 90 days:

- ☐ Complete NIMS 700.a & 200.HCa (https://training.fema.gov/IS/NIMS.aspx)
- ☐ Obtain WebEOC log-in on local server (https://houston.webeocasp.com)
- ☐ Complete online T-Sheet course (http://www.tsystem.com/ Customer Number EP9996)

First Year:

- ☐ Attended 50% of team meetings / trainings
- ☐ Attended all mandatory meetings / trainings
- ☐ Successful completion of Emergency Response to Terrorism (classroom or online) or equivalent (http://www.usfa.fema.gov/nfa/nfaonline/browse/terrorism.shtm)
- ☐ Completes the Physical Agility Test

Continued Team Membership:

- ☐ Continued employment within the ED or EMS
- ☐ Attended 50% of yearly team meetings / trainings
- ☐ Attended all mandatory trainings
- ☐ Complete First Receiver DECON Course

Emergency Medical Task Force Region 6

Mark Sastre
Coordinator
SETRAC
(281)822-4441
mark.sastre@setrac.org
www.setrac.org/emtf6

To get started with EMTF6, create an account at:
www.texasdisastervolunteerregistry.org

@EMTF6

HOUSTON REGIONAL CATASTROPHIC PREPAREDNESS INITIATIVE

Regional Emergency Medical Response Coordination

Concept of Operations

This document is Attachment 3 of the Catastrophic Medical Operation Center (CMOC) Plan

FOR OFFICIAL USE ONLY

February 15, 2019

FORWARD

WARNING: This document is FOR OFFICIAL USE ONLY (FOUO). It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with U.S. Department of Homeland Security policy relating to FOUO information and is not to be released to the public or other personnel who do not have a valid "need-to-know" without prior approval of an authorized official.

Original development of this document and costs for its printing and distribution were supported by Grant Number 2008-CP-T8-0023 to the State of Texas through the Regional Catastrophic Preparedness Initiative (RCPI) Grant Program, as awarded by the National Preparedness Directorate, U.S. Department of Homeland Security. This grant was subsequently conveyed to the City of Houston, as fiscal agent for the broader region, by the Texas Division of Emergency Management through SAA Award Number 08-35000-01.

Initial development of this ConOps was based on a scenario with several mass casualty incidents (MCI) caused by the detonation of multiple IEDs in the 13-county Houston-Galveston Area Council (H-GAC) region that would significantly challenge the emergency response forces within the region requiring the activation of the Catastrophic Medical Operations Center (CMOC) and related plans. This ConOps was expanded to include the 25-county Southeast Texas Regional Advisory Council (SETRAC) area and it is scalable for implementation in response to any emergency medical response for mass casualty incidents.

The opinions, findings, and conclusions or recommendations expressed in this publication are those of the authors and do not necessarily reflect the views of the U.S. Department of Homeland Security, the Texas Division of Emergency Management, or any individual jurisdiction within the 25-county Southeast Texas Regional Advisory Council (SETRAC) region.

Implementation and maintenance of this Regional Emergency Medical Response Concept of Operations (ConOps) is coordinated by SETRAC or the Regional Healthcare Preparedness Coalition (RHPC), a SETRAC committee. For more information, call 281-822-4444. The RHPC and/or SETRAC will review and update this ConOps every five years, or when:

- Ongoing regional planning efforts affect or change this document;
- There are lessons learned or best practices from exercises and real-world incidents that should be incorporated; or
- There are changes in regional structures or processes that render parts of the document inaccurate.

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Record of Changes

Change #	Change Description	Change Made By	Date
1	Original document creation	RCPI Consultants	August 2010
2	Document updates	RCPI Consultants	December 2012
3	Entire document update. Attachments merged into document content, re-formatting, operational considerations added for all-hazard incident response.	Tina Rose on behalf of multiple Red Team Review meetings	November 2018 – February 2019

Introduction

The intent of coordinating a regional emergency medical response to an incident or natural disaster with mass casualties is to provide coordinated efficient medical care to survivors and other impacted individuals. This ConOps places relevant plans in the context of an emergency medical response to an incident or natural disaster within the CMOC 25-county region.

Purpose

The purpose of this Regional Emergency Medical Response (EMR) Concept of Operations (ConOps) is to provide a coordination framework of emergency medical response resources for large-scale, catastrophic incidents that result in mass casualties. This ConOps includes the activation, notification, identification, and integration of medical resources into the incident as well as the evacuation or transfer of patients in preparation for impending natural disasters or from incident site(s) that affects one or more jurisdictions. This document is an attachment to the Catastrophic Medical Operations Center (CMOC) Plan.

Scope

This ConOps includes the coordination of emergency medical response partners for incidents from on-scene management to hospital receipt or transfer of patients. This ConOps focuses on regional support and resource coordination for emergency medical response operations.

The intended audience for this ConOps includes local, regional, state, and federal governmental, non-governmental, private sector, and emergency medical response representatives from jurisdictions in the 25-county CMOC region.

Regional EMR objectives may include:

- Obtaining situational awareness of the incident to deploy resources into the affected area, including activation of the CMOC plan or associated attachments.
- Actions to transport all patients from the scene within 60 minutes.
- Initiating a standardized triage system.
- Identifying medical surge capacity and capability throughout the region.
- Implementing the regional patient tracking system using appropriate technologies throughout the disaster continuum.
- Integrating with established family reception or assistance centers.
- Transferring survivors from triage collection points to area healthcare facilities.
- Establishing staging areas for ambulances.
- Coordinating patient transfer from facilities to an appropriate health care facility based on capability and capacity.
- Coordinating redundant communications.
- Maintaining awareness of decedents and morgue capacity in healthcare facilities.
- Coordinating medical resource needs with jurisdictional authorities.
- Managing outside resources and volunteers
- Establishing linkage between medical care and law enforcement for evidence gathering and investigation requirements.
- Establishing a demobilization process.

Critical Assumptions

- Regional health and medical plans will be activated.
- Local and regional resources will be exhausted or anticipated to be exhausted before requesting state and/or federal assistance.
- The incident may cause widespread disruption in normal traffic flow with limited access to the incident site and/or transport to the medical facilities.
- Timely incident notification is critical to ensure resource deployment (i.e. local resources should be available within minutes to 2 hours of the incident; regional resources may be available within 2-24 hours; state and federal resources may be available in 48+ hours).
- The CMOC will be activated at the appropriate level to assist with identification, notification, activation, and mobilization of regional medical resources, whereas single resource requests may be handled by the on-call SETRAC duty officer (refer to the Regional CMOC Plan).
- Responders and survivors may require decontamination, post-exposure prophylaxis, or alternate forms of medical treatment.
- A Unified Command (UC) will be established, including a medical branch, as soon as possible to provide a coordinated response and avoid duplication of effort.
- Depending on the nature of the incident, law enforcement investigations at multiple scenes and increase scene security of the incident may be triggered.
- Local hospitals could see an influx of self-presenting survivors, which could impact emergency resources.
- Spontaneous unaffiliated bystanders, volunteers, or Good Samaritans will be involved and should be managed and integrated into the response to prevent confusion and redundancy. Procedures should be established to manage them on-scene as they present.
- All assets may not be deployed to a catastrophic incident as each jurisdiction may keep an amount of assets in service for their own needs to respond to routine emergency calls locally.
- The primary role of the Emergency Medical Services (EMS) system during an incident is the triage, treatment, and transportation of patients to definitive care facilities. At any point of an incident, there could be spikes or reductions in pre-hospital needs.
- Increased EMS demand may result in alternate standards of care for transporting and treating patients, including ADA accommodations and access and functional needs.
- Procedures should be established to manage ADA service animals on-scene as they present.
- Receiving facilities will track all incoming patients from the incident(s) utilizing the regional tracking system (e.g. EMTrack).
- Unified Command and/or hospitals may establish one or more family reunification areas depending on the size and scope of the incident.
- On-scene collection points may be established for initial triage and transport to hospitals.
- Hospitals may need to establish triage collection points for triage and possible re-distribution.
- The EMTF 6 Standard Operating Guide (SOG) may be implemented to activate, notify, and mobilize a large EMS response to assist Unified Command under the CMOC plan.
- The regional emergency medical response will be managed by local responders and assisted by CMOC and Emergency Medical Task Force (EMTF) personnel.

Regional Medical Coordination

Incident operations continue until all survivors are transported to a facility for definitive care and all resources are returned to their home base. This includes identifying hospital surge and morgue capacity, as well as managing the supplemental resources arriving at the scene(s). The Catastrophic Medical Operation Center (CMOC) recognizes its unique role and responsibilities to the medical community and may respond to local, regional, state, and national medical emergencies by providing the coordination of medical regional assets, including, but not limited to transportation, surge capacity, patient tracking, and facility requests for resources.

Catastrophic Medical Operation Center (CMOC) Operations

The CMOC will notify health care facilities throughout the region that the CMOC is beginning operations. Health providers may coordinate with the CMOC for patient transfer from the on-scene treatment area to an appropriate health care facility based on its capacity and specialized capabilities. The CMOC anticipates unmet needs of personnel, bed space, pharmaceuticals, and supplies in health care facilities. If the scope of the emergency expands to the point that facilities within the region have exhausted or are depleting internal response assets, the CMOC will assist with the coordination of requests with the following agencies: local fire, police, EMS, city and/or county emergency management office, Texas Department of State Health Services (DSHS), Texas Department of Public Safety (DPS), Texas Disaster District Committee (DDC), and/or Federal Emergency Management Agency (FEMA), and any other applicable agency.

Healthcare Facility Operations

Healthcare facilities involved in the response are expected to activate their emergency operations plan and incident command structures based on the type of incident and/or proximity of an impending disaster. They should plan to communicate patient tracking and plan for additional surge, resources, personnel, equipment and/or supply needs. Primary means of notification and bed availability reporting will be through EMResource. Patient tracking will be reported through EMTrack. Resource requests and situational awareness is shared with CMOC through WebEOC.

EMS Agency Operations

The primary EMS agency and/or medical command should utilize EMResource for emergency room and hospital capacities and should notify receiving hospitals of incoming patients. In a pre-planned event or facility evacuations, the CMOC may coordinate and notify receiving facilities of in-coming patients (see the CMOC plan). EMS maintains patient accountability in the form of documenting where patients were transported from (the various scene locations) and which facility they were transported to via their agency patient tracking method (e.g. manual forms, electronic patient tracking). Activation and notification of additional EMS resources will follow the Regional EMTF 6 Standard Operating Guide.

Operational Considerations

The safety of response personnel will not be compromised and will be factored into all decision making for response operational considerations. Integration with the medical branch established under the Incident Command System (ICS) will be consistent with the National Incident Management System (NIMS) and response priorities will be considered in the following order:

1. Saving and sustaining lives
2. Protecting/preserving public health and safety
3. Mitigating healthcare infrastructure damage
4. Restoring critical healthcare services and infrastructure

Scene Management

Transferring patients from the incident to the EMS triage area should be conducted as rapidly as possible. The triage and movement of patients from the incident sites to appropriate treatment facilities requires coordination at multiple levels. Evidence based practices have demonstrated that transportation of injured individuals to definitive medical care within 60 minutes improves patient outcomes (decreases morbidity and mortality rates). It should be the goal of all scene management personnel/responders to rapidly assess and transport all affected individuals from the scene to a hospital for definitive care within 60 minutes. Protocols will be established by the UC to address the return of transport vehicles to staging (e.g., decontamination, stocking, and personnel). UC should coordinate with CMOC to locate alternative modes of transport should air or other operations be necessary.

Medical Branch

The UC at each incident site will coordinate and communicate their operations with the medical branch. The medical branch will maintain visibility of current ambulance assets and request additional resources before current resources become overwhelmed. Ambulances dispatched to the medical branch remain under the control of the medical branch until they are no longer needed on-scene, at which time they will be demobilized back to the dispatching entity.

Ambulance Staging

Unified Command (UC) will determine the best location for ambulances to stage when they arrive on scene. Should additional regional resources be required, the UC, with CMOC, will identify additional staging locations as needed. This information will be communicated to First Responders (fire and law enforcement) and the CMOC as soon as possible.

Mass Casualty Incident Alerts

Mass Casualty Incident (MCI) alerts have two parts. The initial alert notifies hospitals via EMResource that an incident has occurred and asks how many critical, delayed, and minor patients each facility can take. The second part provides additional information such as location, contamination, potential victim count, and any other pertinent information gathered from the scene. Bed Reports are utilized when the need arises to: move inpatients from one facility to another; receive patients expected to require admission to the hospital; or to gather current surge capabilities for inpatient beds, ICU, ED, and OR capacity from all hospitals in the region.

Communications

The management of internal incident and external public communications may be different based on the jurisdictions impacted. Communications must be established between Unified/Incident Command and the CMOC. Communication strategies have been developed to allow health care facilities' emergency operations centers (EOCs) to communicate with each other and each facility's local city and/or county EOC, as applicable. The medical branch should establish the radio TACC channel and distribute the channels to deployed EMS resources. The medical branch maintains the lines of communication and will report through their assigned chain of command.

Responder Safety and Health

Responders arriving on scene are not likely to know the extent of damage, cause of the incident (e.g. accidental, intentional), potential for secondary devices, and/or environmental exposures. Law enforcement, HazMat, or response teams may be required to secure the scene. Site-specific safety and health plans with work/rest cycles, scene exposures, and personal protective equipment (PPE) recommendations for on-scene personnel should be implemented immediately. Monitoring the health and welfare of personnel is a priority, as fatigue and stress can compromise the effectiveness of operations. Any safety and health resources that are needed will be requested through the normal resource request process.

Site Access

Hospital personnel should have "essential personnel" designation on their facility ID badge. Law enforcement have been made aware of this designation. Currently there is no regional designation for responder credentialing. Planning is underway to develop a regional responder identity credentialing and access management (ICAM) system. During planned events or anticipated natural disasters, a placarding system should be in place designating those EMS agencies that are part of the response.

Patient Tracking

The purpose of patient tracking is to ensure that all patients will be readily located or reunified with family in accordance with the CMOC Plan. Personal belongings that arrive with the patient should be inventoried and tracked according to internal policies. Patient movement will be tracked by the CMOC and receiving facilities upon arrival. Patient tracking information will be reconciled between receiving facilities, CMOC, and the jurisdictional EMS agency in charge. This information will be held confidential under the federal Health Insurance Portability and Accountability Act (HIPAA), and released only to individuals determined as eligible to receive this information.[1] Patients may be transported to the hospital by good Samaritans or private vehicle; therefore, facilities may need to enter them into a tracking system once they arrive.

Civilian Responders

This ConOps does not utilize spontaneous unaffiliated civilian responders, however it is recognized that by-standers, volunteers, or Good Samaritans will show up to assist at the scene, shelters, and hospitals in the minutes, hours, days, or weeks after an incident or natural disaster.

[1] Catastrophic Medical Operations Center, Plan, January 2019.

Each individual agency/facility/jurisdiction should have plans in place to address these medical and non-medical civilian responders often referred to as spontaneous unaffiliated volunteers.

Roles and Responsibilities

Some responsibilities that may be required in a mass casualty incident are suggested below.

Agency	Roles and Responsibilities
Unified Command	▪ Authorizes the commitment of community medical and non-medical resources. ▪ Supports the emergency management of medical operations.
Medical Branch	▪ Provides emergency medical treatment and pre-hospital care to the injured. ▪ Coordinates initial triage and transportation to local medical facilities. ▪ Establishes EMS staging locations and radio use channels. ▪ Assesses need for additional regional medical resources and scene management expertise.
Public Health	▪ Coordinates behavioral and mental health services with community providers. ▪ Coordinates public health messaging (e.g. contamination, safety messaging). ▪ Determines the need for long-term epidemiological tracking of affected individuals (e.g., radiological exposure and infection control).
Fire Branch	▪ Ensure structural integrity; identifies contamination and coordinate decontamination operations. ▪ Set up rehab operations for on-scene responder personnel. ▪ Conducts site assessment(s) with medical operations (e.g., triage and pre-hospital care)
Law Enforcement Branch	▪ Provides security at the scene, staging areas, and triage/transportation sites. ▪ Coordinates with EMS in an IED incident to ensure that secondary devices are not present, including ambulances as they leave the area. ▪ Provides detection capability in areas with medical operations.
Jurisdiction(s) OEM	▪ Supports IC/UC and requests additional resources from CMOC, MACC, DDC, & EOCs, as needed. ▪ Establish Family Assistance Center, Community Resiliency Center, and/or Joint Information Center.
Catastrophic Medical Operations Center	▪ Responds to local, regional, state, or national medical emergencies by providing the coordination of ESF-8 medical response efforts, including, but not limited to, regional assets, subject matter experts, transportation, medical surge capacity, notifications, updates, patient movement and tracking, and facility requests for resources as outlined in the CMOC Plan and associated attachments. ▪ Provides unified command with mass casualty subject matter expertise, resource recommendations, and identification of additional response resources available. ▪ Coordinates the transportation and assignment of patients into health care facilities based on the capacity and capability of the facilities. ▪ Works with governing entities in the coordination of response to ensure that emergency incidents do not adversely affect the quality, capacity, and continuity of health care operations for the region. ▪ Maintains a common operating picture of real-time information that could be important to responders across disciplines in a timely and effective manner. ▪ Maintains patient tracking information for family reunification.
Multi-Agency Coordination	▪ Facilitate situational awareness across affected jurisdictions. ▪ Collect unmet non-medical regional resource need requests.
Texas DSHS	▪ Supports regional response efforts by providing personnel/resource support to the CMOC. ▪ Coordinates behavioral and mental health services with community mental health providers. ▪ Coordinates public health messaging (e.g., contamination issues and safety-related messaging). ▪ Initiate epidemiological processes to track long-term affects when contamination or other health concern issues are present.
TDEM/DPS	▪ Identifies and provides resources in support of the incident, as requested. ▪ Is available to the region for emergency public safety and/or investigation support.

Situational Awareness

Situational awareness is the continuous process of collecting, analyzing, and disseminating information to allow agencies/organizations to proactively anticipate requirements. The need for reliable updates from the scene and receiving facilities is essential to determine:

- Additional staging locations for one or more incident sites;
- When to establish secondary triage at the hospitals;
- The need for medical or specialized treatments due to:
  - exposures (e.g. chemical, biological, radiological, food borne illness, gas leak); or
  - trauma (e.g. building collapse, shooting, explosion, vehicular attack).

During any incident, it is critical to obtain reliable situational awareness of the hazard, critical infrastructure, and transportation routes to identify and deploy needed resources efficiently into the affected area. The essential elements of information (EEI) described below are important components to gaining situational awareness.

Essential Elements of Information

It is critical to deliver appropriate levels of information in a timely manner to all stakeholders during a regional emergency medical response. Essential elements of information (EEI) are used by Unified Command (UC) during response operations to collect data for necessary situational awareness and reports (e.g. SitReps, incident action plans). The EEI examples below provide a starting point for information collection and will likely be expanded when mitigation and recovery statistics are of greater importance in later stages or post-incident.

Critical Infrastructure and Facilities	▪ What is the status of the critical infrastructure in the affected area(s) (e.g. hospitals, urgent care facilities, EMS, local/state public health departments, mental health clinics, and social service agencies)? ▪ What is the status of transportation routes? ▪ What damage has occurred in the affected area (including injuries and fatalities)?
Public Health & Medical	▪ Are there reported or suspected hazardous materials and/or a toxic release? ▪ What are the safety hazards in conducting operations? ▪ Is there a need for personnel protection equipment? ▪ What are the priorities and projected requirements for medical resources/services? ▪ Is assistance available to provide bulk transport support for medical supplies/equipment/personnel? ▪ What are the actual or potential medical resource shortfalls of the affected area?
Communications	▪ Status of telecommunication infrastructure (e.g. Internet, towers) ▪ Reliability of cellular service in affected areas ▪ Status of emergency broadcast system (TV, radio, and cable) and the ability to disseminate information

Pre-Hospital Triage

First responders will conduct initial and ongoing pre-hospital triage at the scene(s) to expedite treatment of those most seriously injured. Rapid triage will allow survivors to be evaluated quickly by emergency medical personnel and moved to an appropriate level of care. At hospitals, additional triage screening will occur to determine change in patient status and appropriate treatment location assignment and priority.

Surge Triage

When self-presenting patients arrive at a facility (not arriving via EMS) and overwhelms the ability of that facility to provide treatment, an alternate triage area may need to be established by the facility (e.g. external, alternate location). CMOC may assign EMS units to the overwhelmed facility to assist in triage and hospital decompression by reassigning and transporting patients to an alternate care facility.

Air Operations

Due to the high-risk associated with air operations, coordination may include the following:

- Mission priorities
- Patient movement
- Fuel consumption
- Flight time
- Air resource staging
- Helipads locations
- Landing zones
- Fly zones
- Air space utilization

Special Situations

When the electrical grid sustains damage, EMPOWER data can be utilized to help identify those that have medically necessary devices dependent on electricity in the community. EMPOWER data is gathered from Medicaid/Medicare records by ASPR and requested through the Texas Department of State Health Services.

Reunification and Reception Centers

Friends and family will require a process to receive information regarding the incident actions and be reunified with their loved ones. Hospitals may establish family reunification/reception centers within the hospital or work with jurisdictional stakeholders for a location within the community. Engaging community stakeholders for volunteer management, call centers, and maintaining accurate communication with family and friends may be critical to successful incident messaging and reunification operations.

Demobilization

Field response operations will continue until all the survivors are transported to a facility for definitive care and all resources are returned to their home base. During demobilization the operations will continue to receive support from unified command and other coordinating entities. Personnel deployed will demobilize under the local/requestors' plans. CMOC and any personnel deployed under the CMOC will demobilize according to the CMOC demobilization plan (see the CMOC Plan Demobilization Standard Operating Procedures).

Fatality Management Overview

All on-scene operations pertaining to fatalities should be directed by the local medicolegal authority. The CMOC will maintain awareness of decedents in healthcare facilities and coordinate resource needs with jurisdictional authorities in the search for surge morgue space. The following considerations may be necessary in an incident with casualties and/or fatalities:

- Type and number of resources (i.e. personnel and equipment) needed for search and rescue of survivors and the decedent recovery or transportation of human remains.
- Location of morgue if a temporary Disaster Portable Morgue Unit (DPMU) and associated resources should be requested for processing and identification of human remains.
- A site location and personnel staffing where family and friends are reunified with survivors, receive available services, obtain information on the incident, and/or provide DNA samples for the identification of human remains, such as the following types of centers:
    a. Family Reception Center (FRC) for an immediate safe and secure location to reunite survivors and/or gather family and friends of missing persons away from the incident site and media to receive updates (e.g. hospitals, airports, and other venues).
    b. Family Assistance Center (FAC) that provides a safe and secure location with a variety of services for family and friends of the missing while simultaneously managing the exchange of accurate, timely, and consistent information for decedent identification. This is usually established by the jurisdiction.
    c. Community Resiliency Center (CRC) that provides referrals or services for the long-term recovery of the family, friends, and community affected by the MCI or MFI. This is usually established by one or more jurisdictions.

The CMOC will designate a liaison position for sitting in the jurisdictional family assistance center to assist with surviving patient identification and family reunification actions. Refer to the Regional Mass Fatality Management (MFM) Concept of Operations (ConOps) for detailed information and examples of jurisdictional FAC operations and personnel recommendations.

PURPOSE:

To establish the protocols for healthcare organizations within the TSA R, H and Q regions to provide and receive timely, relevant, and actionable information that can be used to:

- Assist with the creation of an incident common operating picture that provides information about the operating status of healthcare organizations and their immediate resource needs
- Inform local, state and/or the Federal incident management and other relevant response partners about healthcare organization resource needs to assist with the decisions regarding resource allocation
- Inform healthcare organizations with relevant incident information and status of healthcare delivery operations within the community (e.g., available resources)

PROTOCOLS for Healthcare Essential Elements of Information

Minimal information requirements for the SETRAC Regional Healthcare Preparedness Coalition include but are not limited to the following elements:

- Facility operating status: This information is provided daily and as requested during an incident via EMResource
- Facility structural integrity: This information is provided during a facility specific event (internal disaster) as well as when requested following an incident via EMResource
- The status of evacuations/shelter in-place operations: This information is provided during an incident – either facility specific or regionally significant incident via EMResource and WebEOC
- Critical medical services (e.g., trauma, critical care): This information is provided daily and as requested during an incident via EMResource
- Critical service status (e.g., electric, water, sanitation, heating, ventilation, and air conditioning): This information is provided during a facility specific event (internal disaster) as well as when requested following a regional/local incident via EMResource and WebEOC
- Critical healthcare delivery status (e.g., surge status, bed status, deaths, medical and pharmaceutical supplies, and medical equipment): This information is requested/reported during a regional or local incident as needed via EMResource. Resource requests are transmitted via WebEOC during an incident.
- Staffing status/needs: This information is requested/reported during a regional or local incident as needed via EMResource and WebEOC
- Patient transfer/transport information to include at a minimum: Last name, First Name, Age, Sex, Chief Complaint/Diagnosis, Triage Status, Originating facility and Receiving facility (if known). Additional information may be requested to locate an acceptable receiving facility. This may include: Special equipment needs, Isolation requirements, Special Medical needs (ie: transplant services, NICU, bariatric).

- Emergency Medical Services (EMS) status involving patient transport, tracking, and availability: During a regional event, this information is coordinated via Transportation Sector of CMOC and reported in WebEOC and EMTrack.
- Other information as applicable or identified during a response or recovery from an incident utilizing current technology adjunct including EMResource, WebEOC and EMTrack.

Healthcare Incident Information Validation

During daily operations, validation procedures occur via the SETRAC Duty Officer. If a significant change in facility status occurs, internal disaster is declared, or evacuation of a facility is requested, the SETRAC Duty Officer makes immediate contacts the facility POC to determine correct status and any unmet needs. When requested reporting requirements are not submitted within the timeframe requested, a validation process exists for daily utilization as well as disaster activation. In daily utilization, failure to comply with requested information (ie: bed reporting) the SETRAC TSA Coordinators contact the facility POC to encourage them to complete the requested reported. Following the monthly or DSHS requested bed report, letters are sent to all hospital CEOs thanking them for their compliance and listing all compliant facilities. During disaster activation, information is validated via telephone calls by the CMOC Corridor Representatives, EMS/Transport Sector, and Clinical Director.

Healthcare Information Sharing with the Public

During disaster activation, information is shared from the CMOC with HSR 6/5S or HSR 4/5N, DSHS, and the Joint Information Center. This information includes but is not limited to the following elements:

- The effects of the incident on the healthcare delivery system and the current status of the healthcare infrastructure throughout the region.
- Alternate care site locations, medical support facilities, temporary emergency services locations, and health-related patient care information.

Healthcare Information Systems

The SETRAC Regional Healthcare Preparedness Coalition has systems that are fully integrated across all three HPP TSA regions. These systems include: EMResource and EMTrack. The WebEOC integration is fully capable across TSA Q, TSA R and TSA H. We are current administrators of the Texas Volunteer Disaster Registry for the TSA Q and R regions and have several groups that are active. Our Regional Call Center is manned 24/7 with one central number to request emergency assistance. The CMOC also has one central number that is monitored 24/7 and an on call CMOC Chief is readily available. The regional systems (EMResource., EMTrack, WebEOC and Everbridge have the ability to:

- Integrate with local, regional and state emergency operations information systems used for response
- Provide timely, relevant, and actionable healthcare information to the incident common operating picture
- Provide multi-jurisdictional and multi-disciplinary incident related information to healthcare organizations

- Adhere to HIPAA regulations regarding the receipt and transmittal of personal health information

Bed Tracking
The SETRAC Regional Healthcare Preparedness Coalition maintains and monitors the bed tracking system through EMResource. Our regions subscribe to the state adopted Whole-Bed reporting criteria for regular and emergency bed reporting. Response stakeholders such as EMS, Public Health and Offices of Emergency Management all have "view only" access to the EMResource system for coordinated situational awareness. Monthly EMResource drills are conducted for all three regions.

Patient Tracking
The TSA R, Q, and H regions all have access to EMTrack for electronic patient tracking during an incident. The system allows for user permissions to ensure protected health information is shared with only those entities that have legal rights to view the information, while still maintaining the ability to have an overall picture of patient movement throughout the regions. Exchange of medical records between facilities during an incident is still manual and requires printing of patient care records for transport to another facility. Regional administrators, have access to all users' accounts, establish users and permissions and monitor patient movement. Regional Administrators are SETRAC employees. The general evacuation population of the region is incorporated into the tracking system in the event an evacuee becomes a medical patient during their evacuation or sheltering period. This integration of all populations across the three regions allows for tracking of an individual from entry into the healthcare system through discharge.

Interoperable Communication System
The SETRAC Regional Healthcare Preparedness Coalition has in place redundant communication systems with our healthcare facilities, EMS agencies, local law enforcement, Offices of Emergency Management and Public Health officials. These systems include:

- Landline and cellular telephones
- Two-way VHF/UHF radio
- Amateur (HAM) radio
- Satellite telephones
- VOIP

Additionally, in the event of internet or phone outages, SETRAC has the capability to deploy two fully equipped communications trailers as well as two independent satellite dishes.

Communication Training/Exercise
Regular communication drills are held monthly for EMResource and WebEOC. Radio checks are done monthly as well. Quarterly, EMResource, WebEOC and CMOC trainings are held. EMTrack training is held as requested or when new updates have been made to the system.

Recovery Process Report

1. Incident Name	2. Date Prepared	3. Time Prepared
4. Prepared by (Name and Position)	5. Report To: (Name and Position)	

I. Summary of Current Status/Actions		
1. Staffing	**Assigned To:**	**Follow-up**
a. Current Levels:		
b. Anticipated Shortfalls this Operational Period:		
c. Anticipated Shortfalls next Operational Period:		
d. Staffing Support Areas:		
e. Areas of Concern:		

2. Supplies/Equipment	Assigned To	Follow-up
a. Current Unmet Needs:		
b. Utilization/Burn rate:		
c. On Hand:		
d. Location:		
e. Areas of Concern:		

3. Patient Care Issues	Assigned To	Follow-up
a. In House:		
b. Transferred Out/Evacuated:		
c. Incoming Patients:		
d. Number Arrived:		
e. Deaths:		
f. Areas of Concern:		

4. Facility Issues	Assigned To	Follow-up
a. Electrical Power:		
b. Water:		
c. Sewer:		
d. HVAC:		
e. Phone Lines 1. Internal 2. External		
f. Internet:		
g. IT Computer Systems:		
h. Areas of Concern:		

5. Safety	Assigned To	Follow-up
a. Facility Integrity:		
b. Weather:		
c. Hazardous Materials:		
d. Infectious Agents:		
e. General Conditions:		
f. Areas of Concern:		

6. Security	Assigned To	Follow-up
a. Current Access Control Status:		
b. Visitor Policy in Place:		
c. Check Points:		
d. Areas of Concern:		

II. Summary of Outstanding Issues		
1. Staffing:	**Assigned To**	**Follow-up**
2. Supplies/Equipment:		
3. Patient Care:		
4. Facility:		
5. Safety:		
6. Security:		

7. Unmet Resource Needs:		
8. Outside Resource Requests:		
9. Other:		

III. Current Organizational Structure (Name and Contact Number)		
1. Incident Commander		
2. Liaison Officer		
3. Logistics Chief		
4. Planning Chief		
5. Operations Chief		
6. Finance Chief		

IV. Resources Summary				
Resources Ordered	**Source Identification**	**ETA**	**Arrived**	**Location/Assignment**
IS 201	**Recovery Process Report**			

Medical Counter Measure (MCM) Distribution Plan for Participating Hospitals

November 19, 2018

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Introduction

Purpose

The purpose of this plan is to establish standards and practices for the rapid and efficient delivery of medical countermeasures (MCM) to participating hospitals within the 25-county SETRAC region for dispensing to their staff, families and current patients.

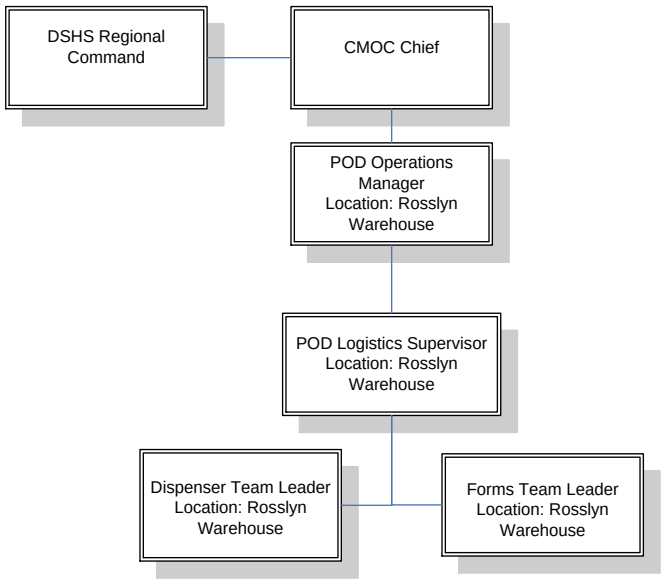
Critical Assumptions

- This plan covers the initial push of medical countermeasures and does not cover the 60-day re-supply medications or vaccinations.
- This plan only applies to acute care facilities with a participating agreement signed with SETRAC and has affirmatively identified SETRAC as their dispensing site.
- The Texas Department of State Health Services (DSHS) will provide adequate medical countermeasures within a short time frame.

Concept of Operations

To provide coordination and rapid dispensing of medical countermeasures after a biological incident, DSHS Public Health Region (PHR) 6/5 South has requested SETRAC establish a MCM Distribution Center to receive, process, and dispense antibiotic caches to hospitals within the region. This document delineates the process to dispense antibiotic caches to participating hospitals through the SETRAC MCM Distribution Center.

Organization Chart



Activation

Upon receipt of mission tasking from public health officials who have determined the need to activate the state and local strategic national stockpile (SNS) plans, SETRAC will notify and mobilize personnel to according to the **MCM Distribution Center Activation Checklist** below.

MCM Distribution Center Activation Checklist	
	SETRAC is notified of MCM activation for the region.
	Receive notification to activate MCM Distribution Plan including: ▪ Timeframe to provide prophylaxis (e.g., 48 hours, 6–10 days) _____ ▪ Hours of MCM Distribution Center operation (e.g., 12 hours, 24 hours) _____
	Contact SETRAC staff to activate MCM Distribution Plan.
	Identify MCM Distribution Center Operations Manager
	Assign SETRAC staff to the Rosslyn Warehouse, as needed ▪ Identify needs for additional outside personnel ▪ Prepare to receive supplies and pharmaceuticals from DSHS PHR 6/5 South
	Upon receipt of cache, break down cache according to Participating Hospital requirements
	Notify participating hospitals of scheduled time for their pick-up of medications
	Troubleshoot all problems as they arise.
	Deactivate the site and all operations.

Staffing Matrix

MCM Distribution Center Position	No. of Staff Needed Per Shift	No. Needed to Staff Two Shifts	No. Needed to Staff Three 8 Hr Shifts
MCM Distribution Center Operations Manager	1	2	3
MCM Distribution Center Logistics Supervisor	1	2	3
Forms Team Leader	2	4	6
Distribution Team Leader	2	4	6
Security (will be furnished by DPS coordinated through PHR 6/5s)	2	4	6

Signage

SIGN	NUMBER	LOCATION POSTED
ENTER HERE	2	Center Bay & Gate 2
STEP 1 – PICK UP TRANSFER FORM HERE	2	By Table
STEP 2 – FILL OUT FORM	2	In queue
STEP 3 – PICK UP CACHE HERE	2	Center Bay
STEP 4 – EXIT	2	Gate 1
RE-SUPPLY	2	Main Road & Gate 3

Supply List

Item Description	Quantity on Hand	Location(s)	Additional Needed
Chairs	20	Warehouse	
Clipboards		POD Box	
MCM Distribution Center Organization Chart		POD Box	
Floor Plan Map	1 map	POD Box	
Job Action Sheets – Annex A		POD Box	
Masking Tape		POD Box	
Closed POD Distribution Plan (hard copy)	1 binder	POD Box	
Attachment A – Screening Form	200 copies	POD Box	
Attachment B – Dispensing Decision Guide	200 copies	POD Box	
Attachment C – Anthrax Fact Sheet	200 copies	POD Box	
Attachment D - Doxycycline	200 copies	POD Box	
Attachment E - Levofloxacin	200 copies	POD Box	
Attachment F - Amoxicillin	200 copies	POD Box	
Attachment G - Ciprofloxacin	200 copies	POD Box	
Pens	2 boxes	POD Box	
Phone Numbers (Internal and External)	1 phone list	POD Box	
Queue Control Devices		Warehouse	
Transfer Forms	200 copies	POD Box	
Signage		POD Box	
Tables	5	Warehouse	
Pallet Jacks	2	Warehouse	
Safety Gloves	10 pr	Warehouse	

MCM Distribution

Once DSHS has requested Medical Countermeasures will be delivered to this region, then the following response actions will be taken by SETRAC (see the Appendix B for Job Action Sheets):

	MCM Distribution Checklist
	Notify SETRAC personnel and assign roles
	Set up Warehouse.
	Communicate with healthcare agencies and public Health.
	Validate number of MCM needed at each participating hospital
	Determine number of MCM needed at each facility – or verify at time of incident if you have the numbers already (Employees x4 + bed count x2 = number of people needing medication)
	Request MCM from DSHS 6/5s
	Create hospital POD packets based on the type of medication received (see Attachments A-G)
	Receive medications from the RSS site
	Dispense to SETRAC staff and families
	Pick, pack the amount necessary based on participating hospital requests
	Determine method of pick up – type of vehicle and determine pick-up time
	Provide all medications requested to the participating hospitals.
	Distribute to participating hospitals
	Hospitals sign-off on transfer forms when picking up medication.
	Status Updates
	Collection of screening forms and returning them to 6/5s
	Request Re-Supply

Demobilization

If the Assistant Secretary for Preparedness and Response (ASPR) or the Texas DSHS determines that unused SNS materiel should be returned, all unused portions of the medical countermeasure cache will be returned to DSHS PHR 6/5 South after the dispensing period. SETRAC will work with the DSHS PHR 6/5 South SNS Coordinator to determine the best method for returning unused SNS material.

SETRAC will maintain the transfer forms and collect the dispensing logs from the participating hospitals for submission to DSHS PHR 6/5s. SETRAC will work with DSHS PHR 6/5s to coordinate the best method to return these documents

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Appendix A: Rosslyn Warehouse Traffic Plan

SETRAC / CMOC
MCM Distribution Traffic Flow Plan

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Appendix B: MCM Distribution Center Job Action Sheets

MCM Distribution Center Operations Manager

You Report to:	The CMOC Operations Chief
Qualifications:	General knowledge of MCM Distribution Center Operations.
Mission:	Provide overall site management for MCM Distribution Center facility; assure communication is maintained with public health.
Immediate Actions:	Site Activation
	Receive notification from Regional Preparedness Director or CMOC Operations Chief to activate MCM Distribution Plan.
	Contact staff and: ▪ Assign staff to Rosslyn Warehouse ▪ Prepare to receive supplies and antibiotics from DSHS PHR 6/5 South
	Set up the MCM Distribution Center layout per the Rosslyn Warehouse floorplan.
	Select a spot to establish a MCM Distribution Center Command Post.
	As personnel arrive, brief employees on ▪ Latest event information ▪ Safety and security information ▪ Media rules and procedures ▪ Hours of operation ▪ Badge requirements ▪ Instructions for receiving prophylaxis before first shift
	Make assignments and handout JAS (See Staffing Matrix Table on Page 3) ▪ MCM Distribution Center Logistics Supervisor ▪ Distribution Team Leader ▪ Forms Team Leader
	Display signage according to the MCM Distribution Center flow (See Appendix A).
	Contact DSHS 6/5s to review security plan and ensure security is in place.
	Secure areas or rooms that are to be closed. Post facility rules and signs.
	Refer all media requests to joint information center or DSHS SMOC.
	Troubleshoot all problems as they arise.
	Deactivate the site and all operations.

MCM Distribution Center Logistics Supervisor

You Report to:	The MCM Distribution Center Operations Manager
Qualifications:	General knowledge of MCM Distribution Center Operations.
Mission:	Provide overall supply support and documentation.
Immediate Actions:	Set up MCM Distribution Center according to floor plan.
	Upon notification, set up the facility according to the floor plan (include signage).
	Ensure Security Officers are stationed at appropriate locations.
	Provide information during briefings regarding hazards in the facility, rooms or areas off limits, locations of restrooms, and evacuation exits and procedures.
	Assign Forms Team Leader to make additional copies of: ▪ Screening Form (Attachment 1) ▪ Dispensing Decision Guide (Attachment 2) ▪ Anthrax information (Attachment 3) ▪ Doxycycline (Attachment 4) ▪ Levofloxacin (Attachment 5) ▪ Amoxicillin (Attachment 6) ▪ Ciprofloxacin (Attachment 7) ▪ Transfer Form (Attachment 8)
	Make arrangements for receipt of antibiotics/vaccine and other medical supplies.
	Make sure all supply requests are sent to the Operations Manager and then to the CMOC.
	Make sure Forms Team Leader collects the completed Transfer Forms.
	Troubleshoot all problems as they arise.
	Deactivate the site and all operations.

MCM Distribution Center Distribution Team Leader

You Report to:	The MCM Distribution Center Logistics Manager
Qualifications:	General knowledge of MCM Distribution Center Operations
Mission:	Direct and coordinate the reception and dispensing of the prophylaxis cache.
Immediate Actions:	Set up route, schedule and process for dispensing to facilities.
	Accept all medications/vaccines and other medical supplies from the DSHS PHR 6/5 South.
	Ensure all Dispensers complete training process specific for their position. ▪ Review the Transfer Form ▪ Review procedure for requesting additional help or supplies
	Work with Logistics Supervisor to ensure that all equipment and supplies are available.
	Ensure that all patient information forms are available for dissemination.
	Brief all staff on procedures for additional supplies, security problems, or other problems.
	Supervise Dispensers.
	Collaborate with the MCM Distribution Center Operations Manager to provide an appropriate number of staff.
	Ensure all paperwork is collected and turned in to the Forms Team Leader.
	Troubleshoot all problems as they arise.
	Report any problems to the MCM Distribution Center Operations Manager.

Forms Team Leader

You Report to:	MCM Distribution Center Logistics Manager
Qualifications:	Administrative Assistant, Clerk
Mission:	Make additional copies of forms and collect all completed Transfer Forms.
Immediate Actions:	Make copies of Transfer Forms from POD Box.
	Get Transfer Form from POD Box
	Begin to copy one for each Participating facility ▪ Screening Form (Attachment 1) ▪ Dispensing Decision Guide (Attachment 2) ▪ Anthrax information (Attachment 3) ▪ Doxycycline (Attachment 4) ▪ Levofloxacin (Attachment 5) ▪ Amoxicillin (Attachment 6) ▪ Ciprofloxacin (Attachment 7) ▪ Transfer Form (Attachment 8)
	As copies are finished, take Transfer Forms and information sheets to Dispenser location.
	Collect completed forms periodically from Dispenser and turn in to MCM Distribution Center Logistics Supervisor.
	Await additional instructions.
	Address any questions to MCM Distribution Center Logistics Supervisor.

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Appendix C: Acronyms

CMOC	Catastrophic Medical Operations Center
DPS	Department of Public Safety
DSHS	Department of State Health Services
MCM	Medical Countermeasure
PHR	Public Health Region
POD	Points of Dispensing
SETRAC	SouthEast Texas Regional Advisory Council
SMOC	State Medical Operation Center
SNS	Strategic National Stockpile

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Appendix D: Placeholder

ATTACHMENTS

Provide Attachments 1-7 to Participating Hospitals
Complete attachment 8 and return to SETRAC

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Attachment 1: Screening Form

Receiving Medication: (write full names and include yourself)	Age	M/F	Under 12?	Pregnant?	Breastfeeding?	Allergic to Doxycycline?	Allergic to Ciprofloxacin?	Allergic to Amoxicillin?
			Check box ✓ for YES, leave blank for NO or DON'T KNOW					
			○	○	○	○	○	○
			○	○	○	○	○	○
			○	○	○	○	○	○
			○	○	○	○	○	○
			○	○	○	○	○	○
			○	○	○	○	○	○
			○	○	○	○	○	○
			○	○	○	○	○	○

Your Phone Number:	Your Address:

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY

Date and Time:		
POD:		

Circle correct medication.			Place sticker label here.
DOXY	CIPRO	AMOXI	
DOXY	CIPRO	AMOXI	
DOXY	CIPRO	AMOXI	
DOXY	CIPRO	AMOXI	
DOXY	CIPRO	AMOXI	
DOXY	CIPRO	AMOXI	
DOXY	CIPRO	AMOXI	
DOXY	CIPRO	AMOXI	
Total:	**Total:**	**Total:**	**Total Dispensed:**

FOR OFFICE USE ONLY

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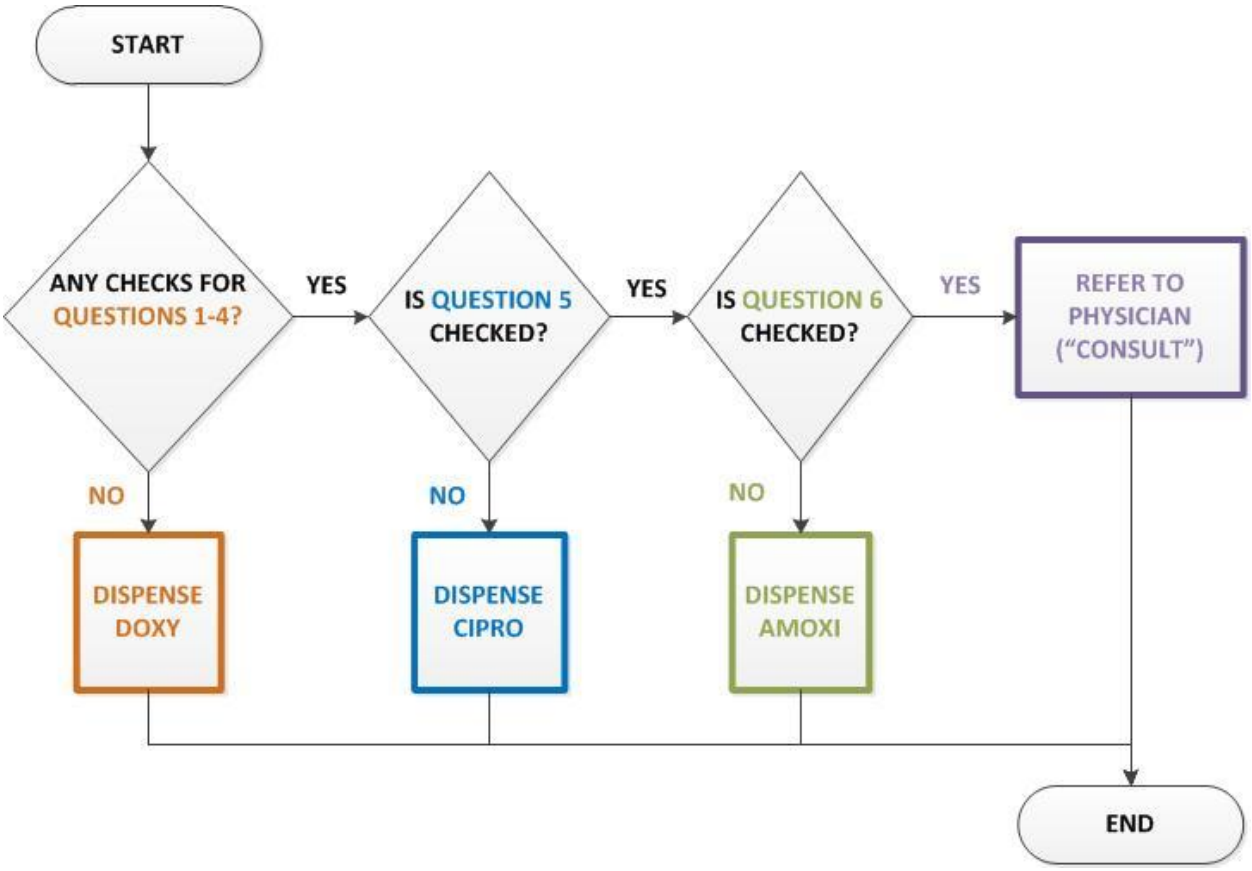
Attachment 2: Dispensing Decision Guide



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Attachment 3: Anthrax Information Sheet

Anthrax: WHAT YOU NEED TO KNOW

What is Anthrax?

Anthrax is a serious disease caused by Bacillus Anthracis, a bacterium that forms spores. A bacterium is a very small organism made up of one cell. Many bacteria can cause disease. A spore is a cell that is dormant (asleep) but may come to life with the right conditions.

Anthrax Type	Symptoms	Time Frame	Treatment	Additional Information
Skin (Cutaneous)	• Small sore develops into a blister. • Blister develops into a skin ulcer with black center. • None of these hurt.	Within 7 days of exposure.	Antibiotics (60-day course)	• In most cases, early treatment with antibiotics can cure cutaneous anthrax. • Even untreated, 80% of those infected do not die.
Lungs (Inhalational)	• Cold or flu-like symptoms (sore throat, mild fever, etc.) • Cough, chest discomfort, shortness of breath.	Between 7 and 42 days of exposure.	Antibiotics (60-day course)	• The most severe type of infection. • In 2001, about half the cases ended in death.
Digestive (Gastrointestinal)	• Nausea, loss of appetite, bloody diarrhea, and fever. • Bad stomach pain.	Within 7 days of exposure.	Antibiotics (60-day course)	• Between one-fourth and one-half of cases end in death.

How Do You Get It?

Anthrax is not known to spread from person to person.

Anthrax from animals. Humans can become infected with anthrax by handling products from infected animals or by breathing in anthrax spores from infected animal products (like wool, for example). People also can become infected with gastrointestinal anthrax by eating undercooked meat from infected animals.

Anthrax as a weapon. Anthrax can also be used as a weapon. This happened in the United States in 2001. Anthrax was deliberately spread through the postal system by sending letters with powder containing anthrax. This caused 22 cases of anthrax infection.

How Dangerous Is Anthrax?

The Center for Disease Control and Prevention (CDC) has classified Anthrax and a Category A agent, which means:

- There is a great threat for a bad effect on public health.
- Anthrax may spread across a large area or need public awareness.
- Anthrax requires a great deal of planning to protect the public's health.

For additional information, visit the Centers for Disease Control and Prevention (CDC) at www.bt.cdc.gov/agent/anthrax**.**

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Attachment 4: Doxycycline

Is there new doxy / cypro information sheets that need to be listed here?

Patient Information: Doxycycline

Doxycycline 100-mg Oral Tablet or Doxycycline Oral Suspension

Take this medicine only as prescribed.

Doxycycline belongs to a class of drugs called tetracycline antibiotics. It is approved by the Food and Drug Administration (FDA) to treat and protect people who have been exposed to anthrax spores.

How to take Doxycycline

ADULTS: Take 1 tablet every 12 hours as directed.
CHILDREN: A child's dose depends on body weight. Give the medicine to your child as directed by the doctor.

Take Doxycycline with food and least one full glass of water. Avoid taking antacids (like Tums or Maalox), cholestyramine (Questran), colestipol (Colestid), dairy products (like milk or yogurt) or vitamins 3 hours before or after taking Doxycycline.
If you miss a dose, start again taking 1 pill every 12 hours. Do not take 2 pills to make up for the missed dose. Finish all your pills, even if you feel okay, unless your doctor tells you to stop. If you stop this medication too soon, you may become ill.

Side effects

Common side effects of Doxycycline include an upset stomach, vomiting, or diarrhea. If you have problems with any of these symptoms, tell your doctor. Less common side effects include dark urine, yellowing of the eyes or skin, sore throat, fever, unusual bleeding or bruising, fatigue, white patches in the mouth. If any of these symptoms occur, call your doctor right away.
Allergic reactions are rare. Signs of an allergic reaction are rash, itching, swelling of the tongue, hands or feet, fever, and trouble breathing. If any of these symptoms occur, call you doctor right away.

***SPECIAL NOTE FOR CHILDREN*:** This medicine may cause staining of the teeth in children younger than 8 years old. This means that their teeth can become grayish in color and this color does not go away. This medicine can also cause bone growth delay in premature infants but this side effect goes away after the medicine is finished.
***SPECIAL NOTE FOR PREGNANT WOMEN*:** There is little data about side effects from the use of this drug during pregnancy. If the mother of an unborn baby takes Doxycycline, staining of baby teeth or poor bone development can result. There is a remote chance of severe liver disease in some pregnant women.

Precautions

- Be sure to tell the doctor if you are allergic to any medicine.
- It is very important to tell the doctor the names of ALL medicines that you are currently taking even pills bought at the store such as vitamins and antacids.
- Doxycycline can make skin very sensitive to the sun which increases the chance of getting severe sunburn. Avoid the sun as much as possible. When outside, wear a long sleeve shirt and hat and always apply sunscreen (30 SPF).
- Birth control pills may not work as well when taking this medication. Be sure to use condoms or another form of birth control until you are finished the entire course of treatment. If you are pregnant or breastfeeding, tell your doctor.
- In women, Doxycycline can cause vaginal itching and discharge commonly known as a yeast infection. Tell your doctor if this happens.
- Tell the doctor if you have ever had problems with your liver or kidneys, or if you have frequent heartburn.

For additional information, visit the Centers for Disease Control and Prevention (CDC) at www.bt.cdc.gov/agent/anthrax**.**

Doxycycline Solution Instructions

Liquid Doxycycline

For infants and children exposed to bioterrorism

How to Make Liquid Doxycycline

25 mg per 5 mL (teaspoon)

You will need:

- One (1) 100-mg doxycycline tablet.
- Something heavy to crush the tablet, such as a metal spoon, the bottom of a cup or glass or a hammer.
- Measuring teaspoon(s) or regular eating teaspoon.
- One small bowl
- These directions.

Please read all instructions before you begin.

Step 1

Put one (1) 100 mg doxycycline tablet into a small bowl.

Crush into powder using the back of the metal teaspoon or the bottom of a cup or glass.

You can also place the tablet in a plastic bag and crush it with something heavy like a hammer or rolling pin. The powder should not have any large pieces of medicine.

Add four (4) teaspoons of water into the medicine powder.

Mix well until the powder dissolves and there is no more powder left at the bottom of the bowl.

Step 2

Weigh your child. Use your child's weight to find the correct dosage on the chart below.

Weight: _____ lbs.

Dosage Chart

You can find out how much medicine to give your child based on your child's weight. Use this chart to find the amount for one (1) dose.

Give this dose two (2) times a day – once in the morning and once in the evening – for as many days as you were told to give this medicine.

Doxycycline oral liquid 25 mg per 5 mL (per teaspoon)	
Weight	**Dose**
Less than 7 lbs	**¼ teaspoon**
7 lbs to 12 lbs	**½ teaspoon**
over 12 lbs to 19 lbs	**¾ teaspoon**
over 19 lbs to 25 lbs	**1 teaspoon**
over 25 lbs to 37 lbs	**1½ teaspoon**
over 37 lbs to 50 lbs	**2 teaspoons**
over 50 lbs to 62 lbs	**2½ teaspoons**
over 62 lbs to 75 lbs	**3 teaspoons**
over 75 lbs to 87 lbs	**3½ teaspoons**
More than 87 lbs	**1 whole tablet (100 mg**

My child's name

_____

My child's dose is

_____

If you do not have a measuring teaspoon then use a regular teaspoon. It is hard to measure one half teaspoon with a regular teaspoon. Do the best you can. It is better to give a little more medicine than not enough.

See Page 2 for more directions.

How to Make Liquid Doxycycline

Continued from previous page

My child's name _____

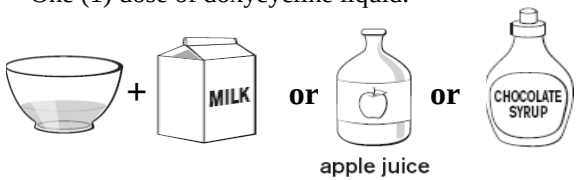
My child's dose is _____

Mix this amount with food or liquid see below.

Step 3

This medication tastes better mixed with a little milk, table sugar or any other sweet food or drink.

One (1) dose of doxycycline liquid.



Mix with:
Chocolate foods or drinks like chocolate syrup, chocolate milk or chocolate pudding are best.

Apple juice or apple sauce sweetened with extra table sugar.

Mix well before using.

You may use this medication for up to 24 hours if it is kept covered and stored at room temperature or in the refrigerator. Throw away any unused liquid after 24 hours and mix fresh every day.

Step 4

How to give the medication to an infant:

Mix medicine with one or two teaspoons of formula or breast milk inside the nipple of the bottle. Let your infant suck on the nipple until all the medicine is gone.

For older children:

Make sure child eats or drinks all of the food or drink that is mixed with medicine. It may be helpful to have the child suck on an ice cube or fruit flavored popsicle before and after giving the medicine. This may help cover up the bad taste. I

Important Information

Mix well before using.

Give this medicine one hour before or two hours after the child takes any:

- Vitamins
- Iron
- Antacids
- Sucralfate (a medicine)

Possible side effects of liquid Doxycycline

- Upset stomach, throwing up and diarrhea.
- Sunburn-use sunscreen on your child before going out in the sun.
- Possible permanent staining of teeth.

Warnings

Stop use and seek medical help if your child develops any of these rare but dangerous symptoms:

- Allergic effects such as: trouble breathing: closing of the throat; swelling of lips, tongue or face; hives.
- Painful swallowing
- Yellowing of skin or eyes, dark urine, stomach pain, throwing up and loss of appetite.
- Bulging soft spot in infants.

Go to:
www.fda.gov/cder/drug/infopage/penG_doxy for more information about doxycycline.

If you have further questions, contact your physician or pharmacist

Adopted for SETRAC from the Illinois Department of Public Health. July 2008.

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Attachment 5: Levofloxacin

Patient Information: Levofloxacin

Levofloxacin 500 mg Oral Tablets or Liquid Suspension

Take this medication only as prescribed.

Levofloxacin is an antibiotic that belongs to the antibiotic group call quinolones. It used to kill many types of bacteria that can infect the lungs, sinuses, skin, and urinary tract.

How to take Levofloxacin

ADULTS: Take 1 tablet once a day.

CHILDREN: A child's dose depends on body weight. Give the medication to your child as directed by your doctor.

Take Levofloxacin with or without food. Try to take the tablet at the same time each day and drink fluids liberally.

If you miss a dose, start again taking your dose at the regular time. Do not take 2 pills to make up for the missed dose. Finish all your pills, even if you feel okay, unless your doctor tells you to stop. If you stop this medication too soon, you may become ill.

Side Effects

Levofloxacin is generally well tolerated. The most common side effects caused by Levofloxacin are mild. They can include the following: nausea, diarrhea, itching, abdominal pain, dizziness, flatulence (gas), rash and vaginitis in women.

Allergic reactions are rare. Signs of an allergic reaction include hives; skin rash; swelling of the tongue, hands or feet; fever; or trouble breathing. If any of these symptoms occur, contact your doctor right away.

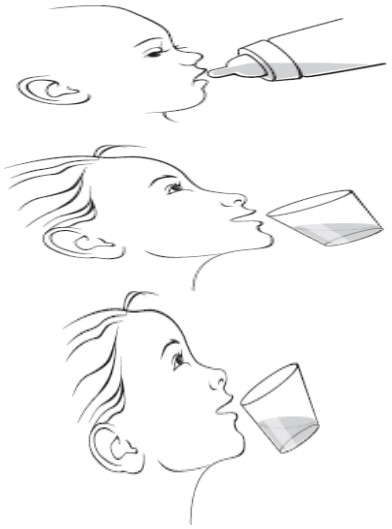
SPECIAL NOTE FOR PREGNANT WOMEN: If you are pregnant or are planning to become pregnant while taking Levofloxacin, talk to your health care professional before taking this medication. It is recommended for use during pregnancy or nursing

Precautions:

- Be sure to tell your doctor if you are allergic to any medicine.
- It is very important to tell your doctor the name of ALL medicines that you are currently taking even pills bought at the store such as vitamins and antacids.
- Taking warfarin (Coumadin) and Levofloxacin together can further predispose you to the development of bleeding problems. If you take warfarin, be sure to tell your health care professional.
- Do not drive or operate machinery until you are sure Levofloxacin is not causing dizziness.
- Levofloxacin can make skin sensitive to light. Avoid excessive exposure to sunlight or artificial violet light. When outside, wear a long sleeve shirt and hat and always apply sunscreen (SPF 30).
- Levofloxacin may produce false-positive urine screening results for opiates using commercially available immunoassay kits. Confirmation of positive opiate screens by more specific methods may be necessary.

For additional information, visit the Centers for Disease Control and Prevention (CDC) at www.bt.cdc.gov/agent/anthrax**.**

Levofloxacin Solution Instructions



Liquid Levofloxacin

For infants and children exposed to bioterrorism

How to Make Liquid Levofloxacin

125 mg per 5 ml (teaspoon)

You will need:

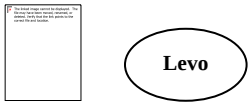
- One (1) 500-mg Levofloxacin tablet
- Measuring teaspoon(s) or regular eating teaspoon.
- One (1) small glass, cup or bowl
- These directions.

Please read all instructions before you begin.

Step 1

- Pour four (4) teaspoons of room temperature water into a small glass or bowl.

- Put one (1) 500 mg Levofloxacin tablet into the water and let it sit for five (5) minutes until the tablet breaks apart.



- Mix well until the powder dissolves and there is no more powder left at the bottom.

Step 2

Weigh your child.

Weight: _____ lbs.

Use your child's weight to find the correct dosage on the chart below.

Dosage Chart

How much medicine to give your child is based on your child's weight.
Use this chart to find the amount for one (1) dose.

Give this dose two (2) times a day – once in the morning and once in the evening .

Weight (lb)	Dose
Less than 8 lbs	¼ teaspoon
8 to 16 lbs	½ teaspoon
Over 16 lbs to 26 lbs	1 teaspoon
Over 26 lbs to 40 lbs	1 ½ teaspoon
Over 40 lbs to 55 lbs	2 teaspoons
Over 55 lbs to 75 lbs	3 teaspoons
Over 75 lbs	1 whole tablet (500 mg)

My child's name

_____

My child's dose is

_____

If you do not have a measuring teaspoon then use a regular teaspoon. It is hard to measure one-half teaspoon with a regular teaspoon. Do the best you can. It is better to give a little more medication than not enough.

See Page 2 for more directions.

How to Make Liquid Levofloxacin

Continued from previous page

My child's name _____

My child's dose is _____

Mix this amount with food or liquid see below.

Step 3

This medication is very bitter. Mix the liquid with food or drink before giving it to your child.

One (1) dose Levofloxacin liquid.

Mix with:

- Chocolate syrup
- Table sugar
- Apple juice or apple sauce
- Sweetened with extra table sugar

Do not mix with:

- Calcium-fortified juice
- Infant Formula
- Breastmilk

Mix well before using.

You may use this medication for up to 24 hours if it is kept covered and stored at room temperature or in the refrigerator. Throw sway any unused liquid after 24 hours and mix fresh every day.

Step 4

How to give the medication to an infant:

Mix medicine with one or two teaspoons of water inside the nipple of the bottle. Let your infant suck on the nipple until all the medicine is gone.

For older children:

Make sure child eats or drinks all of the food or drink that is mixed with medicine.

Important Information

Mix well before using.

Give this medicine one hour before or two hours after your child takes any of these:

- Infant formula, breastmilk, milk or milk-products such as yogurt or ice cream.
- Calcium-fortified juice, vitamins, iron, antacids or sucralfate (a medicine)

Possible Side Effects of Liquid Levofloxacin

- Dizziness lightheadedness
- Upset stomach, throwing up and diarrhea
- Sunburn-use sunscreen on your child before going out in the sun

Warnings

Do not give this medicine before talking to your doctor if your child is taking any of these medicines:

Theophylline, Caffeine, Warfin, or Cyclosporine.

Stop use and seek medical help if your child develops any of these rare but dangerous symptoms:

- Allergic effects such as: trouble breathing: closing of the throat; swelling of lips, tongue or face; hives.
- Pain, burning, tingling, numbness, weakness of hands or feet
- Bone or tendon pain
- Hallucinations, severe confusion, convulsions.

If you have further questions, contact your physician or pharmacist

Adopted for SETRAC from the Illinois Department of Public Health. July 2008.

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Attachment 6: Amoxicillin Instructions

Patient Information: Amoxicillin

Amoxicillin 250mg Oral Tablets or 250mg/5ml Liquid Suspension

Take this medication only as prescribed.

Amoxicillin is an antibiotic that belongs to the antibiotic group called penicillin. You have been given this drug for protection against possible exposure to an infection-causing bacteria.

How to take Amoxicillin

ADULTS: Take 2 tablet three times a day.

CHILDREN: A child's dose depends on body weight. Give the medication to your child as directed by your doctor.

Take Amoxicillin with or without food. Taking Amoxicillin with food or milk may help prevent some stomach upset. Try to take the tablet at the same times each day (every 8 hours) and drink plenty of fluids.

If you miss a dose, start again taking your dose at the regular time. Do not take 2 pills to make up for the missed dose. Finish all your pills, even if you feel okay, unless your doctor tells you to stop. If you stop this medication too soon, you may become ill.

Side Effects

Amoxicillin is generally well tolerated. The most common side effects caused by Amoxicillin are mild. They can include the following: nausea, diarrhea, itching, abdominal pain, dizziness, flatulence (gas), rash and vaginitis in women.

Allergic reactions are rare. Signs of an allergic reaction include hives; skin rash; swelling of the tongue, hands or feet; fever; or trouble breathing. If any of these symptoms occur, contact your doctor right away.

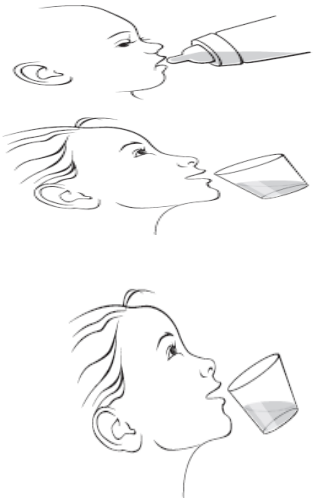
SPECIAL NOTE FOR PREGNANT WOMEN: If you are pregnant or are planning to become pregnant while taking Amoxicillin, talk to your health care professional before taking this medication. Amoxicillin passes through breastmilk, so speak with your physician if you are nursing.

Precautions:

- Be sure to tell your doctor if you are allergic to any medicine.
- Do not take this medicin if you have had an allergic reaction to amoxicillin, penicillin, or cephalosporins such as Keflex or Ceclor..
- Make sure your doctor knows if you are taking gout medicine like probencid (Benemid) as this may cause higher levels of amoxicillin in your blood increasing your side effects.
- While you are taking Amoxicillin, birth control pills may not work as well; make sure you use another form of birth control.

For additional information, visit the Centers for Disease Control and Prevention (CDC) at www.bt.cdc.gov/agent/anthrax**.**

Amoxicillin Instructions



Liquid Amoxicillin

For infants and children exposed to bioterrorism

How to Take Liquid Amoxicillin
125 mg per 5 ml (teaspoon)

You will need:
- Amoxicillin oral suspension – reconstituted
- Medicine dosing spoon.

Please read all instructions before you begin.

Step 1

Weigh your child.

Weight: _____ lbs.

Use your child's weight to find the correct dosage on the chart below.

Step 2

Normal pediatric dose: 80 mg/kg/day divided into equal doses administered orally every 8 hours Maximum dose: 500 mg/dose

5-6 lbs	1.5cc
7-9 lbs	2cc
10 lbs	2.5cc
11-13 lbs	3cc
14 lbs	3.5cc
15-17 lbs	4cc
18 lbs	4.5cc
19-22 lbs	5cc
23-25 lbs	6cc

26-27 lbs	6.5cc
28-30 lbs	7cc
31 lbs	7.5cc
32-33 lbs	8cc
34-35 lbs	8.5cc
36-38 lbs	9cc
39-40 lbs	9.5cc
41 lbs	10cc

Give this dose three (3) times a day

Possible Side Effects of Liquid Amoxicillin

- Upset stomach, abdominal pain
- Seek medical attention or contact your physician if diarrhea, vomiting, dizziness, rash or difficulty breathing occurs

Warnings

Do NOT take liquid Amoxicillin if:

- You are allergic to any ingredient in amoxicillin suspension or another penicillin antibiotic (eg, ampicillin)
- You have infectious mononucleosis (mono)
- You are taking a tetracycline antibiotic (eg, doxycycline)
- You are on probenecid (Benemid);
- You take a blood thinner such as warfarin (Coumadin);
- You are taking an antibiotic such as: azithromycin, clarithromycin, or telithromycin; or sulfa drugs

If you have further questions, contact your healthcare provider.

Adopted for SETRAC from the Illinois Department of Public Health. July 2008.

How to Take Liquid Amoxicillin **Keep refrigerated.** **Stop use and seek medical help** if your child

Continued from previous page

My child's name _____

My child's dose is _____

Give this dose three (3) times a day

Mix this amount with food or liquid see below.

Step 3

You may take amoxicillin with or without food.

Mix well before using.

Shake the oral suspension (liquid) well just before you measure a dose.

Measure the liquid with a special dose-measuring spoon or medicine cup, not with a regular table spoon.

If you do not have a dose-measuring device, ask your pharmacist for one.

The suspension should be discarded 14 days after reconstitution.Throw sway any unused liquid after 14 days.

Step 4

How to give the medication to an infant:
Mix medicine with one or two teaspoons of water, breast milk, or formula inside the nipple of the bottle. Let your infant suck on the nipple until all the medicine is gone.

For older children:
You may place the liquid directly on the tongue, or you may mix it with water, milk, baby formula, fruit juice, or ginger ale..

Drink all of the mixture right away. Do not save any for later use.

develops any of these rare but dangerous symptoms:

- white patches or sores inside your mouth or on your lips;
- fever, swollen glands, rash or itching, joint pain, or general ill feeling;
- severe blistering, peeling, and red skin rash;
- pale or yellowed skin, yellowing of the eyes, dark colored urine, fever, confusion or weakness;
- severe tingling, numbness, pain, muscle weakness; or
- easy bruising, unusual bleeding (nose, mouth, vagina, or rectum), purple or red pinpoint spots under your skin.

If you have further questions, contact your healthcare provider.

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Attachment 7: Cipro Instructions

Patient Information: Ciprofloxacin

Cipro 500 mg Oral Tablets or Liquid Suspension

Take this medication only as prescribed.

Cipro is an antibiotic that belongs to the antibiotic group call quinolones. It used to kill many types of bacteria that can infect the lungs, sinuses, skin, and urinary tract.

How to take Cipro

ADULTS: Take 1 tablet two times a day.
CHILDREN: A child's dose depends on body weight. Give the medication to your child as directed by your doctor.

Take Cipro with or without food. It is best to take Cipro two hours after a meal. Try to take the tablet at the same time each day and drink plenty of fluids.
If you miss a dose, start again taking your dose at the regular time. Do not take 2 pills to make up for the missed dose. Finish all your pills, even if you feel okay, unless your doctor tells you to stop. If you stop this medication too soon, you may become ill.

Side Effects

Cipro is generally well tolerated. The most common side effects caused by Cipro are mild. They can include the following: nausea, diarrhea, itching, abdominal pain, dizziness, flatulence (gas), rash and vaginitis in women.

Allergic reactions are rare. Signs of an allergic reaction include hives; skin rash; swelling of the tongue, hands or feet; fever; or trouble breathing. If any of these symptoms occur, contact your doctor right away.

SPECIAL NOTE FOR PREGNANT WOMEN: If you are pregnant or are planning to become pregnant while taking Cipro, talk to your health care professional before taking this medication.

Precautions:

- Be sure to tell your doctor if you are allergic to any medicine.
- It is very important to tell your doctor the name of ALL medicines that you are currently taking even pills bought at the store such as vitamins and antacids.
- Make sure your doctor knows if you are taking asthma medicines like theophylline, gout medicine like probencid (Benemid) or a blood thinner like warfarin (Coumadin).
- Do not drive or operate machinery until you are sure Cipro is not causing dizziness.
- Cipro can make skin sensitive to light. Avoid excessive exposure to sunlight or artificial violet light. When outside, wear a long sleeve shirt and hat and always apply sunscreen (SPF 30).
- Do not take the following drugs within two hours of taking Cipro: antacids such as Maalox or Mylanta, vitamins, iron supplements, zinc, sucralfate (Carafate).

For additional information, visit the Centers for Disease Control and Prevention (CDC) at www.bt.cdc.gov/agent/anthrax**.**

Liquid Cipro

For infants and children exposed to bioterrorism

How to Make Liquid Cipro
125 mg per 5 ml (teaspoon)

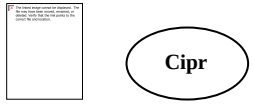
You will need:
- One (1) 500-mg Cipro tablet
- Measuring teaspoon(s) or regular eating teaspoon.
- One (1) small glass, cup or bowl
- These directions.

Please read all instructions before you begin.

Step 1

- Pour four (4) teaspoons of room temperature water into a small glass or bowl.

- Put one (1) 500 mg Cipro tablet into the water and let it sit for five (5) minutes until the tablet breaks apart.



- Mix well until the powder dissolves and there is no more powder left at the bottom.

Step 2

Weigh your child.

Weight: _____ lbs.

Use your child's weight to find the correct dosage on the chart below.

Dosage Chart

How much medicine to give your child is based on your child's weight.
Use this chart to find the amount for one (1) dose.

Give this dose two (2) times a day – once in the morning and once in the evening .

Weight (lb)	Dose
Less than 8 lbs	¼ teaspoon
8 to 16 lbs	½ teaspoon
Over 16 lbs to 26 lbs	1 teaspoon
Over 26 lbs to 40 lbs	1 ½ teaspoon
Over 40 lbs to 55 lbs	2 teaspoons
Over 55 lbs to 75 lbs	3 teaspoons
Over 75 lbs	1 whole tablet (500 mg)

My child's name _____

My child's dose is

_____

If you do not have a measuring teaspoon then use a regular teaspoon. It is hard to measure one-half teaspoon with a regular teaspoon. Do the best you can. It is better to give a little more medication than not enough.

See Page 2 for more directions.

How to Make Liquid Cipro

Continued from previous page

My child's name _____

My child's dose is _____

Mix this amount with food or liquid see below.

Step 3

This medication is very bitter. Mix the liquid with food or drink before giving it to your child.

One (1) dose Cipro liquid.

Mix with:

- Chocolate syrup
- Table sugar
- Apple juice or apple sauce
- Sweetened with extra table sugar

+

or

apple juice

Do not mix with:

- Calcium-fortified juice
- Infant Formula
- Breastmilk

Mix well before using.

You may use this medication for up to 24 hours if it is kept covered and stored at room temperature or in the refrigerator. Throw sway any unused liquid after 24 hours and mix fresh every day.

Step 4

How to give the medication to an infant:
Mix medicine with one or two teaspoons of water inside the nipple of the bottle. Let your infant suck on the nipple until all the medicine is gone.

For older children:
Make sure child eats or drinks all of the food or drink that is mixed with medicine.

Important Information
Mix well before using.

Give this medicine one hour before or two hours after your child takes any milk or milk products.

Possible Side Effects of Liquid Cipro

- Dizziness lightheadedness
- Upset stomach, throwing up and diarrhea
- Sunburn-use sunscreen on your child before going out in the sun

Warnings

Do not give this medicine before talking to your doctor if your child is taking any of these medicines:

Theophylline, Caffeine, Warfin, or Cyclosporine.

Stop use and seek medical help if your child develops any of these rare but dangerous symptoms:

- Allergic effects such as: trouble breathing: closing of the throat; swelling of lips, tongue or face; hives.
- Pain, burning, tingling, numbness, weakness of hands or feet
- Bone or tendon pain
- Hallucinations, severe confusion, convulsions.

If you have further questions, contact your physician or pharmacist

Adopted for SETRAC from the Illinois Department of Public Health. July 2008

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Attachment 8: Transfer Forms

SETRAC Closed POD Transfer Form

Page: 1

Transfer From:	**Transfer To:**
SETRAC 5115 Rosslyn Houston, Texas 77008	

Line #	Item #	NDC Supplier Number	Location	Description	Lot #	Expiry Date	Quantity to Pick	Unit of Measure	Quantity Picked
1			SETRAC Closed POD	Ciprofloxacin 500 mg, 20				CS	
2			SETRAC Closed POD	Doxycycline 100 MG 20s				CS	

Distributed By: _____ Print Name

Signature: _____

Date:_____ Time:_____

Received By: _____ Print Name

Signature: _____

Date:_____ Time:_____

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Regional Ebola Transportation Ambulance (RETA) Plan

November 19, 2018

FORWARD

WARNING: This document is FOR OFFICIAL USE ONLY (FOUO). It contains information that may be exempt from public release under the Freedom of Information Act (5 U.S.C. 552). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with U.S. Department of Homeland Security policy relating to FOUO information and is not to be released to the public or other personnel who do not have a valid "need-to-know" without prior approval of an authorized official.

Development of this document and costs for its printing and distribution were supported by Grant Number CPS/HOSP 2013-043762 to Southeast Texas Regional Advisory Council (SETRAC) via the State of Texas as a contractor for the Hospital Preparedness Program (HPP) grant, as awarded by the Assistant Secretary for Preparedness and Response (ASPR), Centers for Disease Control and Prevention (CDC).

The opinions, findings, and conclusions or recommendations expressed in this publication are a compilation of guidance from the CDC, World Health Organization (WHO), Texas Task Force on EVD, Department of State Health Services, and regional subject matter experts.

The Regional Ebola Transportation Ambulance Plan focuses exclusively on regional support and coordination for screening, isolation, identification, activation, notification, and mobilization. Implementation of this Regional Ebola Transportation Ambulance Plan is coordinated by the Regional Healthcare Preparedness Coalition (RHPC), a committee of regional stakeholders managed by SETRAC. For more information, call 281-822-4444.

This document and its appendices will be maintained by the RHPC and will be reviewed and updated every five years, or when:

- Ongoing regional planning efforts affect or change this document;
- There are lessons learned and best practices from exercises and real-world events that should be incorporated; or
- There are changes in regional structures or processes that render parts of the document inadequate.

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Introduction

The Regional Ebola Transportation Ambulance (RETA) plan was developed based on current literature regarding Ebola Virus Disease (EVD) transmission and mortality rates, the Centers for Disease Control (CDC) guidance, the World Health Organization (WHO) precautions, and The Texas Governor's Task Force on Infectious Disease Preparedness and Response. An outbreak of EVD or other highly infectious diseases would significantly challenge the healthcare, public health, and emergency medical service (EMS) response within the region, resulting in the activation of the Catastrophic Medical Operations Center (CMOC). This plan is an attachment to the existing CMOC Plan. Although this plan was specifically written for transporting patients with the Ebola virus disease it can be adapted for other high consequence infectious diseases (HCID) such as small pox and pneumonic plague.

The RETA plan does not supersede or exclude any existing jurisdictional or regional plans; rather, it provides context for a coordinated regional response for identifying and transporting highly contagious infected patients with the region. Regional guidance, based on CDC guidelines for proper screening of potential EVD suspicious patients, has been distributed throughout the region. The immediate isolation of the suspected patient and prompt notification to the appropriate public health department is the cornerstone to successful implementation of this plan.

Purpose

The purpose of this Regional Ebola Transportation Ambulance (RETA) Plan is to describe a regional approach for emergency medical services, public health, and healthcare to transport patients in a coordinated fashion during an EVD outbreak or other highly infectious disease. This plan provides a process for isolation and transportation of confirmed EVD infected patients throughout the region.

The intended audience for this plan includes local, regional, state, and federal government, non-governmental, private sector, and other emergency response representatives within twenty-five (25) counties and cities within the three Trauma Service Areas (TSAs) that comprise the Southeast Texas Regional Advisory Council (SETRAC) and Regional Healthcare Preparedness Coalition (RHPC) region.

Actions described in this plan are intended to function in coordination with local government, public health, emergency management, and other public safety entities and are not meant to supersede, replace, or compete with other regional or local plans. This plan is an attachment to the Catastrophic Medical Operation Center (CMOC) plan and is scalable, flexible, and adaptable to address other highly infectious disease characteristics. This plan will be used in conjunction with any transportation mission by DSHS and HHS Region 6.

Scope

The Regional Ebola Transportation Ambulance (RETA) Plan includes considerations for patient triage/screening, pre-hospital treatment/transport, decontamination, personal protective equipment (PPE), and waste management as it relates to the ambulance transport of the patient. This plan outlines suspect patient procedures, notification procedures, confirmed positive patient transportation to the designated EVD Treatment Center, the transport vehicle and sending facility decontamination and resupply protocols, and the proper disposal of infected waste. This Plan is scalable, flexible, and designed to be adaptable for other highly infectious diseases.

The geographical footprint supported by this plan includes 25 counties, within the Department of State Health Services Public Health Regions 6/5 South and 4/5 North. The map in Figure 1 shows an overlay of the Trauma Service Areas (TSA) and Public Health with 24-hour reporting numbers.

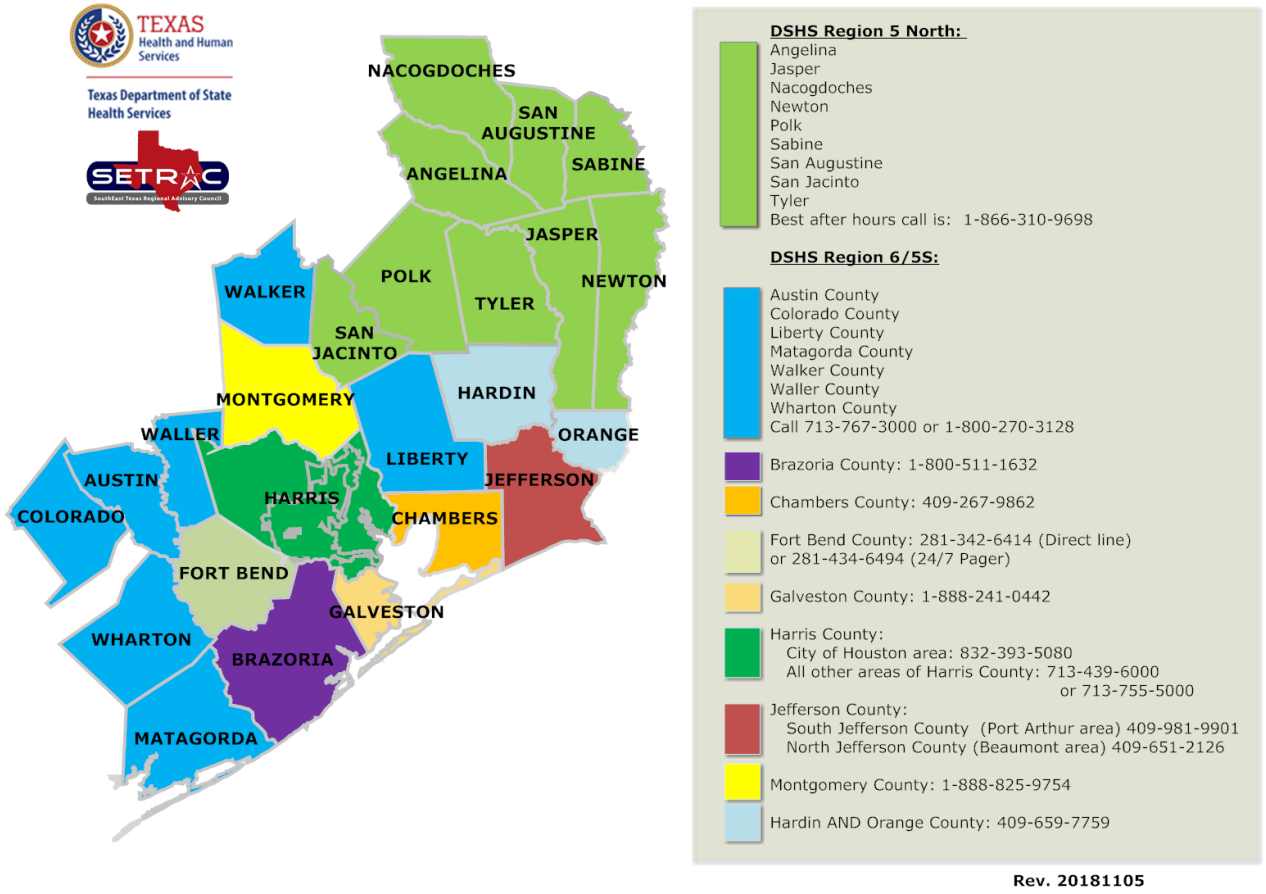

Figure 1: TSA-Q, TSA-R, TSA H and CMOC Regions

Critical Assumptions

- This plan is specifically written for Ebola Virus Disease (EVD) and can be adapted for other high consequence infectious diseases (HCID) such as small pox and pneumonic plague.
- Local and regional health and medical plans will be implemented along with this RETA plan.
- The Catastrophic Medical Operations Center (CMOC) will raise its level of activation to meet the needs of the incident.[1]
- All confirmed high consequence infectious disease (HCID) patients are transported in accordance with CDC guidelines. Some procedures and methods may be modified based on the individual case (contact vs respiratory).
- Hospitals and other healthcare facilities are responsible for screening, isolating, and calling their public health official in accordance with the RHPC regional guidance for EVD triage.
- Hospitals and other healthcare facilities will be responsible for laboratory sampling as outlined in the RHPC regional guidance, and proper packaging and transportation of the specimen to an approved LRN laboratory.
- State medical response and support may be available within six hours after the confirmed positive laboratory test.
- Federal medical emergency response support and resources may be available approximately 72 hours after the confirmed positive laboratory test.
- A primary and back-up regional response asset such as the Regional Ebola Transport Ambulance (RETA) will be available within approximately 3-4 hrs. Scene reporting times will vary depending upon location.
- SETRAC has pre-identified EMS agencies familiar with the region that have:
  - completed special standardized training and possesses standardized equipment; and
  - a current, fully executed Emergency Medical Task Force (EMTF) MOA with SETRAC.
- For EVD, only Polymerase Chain Reaction (PCR) confirmed patients will be transported to one of the State designated Ebola Treatment Centers, or a federally identified Treatment Center.
- Although not necessarily a part of this plan, a State Mission Assignment from the State to SETRAC will cover all costs associated with the care and transportation of:
  - a confirmed (State PCR) EVD case to an identified state facility;
  - Some-Risk or High-Risk individual from home to hospital (9-1-1 support);
  - moderate or highly suspected EVD death from home to Medical Examiner/funeral home;
  - the re-supply of PPE and medical supplies for regional ambulances and initial healthcare facility;
  - the decontamination/cleaning of ambulances, uniforms and initial healthcare facility;
  - the disposal of waste identified as a Category A Infectious Substance (49 CFR 172.134 and 172.323) associated with the care and transportation of an EVD patient.

1 See CMOC Plan, Appendix A: Catastrophic Medical Operations Center Activation

- If the RETA asset is dispatched without a state mission assignment, the requesting entity or patient may be responsible for the costs incurred.
- The RETA may be activated without a confirmed case for decedent pick-up and/or suspect case from a physician's office.
- A high consequence infectious disease (HCID) will cause widespread media attention.

Concept of Operations

The intent of coordinating a Regional Ebola Transportation Ambulance (RETA) is to quickly and robustly provide guidance, support, and transportation of laboratory confirmed positive patients to the appropriate care facility. The safety of healthcare and response personnel will not be compromised, especially due to the potential for secondary transmission and should be factored into all decision making. Response agencies and healthcare facilities should prepare and train their staff in proper use of personal protective equipment (PPE), including donning and doffing, utilization of regional screening guidance, and the identification of isolation locations that follow the Center for Disease Control (CDC) guidance and procedures for identifying and monitoring workers who had exposure to the infected patient.

RETA Activation

The Regional Ebola Transportation Ambulance (RETA) will be dispatched via SETRAC Regional Communications Center (RCC) that operates 24 hours per day, 365 days per year. All employees of the RCC will receive training on the RETA Plan, and at least one employee working every shift should be prepared to activate RETA at any time.

Upon request for activation, the Regional Ebola Transportation Ambulance Plan trained RCC dispatcher will notify the RETA on call. The Public Health individual contacting the Southeast Texas Regional Advisory Council (SETRAC) or the Catastrophic Medical Operation Center (CMOC) to request the ambulance should be prepared to provide the following information:

- Pick up location
- Number of patients
- General physiological status of the patient(s)
- Complicating factors – ie: extensive diarrhea, vomiting, bleeding, or other body fluids
- Ambulance access and/or parking for EVD patient transport
- Additional precautionary requirements

Having this information will allow SETRAC and/or any activated CMOC personell to determine which asset to deploy, what level of response is required, and which receiving location is appropriate for the patient.

Table 1: Summary of Critical Tasks for RETA Notification

Tasks	Agency
Patient identified as some to high suspicion based on screening criteria per public health	All healthcare, EMS, Dispatch Centers, public health
Notification of RETA request made to SETRAC/CMOC	Public Health
SETRAC/CMOC notifies RCC for RETA transport	SETRAC, RCC dispatch
RCC Dispatch notifies on-call RETA of transport request	RCC
RETA prepares crew and identified vehicle and provides ETA	RETA identified EMS

Ebola Virus Disease Presentation

When an incident of this magnitude occurs in the CMOC region, certain protective action plans and procedures will be activated. This includes increasing the Catastrophic Medical Operations Center (CMOC) activation level, and implementing notification to the health care facilities throughout the region. Processes for reporting and monitoring events, matching needs and resources, and deployment of assets are detailed in the regional CMOC Plan.[2]

This plan outlines four scenarios in which a suspected EVD patient could enter the healthcare system. While not all inclusive, the most likely presentations into the healthcare system are outlined in the four plausible scenarios described below:

1. Self-presentation to an acute care facility or Free-Standing Emergency Department (FSED)
2. Self-presentation to a clinic, FSED or physician office
3. 9-1-1 call for assistance
4. Public Health request for home monitoring individual

1. Self-Presentation at Acute Care Facility or FSED

Local healthcare facilities should establish internal procedures for Screening, Isolating, and Notifying Public Health for any patient that meets the criteria as established in the Regional Triage Guidance and in accordance with current CDC guidelines. Once a determination has been made that the presenting patient meets the screening criteria for suspicion of EVD, the patient should be immediately isolated, proper PPE donned by the healthcare workers assigned to that patient, contact kept to a minimum and local public health notified.

A. If the patient meets the CDC specified criteria for testing, public health may request an EVD PCR be drawn and will provide instructions on which laboratory to use. The blood sample should be double bagged, labelled, and hand carried to the laboratory for appropriate packaging and shipment to an identified laboratory capable of testing as outlined in 49 CFR 172.323.

2 See the Catastrophic Medical Operations Center (CMOC) Plan, 2018.

B. The patient should remain in isolation until the preliminary PCR results are communicated back to the facility. If a positive PCR result comes back on the patient, local public health will immediately request SETRAC/CMOC for a RETA transport to a Treatment Center. Upon determination of approved transfer, CMOC will notify the Treatment Center of an impending transfer.

C. The CMOC will activate the RETA when requested by the Authority Having Jurisdiction (i.e. local public health authority or their designee). Planning assumptions acknowledge that the RETA could be activated unnecessarily, but this is preferable to inaction that could lead to a delayed response and further loss of life.

D. The transferring facility is responsible for compliance with all Emergency Medical Treatment Active Labor Act (EMTALA) requirements for a transfer to a higher level of care. Report will be called to the accepting Treatment Center by the transferring facility and CMOC will provide an ETA to the transferring facility to facilitate a smooth transfer. CMOC will communicate regularly with local public health on status of transport.

E. The transferring facility should have a place for the RETA team to don and doff PPE, to coordinate care, and to discuss the transition process for the patient to move from the patient room through the hospital to the RETA for transport. The RETA team will notify CMOC once patient has been transferred to the ambulance and provide an ETA to the Treatment Center. This information will be relayed to the Treatment Center by CMOC.

F. The local Public Health Department will work with the healthcare facility's Infection Control Professional to conduct epidemiological surveillance of healthcare workers involved in care as well as contacts of the patient.

2. Self-Presentation at Clinic or Physician Office[3]

Local health clinics and physician offices should establish internal procedures for Screening, Isolating, and Notifying Local Public Health for any patient that meets the criteria as established in the Regional Triage Guidance and in accordance with current CDC guidelines. Once a determination has been made that the presenting patient meets the screening criteria for suspicion of EVD, the patient should be immediately isolated, proper PPE donned by the healthcare workers assigned to that patient, contact kept to a minimum and public health notified.

A. If the patient meets the CDC specified criteria for testing, public health will arrange transport to an acute care facility capable of isolation and blood draw.

B. The patient should remain in isolation until public health/DSHS requests SETRAC/CMOC for a RETA transport to an acute care facility. Upon determination of the need to transport, CMOC will notify the acute care facility of an impending patient.

[3] In this case the state mission order may not be issued and the patient may not be a confirmed case.

C. The CMOC will activate the RETA when requested by local public health authority or designee and is not responsible for verifying the validity of the request. Planning assumptions acknowledge that the RETA could be activated unnecessarily, but this is preferable to inaction that could lead to a delayed response and further loss of life.

D. The transferring clinic/physician's office call report to the accepting acute care facility and CMOC will provide an ETA to the clinic/physician's office to facilitate a smooth transfer.

E. Upon arrival of RETA to the clinic/physician office, the staff will clear hallways and transport the patient to the ambulance; at which time a hand-off will occur with RETA.

F. RETA will notify CMOC once patient is in the ambulance and provide an ETA to the acute care facility. This information will be relayed to the acute care facility by CMOC.

G. CMOC will communicate regularly with local public health on status of transport.

H. Public Health will begin epidemiological surveillance of healthcare workers involved in care as well as contacts of the patient.

3. Call 9-1-1 for Assistance

When local 9-1-1 receives a call and dispatch performs screening criteria on the caller, information is relayed to the EMS crew. Following regional EMS guidance, in accordance with CDC recommendations, the dispatched ambulance arrives on scene, dons PPE appropriate for universal precautions, and surveys the scene/patient status.

A. If patient meets screening criteria, the crew will exit the premises, don appropriate PPE per CDC guidance, and call their Medical Control with assessment.

B. Medical Control will confer with local public health on the degree of suspicion for EVD. If patient determined as low risk of EVD, the crew will transport with normal protocols.

C. If it is determined that the patient is some or high risk for EVD or there is evidence of gross body fluids at scene and history is indeterminate, the 9-1-1 service will remain on the scene to secure the safety of the patient and public health may notify SETRAC/CMOC of the need for a RETA.

D. SETRAC/CMOC will deploy RETA to the scene for transfer of care. RETA will provide an ETA to the location and to SETRAC/CMOC and this information will be passed on to the 9-1-1 Medical Control.

E. Upon arrival on-scene, 9-1-1 will provide report and formal hand-off of the patient, sharing assessment, history, precautions, physiological status of patient to the RETA.

F. Receiving acute care facility will be notified of an incoming RETA that will coordinate with the receiving facility ETA, patient status, and any additional precautions necessary.

G. Hand-off of the patient at the receiving acute care facility will occur at the back of the ambulance per regional guidance.

H. Public Health will begin epidemiological surveillance of healthcare and EMS workers involved in care as well as contacts of the patient.

4. Public Health Surveillance (Home Monitored Individual)

For individuals in the community currently under public health surveillance for EVD exposure and become symptomatic or it is determined by the monitoring public health department that the individual should be transferred to a hospital for further evaluation, the monitoring public health official may notify SETRAC/CMOC of the need for a RETA if the individual is unable to transport themselves to the hospital.

A. SETRAC/CMOC will deploy RETA to the scene for transfer of care. RETA will provide an ETA to the location and to SETRAC/CMOC and this information will be passed on to the requesting public health official.

B. Receiving acute care facility will be notified of incoming RETA that will coordinate with the receiving facility ETA, patient status, and any additional precautions necessary.

C. Hand-off of the patient at the receiving acute care facility will occur at the back of the ambulance per regional guidance.

D. CMOC will communicate regularly with local public health on status of transport.

E. Public Health will begin epidemiological surveillance of healthcare and EMS workers involved in care as well as contacts of the patient.

Table 2: Summary of Critical Tasks

Tasks	Agency
Screen, Isolate, Notify Public Health for consult	All healthcare, EMS, Dispatch Centers
Institute PPE for contact and droplet precautions	All healthcare and EMS
Obtain, package and transport requested blood sample	Acute care facilities and freestanding ER
Request transport through public health to CMOC to acute care facility	Clinics and physician offices
Request transport through public health to CMOC for PCR confirmed cases to designated Treatment Centers	Acute care facilities and freestanding ER

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Appendix A: RETA Activation Protocol

1. Upon notification of suspected case with laboratory testing to be done, notify Supervisor.
2. Arrange conference call to include the three ambulance services and Supervisor.
3. Ensure "first-up" ambulance service is on standby with wrapped unit. Ensure "back-up" ambulance service can be ready to support.
4. Notify SMOC and request State Mission for transport to Galveston UTMB IF test is positive. Mission to include:
   a. Cost of wrapping, staffing (3 personnel), PPE, transport fee, supplies, equipment
   b. Cost of chase vehicle with personnel
   c. Cost of decontamination of ambulance
   d. Cost of waste incineration
   e. Request for DPS escort with lights on through traffic
5. Notify DDC for "head's up" of STAR request coming via WebEOC
6. Notify Rosslyn Warehouse of possibility of need for PPE cache to initial hospital for support.
7. Maintain communication with sending/receiving facilities and public health officials.
8. If test result is negative, notify all previously mentioned (SMOC, DDC, Supervisor, Warehouse, Ambulance Services) of stand down
9. If test positive, coordinate with sending and receiving facility for transfer time (provide a 2-hour prep time and calculated travel time). Notify on-call RETA 24/7 dispatch number.
10. Sending facility is responsible for obtaining transfer approval from UTMB, completing MOT, report and providing copies of medical records. All forms for transfer should be placed in a watertight sealed clear plastic bag for transport.
11. Maintain communications with sending facility, receiving facility, and chase vehicle regarding progress points on pre-identified TAC channel:
    a. Leaving home base
    b. Arrival at sending facility
    c. Leaving sending facility
    d. Progress en route to receiving
    e. Arrival to receiving facility
    f. Decontamination of personnel
    g. Leaving receiving facility
    h. Decontamination of vehicle
    i. Disposal of waste
    j. Completion of mission
    k. Document all costs associated with Mission with SETRAC finance and submit to SMOC for reimbursement
12. Document issues, concerns, best practices and convene post transport conference call with individuals in #2 as well as sending/receiving facilities, and public health official, if possible.

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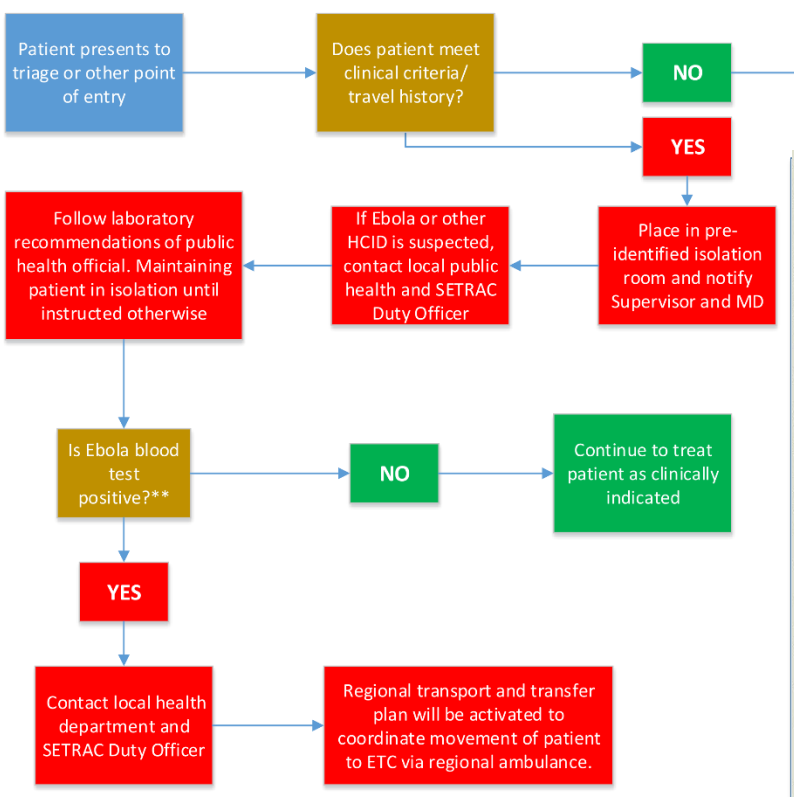
Appendix B: Regional Triage Guidance

Quick Guide Sheet for Ebola/HCID Presentation



DSHS Region 5 North:
Angelina
Jasper
Nacogdoches
Newton
Polk
Sabine
San Augustine
San Jacinto
Tyler
Best after hours call is: 1-866-310-9698

DSHS Region 6/5S:

Austin County
Colorado County
Liberty County
Matagorda County
Walker County
Waller County
Wharton County
Call 713-767-3000 or 1-800-270-3128

Brazoria County: 1-800-511-1632

Chambers County: 409-267-9862

Fort Bend County: 281-342-6414 (Direct line)
or 281-434-6494 (24/7 Pager)

Galveston County: 1-888-241-0442

Harris County:
City of Houston area: 832-393-5080
All other areas of Harris County: 713-439-6000
or 713-755-5000

Jefferson County:
South Jefferson County (Port Arthur area) 409-981-9901
North Jefferson County (Beaumont area) 409-651-2126

Montgomery County: 1-888-825-9754

Hardin AND Orange County: 409-659-7759

**** ONLY Ebola lab tested positive patients will be accepted for transfer at UTMB Ebola Treatment Center**

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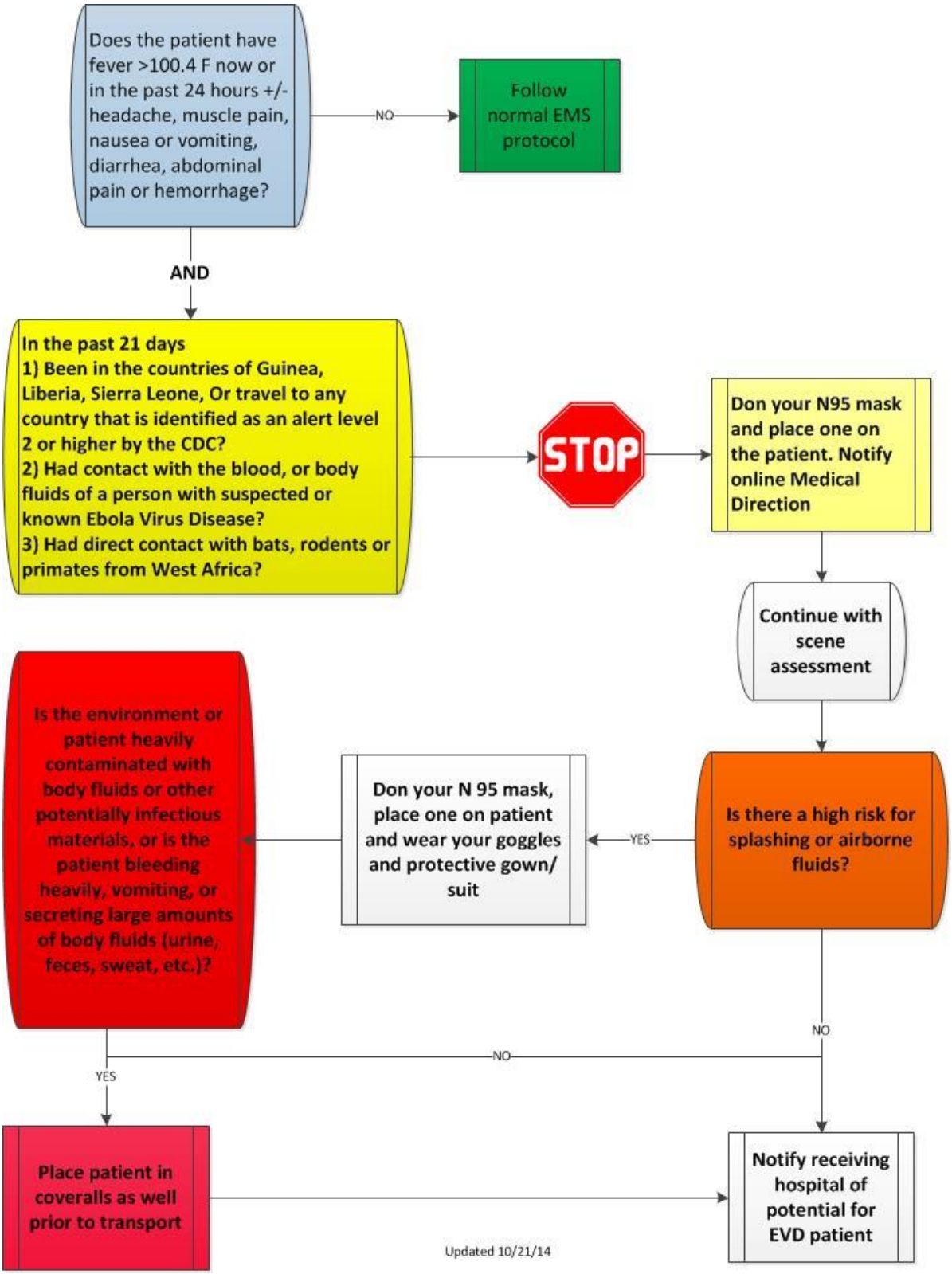
Appendix C: EMS Decision Tree Guidance



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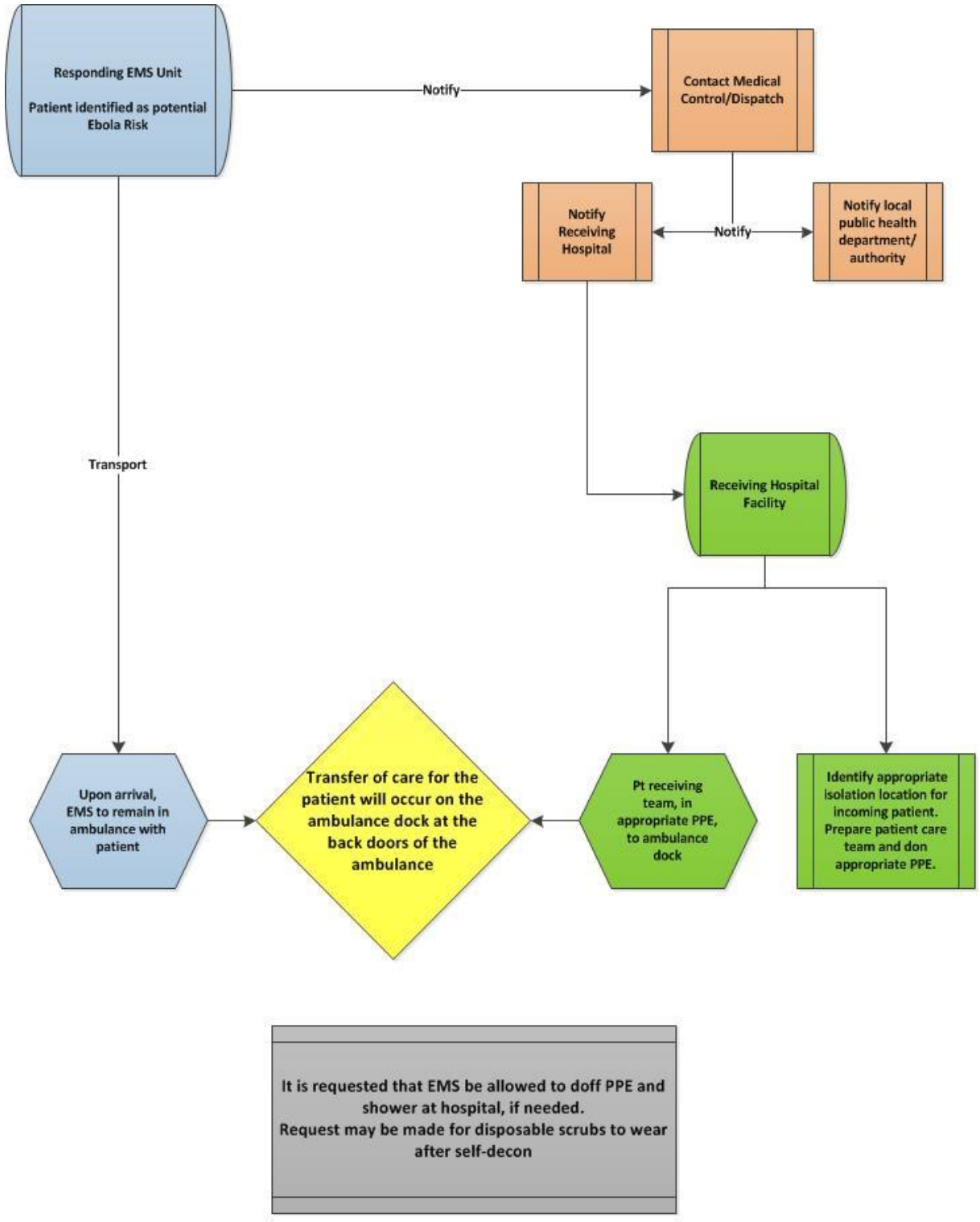
Appendix D: EMS-Hospital Hand-off



Updated 10/21/14

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Appendix E: EMS Special Considerations

Note: these EMS special considerations are specific for the Ebola Virus Disease (EVD) and can be adapted for other infectious diseases.

I. Infection Control/Personal Protective Equipment (PPE)

A. Every effort should be made to contain potentially infectious body fluids by use of emesis bags, biohazard bags, and yellow sheets or other barriers to collect large volumes of diarrhea or other potentially infectious materials.

B. If performing intubation, nebulizer treatment, CPR, open suctioning, or any procedure that may result in aerosolized body fluids, respiratory protection that is at least a NIOSH-certified, fit tested, N95 filtering face piece respirator shall be used.

C. PPE shall be worn upon entry, or put on as soon as the risk is identified, and continue to be worn until the member is no longer in contact with the patient or potentially infectious materials.

D. PPE shall be carefully removed without contaminating one's eyes, mucous membranes, or clothing.

E. PPE shall be placed into a medical waste container at the hospital or double bagged and held in a secure location until it can be properly disposed of.

F. Hand hygiene shall be performed immediately after the removal of PPE.

G. Members should decontaminate to include showering if possible at the hospital.

II. Patient Care Equipment

A. Dedicated medical equipment (preferably disposable) should be used for the provision of patient care.

B. All reusable equipment should be cleaned and disinfected according to manufacturer's instructions. The CDC advises that when used according to the manufacturer's instructions, Environmental Protection Agency (EPA)-registered disinfectants are sufficient to inactivate enveloped viruses such as EVD.

III. Patient Care Considerations

A. Limit procedures, especially those that will increase the risk of exposure to infectious material, to only those which are absolutely necessary prior to arrival at the hospital.

B. Limit or avoid use of needles and other sharps, as much as possible, in a moving vehicle;

C. Needles and sharps should be handled with extreme care and disposed of **immediately** in puncture-proof, sealed containers.

D. Hand hygiene should be performed frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.

E. Pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, and cardiopulmonary resuscitation frequently result in body fluids, such as saliva and vomit. Performing these procedures in a less controlled environment (e.g., moving vehicle) increases risk of exposure of EMS personnel. If conducted, perform these procedures under safer circumstances (e.g., stopped vehicle, hospital destination.)

IV. Patient Transport into Hospital

A. Contact the Medical Control/Dispatch as soon as the patient has been identified as a potential EVD risk. The Medical Control/Dispatch shall immediately notify the receiving hospital to prepare for patient arrival. Any hospital that is following CDC's infection control recommendations and can isolate a patient in a private room is capable of safely managing a patient with EVD.

B. Medical Control/Dispatch shall contact the local health department/health authority.

C. Upon arrival at the receiving facility, transporting crew members shall remain inside the vehicle with the patient, until directed to unload by hospital receiving staff.

D. The transfer of patient care will occur at the back doors of the ambulance. This will allow the hospital to control the movement of suspect EVD patients into hospitals or healthcare facilities. Potential EVD patients should be restricted to entrances away from public waiting areas.

E. Suspected EVD patients should not be moved through, or temporarily left in, waiting rooms.

F. If the patient, stretcher, members' PPE, or other items or equipment is contaminated with potentially infectious material, members shall take care to minimize the transfer of potentially infectious material to hospital surfaces.

V. Environmental Cleaning

A. Diligent environmental cleaning and disinfection and safe handling of potentially contaminated materials is extremely important, as blood, sweat, emesis, feces and other body secretions represent potentially infectious materials.

B. Persons performing environmental cleaning and disinfection shall wear recommended PPE to protect against exposure through contact and/or splashes during clean-up:

1. Gloves
2. Gown (fluid-resistant or impermeable)
3. Goggles
4. Facemask
5. Additional PPE may be required in certain situations, including the presence of copious amounts of blood, other body fluids, vomit, or feces on the patient or in the environment. In these cases, member shall use the following additional PPE as needed **to ensure no skin is exposed**:
   a. Double gloving
   b. Disposable shoe covers
   c. Leg coverings

d. Tyvek body suit- This is not essential to provide care to suspected EDV patients, but it may be more practical than using a gown with separate coverings for the legs and shoes.

C. Patient-care surfaces (stretchers, railings, medical equipment control panels, and adjacent flooring, walls, and work surfaces) are likely to become contaminated and shall be cleaned and disinfected immediately after transport. Hospital-grade agency supplied disinfectants, when used according to the label, are sufficient to kill EVD.

D. A blood spill or spill of other body fluid or substance should be managed according to agency's Infection Control Guidelines.

E. Contaminated reusable patient care equipment shall be placed in biohazard bags and labeled for cleaning and disinfection according to agency policies. Reusable equipment should be cleaned and disinfected according to manufacturer's instruction by trained personnel wearing correct PPE.

F. To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard any contaminated fabrics (including uniforms), linens, and non-waterproof pillows or mattresses as regulated medical waste.

* If proper PPE is utilized, members' uniforms should not be contaminated with potentially infectious material.

G. Ensure that infectious waste is safely contained in clearly marked biohazard bags/containers and disposed of in compliance with agency's guidelines.

VI. Follow-Up & Reporting After Caring for Suspected or Confirmed EVD Patient

A. EMS Personnel with exposure to blood, bodily fluids, secretions, or excretions from a patient with suspected or confirmed EVD shall immediately:

1. Stop working and wash the affected area with a large amount of water or eyewash solution;
2. Contact the Supervisor for assessment and access to post-exposure management services; and
3. Receive medical evaluation and follow-up care, including fever monitoring twice daily for 21 days, after the last known exposure. The member may continue to work while receiving twice daily fever checks, based upon recommendations from local, state, and federal public health authorities.

B. EMS personnel who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an unprotected exposure (i.e., not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with suspected or confirmed EVD should:

1. Not report to work or immediately stop working and isolate themselves;
2. Notify their supervisor, who should notify local and state health departments;
3. Contact physician through Workers' Compensation for assessment and access to post-exposure management services; and
4. Comply with work exclusions until they are deemed no longer infectious to others.

Appendix F: Healthcare Special Considerations

I. Hospital Minimum Expectations for Interim Care

A. Routinely manage all patients using universal precautions

B. All acute care hospitals must be prepared to evaluate patients suspected of having EVD, draw blood specimens, and package and transport specimens for EVD testing as outlined in DSHS EVD Guidelines.

C. Include assessment of patients for the possibility of EVD in triage and evaluation processes.

1. Early symptoms of EVD are similar to other febrile illnesses. Risk posed by patients with early, limited symptoms (i.e., fever, fatigue, headache, muscle pain) is lower than that from patients with severe EVD symptoms (i.e., bleeding, vomiting, and diarrhea).
2. Take a relevant travel and exposure history of all patients. If the patient is unable to provide history due to clinical condition or other communication barriers, history should be elicited from the next most reliable source (i.e., family, friend, or EMS provider).

D. This screening should include Travel/Contact History:

1. Residence in or travel to the continent of Africa, or a country with widespread EVD transmission (specifically Guinea, Liberia, or Sierra Leone) within the previous 21 days.
2. Contact with an individual with confirmed EVD within the previous 21 days.
3. Direct handling of bats or nonhuman primates from a country with widespread EVD transmission.
4. Health care worker in a patient care area or processing laboratory samples for patients with EVD in the U.S. or elsewhere.
5. On any public health monitoring list for EVD, including a self-monitoring list.

E. Further question patients who have a relevant travel and exposure history regarding the presence of signs or symptoms compatible with EVD. These include:

1. Fever (including a history of fever in the last 24 hours, subjective feeling of fever, and the use of antipyretic drugs) ≥100.4°F or 38.0°C.
2. Headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain, or hemorrhage (i.e., bleeding gums, blood in urine, nose bleeds, coffee ground emesis or melena).

II. Patient Management

A. Immediately isolate patients with a relevant travel and exposure history, and who present with fever and symptoms as defined above.

B. Place patient in a private room or area, preferably with a private bathroom or covered commode.

C. Implement administrative and environmental controls (such as a designated area for further evaluation of patients with possible EVD).
   1. At an administrative level, the facility's infection prevention management system, in collaboration with the facility's occupational health department, should establish and implement triage protocols to effectively identify patients who may have EVD and institute the precautions detailed in this document.
   2. Designate individuals as site managers responsible for overseeing the implementation of precautions for healthcare workers and patient safety. A site manager's sole responsibility is to ensure the safe and effective delivery of EVD treatment. These individuals are responsible for all aspects of EVD infection control including supply monitoring and evaluation with direct observation of care before, during, and after staff enter an isolation and treatment area.
   3. At least one site manager should be on-site at all times in the location where the EVD patient is being cared for.
   4. Identify critical patient care functions and essential healthcare workers for care of EVD patients, for collection of laboratory specimens, and for management of the environment and waste ahead of time.
   5. Ensure healthcare workers have been trained in all recommended protocols for safe care of EVD patients before they enter the patient care area.
   6. Train healthcare workers on all PPE recommended in the facility's protocols. Healthcare workers should practice donning and doffing procedures and must demonstrate during the training process competency through testing and assessment before caring for EVD patients.
   7. Use trained observers to monitor for correct PPE use and adherence to protocols for donning and doffing PPE, and guide healthcare workers at each point of use using a checklist for every donning and doffing procedure.
   8. Document training of observers and healthcare workers for proficiency and competency in donning and doffing PPE, and in performing all necessary care-related duties while wearing PPE.
   9. Designate spaces so that PPE can be donned and doffed in separate areas.
   10. Identify and isolate the EVD patient in a single patient room with a closed door and a private bathroom as soon as possible.
   11. Limit the number of healthcare workers who come into contact with the EVD patient (e.g., avoid short shifts), and restrict non-essential personnel and visitors from the patient care area.
   12. Monitor the patient care area at all times, and log at a minimum entry and exit of all healthcare workers who enter the room of an EVD patient.
   13. Ensure that a trained observer watches closely each donning and each doffing procedure, and provides supervisory assurance that donning and doffing protocols are followed.
   14. Ensure that healthcare workers have sufficient time to don and doff PPE correctly without disturbances.

15. Ensure that practical precautions are taken during patient care, such as keeping hands away from the face, limiting touch of surfaces and body fluids, preventing needlestick and sharps injuries, and performing frequent disinfection of gloved hands using an alcohol-based hand rub, particularly after handling body fluids.
16. Disinfect immediately any visibly contaminated PPE surfaces, equipment, or patient care area surfaces using an EPA-registered disinfectant wipe.
17. Perform regular cleaning and disinfection of patient care area surfaces, even absent visible contamination.
18. This should be performed only by nurses or physicians as part of patient care activities in order to limit the number of additional healthcare workers who enter the room.
19. Implement observation of healthcare workers in the patient room, if possible (e.g., glass-walled intensive care unit [ICU] room, video link).

D. Hospitals must be capable of providing supportive care, including other laboratory testing required for patient management, until receipt of laboratory test results.

E. Hospitals must be prepared to evaluate and test for alternative diagnoses that could also be the cause of the patient's signs and symptoms (such as malaria or typhoid fever) based on the areas visited.

F. Patient care decisions should be based on the patient's medical status, history, and evaluation for alternative diagnoses.

G. Avoid unnecessary direct contact.

H. Designate staff members who have been trained in proper PPE to evaluate identified patients.

I. If a patient is exhibiting severe EVD symptoms (e.g., bleeding, vomiting, or copious diarrhea) health care workers must don full PPE.

J. If a patient is exhibiting early symptoms (e.g., fever, fatigue, headache, muscle pain) health care workers should implement standard, contact, and droplet precautions.

K. PPE should be donned and doffed as outlined in CDC EVD Guidelines: Personal Protective Equipment for Health Care Personnel.

L. Health care facilities must provide onsite management and oversight on the safe use of PPE to include continuous safety checks through direct observation of healthcare workers during the process of putting on (donning) and taking off (doffing) PPE.

M. Notify hospital infection control staff and maintain a log of people entering the patient room.

N. Perform only urgent or emergent procedures.

O. Immediately contact appropriate local health department or health service region.

III. Laboratory Testing – Inhouse Clinical-based

A. Healthcare providers are directed to contact local health departments and DSHS HSR to provide awareness of any patients possibly suspected of having EVD in their areas and to evaluate the patient symptoms and risk factors.

B. The Centers for Disease Control's (CDC) recommendations to U.S. clinical laboratories for safe management of all diagnostic specimens from persons under investigation for

EVD are the same as recommendations for other known infectious diseases that are transmitted through blood or body fluids, such as HIV and hepatitis viruses.

C. Clinical laboratories in acute care facilities must also do routine laboratory testing for a person under investigation, such as traditional chemistry, hematology, or other laboratory testing used to support and treat patients.

D. Any person collecting or testing specimens from a patient with suspect EVD should adhere to strict full PPE guidelines, as outlined in CDC EVD Guidelines: Personal Protective Equipment for Health Care Personnel.

E. For transporting specimens within the facility, place them in a durable, leak-proof secondary container. Hand walk specimens to the laboratory. Do not use any pneumatic tube system for transporting suspected EVD specimens.

F. During specimen testing, a certified class II Biosafety cabinet or Plexiglass splash guard should also be used, as well as all manufacturer-installed safety features on all laboratory equipment.

G. In the case of a spill in the laboratory, the basic principles for blood or body substance spill management are outlined in the United States OSHA Blood Borne Pathogens Standards. Clean and disinfect surfaces with a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (i.e., norovirus, rotavirus, adenovirus, poliovirus). Although there are no products with specific label claims against the EVD virus, enveloped viruses such as EVD are susceptible to a broad range of hospital disinfectants used to disinfect hard, non-porous surfaces.

IV. Laboratory Testing – EVD Specific

A. Upon notification and consultation, the local health department and DSHS HSR will consult with the DSHS Emerging and Acute Infectious Disease Branch (EAIDB) to determine if the patient meets the EVD testing criteria.

B. DSHS, in coordination with the local/regional health department, will consult with Centers for Disease Control and Prevention (CDC) for approval to test. If approved, the health department epidemiologist will receive the CDC PUI unique number, which will be used for future communications.

C. DSHS will contact the epidemiologist for Dallas County Health and Human Services (HHS) or Houston Department of Health and Human Services (DHHS) if the patient is located in their service area to discuss approvals and provide pertinent information including: patient name, CDC PUI number, date of birth, symptoms, risk factors, and date of symptom onset.

D. Depending on the service area for the patient, DSHS, Dallas County HHS or Houston DHHS will coordinate with the hospital to provide information regarding packaging and shipping of the specimen to the appropriate testing laboratory (see map of EVD testing service areas in Attachment 1).

E. The EVD testing laboratory will provide guidance for the proper packaging and shipping of specimens.

F. Specimens from suspected EVD patients should be packaged as Category A specimens and shipped as “Suspect Category A Infectious Substance.” (See packaging diagram in Attachment 2)

G. Laboratory individuals must be certified as a Category A shipper prior to packaging the specimen and completing the shipper's declaration forms required by commercial shipping companies.

H. The EVD testing laboratory will not be responsible for providing a courier for the shipment of specimens; the hospital will need to have a plan for shipment of specimens.

I. Specimens should be transported in a timely manner to the laboratory and the laboratory will provide results as rapidly as possible.

V. Test Results and Disposition

A. If testing is **not indicated** or the result is **negative:**

- Alert the appropriate local health department or health service region prior to discharge for appropriate discharge instructions and possible monitoring.

B. If result of testing is **positive:**

- Continue with isolation and appropriate care, and determine health care worker precautions as outlined above.

C. DSHS will determine whether or not to transfer a patient with EVD to an EVD treatment facility after discussion with appropriate health care administrators and medical staff. The decision will be based on the capabilities and capacity of the facility where the patient is diagnosed, EMS capability for transportation, patient status, and patient preferences.

D. If transfer to an EVD treatment facility is approved, hospitals must be prepared to provide supportive care for 12 – 24 hours until transfer is coordinated.

E. The coordination of transportation asset between the sending facility and the receiving facility will be accomplished via SETRAC with notification/request of public health.

F. The sending and receiving facilities will follow all current EMTALA regulations regarding patient transfer to a higher level of care.

G. After patient transport, perform clean-up and disinfection according to CDC EVD Guidelines: Disposal, Transport, and Incineration of EVD Waste for Health Care Facilities and EMS. Do not reuse any durable medical equipment until it has been appropriately cleaned and disinfected as outlined at CDC.

VI. Environmental Cleaning

A. There is no epidemiologic evidence of EVD transmission via either the environment or fomites that could become contaminated during patient care (e.g., bed rails, door knobs, laundry). However, given the apparent low infectious dose, potential of high virus titers in the blood of ill patients, and disease severity, higher levels of precaution are warranted to reduce the potential risk posed by contaminated surfaces in the patient care environment.

B. Be sure staff (this should be performed only by nurses or physicians as part of patient care activities to limit the number of additional healthcare workers who enter the room) wear recommended personal protective equipment (PPE) to protect against direct skin and mucous membrane exposure of cleaning chemicals, contamination, and splashes or spatters during environmental cleaning and disinfection activities.

C. If reusable heavy-duty gloves are used for cleaning and disinfecting, they should be disinfected and kept in the room or anteroom.

D. Be sure staff are instructed in the proper use of personal protective equipment including safe removal to prevent contaminating themselves or others in the process, and that contaminated equipment is disposed of appropriately.

E. Use a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus) to disinfect environmental surfaces in rooms of patients with suspected or confirmed EVD infection. EPA-registered hospital disinfectants with label claims against non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) are broadly antiviral and capable of inactivating both enveloped and non-enveloped viruses.

F. Avoid contamination of reusable porous surfaces that cannot be made single use. Use only a mattress and pillow with plastic or other covering that fluids cannot get through. Do not place patients with suspected or confirmed EVD in carpeted rooms. Remove all upholstered furniture and decorative curtains from patient rooms before use.

G. Routine cleaning of the PPE doffing area should be performed at least once per day and after the doffing of grossly contaminated PPE. Cleaning should be performed by a healthcare worker (HCW) wearing clean PPE. An EPA-registered hospital disinfectant with label claims against non-enveloped viruses (e.g., norovirus, rotavirus, adenovirus, poliovirus) should be used for disinfection. When cleaning and disinfection are complete, the HCW should carefully doff PPE and perform hand hygiene.

H. To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows or mattresses, and textile privacy curtains into the waste stream and disposed of appropriately.

VII. Waste Management

A. Ebola Virus Disease is a classified as a Category A infectious substance regulated by the U.S. Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported offsite for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the regulation. This includes medical equipment, sharps, linens, used healthcare products such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets; and used PPE (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.) or byproducts of cleaning contaminated or suspected of being contaminated with a Category A infectious substance.

B. EVD waste can only be transported for disposal or incineration if prepared according to federal and state guidelines.

C. Layered waste packaging process:

1. Bag waste in approved, properly labeled individual plastic film bags such as red biohazard bags.
2. Prior to closure, treat potentially contaminated waste with a U.S. Environmental Protection Agency (EPA)-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus).
3. Wrap objects with sharp edge to prevent tearing or puncture of the plastic bag.
4. Seal the first filled plastic film bags, with the sealed closure facing upwards, within a second container, consisting of a second approved plastic film bag. Sealing consists

of tying the bag with a knot, heat sealing, tape, adhesive, or another method which insures contents will not leak, but does not tear or puncture the bags.

5. Disinfect exterior of second container with an EPA-registered hospital disinfectant with a label claim for a non-enveloped virus (e.g., norovirus, rotavirus, adenovirus, poliovirus).
6. Place two-layer waste package into a properly labeled, rigid, Category A Infectious Waste container. Outer package must be either a rigid UN Standard or Department of Transportation approved non bulk packaging, such as a polyethylene over pack drum or a minimum triple wall fiberboard containing a 6 mil plastic wall liner.
7. Place absorbent material sufficient to absorb all free liquid (if any) in the bottom of the rigid outer package.
8. Seal and disinfect the exterior surface of the outer package. Before loading for transport ensure the package is not leaking and is closed and sealed as recommended.
9. Category A infectious substance must be accompanied by a shipping paper which includes all the following:
    a. UN number and proper shipping name for the applicable Category A infectious substance – for EVD,
    b. The shipping name is "UN 2814, Infectious Substances, affecting humans."
    c. Hazard class: Division 6.2 (infectious)
    d. Packing group: N/A
    e. Type and quantity of packaging
    f. Emergency response information (e.g., telephone number)
10. Employees who prepare hazardous materials for transportation are hazardous materials employees and must be trained as such. (See OSHA Standards for Protecting Workers from Ebola Virus Disease.) The training must include all the following:
    a. General awareness
    b. Function-specific training
    c. Safety
    d. Security awareness training
    e. Modal-specific training, such as driver training

VIII. Follow-Up and Reporting After Caring for Suspected or Confirmed EVD Patient

A. Personnel with exposure to blood, bodily fluids, secretions, or excretions from a patient with suspected or confirmed EVD shall immediately:
    1. Stop working and wash the affected area with a large amount of water or eyewash solution;
    2. Contact the Supervisor for assessment and access to post-exposure management services; and
    3. Receive medical evaluation and follow-up care, including fever monitoring twice daily for 21 days, after the last known exposure. The member may continue to work while receiving twice daily fever checks, based upon recommendations from local, state, and federal public health authorities.

B. Personnel who develop sudden onset of fever, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage after an unprotected exposure (i.e., not wearing recommended PPE at the time of patient contact or through direct contact to blood or body fluids) to a patient with suspected or confirmed EVD should:

1. Not report to work or immediately stop working and isolate themselves;
2. Notify their supervisor, who should notify local and state health departments;
3. Contact Employee Health for assessment and access to post-exposure management services; and
4. Comply with work exclusions until they are deemed no longer infectious to others

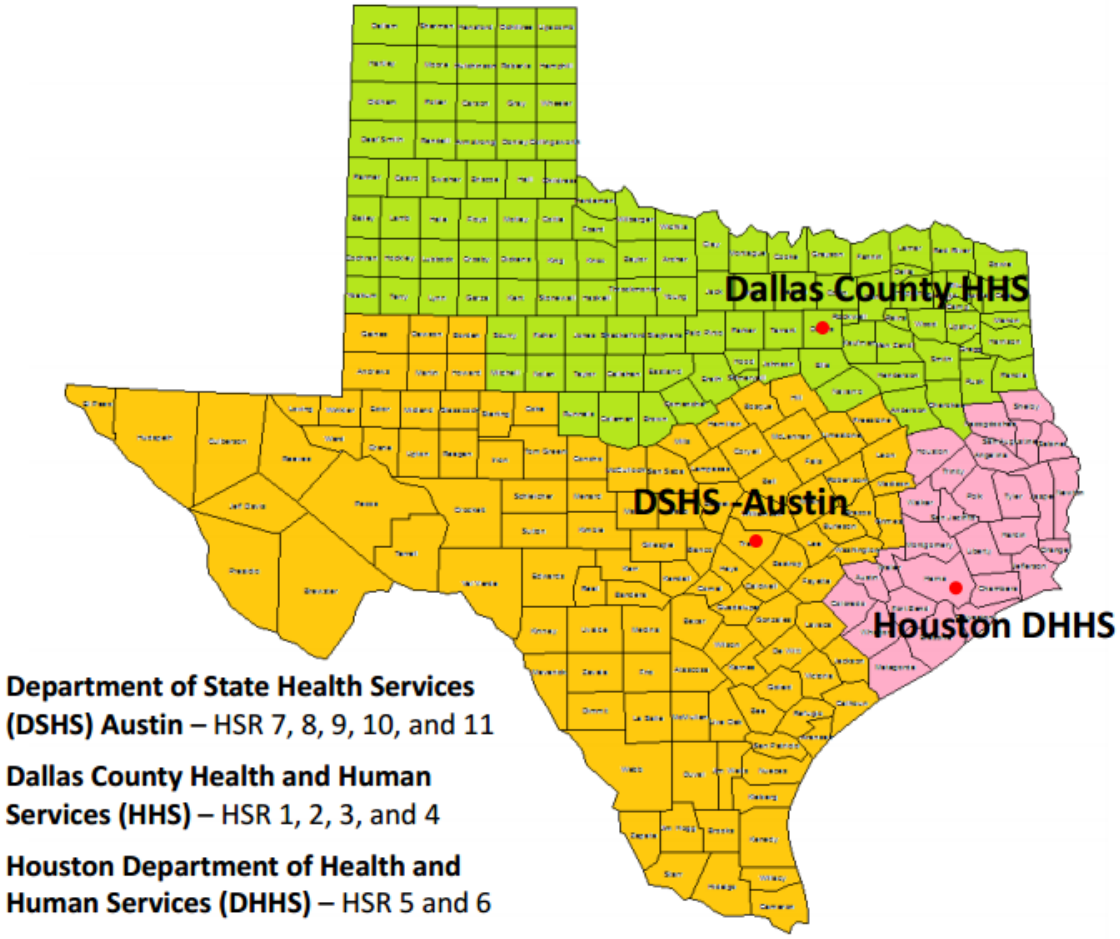

Figure 2: EVD Testing Service Areas

Diagram for Packaging Category A Specimens

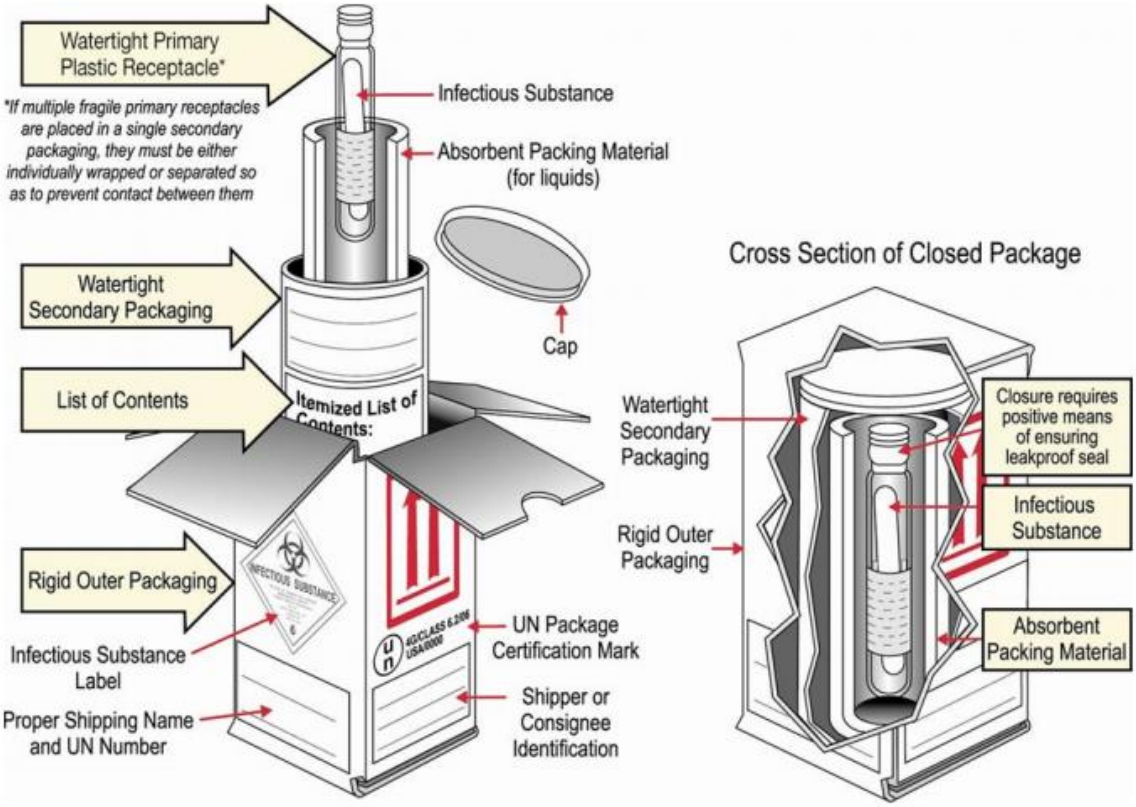

Figure 3: Category A Laboratory Specimen Packaging

Appendix G: Medical Waste Active Incinerators

Texas Authorized Medical Waste Treatment Facilities
With Active Incinerators

(Note: Only 2 of the active facilities have indicated they would accept Ebola contaminated waste. The 2 facilities that indicated that they would accept Ebola contaminated waste are highlighted below.)

1. MSW No. 1741A, (Incinerator) [1]
   Sharps Environmental Service Solid Waste Incineration Facility
   1544 NE Loop, Carthage, TX 75633
   Panola County – Region 5
   CN603013210/RN101849362

2. MSW No. 2232A, UTMB Galveston (Incinerator plus Autoclave)
   301 University Blvd, Galveston, TX 77555-1108
   (409) 772-6359
   Galveston County – Region 12
   (CN601246887)/(RN101921138)

3. MSW No. 2239A,
   Waste Management Resource Recovery & Recycling Center Inc. (Incinerator)
   7505 US Highway 65, Anahuac, TX 77514
   Chambers County – Region 12
   CN603402470/RN100922392

4. IHW No. 50212, Veolia ES Technical Solutions (Incinerator)
   7665 HWY 73 Port Arthur, TX, 77640-2563
   Jefferson County- Region 10
   CN603069626/ RN102599719

5. IHW No., 50089, Clean Harbors Deer Park, (Incinerator)
   2027 Independence Pkwy. S. La Porte, TX, 77571-9808
   Harris County – Region 12
   CN600322796/ RN102184173

Notes: ***(1)*** *Not able to confirm acceptance of seized drugs*

Document Updated 10/16/2014 (Chance Goodin) - DRAFT

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Appendix H: References

http://www.texasebola.org/

http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/distribution-map.html#areas

http://www.cdc.gov/vhf/ebola/hcp/index.html

http://www.cdc.gov/vhf/ebola/hcp/ed-management-patients-possible-ebola.html

http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html

http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html

http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html

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Appendix I: Acronyms

CDC	Centers for Disease Control and Prevention
CMOC	Catastrophic Medical Operations Center
DDC	Disaster District Center
DSHS 4/5N	Department of State Health Services Region 4 and 5 North
DSHS 6/5S	Department of State Health Services Region 6 and 5 South
EMS	Emergency Medical Services
ESF-8	Emergency Support Function
EOC	Emergency Operations Center
FOUO	For Official Use Only
HICS	Hospital Incident Command System
IAP	Incident Action Planning
IC	Incident Command
ICS	Incident Command System
JIC	Joint Information Center
JIS	Joint Information System
MACC	Multi-Agency Coordination Center
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
PCR	Polymerase Chain Reaction
RCC	Regional Call Center
RETA	Regional Ebola Transport Ambulance
RHPC	Regional Healthcare Preparedness Coalition
SETRAC	Southeast Texas Regional Advisory Council
SMOC	State Medical Operation Center
SOC	State Operation Center
TSA-H	Trauma Service Area-H
TSA-Q	Trauma Service Area-Q
TSA-R	Trauma Service Area-R
WHO	World Health Organization