2025 HCC-E REGIONAL RESPONSE PLAN

Endorsed by NCTTRAC Board of Directors
Date: May 13, 2025

Approved by NCTTRAC General Membership
Date: Pending June 6, 2025

Supersedes HCC-E Regional Medical Response Strategy
Date: June 11, 2024

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Record of Revision and Distribution
This document reflects the ongoing work and refinement of HCC-E Healthcare Coalitions regional strategies for emergency preparedness. At a minimum, the document will be reviewed and/or revised by the Regional Emergency Preparedness Committee (REPC) annually or as needed in accordance with REPC SOP.

Table 1. Trauma Service Area-E Record of Revision

Date	Summary of Revision	Reviser
01/08/2024	Updated Trauma Designations; Mass Patient Tracking-Pulsara Application, MIST Member request and responsibilities; Updated contact information and links; and added Chemical Emergency Surge Annex	Robert Pignatelli
01/22/2025	Added the Information Sharing Plan and Resource Management Plan	Tina Martin
01/23/2025	Added the Medical Surge Support Plan	Tina Martin
02/24/2025	Added the Allocation of Scarce Resources and Patient Movement Plans 2025 Staff Review	Jennifer Mertz

Table 2. Trauma Service Area-E Record of Distribution

To Whom: Person/Title/Agency	Method of Delivery	Date
REPC to review and vote to approve	Email/Electronic Vote	05/13/2024
Board of Directors to review and vote to approve	Monthly Meeting	06/11/2024

1. Introduction

1.1. Purpose

    1.1.1. The purpose of the Health Care Coalition E (HCC-E) Regional Response Plan (RRP) is to provide an overview of medical response coordination efforts to natural and manmade events that threaten the emergency healthcare system within HCC-E. This strategy describes HCC-E's support of strategic planning, information sharing, resource management, and medical surge support efforts during large-scale emergency medical response.

1.2. Scope

    1.2.1. The HCC-E Regional Medical Response Strategy covers regional medical response coordination efforts to large-scale emergency events affecting the HCC-E. While this strategy lays out activities and efforts that are common to most emergency incidents, not all incidents are the same, and the elements of this strategy that are executed will vary based on the hazard and scope of any individual incident. This strategy only covers the response for the HCC-E. There may be other agencies within the coalition that may also have a response strategy. Similarly, each resource may have their protocols in place. Please note that these plans do not supersede jurisdictional or agency plans. The statutory authority of HCC-E is limited to the items defined in the following agreements:

        1.2.1.1. Hospital Preparedness Program (HPP) Public/Private Letter of Agreement (LOA) and amendment

        1.2.1.2. Healthcare Coalition Memorandum of Sharing (MOS)

        1.2.1.3. Texas Emergency Medical Task Force (TX EMTF) Memorandum of Agreement (MOA)

        1.2.1.4. NCTTRAC Asset Transfer, Assignment, and Assumption Agreement

        1.2.1.5. Resource-Specific MOA

        1.2.1.6. Please note that these agreements do not supersede jurisdictional, or agency plans nor existing   mutual aid agreements and compacts.

    1.2.2. This strategy was developed with the input of and includes (but is not limited to) the following HCC-E partners and components:

        1.2.2.1. Regional Emergency Preparedness Committee (REPC)

        1.2.2.2. Trauma Service Area E (TSA-E) Emergency Medical Coordination Center (EMCC)

        1.2.2.3. EMTF 2 Subcommittee

        1.2.2.4. Participant Hospitals & Hospital Systems

        1.2.2.5. Participant Emergency Medical Services (EMS)

        1.2.2.6. Participant Public Health (PH) Agencies

        1.2.2.7. Participant Jurisdictional Emergency Managers

        1.2.2.8. Other Provider Types impacted by Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule

1.3. Situation & Assumptions

    1.3.1. Situation

        1.3.1.1. The geographic boundaries of HCC-E align congruently with TSA-E. TSA-E is the geographic area, whereas HCC-E consists of the organizations that make up the coalition. A regional map and a summarized regional Hazard Vulnerability Assessment (HVA) are in the figures below.

County Map of TSA-E
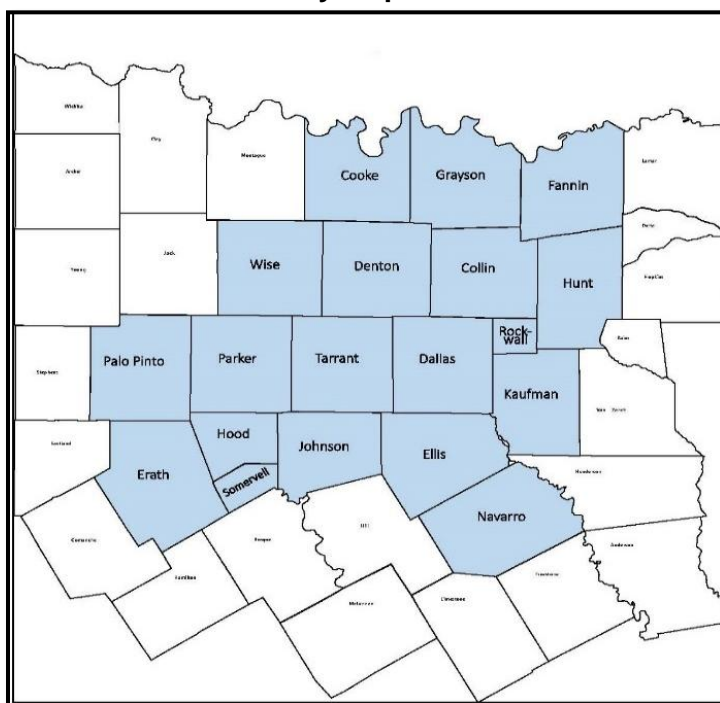
2025 Top Ten HVA
1. **Tornado**
2. **Winter Weather / Freeze Event**
3. **Pandemic**
4. **Power Outage**
5. **Information Technology (IT) System Outage**
6. **Act of Terrorism**
7. **Communication Failure**
8. **Mass Casualty Incident**
9. **Chemical, Biological, Radiological, Nuclear, and Explosive (CBRNE)**
10. **Cyber Security Attack**

      1.3.1.2. The HVA Dashboard may be found at: 2025 HVA.

      1.3.1.3. A list of TSA-E Texas Department of State Health Services (DSHS) Texas Trauma Facilities for 2025 can be found in the TSA-E Regional Trauma System Plan or at the link provided: Texas Trauma Facilities.

   1.3.2. Assumptions

      1.3.2.1. The potential for substantial loss of life is significant during Mass Casualty Incidents (MCI) and patient survival is dependent on the availability and rapid deployment of critical resources.

      1.3.2.2. As established in the Texas Disaster Medical System (TDMS), DSHS Public Health Region (PHR) 2/3 is the Emergency Support Function-(8) (ESF-8) Lead Agency in TSA-E.

      1.3.2.3. The TSA-E EMCC provides support for health and medical care delivery by hospitals and EMS agencies. The EMCC is staffed and operated by NCTTRAC with potential support from local Medical Incident Support Team (MIST) members.

      1.3.2.4. Local jurisdictions should exhaust available resources, including local mutual aid resources, before requesting additional assistance from NCTTRAC.

1.3.2.5. EMTF-2 may be activated in support of a regional disaster. The EMTF-2 Coordination Center is housed in and supported by the EMCC.

1.3.2.6. EMTF-2 will coordinate with the TX EMTF State Coordination Office (SCO) routinely and in disaster response.

1.3.2.7. During an MCI, regionally supported Crisis Standards of Care (CSC), or deviation from conventional standards of care and triage may be implemented to provide the highest level of medical care capable of being delivered under disaster conditions. The HCC-E CSC may be found in Annex A and Annex B, North Texas Mass Critical Care Guidelines Document for Adults and Pediatrics. It is important to note that the responsibility for implementing the crisis standard of care lies solely with the organization.

1.3.2.8. Primary medical treatment facilities may be damaged or inoperable after an incident occurs.

1.3.2.9. The establishment of alternate care sites may be necessary to supplement local healthcare systems. However, barring major infrastructure damage, it is generally preferred to increase surge capacity at existing healthcare facilities as opposed to building temporary care facilities in austere conditions.

1.3.2.10. Deploying agencies are responsible for responder safety and health during all phases of emergency response.

1.3.2.11. Hospitals and EMS agencies will coordinate with their local county Emergency Management (EM) Office routinely and in a disaster response.

1.4. Administrative Coordination

1.4.1. The HCC-E RRP will be reviewed and updated annually. All revisions and review activities will be noted in the Record of Changes. General review procedures involve the following:

1.4.1.1. NCTTRAC staff annually reviews the RRP to ensure consistency with other regional plans.

1.4.1.2. NCTTRAC staff annually reviews recent exercises and real-world incidents and incorporates identified areas of improvement into the RRP.

1.4.1.3. Revised Response Strategy Draft is distributed to HCC members for review and comments.

1.4.1.4. REPC votes to recommend approval of revised RRP.

1.4.1.5. Disaster Clinical Advisory Group (DCAG) votes to recommend approval of revised RRP.

1.4.1.6. NCTTRAC Board of Directors votes to endorse the revised RRP.

1.4.1.7. The revised RRP is voted for approval by NCTTRAC General Membership as part of the TSA-E Regional Trauma System Plan.

1.4.1.8. Revised RRP is submitted to DSHS.

2. Role of the Coalition

2.1. Summary

2.1.1. A regional medical response that is timely, well-coordinated, and regularly exercised can mitigate damage and save lives. The response goal of the HCC-E is to promote resiliency and ensure adequate surge capacity and capability across the HCC during a mass casualty or disaster situation. Effective response and recovery require a coordinated effort among public and private entities. Hospitals and healthcare facilities are critical during an emergency and therefore must be active participants in emergency preparedness efforts by partnering with EMS agencies, EM, PH, and other entities that are active in an emergency response. The HCC-E regional response structure promotes jurisdictional cooperation and coordination but recognizes the autonomy, operational authority, and unique characteristics of each jurisdiction at the facility, local, regional, and state levels. Figure 1 shows the basic structure of the HCC-E Health Care Coalition.
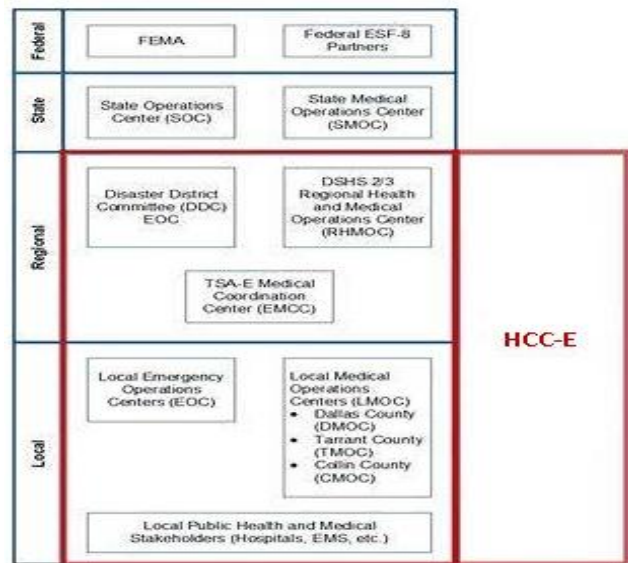
2.2. Member Roles and Responsibilities

2.2.1. Generally, the emergency response roles of the HCC-E and its composite partner organizations follow the following structure:

2.2.1.1. Individual EMS agencies respond to emergency scenes, provide pre-hospital treatment, and transport patients to appropriate healthcare facilities. Immediate response activities are coordinated and overseen by the local incident command structure.

2.2.1.2. Healthcare facilities provide in-depth medical care to patients who arrive at their location (whether via EMS transport, inter-facility patient transfers, or patient self-presentation).

2.2.1.3. The TSA-E EMCC serves as the regional response support arm of the HCC-E. The EMCC does not direct the response activities of individual HCC partner organizations, but rather it provides coordination and support for those response activities to ensure that overall regional medical needs are met. While EMCC activities may vary based on the hazard and scope of the incident, generally the EMCC will notify the HCC-E of emergency incidents, gather, and share essential elements of information across the HCC, coordinate EMTF-2 response activation activities, provide medical resource support for regional medical operations, and help coordinate large-scale patient movement.

2.2.1.4. County PH agencies serve as the ESF-8 Lead Agency for their counties and provide PH surveillance and response to their jurisdictions.

2.2.1.5. DSHS PHR 2/3 operates the Regional Health and Medical Operations Center (RHMOC) and serves as the ESF-8 lead agency within their jurisdiction. The RHMOC supports and coordinates regional public health-related activities whereas the EMCC supports and coordinates regional medical care-related activities.

2.2.1.6. Local EM organizations coordinate overall emergency response activities within their jurisdiction. The Texas Division of Emergency Management (TDEM) will activate local Disaster District Committees (DDC) which support and coordinate regional emergency management-related activities.

2.2.1.7. A detailed breakdown of HCC-E partner organizations and their roles, responsibilities, and resources can be found below.

HCC Partner Types	Roles & Responsibilities	Resources
TSA-E EMCC	• Sharing information between HCC members and with other jurisdictional partners • Maintaining situational awareness • Sharing and coordinating resources • Coordinating patient movement and evacuation • Assisting with the coordination of mass shelter operations • Tracking patients and supporting family reunification • Coordinating assistance centers and call centers • Coordinating psychological care services • Providing HCC liaison support to emergency operations centers • Coordinating EMTF Activation activities	• Radiation Detection Portal • Drive Thru Screening Tent • Flexmort System • Mass Fatality Trailer • Shelter Support • The Mintie Environmental Containment Unit • Medical Operations Coordination Kits • Plum Case Enterprise • RadEye B20 Radiation Survey Meters
EMTF-2	• Coordinated regional medical response • Emergency medical care • Emergency medical transportation • Provision of an Alternate Care Site • Augmentation of medical personnel • HCID medical transportation and care • Wildland fire medical support • Tactical medic support	• Ambulance Staging Management Team (ASMT) • Ambulance Strike Teams (AST) • Air Medical Strike Teams (AMST) • AMBUS • Infectious Disease Response Unit (IDRU) • Radiological Response Unit (RRU) • MIST • Mobile Medical Unit (MMU) • Registered Nurse Strike Teams (RNST) • Tactical Medic Unit Support • Texas Mass Fatality Operations Response Team (TMORT) • Wildland Fire Medical Support Team • VIPER Trailer • Ambulance Staging Manager (ASM) Trailer
EMS	• Provide emergency medical care and transportation • Triage & tag patient with a unique identifier • Activate mutual aid plans or procedures • Notify the EMCC about emergent disasters, including MCIs • Establish an Ambulance Staging Area • Request additional EMS resources	• Advanced Life Support (ALS) • Basic Life Support (BLS) • Mobile Intensive Care Unit (MICU) • Special services (USAR, Trench Rescue, Swift Water, etc.)
Hospitals	• Provide quality patient care for the sick and injured.	• Trauma designated Hospitals • Specialty Care Hospitals

HCC Partner Types	Roles & Responsibilities	Resources
	• Respond to Immediate Bed Availability Request • Update EMResource; NEDOCS and ED Status • Establish Incident Command Center (ICC) • Respond to informational surveys (Critical Infrastructure Survey, Supply Shortages Survey, etc.) • Participating in Patient Tracking Efforts • Provide healthcare system LNO to EMCC	• Burn Centers • Pediatric Hospitals • General Acute Hospitals
Hospital System Transfer Centers	• Participates in HCC-E patient coordination and patient transfer calls during mass patient movement (e.g., Evacuations, hurricanes, internal disasters) • Day-to-day operations still applicable	• Baylor Scott and White Health System • Medical City Health System • Methodist Health System • Texas Health Resources System • Children's Health System • Cook Children's Healthcare System
EM	• Disaster Surveys • Incident Related Situational Awareness • Disaster Summary Outlines • Assist local healthcare providers with resource requests through the STAR process	• City/ County Emergency Managers • City Emergency Operation Centers (EOC) • County EOCs
DSHS PHR 2/3 RHMOC	• Medical Material Management and distribution • Public Health surveillance and epidemiological investigation • Coordination of regional infectious disease testing • Provide PH liaison to regional DDC • Coordinate PH education and communication efforts • Provide PH services to non-public health counties	• RHMOC • Epidemiologist • Strategic National Stockpile (SNS) • Clinical Field Offices
Local PH Departments	• PH Surveillance • PH Education • SNS coordination • Points of Dispensing coordination • Fatality Management • Vector Control • Environmental Inspections	• Epidemiologists • SNS • Shelter Operations Team • Health Department EOC/MOC • Medical Reserve Corp
Texas Disaster District Committee (DDC)	• Assist local officials in carrying out emergency planning, training, and exercises, and developing emergency teams and facilities	• State Resources

HCC Partner Types	Roles & Responsibilities	Resources
	• Coordinate resources of state agencies, as requested by local jurisdictions. • Collect information for situation reports to the state operations center. • Receives and processes STAR request • Identify urgent needs, advise local officials regarding state assistance, • Coordinate deployment of state emergency resources to assist local emergency responders.	
Local EMS Medical Control Centers	• Communication between EMS and Hospitals • Situational awareness for their EMS agencies • Coordination with mass patient movement	• 24/7 Operations • Medical direction • Established communication channels with EMS and Hospitals

2.3. ESF-8 Lead Agency Integration – DSHS

    2.3.1. As the ESF-8 Lead Agency, DSHS PHR 2/3 provides essential emergency PH response information during urgent and emergencies, such as a natural, manmade, or technological disaster. PHR 2/3 Staff will activate, establish, and staff the RHMOC as a single point of contact for directing regional information to local and statewide public health stakeholders.

    2.3.2. The basic organizational structure of the PHR 2/3 RHMOC consists of the Command Staff, Operations Section, Logistics Section, Planning Section, and Finance Section. Within each of these sections, subunits are created based on the complexity of the incident, functions needed, and tasks assigned to each unit.

    2.3.3. DSHS and NCTTRAC will mutually support mass casualty events and disasters, including the mutual provision of ESF-8 liaisons to local EOCs and Disaster District Committees (DDCs). Generally, the RHMOC supports and coordinates regional PH activities whereas the EMCC supports and coordinates regional medical activities. At the DDC level, RHMOC liaisons and EMCC liaisons are generally stationed next to one another to ensure that all ESF-8 response support efforts are well-coordinated. The RHMOC and the EMCC communicate during emergency incidents via point-to-point contact (such as by cell phone, email, or radio).

    2.3.4. The DSHS PHR 2/3 Community Preparedness section is an established notification group in the EMCC Mass Notification System and is notified as HCC-E activity levels change in response to emergencies within the region.

2.4. TSA-E EMCC

    2.4.1. While individual HCC partner organizations are responsible for clinical healthcare delivery and other immediate medical response operations, the EMCC serves as the regional medical response support and coordination arm of the HCC-E. As the HPP Contractor, NCTTRAC staff operates the EMCC. The objective of the EMCC is to support medical services delivery by hospitals and EMS agencies during emergencies.

    2.4.2. The EMCC may support response to local, regional, state, and federal emergencies. Response activities will be scaled as appropriate for the given event and may range from desk support during working hours to 24/7 activation of the EMCC and the provision of liaison officers to work with various regional and state response agencies. Primary functions of the EMCC include:

        2.4.2.1. Regional event notification

        2.4.2.2. Information gathering and sharing

2.4.2.3. Bed availability reporting

2.4.2.4. Crisis applications/communications support

2.4.2.5. Regional medical resource coordination

2.4.2.6. Patient tracking administration support

2.4.2.7. Patient destination decision support

2.4.2.8. HCC liaison supports the DDCs and local EOCs

2.4.2.9. EMTF mobilization/activation coordination

2.4.3. The EMTF-2 Coordination Center is a component of the NCTTRAC EMCC. The EMTF-2 Coordination Center is activated upon publication of State Mission Assignment (SMA) and/or as an emergency incident escalates and such activity is warranted.

2.4.4. The NCTTRAC EMCC works in conjunction with and in support of individual HCC partner organizations and other regional response organizations. The NCTTRAC Executive Director serves as the EMCC Executive Director and maintains final authority for all EMCC actions.

2.4.5. Specific details relating to EMCC position structure and internal operations can be found in Annex B, Trauma Service Area E Medical Coordination Center Standard Operating Guidelines.

3. EMTF-2

3.1. Overview

3.1.1. The goal of the Texas EMTF program is to provide a well-coordinated response, offering rapid professional medical assistance to emergency operation systems during large-scale incidents. Eight EMTFs can be rostered across Texas.

3.1.2. TX EMTF is a regional and statewide medical response capability. NCTTRAC serves as the lead agency for the administration of the EMTF-2 Program for North Central Texas (TSA-E – DFW), North Texas (TSA-C – Wichita Falls), and West Central Texas (TSA-D – Abilene). TX EMTF elements will stand ready to provide medical surge support throughout the State of Texas, and regionally as requested for mutual aid. Designated EMTF-2, the regional task force can provide the following:

3.1.2.1. AST: Team of five ambulances and one strike team leader to provide emergency medical services during a disaster

3.1.2.2. MIST: Provides ESF-8 integrated subject matter expertise to EOCs

3.1.2.3. RNST: Team of Registered Nurses to augment emergency capabilities during a disaster

3.1.2.4. AMBUS: Treatment and transport capability for 20+ patients during a disaster

3.1.2.5. ASMT: Team dedicated to setting up and operating a regional ambulance staging area

3.1.2.6. MMU: Temporary care facility during a disaster with 16 – 32 beds. It consists of tentage, equipment, and staff

3.1.2.7. IDRU: Dedicated transport services and hospital care capability for suspected and confirmed High-Consequence Infectious Disease patients

3.1.2.8. Wildland Fire Medical Support Team: Teams embedded within wildland firefighting units to provide immediate medical care

3.1.2.9. AMST: Air medical transport & evacuation services during a large-scale disaster

3.1.2.10. Tactical Medic Unit Support: Support for Large-Scale/Complex Coordinated Terror Incidents

3.1.2.11. TMORT: Operational assistance to medicolegal authorities with site operations, morgue operations, Victim Identification Center, and Victim Information Center operations following a mass-fatality incident

3.1.3. Asset deployment time may be anywhere between 20 minutes to 2 hours, depending on the asset(s) needed and the situation. When called upon by the State, teams and assets will deploy with costs reimbursed by the State. When called upon locally or regionally, costs must be reimbursed by the receiving jurisdiction or absorbed by the providing agency. More information on EMTF-2 processes and procedures can be found in Annex B, Trauma Service Area E Medical Coordination Center Standard Operating Guidelines.
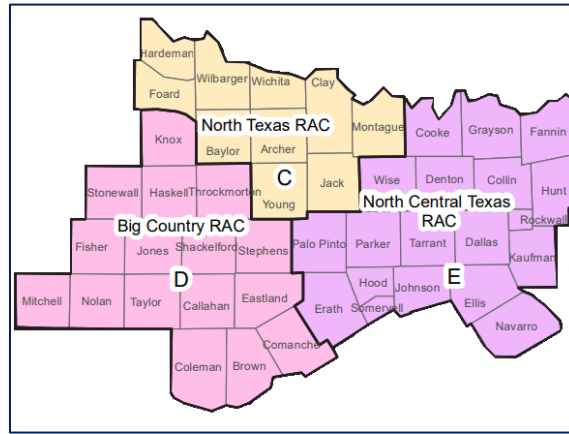
3.2. Mission

3.2.1. Emergency Medical Task Force 2 (EMTF-2) is designed to respond to disasters or events to provide care and/or transportation. EMTF-2 resources may be requested by contacting NCTTRAC or the local DDC.

3.2.2. The mission of EMTF-2 is to augment and support the needs of an impacted community with temporary healthcare infrastructure configured to meet incident needs.

3.2.3. EMTF-2 will 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. To facilitate this readiness, EMTF-2 will utilize the EMTF Coordinator to ensure the highest level of preparedness by sending members to local, regional, and State training and exercises.

3.2.4. EMTF-2/NCTTRAC annually hosts a MIST refresher, and an MMU and Advanced Logistics Warehouse Day.

3.2.5. EMTF-2 also hosts a monthly meeting for team members and agencies to receive information and updates about the program.

3.3. Rosters & Notification

3.3.1. The following Roster & Notification process will be used:

3.3.1.1. Notification: In the event of a notification of deployment the Texas Emergency Medical Task Force State Coordinating Office (TX-EMTF-SCO) will notify the EMTF-2 Coordination Center. The EMTF-2 Coordinator will then send a message via the Everbridge Notification System, polling for specific assets and their availability. EMTF-2 has developed a system of maintaining a pre-screened roster of people and or assets who have signed a MOA with the TX EMTF.

3.3.1.2. Rostering: The EMTF-2 Coordinator will compile a "roster" of agencies, and their available assets based on their responses to Everbridge. Everbridge is the software used for quick communication among EMTF-2 member agencies. Leadership from each agency will communicate to the coordinator the appropriate individuals from their agency they want notifying, them by type of deployment. When an Everbridge is sent out, partners will be notified by cell number, email, or office number. The notifications last 2 hours and will stop once the individual acknowledges it. Everbridge will have specific information starting with the type of readiness level (Awareness, Standby, Activation) and the relevant support information like what personnel and assets are being requested, for how long, and when to muster. The coordinator will compile all the information, make calls to confirm submission and build out the relevant team. Once completed, the EMTF-2 Coordinator will enter the information into appropriate boards on the TXEMTF WebEOC server. Rostering in TXEMTF WebEOC is the primary method of communicating team availability and roster details from the region to the SCO and SMOC.

3.3.1.3. Activation: The SCO will notify the EMTF-2 Coordinator that the rostered assets have been activated once an SMA has been approved. The EMTF-2 Coordinator will then notify the

rostered assets and have them muster at the NCTTRAC Warehouse. While in route to the muster point, the EMTF-2 Coordinator will activate tracking devices, enter members into GroupMe, and Stage Gear, and assign personnel in WebEOC. Upon completion of pre-deployment tasks, the EMTF-2 Coordinator will ensure all members have been briefed on deployment expectations, safety requirements, issued radios, tracking gear, and other deployable equipment. In coordination with the TX-EMTF SCO, all units will be tracked throughout the entire deployment.

3.3.1.4. Demobilization: The TX-EMTF SCO will notify the EMTF-2 Coordination Center of its plans to DEMOB from a deployment. The EMTF-2 Coordinator will work with the deployed members to have them mustered at the NCTTRAC warehouse upon departure from the area of deployment. Upon arrival at the NCTTRAC warehouse, the EMTF-2 Coordinator will collect any gear that accompanied the deployed members. The EMTF-2 coordinator and members will continue to track demobilization statuses via GroupMe. Once members clear Parent Organization, they will continue to be tracked until the member makes it back to their home of residence. Once all activated resources have been reported to be demobilized completely, the EMTF-2 Coordinator will report to TX EMTF SCO the region is demobilized completely.

3.3.1.5. Reconstitution: After the deployment is complete, the EMTF-2 Coordinator along with the NCTTRAC Preparedness and Response personnel will thoroughly inspect all gear and note any damage or issues. Function checks and gear cleaning will occur with any broken or non-functional equipment being reported to the NCTTRAC Response leadership and immediately taken out of service. The reconstitution process of equipment and communication assets is a major priority in the time following an activation; proper reconstitution is critical to maintaining proper standards for readiness.

4. Incident Response: General Concept of Operations

4.1. Incident Notification

4.1.1. Optimal recognition of the need to activate the RMCC and determine the earliest possible and appropriate response actions is a vital factor for a successful outcome. Although not all-inclusive; provided is a general listing of situations/hazards that should be reported to the RMCC Coalition Coordinator and may trigger Plan activation:

4.1.1.1. Almost any declared incident (and subsequent EOP activation) by a Coalition member

4.1.1.2. Awareness through open-source media, and notification by a partner, local, state, or Federal entity

4.1.1.3. An HCO evacuation is imminent

4.1.1.4. Critical shortage of medical and/or ancillary personnel to care for arriving and in-house patients

4.1.1.5. Shortage of medical supplies

4.1.1.6. HCO is damaged or compromised

4.1.1.7. Lack of Critical hospital utility systems and backup systems are in use or not operational

4.1.1.8. Local emergency and/or all-hazard incidents are occurring

4.1.1.9. Any substantive alert message requiring action from LHJ, DSHS 2/3, Federal Government

4.1.1.10. Natural disaster (e.g., widespread tornado or flooding)

4.1.1.11. Biological attack (e.g., anthrax dispersion)

4.1.1.12. Chemical attack or spill

4.1.1.13. Biological disease outbreak (e.g., pandemic influenza)

4.1.1.14. Activation of a jurisdictional Agency's EOP

4.1.1.15. Activation of a nearby Healthcare Coalition

4.1.1.16. Request activation by jurisdictional agency (Tier 3)

4.1.1.17. Evidence that incident circumstance could expand

4.1.1.18. When a similar incident in the past required activation of the RMCC

4.1.1.19. Severe weather incident

4.1.1.20. Radiological threat or incident

4.1.1.21. Terrorist threat or incident

4.1.1.22. Mass Gathering Event

4.1.1.23. Any incident large enough to require resource sharing including:

4.1.1.23.1. Strategic National Stockpile deployment

4.1.1.23.2. Epidemiologic investigation

4.1.1.23.3. Facility Evacuation

4.2. Incident Action Planning

4.2.1. Immediate emergency response goals, strategies, and tactics are determined by the ICS established by the authority having jurisdiction. Similarly, individual HCC partner organizations are responsible for internal strategic planning and goal setting. If the incident affects the HCC Coalition, leadership will meet virtually to help drive the specific strategic planning and goals.

4.2.2. The HCC-E supports regional medical strategic planning efforts through multi-agency coordination. This is usually accomplished through a combination of virtual coordination (via crisis applications and point-to-point communications) and physical coordination in the form of liaison support from HCC partner organizations to the EMCC and from the EMCC to local EOCs.

4.2.3. The EMCC will engage in virtual multi-agency coordination during every operating period. This ensures that important information is gathered and shared across all levels of the emergency healthcare response and that regional ESF-8 response plans, strategies, and objectives are effective and well-informed. Virtual multi-agency coordination activities include:

4.2.3.1. Point-to-point communication with relevant entities affected, including (but not limited to) the following:

4.2.3.1.1. HCC partner organizations (hospitals, EMS agencies, etc.) in the affected area

4.2.3.1.2. County MOCs

4.2.3.1.3. County PH Agencies

4.2.3.1.4. County EOCs

4.2.3.1.5. DSHS PHR 2/3 RHMOC

4.2.3.1.6. DDC 4A (Garland)

4.2.3.1.7. DDC 4B (Fort Worth/Hurst)

4.2.3.1.8. DDC 22 (Sherman)

4.2.3.1.9. EMTF SCO

4.2.3.1.10. DSHS SMOC

4.2.4. The EMCC will provide or arrange HCC liaison support to local EOCs, DDCs, or the RHMOC as needed. EMCC liaisons may be a combination of NCTTRAC staff and/or EMTF-2 MIST members. While ideally the EMCC would provide liaison to all affected EOCs, personnel resources to fill liaison roles can be scarce. EMCC liaison preference will be given to regional EOCs (such as the DDC or RHMOC) first, county MOCs and EOCs (such as the Dallas Medical Operations Center or the Tarrant County Emergency Operations Center) second, and city EOCs (such as the City of Denton Emergency Operations Center) third.

4.2.5. To request an EMCC liaison, partner organizations should call the 24/7 Duty Phone at (817) 607-7020. A formal request via a State of Texas Assistance Request (STAR) may be required.

4.2.6. The EMCC Liaison will serve as a subject matter expert on supporting pre-hospital and hospital emergency medical operations in TSA-E to ensure that regional response strategies, plans, and objectives are consistent with the needs of the HCC-E and its composite partner organizations. Additionally, the EMCC Liaison will help transfer information from the EMCC to the DDC or local EOC and vice versa, including medical resource requests.

4.2.7. The EMCC may request liaison support from HCC partner organizations to balance EMCC staffing with appropriate subject matter expertise. Representatives from EMS, PH, Hospital Systems, and jurisdictional EM may be requested to augment and inform emergency medical support operations during EMCC activation. These representatives may be physically located in the EMCC or provide representation virtually.

4.3. EMCC Emergency

4.3.1. The EMCC is located at 600 Six Flags Drive Suite 150, Arlington, Texas 76011. The EMCC has a radio room with multiple redundant communications systems built-in, a large open space with adjustable table and computer/phone setups, bathrooms, and a shower.

4.3.2. The NCTTRAC warehouse is located at 4408 Barnett Boulevard, Arlington, Texas 76017. The NCTTRAC warehouse functions as a mobilization, demobilization, and reconstitution site for EMTF personnel and HPP medical supplies and equipment. It is also built out with communications and information system redundancy to ensure that it can serve as a secondary EMCC operational site.

4.3.3. While the EMCC maintains the physical space at the 600 Six Flags Drive address, most EMCC work can be done virtually using email, video conferencing, crisis applications, and point-to-point communications (such as cell phones or business phones). Physical EMCC activation versus virtual EMCC activation will be determined based on the details of the incident at hand.

4.3.4. Other relevant emergency facilities for the HCC-E include (but are not limited to):
4.3.4.1. Healthcare System EOCs
4.3.4.2. City EOCs
4.3.4.3. CMOCs
4.3.4.4. County EOCs
4.3.4.5. RHMOC
4.3.4.6. DDC EOCs
4.3.4.7. Public Safety Dispatch Centers
4.3.4.8. Hospitals and Health Care Facilities

4.4. Readiness Levels

4.4.1. Many emergencies follow some recognizable build-up period during which actions can be taken to achieve a gradually increasing state of readiness. The EMCC uses a four-tier system. Readiness Levels will be determined by the NCTTRAC Executive Director or as directed under contract with DSHS SMOC. General actions to be taken at each readiness level are outlined below; specific functions during emergencies will be directed by the NCTTRAC Executive Director.

4.4.2. The following Readiness Levels will be used as a means of recognizing increases in EMCC support posture:

4.4.2.1. Normal: Normal refers to situations that are routine and do not cause interruption in daily operations for NCTTRAC Staff or HCC partner organizations. Limited assistance may be requested from jurisdictions or partners according to established interlocal agreements, mutual aid agreements, or standard operating procedures.

4.4.2.2. Elevated: Elevated refers to a situation that presents a greater potential threat than "Normal Conditions" but poses no immediate threat to life and/or property. General readiness actions may include increased situation monitoring, a review of plans and resource status, determining staff availability, and placing personnel on call for potential emergency operations. Advisory notifications may be published for general situational awareness.

4.4.2.3. Partial Activation: Partial Activation refers to a situation with significant potential and probability of causing loss of life and/or destruction of property. Declaration of a Partial Activation will normally require some degree of warning to the public. General readiness may include continuous situation monitoring, identifying worst-case decision points, increasing preparedness of personnel and equipment, developing/providing the public with information designed to improve emergency health care delivery, preparing for evacuation and shelter operations, and identifying available medical resources including equipment, supplies, and personnel. Other actions may include establishing contact with public health and emergency management partners.

4.4.2.4. Full Activation: Full Activation refers to situations in which hazardous conditions are imminent. This condition denotes a greater sense of danger and urgency than is associated with a "Partial Activation" event. During Full Activation, the EMCC is staffed for 24/7 operations. General readiness actions may include continuous situation monitoring, implementing active resource and information systems support, putting hospitals, EMS, and emergency management professionals on alert, and preparing for the deployment of medical

services assets (including EMTF-2). A SMA will generally accompany a Full Activation and the time will generally exceed 12 hours.

4.5. Incident Recognition

    4.5.1. Generally, individual HCC partner organizations will be the first to learn about emergent incidents. Upon recognition of an emergent incident that will affect the HCC-E, individual HCC partner organizations should notify the EMCC by calling the 24/7 Duty Phone. The 24/7 Duty Phone can be reached using the following numbers:

        4.5.1.1. 24/7 Duty Phone Primary Number: 817-607-7020

        4.5.1.2. 24/7 Duty Phone Secondary Number: 682-225-3559

    4.5.2. The EMCC actively monitors real-world events which have the potential to impact on the healthcare system in TSA-E. Severe weather incidents are often precipitated by some forewarning by the National Weather Service (NWS) in the form of an email NWS Weather Alert. The EMCC will forward significant NWS Weather Alerts to the HCC at large using email distribution lists and EMResource event notifications. Similarly, planned community events with the potential to turn into a MCI may result in the EMCC notifying the HCC at large and initiating a bed availability report in EMResource.

    4.5.3. Information received by the EMCC regarding an incident will be vetted and shared along appropriate distribution lines on EMResource, email, and/or Everbridge.

4.6. Activation

    4.6.1. The general process for a partner organization to request EMCC activation is listed below:

        4.6.1.1. Affected HCC partners should notify the EMCC using the 24/7 Duty Phone as emergencies begin to develop. The EMCC 24/7 emergency duty phone may be reached at (817) 607-7020.

        4.6.1.2. Initial activation requests may be made verbally to start regional support processes – these include (but are not limited to) region-wide alerting and issuing regional bed availability reports.

        4.6.1.3. All formal activation requests must be provided in writing within the first 24 hours following the initial request and should originate from the leadership of the requesting organization.

        4.6.1.4. For non-state activations of the EMCC, a general message such as an ICS-213RR may be used. If email submission of the 213RR is not available, a fax copy of the 213RR may be sent to (817) 608-0399. External partners should establish telephone contact with the EMCC to ensure reception of the request. For state activations of the EMCC, the preferred method is the State of Texas Assistance Request (STAR) in WebEOC. Telephone contact the EMCC 24/7 Duty Phone at (817) 607-7020 to ensure delivery is recommended.

        4.6.1.5. If a 213RR is not available in electronic or hard copy form, written activation requests may be provided in any written narrative format. Follow local jurisdiction processes.

        4.6.1.6. All EMCC activation requests should be concurrently provided to support jurisdictional partners. NCTTRAC will provide partners with a copy of any activation request when it appears that jurisdictional emergency management partners have not been included in the request distribution.

        4.6.1.7. The EMCC is activated in one of three ways:

            4.6.1.7.1. At the direction of the NCTTRAC Executive Director, his/her designee, or available senior staff member.

            4.6.1.7.2. At the direction of the DSHS SMOC (via a SMA)

            4.6.1.7.3. At the request of HCC partner organizations and other regional partners. The authority to approve EMCC activation requests rests with the NCTTRAC Executive Director. Partner organizations that can request EMCC activation include, but are not limited to, the following:

                4.6.1.7.3.1. Regional hospitals, EMS agencies, and EMS Medical Directors

                4.6.1.7.3.2. DDC 4A (Fort Worth/Hurst), DDC 4B (Garland), DDC 22 (Sherman), DDC 7 (Abilene), or DDC 3 (Wichita Falls)

                4.6.1.7.3.3. DSHS PHR 2/3 RHMOC

4.6.1.7.3.4. City and county governments within TSA-E

4.6.1.8. Individual HCC partner organizations may activate their own command centers, emergency operations centers, or emergency operations plans independently of EMCC activations. Individual HCC partner organizations (including County MOCs) maintain activation criteria and protocols that are specific to their organization, jurisdiction, or county, and EMCC activation criteria, methods, and protocols do not supersede those individual procedures.

4.6.1.9. Initial EMCC activation actions can be found in Appendix B, EMCC Activation Activities.

4.7. Notifications

4.7.1. Mass notifications to HCC-E partner organizations occur primarily in EMResource using the "Events" feature. All EMResource users can create events in EMResource, but the EMCC is the primary creator of event notifications. When an emergent incident (such as an active shooter) occurs, HCC partner organizations should create an event notification in EMResource. If they are unable to do so, they should contact the 24/7 EMCC Duty Phone and staff will create the event notification instead. Urgent EMResource event notifications will also be distributed via email using NCTTRAC distribution lists to ensure that all relevant partners are notified.

4.7.2. The EMCC also receives EMResource notifications when certain statuses change – for example, when a hospital updates their status to "Closed" in EMResource, the EMCC is notified via email and text message. This notification can then be passed on to other relevant HCC partner organizations. HCC partner organizations also may set up status change notifications in EMResource. Deployable assets (such as AMBUSs, MERC Trailers, or Mass Fatality Trailers) changing their deployment status in EMResource also trigger email and text notifications to EMCC staff. This information can then be passed on to HCC partner organizations as needed.

4.8. Pre-Hospital Patient Transportation

4.8.1. Patient Destination Decisions

4.8.1.1. To assist EMS with patient destination decision-making, EMCC staff will issue MCI patient surge capacity requests to Hospitals via EMResource.

4.8.1.2. Patient destinations for EMS transport is ultimately set by the on-scene command structure. The on-scene command structure can access EMResource to view MCI bed availability at local hospitals to make effective patient destination decisions. If the on-scene command structure is unable to access EMResource, they can call the EMCC using the 24/7 Duty Phone at (817) 607-7020. The EMCC will then relay bed availability information to the on-scene command structure as needed.

4.8.1.3. Recent national MCIs have revealed that most MCI patients arrive at healthcare facilities using non-conventional methods of transport (self-transport, civilian vehicles, law enforcement, etc.). For this reason, hospitals cannot assume that they will only receive the number of patients they report to EMS that they can take; similarly, non-Trauma designated facilities should still expect to receive self-presenting Trauma patients who simply aim for the nearest hospital. HCC-E recommends that all hospitals create internal surge plans for up to 20 percent of their number of licensed beds.

4.8.2. Patient Transportation

4.8.2.1. Responsibility for transporting patients from the scene to area hospitals ultimately lies with the on-scene command structure. NCTTRAC will support patient transportation operations through the coordination of local mutual aid mass casualty agreements and/or by rostering EMTF assets as needed. To ensure timeliness, the NCTTRAC Duty Phone (817-607-7020) can be called 24/7 for immediate support. Potential EMTF assets to assist with patient transportation include AST and AMBUS. AST and AMBUS requests should follow the identified resource request process using STAR.

4.8.2.2. Upon identification of the patient reception center, NCTTRAC will coordinate with the appropriate decision-makers in charge of patient transport to ensure that everyone is following the same patient distribution plan. HCC-E moved to the Pulsara Platform in 2023 for all patient tracking needs.

4.8.3. Inter-Facility Patient Transfer Coordination

4.8.3.1. Inter-Facility Patient Transfer Coordination during a disaster utilizes many of the same processes and resources that are utilized in day-to-day patient transfer activities. In some emergency or disaster scenarios (including some hospital evacuations), hospitals may be able to coordinate interfacility patient transfers using their normal methods. The TSA-E Medical Coordination Center will only assist a hospital with identifying transfer destinations if the evacuating hospital is unable to identify destinations using their normal methods and requests an EMCC activation.

4.8.3.2. In TSA-E there are 6 healthcare system patient transfer centers. Transfer centers are at centralized locations managing all components of a patient transfer into a hospital system. This includes the process of identifying an accepting physician and coordinating the workflow required to place a patient in the most appropriate patient care unit. Hospitals that do not fall underneath a system transfer center each maintain their transfer request line to receive incoming transfer requests. This may be the House Supervisor, or it may be a dedicated Bed Management/Access center. Below are the 6 different healthcare system patient transfer centers in TSA-E and their contact information.

Transfer Centers	Transfer Phone Number
Baylor Scott and White Health System	(214) 820-6444
Medical City Health System	(877) 422-9337
Methodist Health System	(214) 947-4325
Texas Health Resources System	(888) 782-8233
Children's Health System	(888) 730-3627
Cook Children's Medical Center	(682) 885-3901

4.8.3.3. During a Regional or State mass patient movement event (such as a hospital evacuation) in which the EMCC has been activated to help coordinate interfacility patient transfers, NCTTRAC will notify the Virtual Patient Transfer Coordination Cell (VPTCC) to begin forming a patient distribution plan. The VPTCC consists of representatives from all 6 of the system patient transfer centers plus representatives from Parkland Memorial Hospital and John Peter Smith (JPS). The VPTCC will be notified via an Everbridge notification that prompts representatives from each VPTCC organization to get on a Zoom call 30-60 minutes after receiving the notification. Note that if a hospital evacuation contains specialty patients (such as NICU patients or burn patients), the EMCC will ensure that subject matter experts related to the specialty group are represented in the VPTCC to provide input on the best destination for each patient.

4.8.3.4. On the coordination call with the VPTCC, NCTTRAC will use Pulsara to present the VPTCC with a manifest of patients who need to be placed. Representatives from each VPTCC organization will inform the VPTCC of which patients their organizations can accept. The EMCC will update patient destination information directly in Pulsara.

4.8.3.5. NCTTRAC staff do not make patient destination decisions; it is up to the VPTCC organizations to claim which patients they can accept, and the EMCC will relay that information back to the evacuating hospital (if they are not on the VPTCC call). Ultimate decision-making authority for patient destinations rests with the evacuation facility.

4.8.3.6. Detailed information regarding mass patient movement into TSA-E can be found in Annex B, Trauma Service Area E Medical Coordination Center Standard Operating Guidelines.

4.8.4. Patient Tracking

4.8.4.1. Mass Patient Tracking

4.8.4.1.1. NCTTRAC utilizes Pulsara as the Region's Patient Tracking Application. Pulsara serves as a centralized database for patients associated with an MCI/MFI. The main intent of this application is family reunification by having each EMS/FRO agency transporting patients and each hospital who receives patients associated with an MCI/MFI list them in Pulsara. Entities involved with family reunification efforts can use this information to link patients with their families. Pulsara allows EMS, hospitals, and

jurisdictional partners to communicate seamlessly during large-scale or mass-casualty incidents.

4.8.4.1.2. NCTTRAC can dedicate a MIST member if requested to data quality validation within Pulsara. The MIST member will monitor the patient list and coordinate with the hospitals to verify patient locations and dispositions (admitted, discharged, etc.) and remove duplicate patient records from Pulsara.

4.8.4.1.3. The Texas Emergency Tracking Network (ETN) board is a state system for tracking general population evacuees from the Texas coast throughout the state. While hospitals in TSA-E are not primary users of this system, they may be asked to use ETN to track any evacuees who are transferred from a regional shelter to the hospital and back. The NCTTRAC EMCC will post instructions for using ETN to both the TSA-E Medical Events board and to EMResource.

4.8.5. Family Reunification

4.8.5.1. NCTTRAC will communicate with county PH departments and DSHS Region 2/3 to coordinate the standing up of a regional FRC or FAC. The responsibility of standing up a FRC or FAC is the responsibility of the jurisdiction having authority over the incident. This FRC will take phone calls from family members looking for patients who have been moved into our region. NCTTRAC will not staff or operate the FRC but will provide support via crisis applications and other methods as requested.

4.8.5.1.1. The HCC-E supports the reunification of MCI patients with their families by coordinating with EMS agencies and hospitals to ensure they are entering all patients into Pulsara. This creates a regional database for hospitals and family assistance centers to locate patients reported missing by their families and begin the reunification process.

4.8.5.1.2. Generally, hospitals continue to follow the same family reunification procedures that they follow for non-MCI unidentified patients. Large-scale regional incidents may see the establishment of jurisdiction-sponsored Family Assistance Centers (FACs) to assist in that endeavor. These jurisdictions-sponsored FACs provide a single point of contact for people missing family members involved in the MCI to file missing person reports and receive news about victims of the MCI. DSHS PHR 2/3 may support jurisdiction-sponsored FACs by establishing a missing person's hotline at their phone bank to field calls from individuals reporting a missing person involved with the MCI.

4.9. North Texas Mass Critical Care Guidelines

4.9.1. The HCC-E has adopted the North Texas Mass Critical Care Guidelines developed by the North Texas Mass Critical Care Task Force (NTMCCTF). The NTMCCTF was a regional collaboration of physicians, hospitals, ethicists, clergy, legal professionals, public health experts, elected leaders, and others who gathered to create clinical guidelines for use by physicians, hospitals, first responders, and other healthcare professionals during an overwhelming disaster. CSC documentation for adults and pediatrics (including clinical treatment guidelines) can be found in Annex A, North Texas Mass Critical Care Guidelines.

4.9.2. Individual HCC partner organizations involved in the direct delivery of emergency healthcare services maintain individual emergency operations plans and surge plans that include guidelines intended to prevent the need to implement crisis standards of care for their organization. These guidelines typically cover procedures for conserving critical supplies, substituting available resources, and other methods of adapting clinical practices to ensure that emergency healthcare delivery can continue unimpeded. Additionally, NCTTRAC hosts a cache of durable medical equipment that can be deployed in an emergency scenario to supplement the existing clinical capabilities of a healthcare provider organization. A full listing of the durable medical equipment available can be found in Appendix F, NCTTRAC Regional Assets List.

4.10. Continuity of Operations

4.10.1. Individual HCC partner organizations are expected to develop, exercise, and execute individual Business Continuity/Continuity of Operations plans to minimize the impact of a disaster on their ability to provide emergency healthcare services.

4.10.2. As the HPP Contractor, NCTTRAC has developed a Continuity of Operations plan that is designed to establish policy and guidance to ensure the execution of mission essential functions and to direct the relocation of personnel and resources to an alternate facility capable of supporting operations. This plan outlines procedures for alerting, notifying, activating, and deploying employees; identifying mission essential functions; establishing an alternate facility; and rostering personnel with authority and knowledge of functions. It also identifies essential personnel, essential functions, organizational order of succession, alternate facilities, and communication and IT systems to be used during an interruption of normal operating procedures. The HPP Grantee Continuity of Operations Plan can be found in Annex D, HPP Grantee Continuity of Operations Plan.

4.10.3. Holistic continuity of operations for the emergency healthcare system in TSA-E is addressed through a combination of individual HCC partner organizations' business continuity actions and NCTTRAC continuity of operations actions.

4.11. Demobilization

4.11.1. The following steps will be used for the demobilization process:

4.11.1.1. Demobilization Orders: Full activations are generally accompanied by a mobilization/demobilization order from the DSHS SMOC. This date may be extended or shortened to align with response activities. This order will include the duration of the activation and the estimated financial liability associated with the activation. A notification of the demobilization of the EMCC will be issued to the HCC at large via email distribution lists.

4.11.1.2. Partial Activations: For incidents that do not reach full activation and in the absence of a DSHS SMA the EMCC Director will scale down support activities with briefings to staff and notifications to the HCC at-large. The EMCC will make direct contact with affected entities to ensure that support is no longer needed before reducing activation levels.

4.11.1.3. Archives: The EMCC Staff will archive all mobilization/demobilization orders, activity records, transfer forms, SITREPS, etc. associated with an incident for future reference and for the development of after-action reviews.

4.11.1.4. Reconstitution & Reimbursement: NCTTRAC Logistics will make every reasonable effort to reestablish a pre-incident level of supplies/equipment. The funding for the replacement of supplies/equipment may be requested in a reimbursement packet from NCTTRAC Finance to DSHS Finance. Reimbursement may also flow through jurisdictional or other governmental reimbursement procedures. If no reimbursement opportunities exist, a funding proposal may be moved to REPC for consideration in the Asset Review Process.

4.11.1.5. After Action Review: As the ESF-8 lead agent, DSHS PHR 2/3 is responsible for the development of a region-wide ESF-8 PH and Medical AAR. NCTTRAC will coordinate with and support DSHS PHR 2/3 throughout this effort. A series of gatherings may be planned to obtain input from stakeholders. Additionally, EMCC Staff will design a broad survey to capture sustainment and improvement elements concerning the HCC response. The information gathered in this survey will provide essential content for a draft after-action report. A formal AAR, with an improvement plan, will be developed by NCTTRAC Staff, shared among the HCC, and submitted to DSHS HEPRS. HCC Members are encouraged to participate in regional after actions that are multi-disciplined and collaborative which allow for the integration of medical support activities among all responding entities.

4.12. Recovery

4.12.1. It is mutually beneficial for governmental bodies and healthcare facilities, partners, and coalitions to work together in an organized fashion to expedite recovery efforts after a disaster. Depending on the size and scope of a particular disaster, specific regulatory agencies (local, state, and/or federal) may require specific inspections and approval before allowing occupancy of an affected facility or approval to provide clinical services.

4.12.2. Following an evacuation of a healthcare facility or several facilities following a significant regional disaster, the affected hospitals and healthcare facilities will work closely with the authority having jurisdiction and the EMCC to conduct an organized and efficient recovery. It is important to understand that different hospitals and healthcare facilities may be conducting operations within different phases at the same time. Likewise, specific geographical areas may be operating under different phases based on damage, accessibility, and security considerations. The identification of phases is at the discretion of the healthcare facility leadership for individual hospitals and healthcare facilities and by the authority having jurisdiction as it pertains to a geographical cordon or secured area. For utilizing common language and communicating needs and activities throughout the recovery process, HCC-E will follow a three-phased approach:

4.12.2.1. Phase I: Damage Assessment Phase

4.12.2.1.1. This phase initiates when emergency response operations are complete, and personnel can begin to make damage assessments. The EMCC will begin to survey regional hospitals and healthcare facilities via EMResource and/or electronic survey delivered through email. The goal of this phase is for hospitals and healthcare facilities to conduct an in-depth assessment of damage and other impacts of the disaster on their facility. The EMCC will also be gathering pertinent information regarding jurisdictional damages or outages that could potentially impact the healthcare system. This information will be summarized and shared with regional HCC-E Stakeholders, other regional MOCs, and the DSHS SMOC as necessary and warranted to begin the restoration phase.

4.12.2.2. Phase II: Restoration

4.12.2.2.1. The restoration phase includes the repair and restoration of services to the affected area or facility, including power, water, sewer, and logistical needs required to make the facility function. The EMCC will actively monitor facilities that are in the restoration phase and will support efforts to reestablish critical services. The provision of certain resources may be available through the EMCC. These resources include electrical power generators, emergency PPE, and emergency durable medical equipment. Additionally, the EMCC may be able to support the identification and logistical coordination of certain services such as waste disposal, medical oxygen, and critical communications. The goal of this phase is to complete repairs to render the facility functional and allow the hospital to provide services to the community. This phase is completed as services are restored and healthcare facilities become capable of caring for patients. The EMCC will share healthcare facility statuses with EMS and other stakeholders so that patients are directed to the proper care facility. This information will also be shared on EMResource.

4.12.2.3. Phase III: Medically Operational

4.12.2.3.1. This phase describes partial or complete capability to provide patient care within a hospital or healthcare facility. This phase is initiated when the hospital or healthcare facility completes the restoration phase of recovery for the entire facility or a portion of the facility that provides critical services to the community. The goal of this phase of recovery is for the hospital or healthcare facility to return to normal operations or at least provide critical access services such as emergency services. This phase is complete when the hospital becomes fully operational and can provide patient care at the same level as before the disaster.

5. Information Sharing Plan

5.1. Purpose

5.1.1. The TSA-E HCC Information Sharing Plan is intended to describe how the TSA-E HCC communicates in both normal and response operations. The TSA-E HCC is administered by NCTTRAC. This document describes the various communication and information-sharing methods available within the TSA-E HCC and provides a guide for their use in both normal operations and

response operations. SAFECOM Guidance aligns with the National Emergency Communications Plan (NECP), which emphasizes the need to enhance governance structures, plans, and protocols that enable the emergency response community to communicate requisite information under all circumstances.

5.2. Scope

 5.2.1. Communication and information sharing occur on multiple levels: between individual HCC partner organizations, between HCC partner organizations and the TSA-E EMCC, between the EMCC and outside jurisdictions/organizations (such as HCCs in other Trauma Service Areas), and between the EMCC and DSHS SMOC. The TSA-E HCC Information Sharing Plan is not intended to supplant the communications and information-sharing plans of individual HCC partner organizations; it is intended to describe an overview of the communications and information-sharing methods and procedures available to the HCC at large.

5.3. Communications and Information-Sharing Methods/Systems

 5.3.1. Primary communication methods and information-sharing within the TSA-E HCC are used for both normal operations and response operations. They include the following:

 5.3.1.1. Email

 5.3.1.1.1. HCC member organizations communicate with one another using email on a day-to-day basis. NCTTRAC maintains multiple email distribution lists composed of HCC member organization representatives. Specific distribution lists exist for the following groups: hospital clinical staff, hospital EM, ground EMS personnel, air EMS personnel, EMS medical directors, PH personnel, jurisdictional emergency managers, and REPC voting members. These distribution lists are regularly used to widely disseminate information among HCC members. Individuals can request to be added to a distribution list by sending an email to Admin@ncttrac.org. Additionally, REPC has an active email listserv that HCC members can use to communicate with the HCC at large. Individuals can register for the REPC email listserv at the following link: NCTTRAC Distribution List and Notification Subscriptions.

 5.3.1.2. Business Phone

 5.3.1.2.1. HCC member organizations communicate with one another using business phone lines daily. HCC members and other partners can communicate with NCTTRAC staff using the NCTTRAC office number 817-608-0390. Individual NCTTRAC staff members supporting the TSA-E HCC can be reached using their extension.

 5.3.1.3. Cell Phone

 5.3.1.3.1. HCC member organizations communicate with one another using cell phones daily. The TSA-E EMCC monitors a 24/7 Duty Phone that can be reached at 817-607-7020.

 5.3.1.4. EMResource

 5.3.1.4.1. EMResource is a web-based resource management software that allows users from different healthcare entities to report and view information regarding the emergency healthcare system in a particular region. EMResource is paid for by DSHS and hosted by Juvare, with regional administration assigned to HPP contractors. NCTTRAC administers EMResource for TSA-E. HCC member organizations regularly use EMResource to share EEI with the HCC on a day-to-day basis.

 5.3.1.4.1.1. HCC member organizations can also use EMResource to send notifications to HCC for any events that might affect the emergency healthcare system in TSA-E. Non-emergency events that are regularly created in EMResource include hospital construction that affects EMS traffic and planned utility outages affecting service provision.

5.3.1.4.1.2. EMResource use is expanded during an emergency to include both mass notification of emergency events and the sharing of additional EEI. Examples might include creating an event that sends a text and email notification to HCC members about an emergent MCI, the daily reporting of current inventory levels of certain medications during a critical medication shortage, or on-the-fly status updates for hospitals affected by a municipal water failure. The key is flexibility – EMResource can be adapted to support the sharing of almost any non-narrative information fields. EMResource will not be used to share PHI such as patient names or medical conditions.

5.3.1.4.1.3. Detailed EMResource definitions, policies, and utilization procedures can be found in the EMResource Policy Document.

5.3.1.5. Pulsara

5.3.1.5.1. The Pulsara platform is a HIPPA-compliant, secure, easy-to-use patient tracking tool app we use in TSA-E HCC region and for EMTF disaster deployments with both EMS agencies and Hospitals. Pulsara helps facilitate and streamline patient care coordination between hospitals and EMS.

5.3.2. Secondary Methods

5.3.2.1. Secondary methods of communication and information-sharing are used when primary methods are inadequate. This can be due to communications failure (such as an internet outage by a specific provider) or due to increased communications needs caused by medical response operations. These methods are typically not used in normal operations (with limited exceptions). Secondary communications and information-sharing methods include the following:

5.3.2.1.1. Public Safety Radio Systems

5.3.2.1.1.1. Multiple public safety radio systems within TSA-E are not accessible to all members of the HCC. For example, a hospital system might have a private radio channel that connects only hospitals within that system, or a city might have a trunked radio system through which hospitals within the city can talk to the city EOC. Some HCC member organizations may use public safety radio systems as a primary communication method (for example, an EMS agency might communicate via radio with a hospital to deliver incoming patient details) – the HCC encourages this behavior, as it creates a regularly practiced communication method that can be used in the event of an internet or phone line failure. However, these systems are typically limited in scope, so HCC members should have additional secondary communications methods in place to share information with HCC members who might not be a part of the same public safety radio system.

5.3.2.1.1.2. All HCC members should ensure that they have at least one public safety radio that is programmed with the statewide interoperability channels. Please note that the statewide interoperability channels are not to be used for daily operations, but only in the event of a disaster or emergency. Additionally, HCC member organizations must execute a signed Memorandum of Understanding with Texas DPS before using the statewide interoperability channels.

5.3.2.2. D/FW Wide Radio System

5.3.2.2.1. The Dallas/Fort Worth Wide Area Radio System (D/FW Wide) is a Motorola MOTORBO "Connect Plus" system operating on the UHF spectrum. Six interconnected tower sites are providing D/FW Wide coverage across TSA-E – these towers are in Cedar Hill, Dallas, Denton, Fort Worth, Hillsboro, Howe, and McKinney. While D/FW Wide covers most of TSA-E, Erath and Palo Pinto counties currently fall outside of its footprint. D/FW Wide is managed by Megahertz Technology – HCC member organizations who wish to get access to the D/FW Wide Radio System should contact Joe Froehlich at joef@mhztech.com. There is a recurring cost per radio for D/FW Wide access.

5.3.2.2.2. D/FW Wide serves as a redundant radio system that allows hospitals to communicate with other hospitals and the EMCC if primary communications

methods fail. While some hospital systems may have private talk groups built out on the D/FW Wide system, regional HCC communication on D/FW Wide occurs on the "D-DFW Wide" channel.
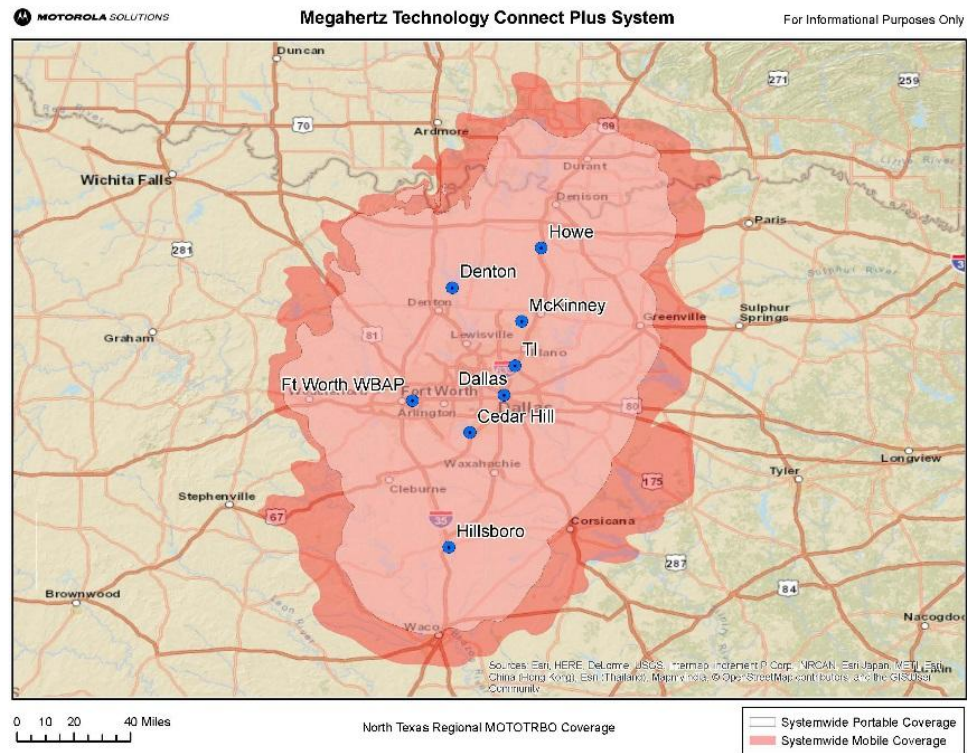
5.3.2.3. Amateur Radio

5.3.2.3.1. Amateur radio serves as the last redundant communication method for HCC TSA-E. NCTTRAC has purchased a large cache of amateur radios, antennas, and coax cables for distribution and installation with HCC member organizations. Each HCC member organization should have an operable amateur radio installed and ready to use, as well as a plan to provide a licensed ham radio operator for its use. It is important to note that an individual must have an amateur radio license from the FCC to legally transmit on an amateur radio. HCC member organizations are encouraged to partner with local amateur radio organizations in their area to provide amateur radio volunteers; this ensures that critical facility staff will not be tied down to the radio in the event of a communication failure.

5.3.2.3.2. TSA-E has many repeaters with footprints that cover multiple counties; however, there is not currently a single amateur radio repeater with a coverage area that encompasses all of TSA-E. For amateur radio use, TSA-E is broken up into four geographic regions based on county, and each region is assigned a primary amateur radio repeater for use during a communications failure. These geographic regions and their primary repeaters are shown.
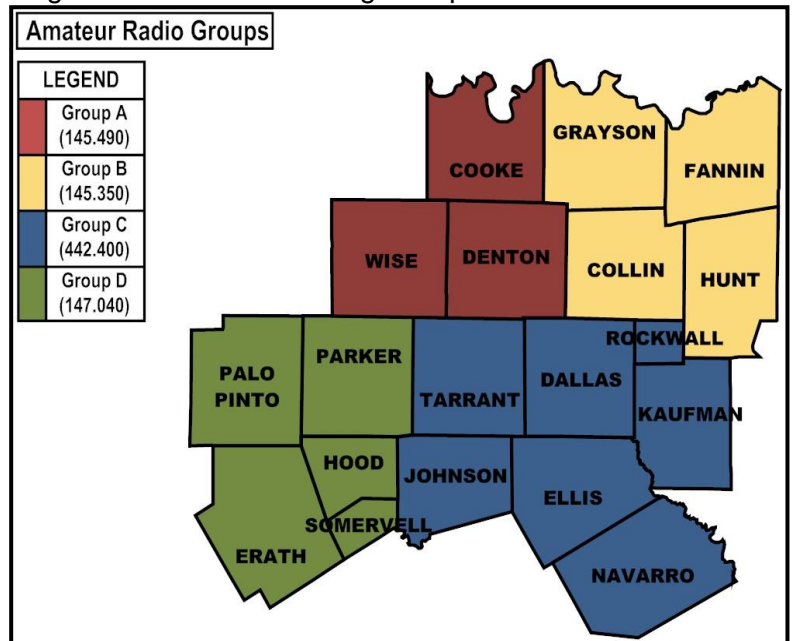
5.3.2.3.3. While the four repeaters outlined above serve as primary repeaters, each amateur radio purchased by NCTTRAC is programmed with over 170 frequencies, including over 100 repeaters. Should one of the primary repeaters become inoperable during a communications failure, HCC member organizations should begin monitoring other repeaters in their area. The EMCC will locate a working secondary repeater and begin transmitting on it for HCC redundant communications.

5.3.2.3.4. It is important to note that amateur radio frequencies are unsecured; anyone with a radio can listen. For this reason, HCC member organizations should never discuss PHI in the same room as the amateur radio.

5.3.2.3.5. Satellite Phones

5.3.2.3.6. Satellite phones allow HCC members to make phone calls when cellular service is down. Generally, paying for satellite telephone service is expensive, so satellite phones are generally only used during communications failure. The TSA-E EMCC has two satellite phones that will be monitored 24/7 during a communications failure. Their numbers are listed below. A full list of HCC member organizations with satellite phones can be found in the HCC Communications Capabilities Matrix in Appendix A.

5.3.2.3.7. EMCC Sat Phone 1 – 8816-224-99633

5.3.2.3.8. EMCC Sat Phone 2 – 8816-224-99634

5.3.2.4. Mobile Satellite (MSAT) Units

5.3.2.4.1. MSAT Units allow users to talk over satellite-based talkgroups designated for interoperable communications. Currently, the TSA-E HCC has 6 portable MSAT

units capable of being deployed, 2 base-station MSAT units (in the EMCC and at the NCTTRAC Warehouse), and 7 Mobile MSAT Units installed in the 5 regional AMBUSes and the two regional MERC Trailers.

5.3.2.5. Starlink Satellite Communication Units

5.3.2.5.1. Starlink is a satellite internet service that provides high-speed, low-latency broadband internet to users around the world. It's ideal for regions with unreliable or unavailable connectivity. Currently, the TSA-E HCC has 11 units capable of being deployed.

5.3.2.6. Everbridge

5.3.2.6.1. Everbridge is a mass notification software that allows for quick notification before, during, and after a critical event with targeted two-way communications. TSA-E HCC can utilize Everbridge for quick notification to partners during a critical event and is used by EMTF for the rostering of assets during a statewide disaster.

5.4. Communication and Information-Sharing Procedures

5.4.1. Point-to-point communication in normal operations is primarily accomplished through standard business methods (email, business phones, cell phones, and fax). Additionally, some HCC partner organizations may choose to use public safety radio for inter-organizational communications (such as an EMS agency transmitting incoming patient information to a hospital Emergency Department (ED) via a trunked radio system). The NCTTRAC EMCC communicates with the TSA-E HCC at large using email distribution lists, email listservs, and EMResource event notifications. HCC partner organizations share essential elements of information with the HCC at large primarily using EMResource. The NCTTRAC EMCC communicates with DSHS and external partners using standard business methods.

5.4.1.1. Alerting/Notifications

5.4.1.1.1. Individual HCC partner organizations use EMResource event notifications and EMResource status updates to notify the HCC at large about internal issues. For example, hospitals often create EMResource events to notify EMS providers about facility construction affecting normal EMS traffic. Similarly, hospitals should use EMResource to update their ED status, their NEDOCS, and their bed availability daily. Other HCC partner organizations can choose to be notified of these changes via text notifications or email notifications (for example, EMS providers often set up text notifications to organizational supervisors so that they are immediately notified when a hospital in their service area moves their ED status to "Advisory"). In place of emergent notifications, some organizations choose to set up EMResource on a screen where it can be actively monitored 24/7.

5.4.1.1.2. When a hospital reports that their ED is "Closed" in EMResource, text notification and an email notification are automatically sent to NCTTRAC EMCC staff. The NCTTRAC EMCC reaches out to the facility in question using business phone lines first and cell phone lines second to confirm the cause of the ED closure and check for any unmet needs. If the EMCC is unable to contact the hospital using business phones, cell phones, or email, the EMCC will begin to employ secondary communications methods/systems to contact the facility.

5.4.1.1.3. The NCTTRAC EMCC notifies the HCC at large about relevant information primarily using email distribution lists and email listservs. For more urgent notifications (such as the potential for severe weather, the EMCC will also create an EMResource event.

5.4.1.2. EMResource Essential Elements of Information

5.4.1.2.1. Hospital ED Status

5.4.1.2.2. Hospital NEDOCS

5.4.1.2.3. Hospital Service Line Availability

5.4.1.2.4. Hospital Bed Availability

5.4.1.2.5. Hospital Psych Bed Availability

5.4.1.2.6. Air Medical Unit Availability

5.4.1.2.7. AMBUS Deployment Status

5.4.2. Regional Emergency/Disaster Operations

5.4.2.1. Communication and information sharing in an emergency should largely follow the same procedures and use the same methods as during non-emergency situations. Most point-to-point communication still occurs over email, business phones, cell phones, and public safety radio, and EMResource remains the primary tool for sharing essential elements of information. However, emergencies often create advanced communications and information-sharing needs that are not adequately met for HCC partners, patients, and visitors by the procedures followed and methods used in normal operations.

5.4.2.2. Alerting/Notifications

5.4.2.2.1. During regional emergency/disaster operations, individual HCC partner organizations can use the NCTTRAC 24/7 Duty Phone (817-607-7020) to notify the EMCC about emergent issues affecting their organization or community. The EMCC will then use EMResource event notifications and email distribution lists to notify the HCC at large. Additionally, the EMCC monitors common situational awareness tools such as newsfeeds, EMResource, and email traffic to ensure that relevant information is captured and passed on to the HCC at large as needed. The DSHS SMOC notifies the EMCC of relevant information using EMResource event notifications, cell phones, and email.

5.4.2.2.2. Deployable assets (including 5 regional AMBUSes, 2 regional MERC Trailers, and 4 regional Mass Fatality Trailers (MFTs) are built as individual resources in EMResource. When these resources update their "Deployment Status", it generates an email and text notification to EMCC staff. This information is then passed down to HCC partner organizations as needed.

5.4.2.3. Primary Communication Systems Failure

5.4.2.3.1. Certain emergency/disaster scenarios might impact the functionality of primary communications methods. For example, a tornado might damage critical communications infrastructure rendering business and cell phones inoperable, or a cyber security threat might make email communication impossible. In scenarios where primary communications methods go down, individual HCC partner organizations should begin activating their own redundant communications plans and equipment to maintain communication channels with other individual HCC partner organizations.

5.4.2.3.2. The NCTTRAC EMCC will begin reaching out to HCC partner organizations in the affected area using all secondary communications methods available. For example, in the event of a cell and landline phone outage, the NCTTRAC EMCC will use a satellite phone to call HCC member organizations with satellite phones, will use the D/FW Wide regional radio systems to contact HCC partner organizations who have access to those systems, and will use amateur radio to contact all other HCC partner organizations. Individual HCC partner organizations are expected to manage the operation and staffing of secondary communications systems for their organization.

5.4.2.3.3. HCC-E Partners utilize EHR to store and access PHI. NCTTRAC does not facilitate the use of telemedicine for individual facilities or organizations within our region.

5.4.2.4. Communications Monitoring

5.4.2.4.1. All resources provided in the HCC-E forms of communication and procedures will be monitored and vetted information will be provided to the coalition accordingly to avoid mis-, dis-, and mal-information. All accounts are created with new users and validation by their organization is provided before accounts can be created.

6. Resource Management Plan

6.1. Purpose

6.1.1. TSA-E HCC Resource Management Plan is intended to describe how TSA-E HCC manages

resource allocation in both normal and response operations. The TSA-E HCC is administered by NCTTRAC. This document describes the facilitation of resource management and planning among recipients, HCCs, HCC members, and their partners to mitigate shortfalls, maintain operations, and sustain delivery of patient care services during an emergency or disaster. Resource Management occurs on multiple levels: between individual HCC partner organizations, between HCC partner organizations and the TSA-E EMCC, between the EMCC and external organizations (such as HCCs in other Trauma Service Areas), and between the EMCC and the DSHS SMOC.

6.2. Allocation of Scarce Resource Plan

    6.2.1. Scarce Resource Management in a Protracted Event

        6.2.1.1. HCC-E plays a critical role in managing scarce resources during a prolonged crisis by ensuring equitable distribution, informed policy decisions, and effective coordination among stakeholders. This includes overseeing information management, supporting health entities, guiding allocation decisions, and facilitating interagency collaboration.

    6.2.2. Managing Information, Equity and Policy Decisions

        6.2.2.1. NCTTRAC along with our regional partners develops and circulates evidence-based guidelines for resource allocation, ensuring policies prioritize vulnerable populations while adhering to legal and ethical frameworks. Real-time data collection and analysis drive policy adjustments, enhancing resource allocation efficiency.

    6.2.3. Managing Resource Requests & Allocation Decisions

        6.2.3.1. Resource requests and allocation decisions are managed through structured prioritization frameworks that guide fair distribution when demand exceeds supply. Transparent decision-making ensures regional partners understand allocation rationale and adjustments, while conflict resolution mechanisms address disputes using mediation and established ethical principles. Supporting healthcare and EMS planning is another key focus, where HCC-E helps identify crisis standards of care thresholds for indicators and triggers of the Allocation of Scarce Resource Plan to ensure that emergency medical services remain functional during prolonged scarcity.

    6.2.4. Training and Exercise

        6.2.4.1. Training and exercises are integral to preparedness, incorporating scenario-based drills into public health, emergency management, and healthcare training programs. Policy implementation is tested through simulations and tabletop exercises. Cross-sector collaboration is strengthened by fostering partnerships between HCC-E partners including healthcare, emergency response, and government agencies to improve preparedness. HCC-E also assists healthcare providers and EMS agencies in navigating state and federal resource request processes and fosters regional collaboration to optimize resource sharing and reduce competition.

        6.2.4.2. NCTTRAC plays a pivotal role in ensuring a coordinated, equitable, and efficient response to scarce resource conditions in protracted events. Through policy leadership, resource management, healthcare support, training initiatives, and multi-level coordination, we help sustain critical services while upholding ethical and legal standards.

    6.2.5. Engaging Community Partners for Equitable Scarce Resource Allocation

        6.2.5.1. To ensure that the allocation of scarce resources is fair, effective, and compliant with federal nondiscrimination laws, we will actively engage community partners that represent the populations most impacted by disasters, including those advocating for at-risk individuals with specific healthcare needs. Our approach will involve inclusive regional collaboration, culturally competent planning, and transparent decision-making.

        6.2.5.2. NCTTRAC will establish ad-hoc advisory committees composed of representatives from community-based organizations, advocacy groups, disability rights organizations, tribal health entities, faith-based groups, and local public health agencies. These committees will help shape resource allocation policies that address the unique needs of racial and ethnic minorities, individuals with disabilities, older adults, low-income populations, and those with chronic medical conditions. By leveraging their expertise, we will ensure that allocation

frameworks do not disproportionately burden historically marginalized communities and align with legal protections.

6.2.6. Allocation of Scarce Resources Plan in Compliance with Federal Nondiscrimination Laws

    6.2.6.1. Our Allocation of Scarce Resources Plan is designed to uphold federal nondiscrimination laws, ensuring that civil rights remain protected during emergencies and disasters. By shifting the focus from clinical triage criteria to system-wide coordination, we aim to maintain a consistent level of care and maximize the use of available healthcare resources across our jurisdiction. Ethical considerations and expert consultation are prioritized by establishing a Scarce Resource Ethics Ad-hoc Advisory Committee to oversee decision-making and ensure adherence to equity-based principles. Engage SMEs in bioethics, public health, emergency medicine, and civil rights law to provide real-time guidance during crises.

6.2.7. Guidance for EMS and Providers on Crisis Care Strategies

    6.2.7.1. NCTTRAC has developed EMS and healthcare provider guidance for crisis care, emphasizing resource coordination over exclusionary triage models. Provide standardized crisis care training for frontline responders to optimize patient outcomes while maintaining legal compliance. Community and healthcare provider engagement is bolstered through education on nondiscrimination laws, bias, and crisis care best practices. Actively engage community-based organizations representing at-risk populations, ensuring that allocation frameworks reflect diverse needs.

    6.2.7.2. The development of clear public messaging strategies to maintain transparency and build public trust during crisis conditions can reduce communication gaps.

6.2.8. Indicators & Triggers for Activation and Response

    6.2.8.1. Thresholds for crisis activation are based on resource scarcity indicators, including hospital capacity, EMS call volume, and supply chain disruptions. State and jurisdiction response actions when resource scarcity exceeds standard mutual aid capabilities, ensuring equitable and data-driven interventions have been outlined.

6.2.9. Operational Framework for Information Management & Policy Coordination

    6.2.9.1. The Information-Sharing Plan component of the Response Plan has established an information-sharing platform to track real-time resource availability, medical surge capacity, and EMS needs. Along with a multi-agency coordination structure for decision-making on scarce resource allocation, ensuring expert input and transparency to provide technical support for healthcare entities through real-time engagement with subject matter experts.

6.2.10. Legal & Regulatory Support for Health Care Strategies

    6.2.10.1. State or jurisdiction declarations and powers define emergency declarations, and the specific authorities granted to allocate resources efficiently.

    6.2.10.2. Credentialing & Licensure Support facilitate expedited credentialing for interstate and intrastate health care workforce deployment.

    6.2.10.3. Liability protection for providers advocates for legal safeguards that protect healthcare workers and EMS personnel making good-faith decisions under emergency conditions.

    6.2.10.4. Alternate systems of care support expanded care delivery models, including telemedicine, community-based care, and alternate care sites.

    6.2.10.5. Regulatory relief for billing and collection secures waivers for reimbursement policies, allowing providers to receive payment for services rendered under crisis conditions.

    6.2.10.6. State and jurisdictional agency support ensures government agencies provide sustained operational and logistical support for crisis care efforts.

    6.2.10.7. By implementing this comprehensive and legally compliant resource allocation plan, we ensure equitable access to care, operational resilience, and legal protections while maintaining public trust and healthcare system stability during prolonged resource scarcity.

7. Patient Movement Plan

7.1. Purpose

7.1.1. The coordination of patient movement and load balancing is critical to improving access to care and supporting equity during emergencies and disasters. This plan outlines the protocols for patient transport, use of coordination centers, and patient tracking, ensuring efficient and effective emergency response. Patient movement planning should begin with the recipient and incorporate specifics from each HCC. Large-scale patient movement involving multiple HCCs or states requires a higher level of coordination, which this plan addresses. This Patient Movement Plan ensures a coordinated approach to patient transport, tracking, and equitable access to care during emergencies. By engaging key partners across multiple sectors, the plan enhances resilience and preparedness in the healthcare system, ensuring that all patients receive timely and appropriate care.

7.1.2. Patient Transport and Tracking

    7.1.2.1. Patient transport services play a vital role in ensuring the safe and timely movement of individuals requiring medical attention. EMS agencies, private and public transportation providers, and specialized transport services will be integrated into the response system. A robust patient tracking system will be utilized to maintain real-time visibility on patient movement and status.

7.1.3. Use of Coordination Centers

    7.1.3.1. Coordination centers will function as hubs for communication, patient movement oversight, and resource allocation. These centers will collaborate with EMS, hospitals, and specialty transport services to streamline patient transfers and maintain equitable distribution of healthcare resources.

7.1.4. Key Partnerships and Coordination Strategies

    7.1.4.1. Hospitals

        7.1.4.1.1. Establish a regional patient transfer agreement.

        7.1.4.1.2. Utilization of EMResource for real-time bed availability updates.

        7.1.4.1.3. Ensure hospitals are prepared to receive patients from different transport services, including EMS and specialty transport.

    7.1.4.2. Long-Term Care Facilities

        7.1.4.2.1. Develop a patient transfer protocol in coordination with skilled nursing and rehabilitation centers.

        7.1.4.2.2. Identify transportation services suitable for non-acute patients requiring relocation.

        7.1.4.2.3. Maintain a database of available beds to facilitate rapid patient placement.

    7.1.4.3. EMS

        7.1.4.3.1. Establish clear guidelines for EMS activation and patient triage during mass casualty incidents.

        7.1.4.3.2. Utilize a centralized dispatch system for optimized ambulance allocation.

        7.1.4.3.3. Coordinate between private and public EMS providers to maximize resource utilization.

    7.1.4.4. Regional Emerging Special Pathogen Treatment Centers (RESPTCs)

        7.1.4.4.1. Engage in collaborative planning efforts for infectious disease outbreaks.

        7.1.4.4.2. Develop transport and isolation protocols for special pathogen events.

        7.1.4.4.3. Conduct joint training exercises to ensure preparedness for regional patient surges.

    7.1.4.5. ROHRS Sites

        7.1.4.5.1. Establish a coordination framework for resource sharing and patient movement.

        7.1.4.5.2. Ensure alignment with federal and state emergency management protocols.

    7.1.4.6. Federal Coordination Centers

        7.1.4.6.1. Engage with the National Disaster Medical System (NDMS) to facilitate large-scale patient evacuations.

        7.1.4.6.2. Maintain communication with federal agencies for resource requests and response alignment.

    7.1.4.7. Community Organizations

        7.1.4.7.1. Partner with local organizations to provide transportation assistance for vulnerable populations.

        7.1.4.7.2. Establish outreach initiatives to ensure equitable access to emergency medical care.

7.1.4.7.3. Develop culturally appropriate communication strategies to address specific community needs.

7.1.5. Incident Management

7.1.5.1. Integration with the states or jurisdiction's incident management structure is essential for effective patient movement, load balancing, evacuation, and family reunification. The plan will align with the Incident Command System (ICS) and coordinate with the agency leading healthcare response incident management. Key strategies include:

7.1.5.1.1. Establishing a direct communication link with the Emergency Operations Center (EOC) for real-time updates and resource coordination.

7.1.5.1.2. Assigning liaisons to work within the state or jurisdiction's Unified Command to facilitate decision-making and ensure seamless integration of patient movement efforts.

7.1.5.1.3. Collaborating with emergency management agencies, public health departments, and healthcare coalitions to streamline evacuation procedures and load balancing across medical facilities.

7.1.5.1.4. Utilizing state-approved data systems to track movement and maintain situational awareness.

7.1.5.1.5. Ensuring that family reunification efforts are coordinated with emergency response agencies and community support organizations to provide accurate information and assistance to affected families.

7.1.6. Transfer Agreements

7.1.6.1. To ensure specialized care for critical patients, key transfer agreements have been established with at least one receiving facility for pediatric, trauma, and burn patients:

7.1.6.1.1. Pediatric Patients: Agreement with Children's Medical Center Dallas to handle specialized pediatric emergencies and intensive care cases.

7.1.6.1.2. Trauma Patients: Partnership with Baylor University Medical Center to provide comprehensive trauma care and surgical interventions.

7.1.6.1.3. Burn Patients: Coordination with Parkland Health & Hospital System, Regional Burn Center to ensure immediate transfer and specialized burn care treatment.

7.1.7. Medical Coordination

7.1.7.1. To effectively conduct patient movement, load balancing, evacuation, and related activities, the EMCC will serve as the primary mechanism for coordination. The EMCC will:

7.1.7.1.1. Facilitate communication and coordination between hospitals, EMS, and emergency management agencies

7.1.7.1.2. Monitor and manage patient distribution to ensure optimal resource utilization.

7.1.7.1.3. Oversee real-time patient tracking and hospital capacity updates.

7.1.7.1.4. Coordinate with specialty care centers to prioritize patient needs and transport logistics.

7.1.7.1.5. Ensure alignment with state and federal emergency response frameworks.

7.1.8. EMS Plans

7.1.8.1. Collaboration with HCCHCC members and additional health care readiness partners is essential for reviewing and updating EMS plans to enhance response efficiency. EMS plans will include:

7.1.8.1.1. Disaster-Related Dispatch and Response: Implementing coordinated dispatch strategies for efficient EMS activation.

7.1.8.1.2. Mutual Aid and Regional Coordination: Establishing agreements between EMS agencies to share resources and personnel during disasters.

7.1.8.1.3. Data-Sharing: Developing a centralized platform for real-time communication between EMS, hospitals, and emergency response agencies.

7.1.8.1.4. Pre-Hospital Triage and Treatment: Standardizing triage protocols to ensure proper patient prioritization.

7.1.8.1.5. Load-Balancing and Transportation: Optimizing ambulance distribution and ensuring equitable hospital load balancing.

7.1.8.1.6. Supplies and Equipment: Maintaining adequate stockpiles of essential medical supplies and ensuring rapid deployment capability.

7.1.9. Integration with the EMCC
   7.1.9.1. Using the EMCC or other mechanisms to monitor healthcare facility capacity and manage medical transport to the closest appropriate hospital-based emergency department, designated trauma center, or specialty referral center.
7.1.10. Community Medical Transport Needs
   7.1.10.1. Communities most impacted by disasters often face unique medical transport challenges. This plan identifies and addresses these needs through:
      7.1.10.1.1. Assessment of Community-Specific Needs: Conducting regular assessments to determine the specific medical transport requirement of high-risk communities, including rural areas, elderly populations, and individuals with disabilities.
      7.1.10.1.2. Specialized Transport Services: Partnering with non-emergency medical transport providers to ensure access to dialysis, chemotherapy, and other routine but essential medical treatments.
      7.1.10.1.3. Emergency Evacuation Support: Establishing agreements with community-based organizations to assist in the evacuation of individuals with mobility challenges.
      7.1.10.1.4. Coordination with Local Transit Services: Working with public transportation agencies to integrate medical transport into emergency response planning.
      7.1.10.1.5. Community Outreach and Education: Informing residents about available transport resources and ensuring culturally appropriate communication to maximize accessibility and utilization.
7.1.11. Federal Patient Movement
   7.1.11.1. This patient movement plan aligns with Federal Coordination Center (FCC) operations and the NDMS Definitive Care Memorandum of Agreement (MOA) by:
      7.1.11.1.1. Supporting FCC Operations: Collaborating with FCCs to facilitate patient movement during federally coordinated responses, including mass casualty incidents and disaster evacuations.
      7.1.11.1.2. NDMS Coordination: Ensuring seamless integration with NDMS to provide definitive care for patients requiring specialized treatment outside of disaster-affected areas.
      7.1.11.1.3. Resource Allocation: Coordinating with federal agencies to allocate transportation assets, hospital placements, and logistical support for large-scale patient movements.
      7.1.11.1.4. Tracking and Reporting: Utilizing federal patient tracking systems to ensure accountability and visibility of patient movement across state and federal levels.
      7.1.11.1.5. Training and Exercises: Engaging in joint training programs with FCCs and NDMS partners to enhance preparedness and response capabilities.
7.1.12. Mitigation Strategies for Extended Downtime Events
   7.1.12.1. To address potential impacts of extended downtime events, this plan integrates with the ESF-8 lead agency coordinating healthcare response incident management. Key mitigation strategies include:
      7.1.12.1.1. Resource Availability: Leveraging coalition-, state-, and regional-level resources to support critical medical services during downtime events.
      7.1.12.1.2. Emergency Power and Backup Systems: Ensuring healthcare facilities have backup power systems and redundant communication capabilities.
      7.1.12.1.3. Escalation Protocols: Establishing clear escalation pathways to state, regional, and federal agencies when downtime risks exceed local capacity.
      7.1.12.1.4. Cross-Facility Support: Enabling resource-sharing agreements among HCC members to maintain patient care services.
      7.1.12.1.5. Incident Response Coordination: Engaging healthcare partners in coordinated response efforts to sustain operations and mitigate service disruptions.

7.2. Activation
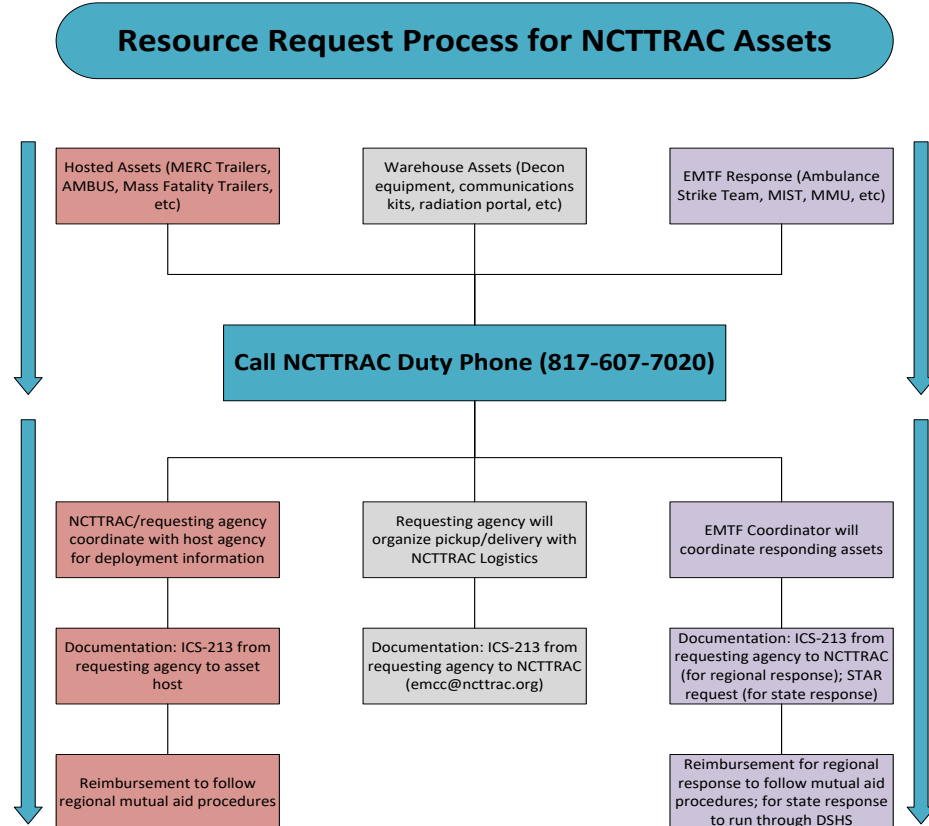   7.2.1. Activating the Allocation of Scarce Resource Plan is only after all other efforts to address resource shortages have been exhausted. As it relates to the activation of crisis standards of care, the triggers are crucial decision points based on changes in resource availability that require a modification of health care service delivery along the continuum of care. Triggers occur at a point

where strategies implemented to mitigate shortages and coordinate available critical resources are no longer sufficient to provide care equivalent to the usual standard of care. Provisions specifying that scarce resource allocation decisions impacting patient care should be supported by REPC and DCAG.

7.2.2. Supplies

7.2.2.1. Individual HCC partner organizations manage internal resources according to internal plans and procedures. Medical resource management in the immediate response is directed by the ICS of the jurisdiction having authority. The HCC-E coordinates the sourcing and delivery of medical response resources at the regional level.

7.2.2.2. HCC partner organizations that receive supplies and equipment purchased with HPP funds are required to sign an HCC MOS, NCTTRAC Property Transfer Agreement, or a resource-specific MOA. The MOS, MOA, and NCTTRAC Property Transfer Agreement each outline how all HPP-purchased and tracked supplies and equipment can be shared from one HCC partner organization to another based-on need. The HCC MOS can be found in Annex E, Healthcare Coalition Memorandum of Sharing.

7.2.2.3. The NCTTRAC warehouse maintains several medical assets that can assist with large-scale medical response and medical sheltering operations. The EMCC is poised to provide these assets to regional medical response and sheltering partners upon request. Organizations should attempt to fill resource needs through existing mutual aid contracts and their city/county government before requesting resources or assets from NCTTRAC.

7.2.2.4. HCC partner organizations and external partners can request regional assets by contacting the EMCC using the 24/7 Duty Phone at (817) 607-7020. Submission of an official ICS-213RR will be required before the transfer of assets. During large-scale emergency events, the STAR process may replace the ICS-213RR. All receiving agencies will be required to sign an NCTTRAC Transfer Agreement (Appendix G, NCTTRAC Property Transfer Agreement) upon receipt of the requested assets. Figure 6 diagrams the resource request process for NCTTRAC assets.

Resource Request Process for NCTTRAC Assets

| Hosted Assets (MERC Trailers, AMBUS, Mass Fatality Trailers, etc) | Warehouse Assets (Decon equipment, communications kits, radiation portal, etc) | EMTF Response (Ambulance Strike Team, MIST, MMU, etc) |

Call NCTTRAC Duty Phone (817-607-7020)

NCTTRAC/requesting agency coordinate with host agency for deployment information	Requesting agency will organize pickup/delivery with NCTTRAC Logistics	EMTF Coordinator will coordinate responding assets
Documentation: ICS-213 from requesting agency to asset host	Documentation: ICS-213 from requesting agency to NCTTRAC (emcc@ncttrac.org)	Documentation: ICS-213 from requesting agency to NCTTRAC (for regional response); STAR request (for state response)
Reimbursement to follow regional mutual aid procedures		Reimbursement for regional response to follow mutual aid procedures; for state response to run through DSHS

7.2.2.5. All non-disposable items are required to be returned to NCTTRAC upon completion of their use. The requested agency should contact 24/7 Duty Phone at (817) 607-7020 when finished using the items to coordinate the return of the items to the NCTTRAC warehouse. NCTTRAC Logistics will either receive the items at the NCTTRAC warehouse or pick up the items from their temporary location. For disposable items, NCTTRAC Logistics will provide the requesting agency with guidance regarding proper disposition paperwork.

7.2.2.6. When deploying resource caches, the manufacturer's guidance according to operation and storage may not be available in a disaster response. Certain durable medical equipment and cache crates should be returned to NCTTRAC. Non-durable equipment, medical devices, and drugs should be charged as a disaster response loss/cost. NCTTRAC Logistics will guide receiving organizations regarding the reconstitution and/or disposition of deployed resource caches. If items that require climate control are returned with appropriate records proving sustainment of climate controls, then these items may be returned to the cache during the post-disaster reconstitution phase of operations. If no records validate adherence to the manufacturer's guidance during transportation, storage, or operational periods, then returned items shall be quarantined, appropriately disposed of, and charged as a disaster response cost.

7.2.2.7. In addition to supporting regional medical response operations, the NCTTRAC warehouse holds supplies that can be used to support medical operations in local or regional general population shelters.

7.2.2.8. Any fatalities associated with mass casualties or large-scale patient movements will be handled through standard procedures between hospitals and county medical examiners' offices. The EMCC will support these efforts in any way possible, including giving county medical examiners' offices access to Pulsara to assist with next of kin notification.

7.2.2.9. NCTTRAC has purchased deployable refrigerated MFT, each with a holding capacity of 20 decadents. There are currently four MFTs in TSA-E with the following agencies: Ferris Fire Department (FD), Burleson FD, Grayson County OEM, and the NCTTRAC Warehouse. For a full list of MFTs, please consult the Regional Assets List. Partner agencies can request the temporary use of an MFT by calling the 24/7 Duty Phone at (817) 607-7020 or contacting the host agency directly.

7.2.2.10. In addition to MFTs, NCTTRAC owns mass fatality management equipment and supplies such as a BioSeal Mass Fatality Response System, FlexMorts, and multiple cases of post-mortem bags. To request the use of NCTTRAC's mass fatality management equipment, partner agencies should follow the resource request process identified above.

7.2.3. Activating MOS

7.2.3.1. The affected hospital or EMS agency should call the NCTTRAC EMCC duty phone (817-607-7020) and state that they are experiencing an internal disaster due to a critical supply shortage and want to ask other hospitals or EMS agencies in the region if they can share any supplies.

7.2.3.2. NCTTRAC will gather the following information from the requesting hospital or EMS agency:

7.2.3.3. Confirmation of internal disaster due to the supply chain issue.

7.2.3.4. All specifications for all items needed.

7.2.3.5. How many days' worth of supplies is on hand for each requested item

7.2.3.6. The requestor's Point of Contact.

7.2.3.7. NCTTRAC will create an EMResource notification that details the resource-sharing request and asks any hospitals or EMS agencies who can share the requested supplies to contact the NCTTRAC EMCC.

7.2.3.8. NCTTRAC will send an email to the coalition with the same information as the EMResource notification for further distribution.

7.2.3.9. If another hospital or EMS agency can share supplies with the affected entity, they will contact the NCTTRAC EMCC, and we will link up the requesting and sending entities.

7.2.4. North Texas Mass Critical Care Guidelines

7.2.4.1. The HCC-E has adopted the North Texas Mass Critical Care Guidelines developed by the NTMCCTF. The NTMCCTF was a regional collaboration of physicians, hospitals, ethicists, clergy, legal professionals, public health experts, elected leaders, and others who gathered to create and share clinical guidelines for use by physicians, hospitals, first responders, and other healthcare professionals during an overwhelming disaster. CSC documentation for adults and pediatrics (including clinical treatment guidelines) can be found in Annex A, North Texas Mass Critical Care Guidelines.

7.2.4.2. Individual HCC partner organizations involved in the direct delivery of emergency healthcare services maintain individual emergency operations plans and surge plans that include guidelines intended to prevent the need to implement crisis standards of care for their organization. These guidelines typically cover procedures for conserving critical supplies, substituting available resources, and other methods of adapting clinical practices to ensure that emergency healthcare delivery can continue unimpeded. Additionally, NCTTRAC hosts a cache of durable medical equipment that can be deployed in an emergency scenario to supplement the existing clinical capabilities of a healthcare provider organization. A full listing of the durable medical equipment available can be found in Appendix F, NCTTRAC Regional Assets List.

7.2.5. COOP

7.2.5.1. Individual HCC partner organizations are expected to develop, exercise, and execute individual COOP to minimize the impact of a disaster on their ability to provide emergency healthcare services.

7.2.5.2. As the HPP Contractor, NCTTRAC has developed a COOP that is designed to establish policy and guidance to ensure the execution of mission essential functions and to direct the relocation of personnel and resources to an alternate facility capable of supporting operations. This plan outlines procedures for alerting, notifying, activating, and deploying employees; identifying mission essential functions; establishing an alternate facility; and rostering personnel with authority and knowledge of functions. It also identifies essential personnel, essential functions, organizational order of succession, alternate facilities, and communication and IT systems to be used during an interruption of normal operating procedures. The HPP Grantee COOP can be found in Annex D, HPP Grantee COOP.

7.2.5.3. Holistic continuity of operations for the emergency healthcare system in TSA-E is addressed through a combination of individual HCC partner organizations' business continuity actions and NCTTRAC continuity of operations actions.

7.2.5.4. HCC-E will support medical supply chain needs when events stress the system.

7.2.5.4.1. Full access to the healthcare supply chain including medical and non-medical supplies, pharmaceuticals, blood products, industrial fuels, medical gases, etc.

7.2.5.4.2. Redirect supplies already within the hospital's supply chain to areas first impacted

7.2.5.4.2.1. Activate MOS with equipment or supply vendors for identified contents

7.2.5.4.2.2. Coordinate with private sector vendors on distribution and resumption of normal supply delivery

7.2.5.4.2.3. Coordinate with PH departments to request medical countermeasures and pharmaceutical cache

7.2.5.4.2.4. Coordinate with the state to activate and distribute equipment and pharmaceutical cache via STAR request

7.2.5.4.3. Ensuring that adequate levels of supplies and equipment are maintained for healthcare providers is critical. The NCTTRAC warehouse maintains certain amounts of supplies and equipment that may be requested for support at an event. If a facility or the emergency healthcare system at large begins to realize a shortage of critical supplies, the HCC can make resource purchases or requests to the state to meet any unexpected demand in supplies.

7.2.6. Fatality Management

7.2.6.1. In HCC-E any fatalities associated with mass casualties or large-scale patient movements will be handled through standard procedures between hospitals and county medical

examiners' offices. The EMCC will support these efforts in any way possible, including giving county medical examiners' offices access to Pulsara to assist with next of kin notification.

7.2.6.2. The ability to coordinate with other organizations (e.g., law enforcement, healthcare, EM, and medical examiner/coroner) to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects.

 7.2.6.2.1. This broad scope of activities requires coordinated plans and responses from healthcare, PH, and EM as well as medical examiners/coroners, funeral/ cremation services, and many other governmental and non-governmental entities.

 7.2.6.2.2. When a catastrophic emergency occurs, hospital morgues will quickly reach capacity, and hospitals will need to implement internal mass fatality plans. If a hospital should declare an internal disaster that affects its morgue capabilities, in any type of capacity, the hospital should have pre-determined plans to help facilitate and coordinate fatality management operations included in their EOP.

  7.2.6.2.2.1. In the event all local jurisdiction resources are exhausted, NCTTRAC can assist with the coordination of the following: (NCTTRAC Duty Phone – 817.607.7020)

  7.2.6.2.2.2. Deployment of Regional Mass Fatality Trailers (20 descendants)

  7.2.6.2.2.3. Deployment of Regional Mobile FlexMort Mortuary Systems

  7.2.6.2.2.4. Contact DSHS 2/3 PH for the availability of state resources

  7.2.6.2.2.5. FEMA resource availability

  7.2.6.2.2.6. STAR will need to be submitted with any regional, state, or federal resources request

7.2.7. Stockpile Activations

7.2.7.1. The SNS is a national repository of antibiotics, chemical antidotes, antitoxins, life support medications, IV administration, airway maintenance supplies, and medical/surgical items. The SNS is designed to supplement and resupply state and local PH agencies in the event of a national emergency anywhere and at any time within the United States or its territories. The SNS can be used in emergencies resulting from terrorist events or chemical, biological, radiological/nuclear, or explosive incidents.

7.2.7.2. One specific program of the SNS that is used for chemical exposure is the CHEMPACK program. The CHEMPACK program is specific for nerve agent exposure only. CHEMPACK containers are managed federally by ASPR in conjunction with DSHS.

7.2.7.3. The CHEMPACK program strategically places containers with antidotes for nerve agent exposure across the state that can be rapidly accessed and utilized. There are two types of CHEMPACK containers:

 7.2.7.3.1. Hospital Containers- consist primarily of multi-dose vials that require reconstitution. Hospital containers are housed primarily in hospitals and can treat up to 1,000 patients.

 7.2.7.3.2. EMS Containers – consist primarily of auto-injectors that can be rapidly deployed in the field for treatment of individuals at the point of injury. EMS containers are housed primarily at Fire/EMS stations and provide treatment for up to 454 patients.

7.2.7.4. Antidotes in the CHEMPACK containers include atropine, pralidoxime, and diazepam.

7.2.7.5. To utilize the contents of a CHEMPACK container, the following process applies.

 7.2.7.5.1. First, DSHS PH Regional offices host Regional SNS Coordinators who support CHEMPACK efforts within their assigned region. The SNS coordinators work closely with the individual sites that house the CHEMPACK containers. Each site maintains a list of individuals who have "decision authority" to open the container. It should be made clear that there is not a complex process to activate a container. If the chemical agent is suspected to be a nerve agent in nature, based on signs and symptoms of the affected individual, the container can and should be utilized to mitigate mortality.

 7.2.7.5.2. If you are a hospital, fire, EMS, or other public health and medical entity and would like to better understand the placement of CHEMPACK containers in TSA E, you may contact DSHS PHR 2/3 at 817-264-4500.

7.2.8. Staffing

7.2.8.1. The potential for substantial loss of life is significant during MCI and patient survival is dependent on the availability and rapid deployment of critical resources. As established in the Texas Disaster Medical System (TDMS), DSHS PHR 2/3 is the ESF-8 Lead Agency in TSA-E. The TSA-E EMCC provides support for health and medical care delivery by hospitals and EMS agencies. The EMCC is staffed and operated by NCTTRAC with potential support from local MIST. Local jurisdictions should exhaust available resources, including local mutual aid resources, before requesting additional assistance from NCTTRAC. EMTF-2 may be activated in support of a regional disaster. The EMTF-2 Coordination Center is housed in and supported by the EMCC. EMTF-2 will coordinate with the TX EMTF SCO routinely and in disaster response. During MCI, regionally supported CSC, or deviation from conventional standards of care and triage may be implemented to provide the highest level of medical care capable of being delivered under disaster conditions. The HCC-E CSC may be found in Annex A and Annex B, North Texas Mass Critical Care Guidelines Document for Adults and Pediatrics. It is important to note that the responsibility for implementing the CSC lies solely with the organization. Primary medical treatment facilities may be damaged or inoperable after an incident occurs. The establishment of alternate care sites may be necessary to supplement local healthcare systems. However, barring major infrastructure damage, it is generally preferred to increase surge capacity at existing healthcare facilities as opposed to building temporary care facilities in austere conditions. Deploying agencies are responsible for responder safety and health during all phases of emergency response. Hospitals and EMS agencies will coordinate with their local county EM Office routinely and in disaster response.

7.2.8.2. The HCC-E will assist with healthcare staffing when facilities have more patients than staff to care for them.

7.2.8.2.1. A medical surge event will require agencies to fully engage available staff to increase and maintain an expanded workforce and staffing levels. Regulatory considerations should be considered when implementing surge staffing strategies, including but not limited to state licensure, liability insurance, and CMS 1135 waivers. Some potential staff augmentation strategies include:

- [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)
- Coordinate cross-training for clinical staff
- Coordinate with contracted staffing agencies to increase the availability of critical medical staff
- Coordinate with volunteer groups to supplement medical and non-medical personnel
- Coordinate with colleges and/or universities to utilize non-conventional staff or expanded scope or practice (i.e., student nurses, medical students, military licensed staff)
- EMTF / State Support

7.2.8.2.2. The EMTF program can deploy teams of clinical professionals to assist in areas experiencing disaster-related patient surges. For hospitals, these teams are called RNST. While the clinicians provided via the EMTF program may not possess specific training or experience, they are experienced emergency healthcare providers who can supplement a local response organization's ability to treat patients.

7.2.8.2.3. To request an RNST or an AST, the requesting agency should first call the EMCC Duty Phone at 817-607-7020 to talk through the logistics of the request. While the initial call to the EMCC Duty Phone can start the deployment process, a STAR must be submitted by the EM agency associated with the city and/or county where the requesting agency is located.

7.2.9. Patient Movement

7.2.9.1. When EMS agencies experience catastrophic events, they have an immediate impact on the coalition. Several issues directly impact EMS and create downstream issues.

7.2.9.2. When major issues occur at EMS Agencies, it has a direct effect on hospitals being able to accept and transfer patients.

7.2.10. Volunteer Process

7.2.10.1. Volunteers, both medical and community members, are key to improving the PH of everyone in this great state. What's more, there are a variety of ways to get involved.

7.2.10.2. Statewide Volunteer Programs

7.2.10.2.1. Texas Disaster Volunteer Registry - Part of the Emergency Systems for the Advance Registration of Volunteer Health Professionals (ESAR-VHP) Program which serves to pre-register volunteers and verify professional licensure so that efficient, effective response can be coordinated during and after any disaster.

7.2.10.2.2. Office of Medical Reserve Corps - Helps communities establish, implement, and maintain MRC units that engage volunteers to strengthen public health, emergency response, and community resiliency. MRC volunteers train – individually and with other members of the unit.

7.2.10.2.3. Texas Association of Regional Councils Emergency Preparedness - Volunteer to support local fire, law enforcement, emergency medical services, and community public health efforts. Also contribute to the four stages of emergency management: preparedness, prevention, response, and recovery.

7.2.11. Telemedicine

7.2.11.1.1. HCC-E Partners utilize Telemedicine as an alternative form of healthcare. NCTTRAC has active Pulsara accounts and will assist with all incidents within the HCC-E upon request. This telemedicine platform allows for effective communication, visibility, and patient tracking for documentation purposes.

8. Medical Surge Support Plan

8.1. Introduction

8.1.1. The purpose of the Medical Surge Support Plan is to describe the response activities of HCC-E when dealing with a medical surge incident. This plan may be activated in the event of a MCI that may result in disruption to healthcare delivery. The Medical Surge Support Plan defines the actions, roles, and responsibilities necessary for a collaborative and coordinated response. It is intended to not only identify regional response activities but also to provide potential best practices to individual entities responding to a medical surge incident.

8.1.2. This document describes the response activities of the HCC TSA-E. It includes response considerations for individual healthcare providers, roles, and responsibilities for the major stakeholders within the HCC, and operational strategies for the HCC at large. As the regional contractor for the HPP, NCTTRAC TSA-E EMCC serves as the execution arm of many regional response activities. Operations described in this response plan are intended to function in coordination with local government, local PH, EM, and other public safety entities. The Medical Surge Support Plan does not supersede, replace, or compete with other regional or local operational plans. It is intended to supplement individual organizational plans and help integrate individual organization response activities into the greater HCC response to a medical surge incident.

8.2. Concepts of Operation

8.2.1. Activation of the Medical Surge Support Plan

8.2.1.1. The Medical Surge Support Plan will be activated when an MCI and/or a medical surge incident occurs that disrupts the level of care provided by a healthcare provider.

8.2.1.2. To activate the Medical Surge Support Plan, the initial responding agency calls the 24/7 EMCC Duty Phone at 817-607-7020 to inform the EMCC that there has been a medical surge incident. The individual who calls the EMCC Duty Phone should provide the following information:

8.2.1.2.1. Callback number

8.2.1.2.2. Incident location

8.2.1.2.3. Incident description

8.2.1.2.4. Assets needed

8.2.1.3. The EMCC will notify the HCC about the medical surge incident.

8.2.1.4. Hospitals will report their MCI Patient Surge Capacity in EMResource.

8.2.1.5. The EMCC will roster EMTF response assets (if needed).

8.2.1.6. The responding EMS agency will begin transporting patients using information about hospital MCI patient surge capacity obtained from EMResource.

8.2.1.7. The chosen triage methodology during an MCI in TSA-E would be up to the discretion of the EMS agency's Medical Director, but the official regional recommendations are to utilize either START/JumpSTART or SALT triage.

8.2.1.8. EMS and hospitals will enter all patients from the medical surge incident in Pulsara.

8.2.1.9. The EMCC will coordinate a medical surge incident Coordination Call among the responding EMS agencies and all involved hospitals from the medical surge incident.

8.2.1.10. The EMCC will notify the DSHS SMOC of the incident.

8.2.1.11. The EMCC will set up the Patient Transfer Assistance Cell to assist in coordinating the transfer of medical surge patients to other capable hospitals within the state (if needed).

8.2.1.12. Specialty Surge Annex documents are as follows:

8.2.1.12.1. Pediatric and Perinatal Surge Annex

8.2.1.12.2. Burn Surge Response Annex

8.2.1.12.3. Special Pathogen Annex

8.2.1.12.4. Radiation Emergency Surge Annex

8.2.1.12.5. Chemical Emergency Surge Annex

8.2.2. Notifications

8.2.2.1. Upon receiving notice of a medical surge incident, the EMCC will send an EMResource notification to all hospitals and EMS agencies in the region stating that there has been a medical surge incident and that the Medical Surge Support Plan has been activated.

8.2.2.2. This notification will prompt all hospitals to enter their MCI Patient Surge Capacity numbers in EMResource and will instruct hospitals who receive patients from the medical surge incident to enter those patients in Pulsara. Additionally, this notification will include all known information about the medical surge incident, including:

8.2.2.2.1. Incident location

8.2.2.2.2. Estimated number of patients

8.2.2.2.3. Pulsara Incident Name

8.2.3. Roles and Responsibilities

HCC Partner Type	Roles and Responsibilities
TSA-E EMCC	• Regional coordination of healthcare response operations. • Gather and share relevant response information between HCC members and other response partners. • Maintain situational awareness. • Share and coordinate resources. • Coordinate with EMS/Medical Control to provide hospital MCI patient surge capacity information. • Provide guidance and support to hospitals regarding patient tracking and local jurisdictions with family reunification. • Coordinate with patient transfer centers and individual hospitals to assist with the interfacility transfer of chemical patients to appropriate facilities. • Provide HCC liaison support to EOC and regional disaster district committees. • Coordinate EMTF activation activities.

HCC Partner Type	Roles and Responsibilities
DSHS – Central	• Collect information concerning the medical surge incident. Coordinate with the Governor's Office as needed.
DSHS PHR 2/3	• Monitor situation and resource requests. • Activate RHMOC. • Serve as a liaison between local jurisdictions and the SMOC.
Hospitals	• Activate and implement response plans and surge strategies. • Provide advanced medical care to patients. • Leave the wristband on the patient until they are discharged home. • Manually enter or scan the wristband's unique identifier into a pre-identified query-able field within EMR. • Receive interfacility transfers of complex medical patients. • Respond to EMResource alert notification about a medical incident and update MCI Patient Surge Capacity information. • Keep MCI Patient Surge Capacity information updated in EMResource as needed. • Enter all medical surge incident patients into Pulsara. • Record all patient tracking/transfer activity in Pulsara. • Provide situational information as requested by the EMCC. • Participate in Regional Coordination Calls. • Prepare and support a FAC. • Provide standard clinical treatment to all patients.
EMS Agencies	• Place a wristband on every patient transported to a hospital-based ED • Manually enter or scan the wristband's unique identifier into a pre-identified NEMSIS-compliant, query-able field within the ePCR. • Provide emergency medical care and transportation to patients. • Treat and stabilize life-threatening injuries. • Notify the EMCC of the medical surge incident at 817-607-7020. • Use local protocols and hospital MCI Patient Surge Capacity reported in EMResource to distribute patients to hospitals. • Enter all medical surge incident patients into Pulsara. • Activate mutual aid plans or procedures. • Establish an Ambulance Staging Area at the scene if needed. • Support interfacility transfers to a higher level of care as needed.
Local PH	• Monitor the situation and resource requests. • Establish and support local FAC/FRC. • Coordinate with PH, health care, and BH. • Assist in crafting public messaging to address the public's need for health and prevention messaging. • Provide SMEs to determine what will be suitable and have a minimal negative effect on the public.
EM County/Local	• Activate EOC as appropriate. • Assist with resource requests as needed. • Assist local healthcare providers with resource requests through the STAR process. • Public information and warning messaging.

HCC Partner Type	Roles and Responsibilities
EMTF	• Provide MIST upon regional or state requests. • Coordinate deployment of EMTF assets. • Notify EMTF partners of potential medical Incidents via Everbridge.
DCAG	• The HCC-E DCAG gathers and provides clinical expertise, acting as the clinical point of contact with healthcare entities, EMS agencies, and external SMEs. • DCAG will be involved in medical surge incidents, as needed.

8.2.4. Information Gathering/Coordination

    8.2.4.1. The primary platforms for information gathering and coordination during a medical surge incident are EMResource, Pulsara, and the Regional Coordination Calls.

        8.2.4.1.1. EMResource

            8.2.4.1.1.1. Hospital MCI Patient Surge Capacity: MCI capacity statuses are based upon STAR/SALT triage categories. The triage color indicates the number of surge patients presenting to the facility that fall under the corresponding category.

                8.2.4.1.1.1.1. MCI Green – minor/minimal

                8.2.4.1.1.1.2. MCI Yellow – delayed

                8.2.4.1.1.1.3. MCI Red – immediate

                8.2.4.1.1.1.4. MCI Black – deceased or expectant

        8.2.4.1.2. Pulsara

            8.2.4.1.2.1. Regional MCI Patient Tracking Software

                8.2.4.1.2.1.1. EMS Medical Surge Incident: The EMS incident commander will create the medical surge incident in Pulsara for EMS and hospital incident tracking.

                8.2.4.1.2.1.2. EMS and Hospital Medical Surge Incident Patient Channel: Use to scan the wristband into Pulsara of each patient EMS and hospitals encounter involved in the medical surge incident, completing as much information as possible to aid in tracking each patient. Also used to transfer patients from one facility to another.

                8.2.4.1.2.1.3. Missing Persons Medical Surge Incident: Is used to show each missing person who has been reported to the Family Assistance/Reunification Team.

        8.2.4.1.3. Regional Coordination Calls

            8.2.4.1.3.1. These calls will be a platform for narrative-based updates from all responding facilities/agencies regarding their current operations in response to the medical surge incident.

            8.2.4.1.3.2. Coordination calls will be held at regular intervals until determined that they are no longer needed, or the surge event has ceased.

    8.2.4.2. After the initial medical surge incident notification, the EMCC will regularly update the EMResource Event Notification with new information as it becomes available.

    8.2.4.3. The EMCC will host regular Regional Coordination Calls to allow for immediate information sharing and operational coordination among all HCC responding entities.

    8.2.4.4. The EMCC will aggregate information from all sources to build and distribute a Healthcare Coalition medical surge incident Situation Report (SitRep) at least once per day. This SitRep will be distributed via email.

9. Regional Mass Casualty Incident

9.1. **A MCI is generally defined as any emergent incident that generates patients in numbers great enough to overwhelm the local emergency healthcare response capabilities. Each jurisdiction**

and HCC partner organization will have different thresholds for what constitutes an MCI; the current Regional MCI Framework collaborative project between NCTTRAC, NCTCOG, and DSHS PHR 2/3 seeks to standardize regional MCI thresholds to ensure that all regional partners share a common language when describing and responding to emergency incidents. This section provides an overview of the HCC-E response to an MCI that affects multiple HCC partner organizations. NCTTRAC partnered with NCTCOG and DSHS PHR 2/3 to develop a Regional Mass Casualty Incident Framework. The Regional MCI Framework will inform HCC-E's response to an MCI in future iterations of the HCC-E Regional Medical Response Strategy and may be found within this document at References, Regional and Local, F, or within the NCTTRAC website.

9.2. Individual HCC partner organizations are responsible for developing and maintaining individual MCI response plans, and this plan does not override or supplant those efforts. Direct healthcare delivery and patient treatment remain the responsibility of individual healthcare providers and on-scene response coordination remains the responsibility of the Incident Command System activated by the jurisdiction having authority. This section describes the general concept of operations for a regional HCC response to a mass casualty incident.

9.3. Concept of Operations
    9.3.1. HCC Notification of MCI
        9.3.1.1. Generally, the local 911 Public Safety Answering Point (PSAP) is the first entity to be notified of a mass casualty incident. Local 911/PSAP then notifies local emergency responders, who then notify city/county emergency management or public health organizations. Hospitals must be notified of an MCI as soon as possible to allow for the early execution of patient surge plans geared towards enhancing a facility's ability to receive an influx of patients; however, recent national MCIs have shown that often hospitals are first notified by incoming patients themselves. To address this gap, HCC has recommended the use of Pulsara. Pulsara allows EMS and hospitals to communicate within minutes. Once added to an incident, viewing patients, and updating their information (demographics, vitals, missing vs united) can easily be accomplished in Pulsara. Efforts are being made to encourage local 911/PSAPs to notify the EMCC 24/7 Duty Phone of emergency MCIs.
        9.3.1.2. HCC-E notification is currently accomplished through the EMResource event notification template "Mass Casualty Incident," which sends emergency email and text notifications to HCC-E partner organizations containing details about the MCI and instructing hospital users to begin updating the MCI bed availability categories for their facility. The EMResource event notification can be created and distributed by local EMS or by a hospital that begins receiving MCI-related patients. If an EMS agency or hospital is notified about a MCI and has not seen an EMResource event notification go out, they should create the notification themselves provided that occupying the resources necessary to do so does not affect their ability to provide patient care.
        9.3.1.3. Once an MCI is discovered, local EMS agencies and receiving hospitals should notify the EMCC using the 24/7 Duty Phone at (817) 607-7020 or add the NCTTRAC EMCC to an incident in Pulsara. The EMCC will then create the EMResource event notification (if it has not yet been created) and send emails through existing distribution lists to notify the HCC-E at large about the MCI.
    9.3.2. HCC-E Common Operating Picture
        9.3.2.1. To ensure that all HCC-E partner organizations are operating with up-to-date information regarding the incident and its associated hazards, the HCC-E uses EMResource and email distribution lists to share information and develop a common operating picture.
        9.3.2.2. Individual HCC partner organizations update specific statuses in EMResource to inform the HCC about the situation at a particular facility or organization (for example, "Hospital Command Center Status").
        9.3.2.3. In addition to the initial event notifications sent to HCC at large, the EMCC will continue to distribute critical information using EMResource event notifications and email distribution lists throughout the incident.

9.3.3. HCC-E On-Scene Response Support

9.3.3.1. Triage

9.3.3.1.1. HCC-E has recommended that responding agencies use SALT/START/JUMP-START for triage in TSA-E. The initial responding ambulance crew will be responsible for the initial scene size-up, activating the MCI Plan, and contacting the Incident Commander on scene. Incident Command will be established and conducted in accordance with ICS Procedures.

9.3.3.1.1.1. Establish a Medical Branch structure to meet the needs of the incident

9.3.3.1.1.2. The objective of the Medical Branch is to provide rapid Triage, Treatment and Transport

9.3.3.1.1.3. Rapidly evaluate the scene

9.3.3.1.1.4. Working with the Incident Commander, develop a management strategy.

9.3.3.1.1.5. Request necessary resources to manage the incident

9.3.3.1.1.6. Assign responsibility and delegate authority to subordinates to accomplish the incident needs and objectives by use of Sections, Branches, Groups, and/or Units according to the National Incident Management System.

9.3.3.1.1.7. Constantly review & evaluate the effectiveness at the incident site

9.3.3.1.1.8. Phase down the incident and demobilize as appropriate

9.3.3.2. Scene Size-Up (A scene size-up will consist of the following:)

9.3.3.2.1. Safety assessment of any threats and/or hazards

9.3.3.2.2. Type and/or cause of the incident

9.3.3.2.3. Approximate number of patients involved

9.3.3.2.4. Triage categories if known

9.3.3.2.5. Declare and MCI to activate the plan

9.3.3.2.6. Establish Incident Command & request additional resources

9.3.3.2.7. Identify and control staging, ingress

9.3.3.3. On Scene Triage

9.3.3.3.1. Initial on-scene resources will promptly begin triage

9.3.3.3.2. Establish and identify a Triage Area at or near the entrance of the Ambulance Exchange Point (AEP)

9.3.3.3.3. A Texas wristband, which has a colored triage tag attached (Green, Yellow, Red, Grey, and Black) will be placed on the victims.

9.3.3.3.4. The Triage Group is responsible for initiating a Casualty Collection Point (CCP) if the incident warrants it.

9.3.3.3.5. If a CCP is established, the Triage Group will be responsible for selecting the order of patients to be moved into formal treatment areas.

9.3.3.4. Start Triage

9.3.3.4.1. The Simple Triage and Rapid Treatment (START) system was developed to allow first responders to triage multiple victims in 30 seconds or less, based on three primary observations: Respiration, Perfusion, and Mental Status (RPM). JumpSTART was designed specifically for triaging children in disaster settings. Though JumpSTART was developed for use in children from infancy to age 8, where age is not immediately obvious, it is used in any patient who appears to be a child (patients who appear to be young adults are triaged using START).

9.3.3.4.2. Only two interventions are allowed during triage:

9.3.3.4.2.1. Opening the airway (two times) to verify respirations.

9.3.3.4.2.2. Opening the airway (two times) to verify Triage color coding to patient priorities of treatment and/or transportation as follows:
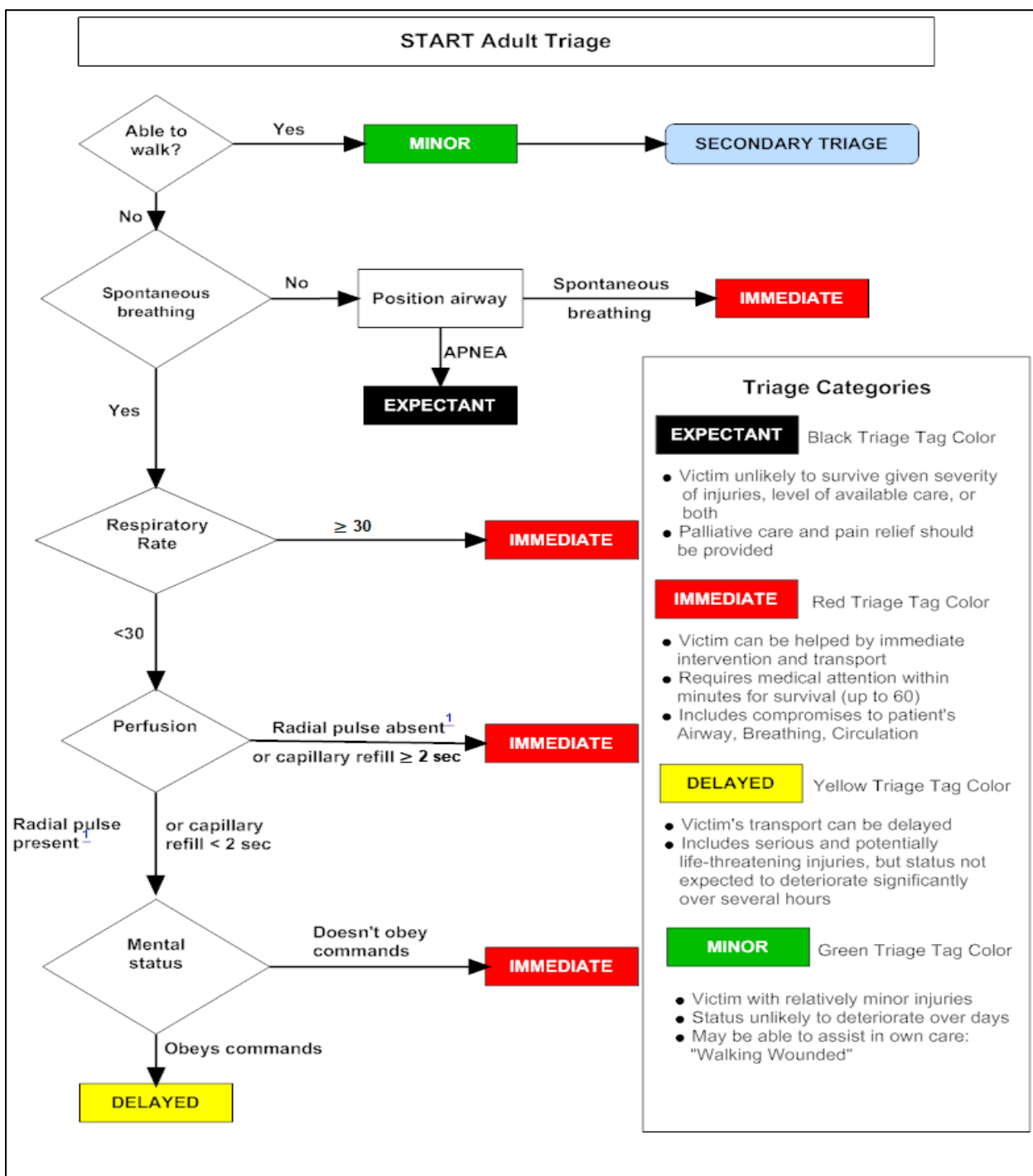
9.3.3.4.2.2.1. BLACK (DECEASED): Do not remove bodies from the scene until authorized by proper officials. DO NOT START CPR until all patients have been tagged and the necessary resources are available.

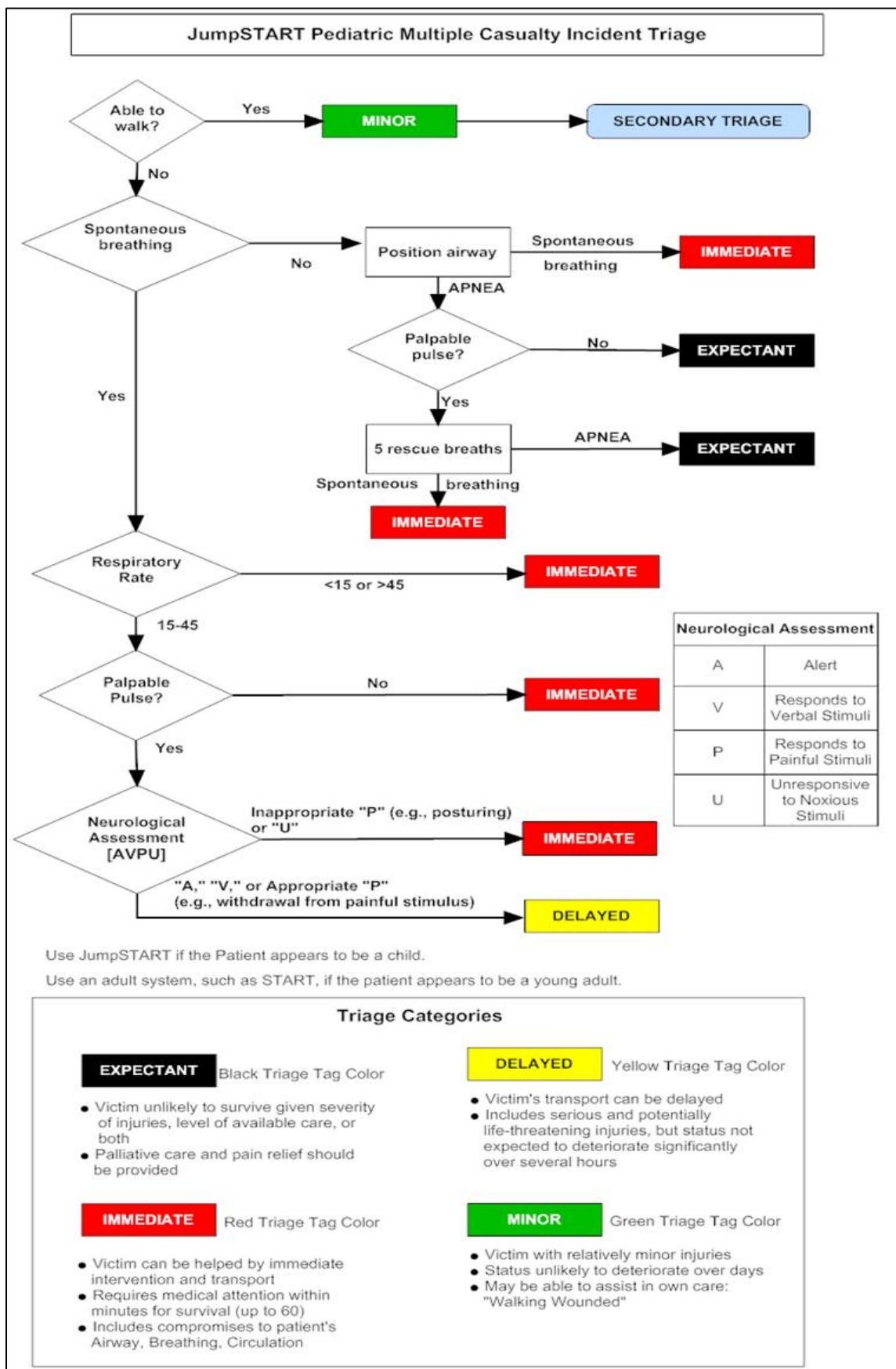9.3.3.4.2.2.2. RED (IMMEDIATE): Patients requiring immediate treatment and transport.

9.3.3.4.2.2.3. <mark>YELLOW</mark> (DELAYED): Patients whose transport can be delayed up to one hour

9.3.3.4.2.2.4. <mark>GREEN</mark> (MINOR): Walking wounded whose injuries do not require ambulance transportation.

9.3.3.4.3. The triage process will begin with a patient assessment and should be limited to 30 seconds per patient.

JumpSTART Pediatric Multiple Casualty Incident Triage

Neurological Assessment

A	Alert
V	Responds to Verbal Stimuli
P	Responds to Painful Stimuli
U	Unresponsive to Noxious Stimuli

Use JumpSTART if the Patient appears to be a child.

Use an adult system, such as START, if the patient appears to be a young adult.

Triage Categories

EXPECTANT Black Triage Tag Color
- Victim unlikely to survive given severity of injuries, level of available care, or both
- Palliative care and pain relief should be provided

DELAYED Yellow Triage Tag Color
- Victim's transport can be delayed
- Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours

IMMEDIATE Red Triage Tag Color
- Victim can be helped by immediate intervention and transport
- Requires medical attention within minutes for survival (up to 60)
- Includes compromises to patient's Airway, Breathing, Circulation

MINOR Green Triage Tag Color
- Victim with relatively minor injuries
- Status unlikely to deteriorate over days
- May be able to assist in own care: "Walking Wounded"

9.3.3.5. SALT Triage

9.3.3.5.1. SALT Triage is the product of a CDC-sponsored working group. SALT (Sort-Assess-Lifesaving Interventions-Treatment and/or Transport) was developed as a national all-hazards mass casualty initial triage standard for all patients (e.g., adults, children, special populations). The big difference between START and SALT triage is that SALT includes a grey or "expectant" category for patients who are still clinically alive but have obvious, massive injuries or other conditions that will almost certainly be fatal. The Expectant category is intended to keep those patients from being triaged Red or immediately and using resources that could be better assigned to patients with a better chance of living.

9.3.3.5.1.1. Sort patients

9.3.3.5.1.1.1. Move "Walking wounded" from the scene to a designated area

9.3.3.5.1.2. Assess remaining patients

9.3.3.5.1.2.1. Perform the following lifesaving interventions:

9.3.3.5.1.2.1.1. Control major hemorrhage

9.3.3.5.1.2.1.2. Open airway

9.3.3.5.1.2.1.3. If the child, consider 2 rescue breaths

9.3.3.5.1.2.1.4. Chest decompression

9.3.3.5.1.2.1.5. Auto-injector antidotes

9.3.3.5.1.3. Triage color coding to patient priorities of treatment and/or transportation as follows:

9.3.3.5.1.3.1. BLACK (DECEASED): Do not remove bodies from the scene until authorized by proper officials. DO NOT START CPR until all patients have been tagged and the necessary resources are available.

9.3.3.5.1.3.2. GRAY (EXPECTED): The patient is expected to die. DO NOT START CPR until all patients have been tagged and the necessary resources are available.

9.3.3.5.1.3.3. RED (IMMEDIATE): Patients requiring immediate treatment and transport.

9.3.3.5.1.3.4. YELLOW (DELAYED): Patients whose transport can be delayed for up to one hour.

9.3.3.5.1.3.5. GREEN (MINOR): Walking wounded whose injuries do not require ambulance transportation

SALT Triage Algorithm
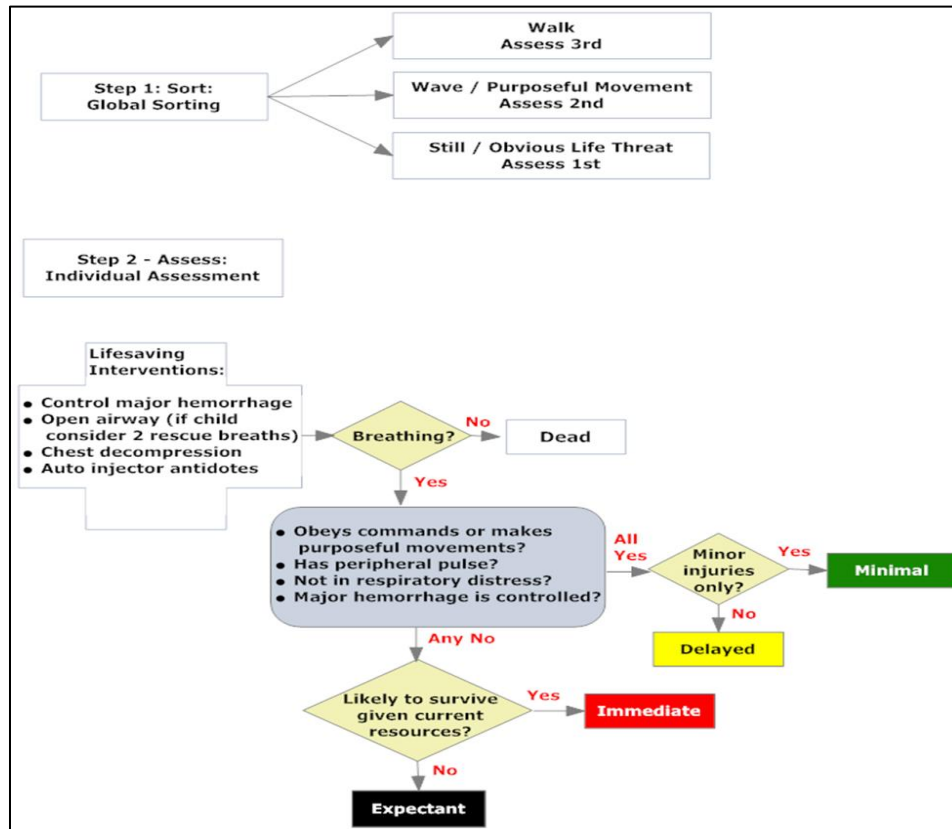
9.3.3.6. HCC-E also recommended the use of the EMS Triage wristband during an MCI. This wristband has been designed with the triage categories included. Responders can simply rip off and discard the triage categories that they do not need, leaving the remaining color as the triage category of the patient. This wristband is designed to stay on the patient throughout their entire healthcare experience. Patients who did not arrive at the hospital by EMS, once identified that they were part of the MCI, should receive an EMS Triage wristband, so that they too can be tracked as a part of the incident.

9.3.3.7. EMS Responsibility
    9.3.3.7.1. EMS is responsible for placing a wristband on every patient transported to a hospital-based emergency department.
    EMS is to manually enter or scan the wristband's unique identifier into a pre-identified NEMSIS-compliant, query-able field in the electronic patient care report (ePCR).
9.3.3.8. Hospital Responsibility
    9.3.3.8.1. Leave the wristband on the patient until discharged home – do not cut or remove
    Manually enter or scan the wristband's unique identifier into a pre-identified query-able field within the electronic medical record (EMR)
    If the wristband is inadvertently removed:
- Place a new wristband on the patient
- Cover or cross out the new barcode and identification number
- Write the previous identification number on the new wristband with a permanent marker

Pulsara was also recommended by HCC-E as a tool that allows for quick patient entry. Pulsara is a day-to-day patient-focused communication tool that links EMS and hospitals on a single "channel" for each patient. Users can control how small or wide an incident can be viewed. Users can also control who has access to their incident by adding only relevant partners to the incident channel. Once an incident is started, partners added to the channel can create new patients to the channel by adding minimal information (sex, triage category) or very detailed information by scanning the Texas EMS wristband or an individual's driver's license.

HCC-E supports on-scene response support primarily through the coordination of EMTF assets and teams. A detailed description of EMTF-2 assets, teams, and how to request them can be found in Section VI, Emergency Medical Task Force-2.

9.3.3.9. HCC-E Hospital Response Support

9.3.3.9.1. As patients generated by a mass casualty incident are transported (by EMS and by non-EMS means) to local hospitals, those hospitals are likely to face resource shortages due to the rapid patient surge. To help support affected hospitals, the EMCC will reach out to hospitals closest to the scene of the mass casualty incident via cell phone and business phone when possible and via public safety radio or amateur radio if cell and business phone services fail. The EMCC will confirm that the hospital is executing internal surge protocols and gather a list of needs for each affected facility.

9.3.3.9.2. At the request of an affected facility, the EMCC will help coordinate deployable EMTF assets including Ambulance Strike Teams (ASTs), AMBUSes, Registered Nurse Strike Teams (RNSTs), and a Mobile Medical Unit (MMU). These assets can help hospitals offload patients to unaffected medical facilities or increase surge capacity to alleviate the resource strain on the affected hospital.

10. References and Annexes

10.1. References

10.1.1. Federal

10.1.1.1. [Office of the Assistant Secretary for Preparedness and Response, 2017-2022 Healthcare Preparedness and Response Capabilities](#)

10.1.1.2. [Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR Parts 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 491, and 494 (CMS Emergency Preparedness Rule)](#)

10.1.1.3. [Robert T. Stafford Disaster Relief & Emergency Assistance Act, 42 U.S.C. 5121](#)

10.1.1.4. [Emergency Planning and Community Right-to-Know Act, 42 USC Chapter 116](#)

10.1.1.5. [Emergency Management and Assistance, 44 CFR](#)

10.1.1.6. [National Incident Management System](#)

10.1.1.7. [National Response Framework](#)

10.1.1.8. [National Strategy for Homeland Security, October 2007](#)

10.1.1.9. [ASPR TRACIE Pediatric Surge](#)

10.1.1.10. [ASPR TRACI Topic Collection: Hospital Surge Capacity and Immediate Bed Availability](#)

10.1.1.11. [ASPR Chapter 1: Overview of MSCC, Emergency Management and the Incident Command System](#)

10.1.1.12. [SAFECOM Guidance](#)

10.1.2. State

10.1.2.1. [Government Code, Chapter 418 (Emergency Management)](#)

10.1.2.2. [Government Code, Chapter 421 (Homeland Security)](#)

10.1.2.3. [Government Code, Chapter 433 (State of Emergency)](#)

10.1.2.4. [Government Code, Chapter 791 (Inter-local Cooperation Contracts)](#)

10.1.2.5. [State of Texas Emergency Management Plan Annex H: Public Health and Medical (August 2015)](#)

10.1.2.6. [Texas Administrative Code, Title 25, Part 1, Chapter 133, Subchapter C. Rule 133.45 (Hospital Disaster Preparedness Requirements)](#)

10.1.2.7. [Health & Safety Code, Chapter 778 (Emergency Management Assistance Compact)](#)

10.1.2.8. [Executive Order of the Governor Relating to Emergency Management and Homeland Security](#)

10.1.2.9. [Executive Order of the Governor Relating to the National Incident Management System](#)

10.1.2.10. [Administrative Code, Title 37, Part 1, Chapter 7 (Division of Emergency Management)](#)

10.1.2.11. [The Texas Homeland Security Strategic Plan, 2021-2025](#)

10.1.2.12. [The State of Texas Disaster Medical System Overview](#)

10.1.2.13. [DSHS: Disaster and Recovery – State Medical Operation Center (SMOC)](#)

10.1.3. Regional and Local

10.1.3.1. [NCTTRAC Regional Trauma System Plan (2023)](#)

10.1.3.2. [TSA-E Health Care Coalition Regional Preparedness Strategy, 2023](#)

10.1.3.3. [Health Service Region 2/3 Regional Health Medical Operation Center Procedural Guide, Version 1.0, February 2017](#)

10.1.3.4. [TSA-E Regional Health Care Preparedness Coalition, TSA-E Regional High Consequence Infectious Disease (HCID) Concept of Operations (CONOPS)](#)

10.1.3.5. [NCTTRAC 2022-2023 HPP Scope of Work (SOW)](#)

10.1.3.6. [NCTTRAC Mass Casualty Incident Framework](#)

10.1.3.7. [Resource Request (ICS 213 RR) Form](#)

10.2. Annexes

    10.2.1. Due to the sensitive nature of these documents, you must be logged in to NCTTRAC to access these in a view-only capacity.

        10.2.1.1. [Annex A: North Texas Mass Critical Care Guidelines: Adult](#)

        10.2.1.2. [Annex B: North Texas Mass Critical Care Guidelines: Pediatric](#)

        10.2.1.3. [Annex C: TSA-E Medical Coordination Center Standard Operating Guidelines](#)

        10.2.1.4. [Annex D: Healthcare Coalition Memorandum of Sharing](#)

        10.2.1.5. [Annex E: NCTTRAC Regional Assets List](#)

        10.2.1.6. [Annex F: NCTTRAC Property Transfer Agreement](#)

        10.2.1.7. [Annex G: HCC-E Infectious Disease Response Annex](#)

        10.2.1.8. [Annex H: HPP Grantee Continuity of Operations Plan](#)

        10.2.1.9. [Annex I: The State of Texas Disaster Medical System Overview](#)

        10.2.1.10. [Annex J: North Central Texas Mass Casualty Incident Framework](#)

        10.2.1.11. [Annex K: HCC-E Pediatric and Perinatal Surge Annex](#)

        10.2.1.12. [Annex L: HCC-E Regional Burn Surge Annex](#)

        10.2.1.13. [Annex M: HCC-E Regional Radiation Surge Annex](#)

        10.2.1.14. [Annex N: HCC-E Chemical Emergency Surge Annex](#)