BCHCC

Big Country Health Care Coalition

2019 Healthcare Coalition Response Plan

Trauma Service Area D (TSA-D)

NCTRAC

NORTH CENTRAL TEXAS
TRAUMA REGIONAL ADVISORY COUNCIL

Contents

Regional Healthcare Coalition Emergency Response Plan

Version 1, January 29, 2019

Record of Revision and Distribution

This document reflects the ongoing work and refinement of Trauma Service Area-D regional strategies for emergency preparedness and disaster response. The document will be revised annually or as needed to reflect continuous process improvement.

Date Approved: 6/11/19

Table 1. Trauma Service Area-D Record of Revision

Date	Summary of Revision	Reviser
2/14/19	Response Plan Recommended By HCC-D	Toby Harbuck
6/4/19	Response Plan Recommended By HCC-E Regional Emergency Preparedness Committee	NCTTRAC Staff
6/11/19	Response Plan Approved By NCTTRAC Board of Directors	NCTTRAC Staff

Table 2. Trauma Service Area-D Record of Distribution

To Whom: Person/Title/Agency	Method of Delivery	Date
BCHCC Executive Committee	Email	2/7/2019
BCHCC Coalition Voted to Approve	Monthly Meeting	2/14/2019

Introduction

Purpose

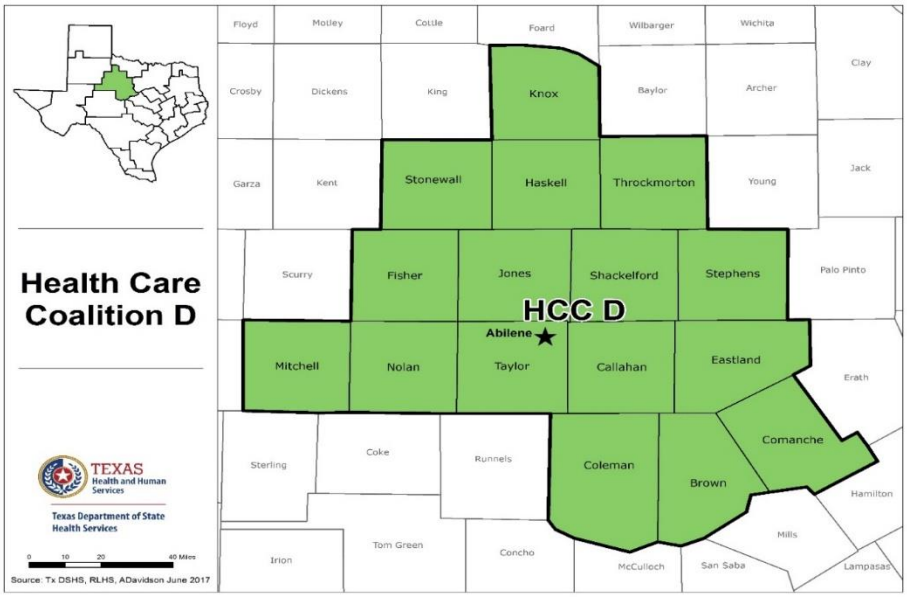
The purpose of this plan is to provide a concept of operations for a coordinated healthcare response to a natural, technological, or human caused disaster in the sixteen-county region that is supported by Trauma Service Area-D Healthcare Coalition. The Regional Coalition Response Plan was developed with extensive input from leaders representing hospitals, emergency medical services, public health, emergency management agencies and other organizations across Trauma Service Area-D HCC sixteen county region.

Coalition Boundaries

The geographical area served by TSA-D includes sixteen counties and all municipalities within. TSA-D strives to improve an all-hazard medical response in West Central Texas through effective communication, planning, coordinated exercises, and collaboration between regional health care organizations, emergency responders, local/regional emergency management directors, public health and other emergency response planners.

- Knox
- Stonewall
- Haskell
- Throckmorton
- Fisher
- Jones
- Shackelford
- Stephens
- Mitchell
- Nolan
- Taylor
- Callahan
- Eastland
- Coleman
- Brown
- Comanche

County Map of the HCC – D Region



The healthcare system in the sixteen-county region is a network of providers of hospital, ambulatory care, in-home services, long-term care, behavioral health, and ancillary care services. Healthcare services across the region are organized into systems, medical groups, public services, and individual providers. Taylor County hosts the only Level 2 regional trauma center. The following is a listing of the Trauma-Designated facilities that provide point of care service within the Coalition boundaries.

- 1 Level III Major Trauma Facility.
- 12 Level IV Basic Trauma Facilities.

Trauma Service Area-D (TSA-D) is a collaborative network of healthcare organizations and their respective public and private sector response partners. Together, we serve as a multi-agency coordination group to assist Emergency Management and Emergency Support Function-8 (ESF-8), with preparedness, response and recovery activities related to health and medical disaster operations. In preparedness and response, TSA-D coordinates healthcare emergency response with regional partners for: situational awareness, patient tracking, resource coordination, and operational response.

The Coalition helps to improve medical surge capacity and capability, further enhancing a community's health system preparedness for disasters and public health emergencies. The Coalition augments local operational readiness to meet the health and medical challenges posed by catastrophic incidents. This is achieved by engaging and empowering all parts of the healthcare community, and by strengthening the existing relationships to understand and meet the actual health and medical needs of the whole community.

Scope

The Regional Healthcare Coalition Emergency Response Plan is applicable for incidents necessitating local and/or regional healthcare response coordination among partners within jurisdictions encompassed by TSA-D.

It is important to emphasize that TSA-D activities during an incident response does not supersede or subvert the authority of public officials acting as the incident command or area command authority for the overall incident. Rather, TSA-D supports the response by enhancing the integration and performance of responding healthcare organizations. It should also be noted that TSA-D does not have command and control authority and will only provide support to healthcare organizations (Tier 1) and jurisdictional authorities (Tier 3) Medical Surge Capacity and Capability Management Organization Strategy.

The Information in this plan applies to the roles and responsibilities of TSA-D and coalition partners such as: healthcare organizations (HCOs). Local public health jurisdictions (LHJ), Emergency Medical Services (EMS), emergency management departments and agencies, etc. Plan information may also be applicable to other organizations such as non-governmental and local, state, federal, and tribal partners. The Plan includes a general concept of operations for healthcare activities during disaster response operations. Broader health, medical and mortuary response activities are covered in county ESF-8 (Health, Medical, and Mortuary) plans or in relevant functional response plans. This plan is compatible with federal and state emergency response plans, promotes the coordination of an efficient and effective response by utilizing the concepts outlined in the National Incident Management System, and establishes common goals, strategies and terminology with other regional and local plans.

Situations and Assumptions

Coalition Governance

TSA-D Executive Board serves as voting members of TSA-D and are responsible for the everyday governance of the region. The Executive Board represents the geographic and discipline diversity of the TSA-D members and communities, and assumes authority over the region. For further information on TSA-D Governance please refer to HCC-D Preparedness Strategy (Annex).

Coalition Members

Coalition members are HCOs and Emergency Management Organizations that agree to work collaboratively towards healthcare preparedness and emergency response activities. For a full listing of TSA-D members and partners and their role within the Coalition please refer to HCC-D Preparedness Strategy (Annex).

Risk Assessment

TSA-D conducts risk analysis to identify key concerns as well as potential gaps in response systems and resources. To ensure preparedness and response activities align with identified healthcare and regional vulnerabilities; TSA-D has worked with healthcare, public health, and emergency management partners to assess hazards throughout the 16-county region. Through this process, hazards were identified and prioritized based on input from healthcare emergency preparedness facility leaders. The Regional Healthcare Hazard Vulnerability Assessment (HVA) was developed as a tool to benchmark emergency management activities between and within TSA-D and its partners. For a summary of Hazard Vulnerability Assessment and Gap Analysis please refer to HCC-D Preparedness Strategy (Annex).

Planning Assumptions

This plan outlines the activities necessary to manage events requiring coordination of resources among regional partners. Planning assumptions for the purposes of this plan include:

1. Public need for health information and health and medical services will likely increase during disaster.
2. Impacted facilities have activated their emergency operations plan and staffing of their facility operations center.
3. A disaster may require the triage and treatment of large numbers of individuals, which will have a direct impact on healthcare facilities and workers.
4. Incident response resources and personnel could be limited in disasters while injuries, illnesses, and the need for medical resources may increase.
5. Healthcare organizations will commit their internal organizational and/or system resources to address their own internal challenges prior to releasing resources to other healthcare organizations.
6. Healthcare organizations will commit their internal resources and contracts to address issues within their organizations before requesting resources and support from other healthcare organizations or partners.
7. Pediatric and other specialty care patients, including those that are critically ill, may present to any hospital, closest urgent care, or other healthcare facility during a disaster, including those that do not normally treat those specialty or pediatric populations.

8. Healthcare organizations will incorporate and address the unique needs and circumstances of vulnerable and specialized populations in emergency response planning.
9. During a disaster that results in critical infrastructure disruption and/or a patient surge, transport and transfer of patients to specialized hospitals might not be immediately feasible.
10. Infrastructure impacts, such as damage to bridges or road closures, may affect staff, patient, and supply transport through the region.
11. Essential goods and services, such as food, water, and medical supplies may be in short supply or unavailable during or following a disaster.
12. Healthcare organizations will rely on existing emergency service contracts with medical suppliers and other key vendors to sustain essential patient care services for the maximum extent possible, and will have plans in place to manage, as much as possible, critical functions for a minimum of 96 hours.
13. A disaster or similar event may impact communications within a healthcare organization as well as between healthcare organizations and response partners, thereby creating additional challenges during the response.
14. Healthcare organizations will likely be a priority for critical infrastructure service restoration, such as power, water, communication and transportation systems, when impacted during or following a disaster.
15. Healthcare organizations that are part of the Plan will follow the National Incident Management System (NIMS) using Incident Command System (ICS).
16. This plan is based on certain assumptions about the existence of specific resources and capabilities that are subject to change. Flexibility is therefore built into this plan. Some variations in the implementation of the concepts identified in this plan may be necessary to protect the health and safety of patients, healthcare facilities and staff.

Concept of Operations

Introduction

The process outlined below describes the basic flow of TSA-D response to a disaster and emergency situations and the steps and the activities that may need to be accomplished. Not all steps and activities will apply to all hazards.

Coalition Response Objectives

Goal: Promote integration of Coalition member organizations into the broader community response. Objectives to support this goal include the following:

- Utilizing the concepts within Management Organization Strategy Six-Tier Construct facilitate information sharing among participating healthcare organizations (Tier 1) and with jurisdictional authorities (Tier 3) to promote common situation awareness.
- Facilitate resource support be expediting the mutual aid process, or other resource sharing arrangements among Coalition members, and supporting the request and receipt of assistance from local, State, and Federal authorities.
- Facilitate the coordination of incident response actions for the participating healthcare organizations so incident objectives, strategy, and tactics are consistent for the healthcare response.

- Facilitate the interface between TSA-D and relevant jurisdictional authorities (Tier 3) to establish effective support for healthcare system resiliency and medical surge.

For further information on the management organization strategy and the six-tier construct refer to the HCC-D Preparedness strategy (Annex).

Role of the Coalition in an Incident

During an emergency response, TSA-D's Regional Medical Control Center (RMCC) Response Team conducts a range of activities to achieve its stated objectives. Please see below:

- Provide notification to member organizations and other coalitions that an actual or potential incident is developing. Allowing for a very rapid response on a 24/7 basis.
- Provide mechanisms to rapidly disseminate information from Incident Command and other authorities to Coalition member organizations so that they can effectively and safely participate in emergency response.
- Rapidly disseminate information from Coalition member organizations to Incident Command and other authorities, at their request.
- Convene (often virtually) specific personnel from Coalition member organizations at the request of incident command authorities to discuss strategic issues or make policy recommendations related to the healthcare response.
- Provide Coalition member organizations incident-related information that is not otherwise readily available.
- Disseminate resource needs to member organizations and help match organizations that request mutual aid other assistance with organizations that can provide the needed assistance.
- Facilitate the coordination of response actions among member organizations when requested by the Coalition's responding members and/or by jurisdictional authorities.
- Support evacuation activities, patient transfers and patient tracking.
- Support shelter-in-place activities.
- Identify time-sensitive performance metrics for Coalition response (e.g., notification of incident to Coalition members; time to bed availability reporting; time to setting up field triage; time to appropriately distribute casualties; time to state transportation resources to transport casualties; time to update patient tracking info at intervals; and time to staff a family assistance center).

Command, Control and Coordination-Partner Organizations, Agencies & Departments

Healthcare Organizations

TSA-D includes a full range of healthcare assets that provide "point of service" medical care and other medically related services during a mass casualty and/or mass effect incident. Healthcare organizations include any of the following categories of partners: hospitals, long-term care (skilled nursing facilities, assisted living facilities, home health, hospice, etc.), outpatient facilities (clinics, urgent care, ambulatory surgery centers, tribal health, dialysis, etc.), and blood providers. Healthcare facilities/systems will attempt to manage incidents within their organizations as best as possible. Healthcare organizations will activate emergency procedures, plans, and/or command and control centers as needed to prepare for, respond to, and/or recover from any incident. If additional external resources are necessary, the healthcare organizations may request resources from any of the

following avenues: health or medical vendor; the RMCC; local emergency management or EOC; Local Health Jurisdictions; and other partner organizations. If healthcare organizations request resources via the RMCC, they are to follow the Regional Resource Request Flow Chart (Attachment B).

Healthcare organizations may receive a surge of patients due to an incident. Healthcare organizations are to follow internal procedures for managing a surge as much as possible. Healthcare organizations may request support from local partners for resources, staff, and coordination at any time.

If RMCC is activated to support healthcare operations, healthcare facilities/systems will support those operations in the following ways:

- RMCC Response Team Resources: Healthcare organizations not directly involved in the incident will be asked to provide personnel to perform key response functions within the RMCC.
- Situational Awareness: Provide requested information in a timely manner as feasible prior to, during and/or following the incident:
    - ➞ Respond to immediate Bed Availability Request
    - ➞ Update EMResource
    - ➞ Establish Hospital Incident Command Center
    - ➞ Respond to information surveys in accordance with Regional Healthcare Coalition Situational Awareness Standard Operating Procedure (Annex)
- Public Health: Notify public health of notifiable conditions as required by the Texas Administrative Code (TAC).
- Resource Coordination: Request support for resources through the RMCC or local emergency management in accordance with Regional Healthcare Resource Request Flow Chart (Attachment C).
- Mutual Aid: Support requests for mutual aid when possible.
- Patient Tracking: Support patient tracking operations by sharing patient information with the RMCC (as applicable).
- Clinical/Policy coordination: Support request for guidance and feedback on clinical or policy coordination efforts.

To the best of their ability, healthcare organizations will respond to requests for information from the RMCC and any other partner organizations. Additionally, healthcare organizations may be called upon to support local alternate care systems response efforts by the LHJs, according to county-specific plans (see county-level plans for more information).

Health Departments/Jurisdictions

Upon receiving notification of activation of this plan, health departments/jurisdictions at the local, state, and/or federal level may seek information regarding the incident from the RMCC and/or healthcare partners. Health departments/jurisdictions will lead the ESF-8 role for public health and medical services preparedness and response, and may activate and/or staff emergency operations, or similar centers. If activated, health departments/jurisdictions will inform the RMCC.
LHJs are the lead entities for several health-related response operations. These include:

- Epidemiological investigations.

- Alternate care systems operations.
- Coordination with partners for family assistance plans.
- Fatality management operations.
- Medical countermeasures operations.
- Environmental health operations.
- Medical Reserve Corp coordination (when and where applicable).
- Public and risk communications regarding a health-related incident.

Any of the above-mentioned or similar activities may be performed in coordination with partners such as The Texas Department of State Health Services (DSHS), local/state emergency management agencies, EMS agencies, healthcare organizations and the RMCC.

Emergency Management Departments/Agencies

Upon receiving notification that the Plan has been activated, emergency management departments at the local, state and/or federal level may seek information regarding the incident from the RMCC and/or healthcare partners. Healthcare organizations may request resources through the RMCC (for medical and non-medical resources) which may then be forwarded along to relevant emergency management partners. Healthcare organizations may also go directly to their local emergency management partners (for non-medical resources). In this instance, either the requesting healthcare organization or emergency management agency may inform the RMCC of the request.
Emergency management departments will lead response coordination, which may include serving as a conduit to state and/or federal emergency management partners, and may activate EOCs. If activated, emergency management departments will inform the RMCC, and may request an RMCC representative/liaison.

Emergency Medical Services

EMS and private ambulance partners play a key response role in both the pre-hospital and inter-facility transfer environments. Upon activation of this plan, EMS agencies will:

- Coordinate patient movement with the RMCC.
- Triage & tag patient with unique identifier.
- Coordinate with local/regional LHJs/EOC to establish ambulance staging area.
- EMS will coordinate with the RMCC and provide and receive situational awareness information concerning the response.
- EMS agencies may also be asked to fulfill other response roles such as representation at an EOC and/or RMCC.

Emergency Medical Task Force-2 (EMTF-2)

Texas EMTF is a regional and statewide medical response capability. NCTTRAC serves as the lead agency for 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 is capable of providing ambulance buses, mobile medical units, nurse strike teams, ambulance strike teams, Ambulance Staging Management, Medical Incident Support Teams (MIST), and Infectious Disease Response Units (IDRU). When called upon by

locally or regionally, costs must be reimbursed by the receiving jurisdiction, or be absorbed by the providing agency. When incident support exceeds regional capability, the jurisdiction and/or the RMCC will notify the Disaster District Chair 7 (DDC-7) via the established STAR request process.

ESF-8 Lead Agency Integration (Department of State Health Services (DSHS))

DSHS Public Health Region 2/3 (DSHS 2/3) operates the Regional Health and Medical Operations Center (RHMOC) for Trauma Service Area D (TSA-D). The RHMOC serves as the regional public health and medical coordination point during regional and statewide incidents. When activated, the RHMOC will house regional public health and medical partners to ensure that regionally-based resources and mutual aid are used for public health and medical response.

The Texas Department of State Health Services, TSA-D and LHJs (when applicable) will mutually support mass casualty events and disasters, including the provision of ESF-8 liaisons to local Emergency Operations Center (EOCs) and Disaster District Committees (DDCs). The RHMOC is responsible for the following:

- Coordinate multi-jurisdictional response.
- Coordinate with federal and neighboring state partners if the response exceeds local and state resources.
- Provide support for patient movement, as necessary.
- Provide support for medical and non-medical resource needs of local healthcare providers, including the coordination of state and national stockpiles of resources.
- Provide direction on legal and statutory regulations and modifications.

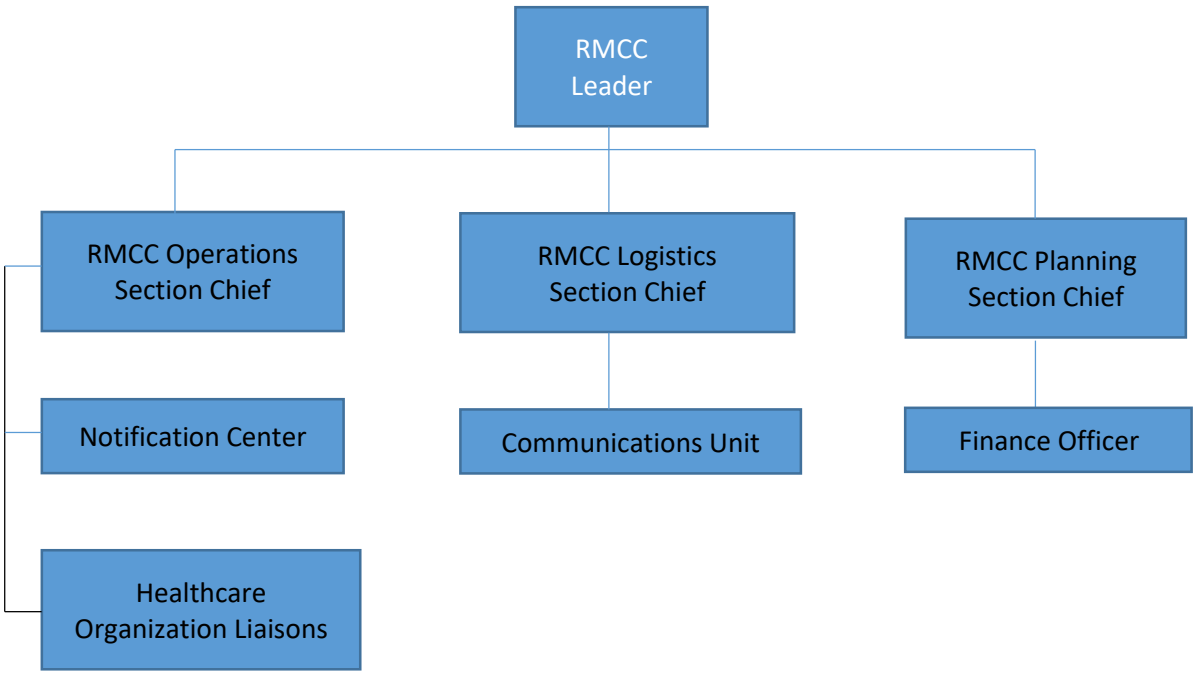
Federal Government

- Coordinate with DSHS when response exceeds local and state resources.
- Provide standardized infectious disease guidance throughout the nation as warranted.
- Coordinate federal level resources, requests, and any national stockpiles of resources.
- Coordinate federal level response capabilities including: National Disaster Medical System, Federal Medical Stations, Disaster Medical Assistance Teams, Disaster Mortuary Response Team, Urban Search and Rescue, CHEMPACK, Strategic National Stockpiles, etc.
- Military partners may support regional medical and non-medical response with resources, personnel, and coordination.

Coalition Response Organizational Structure

In order to quickly and effectively initiate emergency operations, TSA-D has adopted an Incident Command System (ICS) model for managing the RMCC. As with traditional ICS descriptions, only the RMCC positions that are required to respond to an incident will be activated. TSA-D expects to respond to the majority of its incidents with one to three individuals that will conduct all RMCC functions. Individuals that staff the RMCC are employees of TSA-D members/partners. Back-up staffing and resources have been identified for each essential RMCC function and are detailed in the HCC-D Regional Medical Control Center Standard Operating Guideline. An RMCC organizational chart can be found in Figure 1 below.

Chart 1. RMCC Organizational Structure



Response Operations

Day-To-Day Activities

TSA-D will function in a decentralized nature during normal day-to-day activities. In order to be immediately available to conduct no-notice response actions there are two functions that are continuously operational during these times of non-response:

1. Must always have the ability to rapidly receive information and notify Coalition members of an emergency, and
2. Must have a sound decision-making process to determine whether additional actions are necessary at the onset of the incident.

In order to maintain a baseline of operation and readiness for immediate response TSA-D maintains two primary functions as described below:

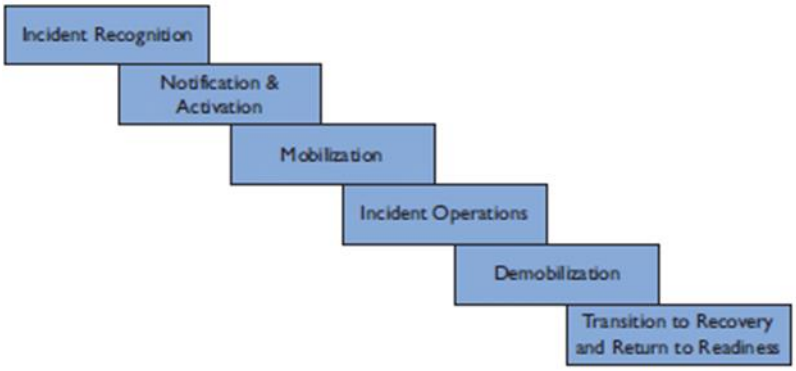
1. Healthcare Coalition Coordinator, and
2. Regional Medical Control Center (RMCC) with an on-call fully staffed response team (see RMCC Concept of Operations).

Stages of Incident Response

TSA-D has conceptualized its incident response and recovery in distinct stages that occur sequentially as the incident evolves. These stages provide the framework for the Concept of Operations (see Figure 1).

Figure 1. Stages of Incident Response and Early Recovery

Figure 1 depicts the Stages of incident response and early recovery. They are from top to bottom: Incident Recognition; Notification and Activation; Mobilization; Incident Operations; Demobilization; Transition to Recovery and Return to Readiness



Incident Recognition

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 on situations/hazards that should be reported to the RMCC Coalition Coordinator and may trigger Plan activation:

- Almost any declared incident (and subsequent EOP activation) by a Coalition member.
- Awareness through open source media, notification by a partner, local, state or Federal entity.
- An HCO evacuation is imminent.
- Critical shortage of medical and/or ancillary personnel to care for arriving and in house patients.
- Shortage of medical supplies.
- HCO is damaged or compromised.
- Lack of Critical hospital utility systems and back-up systems are in use or not operational.
- Local emergency and/or all-hazard incident is occurring.
- Any substantive alert message requiring action from LHJ, DSHS 2/3, Federal Government.
    - ➞ Natural disaster (e.g. widespread tornado or flooding)
    - ➞ Biological attack (e.g. anthrax dispersion)
    - ➞ Chemical attack or spill
    - ➞ Biological disease outbreak (e.g. pandemic influenza)
- Activation of a jurisdictional Agency's EOP.
- Activation of a nearby Healthcare Coalition.
- Request activation by jurisdictional agency (Tier 3).
- Evidence that incident circumstance could expand.
- When a similar incident in the past required activation of the RMCC.
- Sever weather incident.
- Radiological threat or incident
- Terrorist threat or incident
- Mass Gathering Event

- Any incident large enough to require resource sharing including:
    - ➞ Strategic National Stockpile deployment
    - ➞ Epidemiologic investigation
    - ➞ Facility Evacuation

Plan Notification & Activation

The Plan, in part or in its entirety, will be activated during any incident that warrants coordination between one or more healthcare organizations and other emergency response partners or upon request by local, state, Federal agencies. When activated, the RMCC supports healthcare response coordination as part of the ESF-8 response. Upon activation of local emergency management, the RMCC will activate to support ESF-8 operations, in coordination with the LHJ. This activation may occur concurrently with activation of other plans within and/or outside the region.
Upon recognitions of an emergent incident the identifying organization should notify the RMCC by calling the 24/7 Duty Phone. The 24/7 Duty Phone can be reached using the Following Number:

- 325-793-8415

A request for activation of the plan may originate from any local healthcare organization, local and/or state EOC/RMCC, LHJ, or emergency management agency, or similar organization, as well as the TSA-D Executive Board (leadership) and Coalition Coordinator. An activation request will be communicated to TSA-D:

- Any of the organizations listed above can request activation of the Plan in part or in its entirety.
- The TSA-D leadership or Coalition Coordinator will receive requests for Plan activation and alert all members. Authorized personnel to make notification of incident include:
    - ➞ Executive Board Member
    - ➞ Healthcare Coalition Coordinator
    - ➞ RMCC Leader

The general process for a partner organization to request an RMCC activation is listed below:

- Initial activation request may be made verbally to start the support processes – these may include:
    - ➞ Region-wide alerting
    - ➞ Issuing regional bed availability reports
    - ➞ Creation of a WebEOC incident
- All formal activation requests must be provided in writing within the first operational period following the initial request and should originate from the leadership of the requesting organization.
- For non-state activations of the RMCC, a general message such as an ICS-213RR may be used (Attachment D).
    - ➞ If email submission of the 213RR is not available, a fax copy of the 213RR may be sent to (325) 676-9541.
    - ➞ External partners should establish telephone contact with the RMCC to ensure reception of the request.

    - For state activations of the RMCC, the preferred method is the State of Texas Assistance Request (STAR) in WebEOC.
    - Telephone contact to the RMCC 24/7 Duty Phone at (325) 793-8415 to ensure delivery is recommended.
- 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.
- All RMCC activation requests should be concurrently provided to supporting jurisdictional partners. The RMCC will provide partners a copy of any activation request when it appears that jurisdictional emergency management partners have not been included in the request distribution. For further details, refer to Regional Healthcare Coalition Situational Awareness Procedure (Annex).

The TSA-D Regional Medical Control Center (RMCC) will activate prior to or immediately following activation of this Plan.

- Partner EOCs may activate prior to or following activation of the Plan. The RMCC will operate in coordination with any other activated local/regional/state EOC.

The RMCC will notify partners as quickly as possible via email, EMResource, and phone/text upon activation of this Plan.

- Partners that may be notified by the RMCC include healthcare organizations, LHJs, emergency management departments, emergency medical services (EMS) agencies, and DSHS 2/3, DDC-7, Disaster Clinical Advisory Committee (in development) and the Healthcare Executive Response Committee, when applicable.

Activation Methodology

TSA-D has adopted a scalable methodology that allows for partial activation of the Plan which also allows for rapid staffing of the designated RMCC positions. It begins with the Coalition Coordinator transitioning to the RMCC Leader position. The RMCC Leader then designates which RMCC positions will be initially staffed based on the parameters of the incident, which members and partners are to be notified and which pre-established urgency categories and message templates will be used to convey importance and need for relevant response actions.

RMCC pre-established activation levels are as followed:

- Partial RMCC Activation – This entails minimal staffing of the RMCC and is less robust than a “full” activation. Depending on the nature of the incident it may include activation of only a single position within the RMCC (Leader).
- Full RMCC Activation – Because the Coalition’s response is scalable, the RMCC may initially activate only a single position and rapidly scale to full activation as specific response needs are identified. This is also dependent on the nature of the incident.
- RMCC Alert – This level requires no specific response actions by notified personnel. Monitoring of the incident for further developments and ensuring availability for immediate activation is the objective.

RMCC pre-established urgency categories:

1. Update – Provides non-urgent incident information and suggests nor urgent actions and is to be used in both emergency and non-emergency times. The RMCC Advisory is transmitted to all Coalition members via EMResource, Text Message and Email.

2. RMCC Advisory – This level requires no specific response actions by notified personnel. RMCC leader monitors the incident for further developments and ensures availability for immediate activation, if indicated. The RMCC Advisory is transmitted to all Coalition members via EMResource, Text Message and Email.
3. RMCC Alert – Provides urgent information and indicates that some response action on the part of the message recipient may be necessary. RMCC Alert is also used for ongoing notification during an emergency to convey urgent information/recommended actions and that they should stand ready for possible activation. The RMCC Advisory is transmitted to all Coalition members via EMResource, Text Message and Email.
4. Activation – Provides notice to all Coalition members and partners that the RMCC has been activated. Convey the pre-established activation level and to request staffing resources for the RMCC. The RMCC Advisory is transmitted to all Coalition members via EMResource, Text Message and Email.

Mobilization

In order to transition from baseline operations to RMCC activation for emergency response, TSA-D has developed a pre-established set of procedures (see RMCC SOG). Cited below are a few of the more critical elements that must be immediately addressed when mobilizing.

- RMCC Personnel: Will receive activation notification to assemble and be briefed either virtually or in one of two identified brick and mortar physical locations, see below:

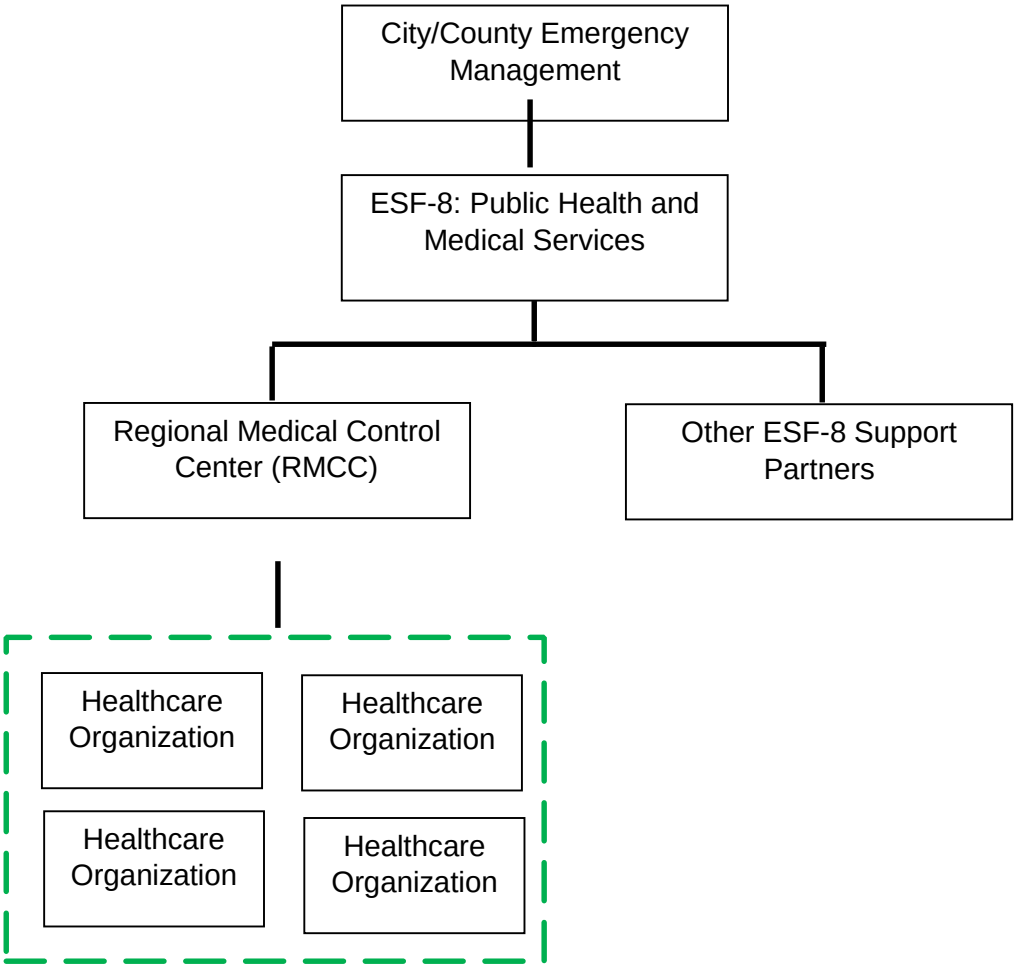
Primary RMCC Site	Alternate RMCC Site
West Central Texas Council of Governments 3702 Loop 322 Abilene, TX 79602	Hendricks Medical Center EOC 1900 Pine St Abilene, TX 79601

- Healthcare Executive Response Committee (In Development): Even if services of the Healthcare Executive Response Committee are not immediately needed, mobilization procedures dictate that their contact information be verified and is on hand for rapid response.
- Disaster Clinical Advisory Committee (In Development): Will be immediately notified via RMCC pre-established urgency level actions (see RMCC pre-established urgency categories above).
- Maps to facility: Maps to reach the facility with 24hr entry points will be distributed.
- Rapid conversion of RMCC space: Instructions on how to set up operational space.
- Required Technology & Supplies: List of procedures that includes primary and backup telephones, cellular, teleconference, computers/internet, radios and direct connect devices.
- Emergency Power: Availability of backup electrical, water and other utilities will be verified prior to manning designated RMCC site.

Incident Operations

Upon activation, the RMCC will support ESF-8: Public Health and Medical Services operations. The RMCC will support healthcare response coordination under ESF-8 even if the local EOC is not fully activated (Figure 1).

Figure 1: Command, Control, and Coordination of Healthcare Response Coordination



TSA-D, via its Regional Medical Control Center (RMCC), serves as the lead for healthcare preparedness, response and recovery coordination within the Knox, Stonewall, Haskell, Throckmorton, Fisher, Jones, Shackelford, Stephens, Mitchell, Nolan, Taylor, Callahan, Eastland, Coleman, Brown and Comanche counties. The RMCC supports the greater ESF-8 response through the primary roles of:

1. Developing and disseminating healthcare situational awareness.
2. Coordinating healthcare resource requests.
3. Initiating and administering regional patient tracking.
4. Coordinating healthcare policy and operational response.

RMCC operations may include any combination of these roles, and other secondary responsibilities, tasks, operations, etc.

Regional Medical Control Center (RMCC)

To fulfill its mission of supporting healthcare organizations and coordinating regional healthcare response the RMCC will conduct the following:

- Maintain healthcare situational awareness of the incident and disseminate information to partner organizations as necessary (see Regional Situational Awareness Procedure-in development). This information may include:
    - ➞ Utilizing ICS Form 207 designate the structure of the RMCC (which positions will be staffed for the emergency) and distribute to stakeholders (Attachment E).
    - ➞ Establish Incident (Control) Objectives
        - Facilitate situational awareness for HCOs and partners
        - Provide resource support to HCOs and partners
        - Facilitate coordination across participating Coalition organizations
        - Facilitate the interface between jurisdictional authorities and Coalition member organizations
    - ➞ Establish Operational Period Objectives
        - Obtain and aggregate initial situation and resource assessments at individual healthcare organizations
        - Obtain initial situation and resource assessment from jurisdictional authorities and regional sources
        - Facilitate early, critical requests for assistance from impacted Coalition member organizations
        - Obtain initial response strategies used by Coalition member organizations and assess these to identify potential conflicts or gaps
    - ➞ Information gathering may include surveys to healthcare and other partner organizations as well as other reporting efforts.
- Coordinate requests for healthcare information from external agencies and organizations. These may include request from local, regional, state, and federal partners such as public safety agencies and non-governmental organizations.
- Establish coordination relationships with relevant organizational, local, regional and/or state emergency operations/coordination centers (EOC). This coordination may include providing a liaison to an individual EOC.
- Conduct liaison activities with Jurisdictional and Regional Agencies
- Administer EMResource and WebEOC to include:
    - ➞ Training
    - ➞ Emergency alerting
    - ➞ Event reporting
    - ➞ Situation reporting
    - ➞ Patient tracking
    - ➞ Tracking of evacuees
    - ➞ Resource request

Healthcare Situational Awareness

Effective response and coordination is dependent on accurate situational awareness. To achieve the level of situation awareness needed to ensure a coordinated response, intelligence must be accurate, current and relevant. In addition, situational awareness must be shared in a timely manner with appropriate response partners and stakeholder. It is understood requests for information may come from many sources, including city/county/state leadership and elected officials. In development is the Regional Healthcare Coalition Situation Awareness Procedure (Annex) that

outlines the process for gathering, analyzing, and distribution of critical situational awareness intelligence for healthcare during an incident and is a pillar of the RMCC operations. The situational awareness process is rooted in the operational objectives; the RMCC takes a time-tiered and targeted approach to gathering data to provide a comprehensive picture of the impacts to healthcare. Products and information are distributed on a regular schedule with appropriate partners to guide response decision making.

Resource Requesting

The RMCC is responsible for supporting healthcare facility resource request and coordinating the prioritization of scarce resources prior to, during, and/or following an incident. The RMCC initially supports resource request by forwarding requests to the larger healthcare community on behalf the requesting healthcare facility. The requesting healthcare facility remains the primary point of contact (POC) for any offers of support. If a request is unable to be filled with the healthcare community, the RMCC will forward the request to the appropriate LHJ and/or Emergency Management agency according to local procedures. The requesting healthcare care facility remains the primary POC. When requesting a resource, Coalition members are asked to adhere to the Regional Resource Request Flow Chart which is in development (Attachment C). Below is a listing (not all inclusive) of the resources the RMCC will assist in coordinating.

- Medical Caches
- Emergency Diagnostic Equipment & DME
- Medical Devices
- Emergency electrical power generation
- PPE
- Radiological detection equipment
- Communication equipment
- Triage tags
- Morgue Trailers

In the event of a scarce resource situation (i.e. supply of resources cannot meet the need), the RMCC may coordinate with LHJs that will then provide guidance on resource prioritization. Once guidance has been provided, the RMCC becomes the broker of the scarce resources(s). Any request for scarce resources are made through the RMCC and the RMCC becomes the primary POC for any offers of assistance. The RMCC forwards appropriate offers of assistance to requesting healthcare facilities to manage final approval and logistical coordination. Coalition members are to follow the Regional Scarce Resource Flow Chart which is currently in development (Attachment C).
Additionally, TSA-D is developing a Coalition Resource Tracking Plan (in development) to support the coalition resource response efforts (Annex).

Patient Tracking

Accurate and timely tracking of patients in mass casualty incident or healthcare facility evacuation is vital to avoid adverse consequences for patients, their families, responding organizations, and community recovery. Patient tracking is the process for documenting and following information about a patient including the patient's physical location and other limited information, such as condition, disposition, and patient identifying information. In development is a Regional Patient Tracking Concept of Operations (Annex) that provides a framework for accurate patient tracking through an online system (WebEOC) and paper-based backup.

Incident Action Planning

Incident Action Planning is an iterative process that continuously evaluates the success of the organization and determines whether the stated objectives, strategies, and tactics need to be revises. TSA-D will conduct Incident Action Planning when initial incident parameters meet the following:

- Incident involves or impacts a significant number of Coalition member organizations.
- An incident is projected to be long in duration.
- Incident response appears exceptionally complex, such as after a large-scale bioterrorism incident.

Clinical and Healthcare Policy Recommendations (In Development)

During response operations, the LHJs may seek recommendations to support decision-making during an incident. The LHJs may seek guidance to provide evidence to identify a crisis situation, to determine what guidance to provide to healthcare organizations around the region, and how to implement change to standards of care, etc.

Specialized Incidents

Medical Surge and Patient Movement

Medical surge events can be acute, such as mass casualty incident (MCI) or longer-term, such as a months-long infectious disease incident. Either scenario would likely result in a surge of patients impacting the healthcare, public health, and EMS systems, locally or across county lines. Medical surge is coordinated by individual healthcare facilities using internal protocols and tools. Medical surge is coordinated using patient movement plans, situational awareness, and resource requesting. In development is a Regional Patient Movement Response Plan that the RMCC will administer (Annex) to support the coordinated movement of patients due to an MCI, hospital evacuation, or long-term care facility evacuation. Additionally, the RMCC maintains the following resources to support surge and patient movement operations:

- Patient tracking processes.
- Online Process (WebEOC)
- Situational awareness procedures.
- Resource requesting protocols.
- Coordinates alternate care systems planning with Public Health.

In a large-scale patient movement operation, patients may need to be moved outside of the county to accommodate their care needs. In development is a Multi-Regional Patient Movement Plan (Annex) that outlines the process and responsibilities associated with patient movement operations in North Texas.

Acute Infectious Disease

Acute infectious diseases represent a potential threat to the healthcare, public health, and EMS systems, among others. These threats could emanate from a novel or unknown pathogen, a known pathogen, or a common disease such as influenza impacting a much great number of people than normal levels. To response to the incident, TSA-D administers a High Consequence Infectious Disease Concept of Operations (Annex) to provide a coordinated regional response related to the potential

consequences of an acute infectious disease outbreak. The plan describes the coordination of decision making, operations, and communication for an acute infectious disease response. This plan works in close coordination with LHJs planning for infectious disease response.

Scarce Resource Management & Crisis Standards of Care

As shown in previous responses to large scale disasters, it is vital to the continued operations of our healthcare system to plan for possible changes in protocols, guidelines, and standards of care that may occur during this type of incident. Crisis standards of care may be a secondary impact due to a wide range of potential disruptions to the healthcare delivery system including:

- Extremely scarce resources.
- Impacts to the healthcare infrastructure.
- Impacts to staffing levels.
- Shortage of care due to large-scale surge in patients.

The Institute of Medicine outlines a framework to define surge capacity with the healthcare systems as a continuum; from conventional to contingency and finally crisis. In development is a Regional Scarce Resource Management and Crisis Standards of Care Concept of Operations (Annex) to provide a coordinated decision making and healthcare response to mitigate and response to a crisis situation(s). This concept also includes scarce resource management tools including: Scarce resource cards, algorithms and worksheets, and triage team guidelines.

Medical Countermeasures

LHJs and/or DSHS will lead the coordination and execution of the distribution of mass vaccine and/or pharmaceutical distribution and dispensing/vaccination. Healthcare systems may assist in the distribution and dispensing/vaccination. Resource allocations will be established based on criteria developed at the time of the incident, and consistent with the needs of the incident. The TSA-D will coordinate with the LHJs and healthcare system as appropriate to support medical countermeasure operations. For more information, refer to the LHJ medical countermeasure plans.

- The CHEMPACK program, established by the Centers for Disease Control and Prevention (CDC), creates forward placement of sustainable repositories of nerve agent antidotes in numerous locations throughout the United States so that they can be immediately accessible for the treatment of affected persons. Hospital-level units are housed in hospitals and EMS units throughout the counties with the aim of providing geographical availability of antidotes.

Pediatrics

In incidents, pediatric patients may present to any hospital. It may not be possible to transfer patients to traditional pediatric receiving facilities immediately following an incident; therefore, all hospitals must be prepared to receive and care for pediatric patients. In development is a Hospital Guideline for the Management of Pediatric Patients in Disasters Toolkit (Attachment F) with basic information and guidelines for the short-term acute care and definitive management of pediatric patients. This toolkit provides step-by-step processes and tools to support the development of pediatric care capabilities within non-pediatric facilities.

Mass Fatality and Family Assistance

In the event an incident requires management of a large number of fatalities, healthcare facilities should enact facility plans and processes to appropriately care for, manage, and track the remains of

decedents. In development are guidelines and a plan template for healthcare facilities on the care and tracking of human remains if the medical examiner or coroner's operations are delayed (Attachment G). Additionally, healthcare facilities may have family members contacting or appearing at their facility requesting information on their loved ones. Healthcare facilities should coordinate their needs and processes with the appropriate county agencies (medical examiner/coroner and/LHJ/emergency management) for mass fatality management and family reunification operations. Also in development are additional guidelines to support Family Reception Services Guidelines for Hospitals and other point of service healthcare providers (Attachment H). TSA-D maintains (2) deployable refrigerated Mass Fatality Trailer with the capacity of 20 decedents and a Cache of BioSeal post-mortem bags.

Communications

The RMCC will use four primary communication means to inform partners of the plan's activation and subsequent response activities: email, EMResource (text, email), conference call and WebEOC. Additionally, the RMCC administers a redundant alerting application JPS VIA that can be used as a primary and redundant communication source (in development). The RMCC will participate in local, regional, or multi-regional joint information systems/centers, as appropriate. In development is a Regional Crisis Communications Plan (Annex) that will be administered by TSA-D.

Email

The RMCC will disseminate activation information and any subsequent incident updates via email. Key partners outlined in this plan (e.g. healthcare organizations, public health agencies/jurisdictions, emergency management departments, EMS agencies, etc.) will always receive RMCC email communications assuming intact communications infrastructure. The RMCC may also use other communication devices such as radios, fax, satellite phone in addition to, or in the absence of, email functionality.

EMResource

EMResource is a web-based application supplying healthcare organizations communications and resource tools to assist in preparing for and coordinating emergency response operations. EMResource serves two primary roles: daily tracking of facility status and bed availability; and incident management and situational awareness during an emergency or disaster response. EMResource use prior to and upon activation of this plan may include:

- Provide healthcare organizations with escalation updates (Update, Advisory, Alert, and Activation).
- Alert partners of the plans activation.
- Request bed availability.
- Post response documents.

Conference Call/Webinar/Video Conference

The RMCC may use conference calls/webinar/video conference to coordinate discussions or information sharing to seek input, guidance, or consensus on operational components. Participants will be incident specific and may include a variety of individuals and organizations.

WebEOC

WebEOC is a web-based crisis management system developed to improve coordination, communication, and coordination of organizations, agencies, and assets while planning for, responding to, or recovering from man-made and natural disasters. WebEOC is uniquely developed to address risks and vulnerabilities specific to TSA-D. North Central Texas Trauma Regional Advisory Council (NCTTRAC) hosts the regional installation of WebEOC for TSA-D.

- Common situational awareness during an incident is distributed and amassed using WebEOC. NCTTRAC hosts an ESF-8 specific WebEOC server that can share information with other WebEOC servers active in TSA-D. Within our regional Healthcare organizations will primarily use the NCTTRAC WebEOC server while public safety and emergency management organizations utilize the Texas LoneStar server.
    - ➞ Local Medical Events board is where any healthcare partner with access can create informational posts regarding their facility/agency in time of crisis. Users that create a post in Local Medical Events have the options to share that post with the TSA-D Medical Events board, which in return will be shared with other WebEOC servers.
    - ➞ The TSA-D Medical Event board is where regional information for all users will be posted. During a fusion incident, the information posted in TSA-D Medical Events is visible to the LoneStar server.
    - ➞ The ESF-8 Medical Events board is a read-only board for the NCTTRAC WebEOC server. DSHS State Medical Operations Center (SMOC) will post to this board with any information relating to the Incident Action Plans or SMOC staffing information. North Central Texas Activity Board – the North Central Texas Activity Board is a read-only board for the NCTTRAC WebEOC server. This board is where other regional WebEOC servers post information that is more related to jurisdictional emergency management such as shelter operations information.

Demobilization

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 RMCC will be issued to the Coalition at-large via email distribution lists.

Partial Activations

For incidents that do not reach full activation and in the absence of a DSHS SMA the RMCC Leader will scale down support activities with briefings to staff and notifications to the Coalition at-large. The RMCC will make direct contact with affected entities to ensure that support is no longer needed prior to reducing activation levels.

Archives

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

Reconstitution & Reimbursement

TSA-D and NCTTRAC Logistics will make every reasonable effort to re-establish a pre-incident level of supplies/equipment. The funding for replacement of supplies/equipment may be requested in a reimbursement packet from TSA-D and NCTTRAC Finance to DSHS Finance. If no reimbursement opportunities exist, a funding proposal may be moved to TSA-D for consideration in the Asset Review Process. The primary cost for operating the RMCC is personnel time, which will be donated by the Coalition member organizations. However, records of personnel time will be kept and archived for future reference.

After Action Review

TSA-D, with the support of DSHS 2/3, will develop a region-wide ESF-8 Public Health and Medical After Action Report. A series of gatherings may be planned in order to obtain input from stakeholders. Additionally, RMCC staff will design a broad survey to capture sustainment and improvement elements with respect to the response. The information gathered in this survey will provide essential content for a draft after action report. A formal AAR, with improvement plan, will be developed by TSA-D, shared among the Coalition, and submitted to DSHS HEPRS. Coalition members are encouraged to participate in regional after actions that are multi-discipline and collaborative which allow for integration of medical support activities among all responding entities.

Recovery

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.

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 RMCC to conduct an organized and efficient recovery. For the purpose of utilizing common language and communicating needs and activities throughout the recovery process the Coalition will follow a three-phased approach:

a) Phase 1 – Damage Assessment Phase
b) Phase 2 – Restoration Phase
c) Phase 3 – Medically Operational Phase

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 upon 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.

a) Damage Assessment Phase
   This phase initiates when emergency response operations are complete and personnel can begin to make damage assessments. The RMCC will begin to survey regional hospitals and

healthcare facilities via EMResource, WebEOC, 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 the facility. The RMCC 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 Coalition stakeholders, other regional MOCs, and the DSHS SMOC as necessary and warranted in an effort to begin the restoration phase.

b) Restoration Phase

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 RMCC 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 RMCC. These resources include electrical power generators, emergency PPE, and emergency durable medical equipment. Additionally, the RMCC 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 in order to render the facility functional and allow the hospital to provide services to the community. This phase is completed as services become restored and healthcare facilities become capable of caring for patients. The RMCC 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.

c) Medically Operational

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 is able to provide patient care at the same level as prior to the disaster.

Administrative Support

A. Review Process and Plan Update

1. Sections of this plan will be updated as-needed following exercises or real-world events in coordination with regional partners.
2. The plan will be provided to regional partners and members for review and input.
3. Following review, modifications will be made by the Plan Development Workgroup, approved by the TSA-D Executive Board and a copy will be provided to regional partners and members. Healthcare organizations are expected to share the updated plan internally with appropriate colleagues, leadership, etc.

B. Maintenance

At a minimum the document will be revised annually or as needed by the Plan Development Workgroup and Trauma Service Area-D (TSA-D) Executive Board following the process outlined above.

C. Training and Exercise

Training on roles and responsibilities for all relevant partner agencies will occur following the adoption of the finalized Regional Healthcare Coalition Emergency Response Plan. Exercises of portions of this plan, annexes, or attachments, including tabletops and functional will occur with healthcare organizations, LHJs, DCAC, HERC, and other relevant stakeholders.

D. References

- Department of Health & Human Services. Medical Surge Capacity and Capability: A Management System for integrating Medical and Health Resources During Large-Scale Emergencies.
- Office of the Assistant Secretary for Preparedness and Response, 2017-2022 Health Care Preparedness and Response Capabilities.
- National Incident Management System.

Annexes to this Plan

- Regional Healthcare Coalition Situation Awareness Procedure. (in development)
- Regional Medical Control Center Concept of Operations. (in development)
- Regional Coalition Resource Tracking Plan. (in development)
- Regional Coalition Patient Tracking Concept of Operations. (in development)
- Regional Coalition Patient Movement Response Plan. (in development)
- Multi-Regional Patient Movement Plan. (in development)
- High Consequence Infectious Disease Concept of Operations. (in development)
- HCC-D Preparedness Strategy.
- Scarce Resource Movement and Crisis Standards of Care Concept of Operations. (in development)
- Regional Crisis Communication Plan. (in development)

Acronyms

AAR – After Action Report
DCAC – Disaster Clinical Advisory Committee
DDC-7 – District Disaster Coordinator
DME – Durable Medical Equipment
DSHS – Department of state Health Services
EMS – Emergency Medical Services
EOC – Emergency Operations Center
EOP – Emergency Operation Plan
EMTF – Emergency Medical Task Force
ESF-8 – Emergency Support Function-#8
HCC-D – Health Care Coalition - D
HCO – Health Care Organization
HEPRS – Health Emergency Preparedness Response Section
HERC – Healthcare Executive Response Committee
HERT – Hospital Emergency Response Team
ICS – Incident Command System
LHJ – Local Health Jurisdiction
MCI – Mass Casualty Incident
MSCC – Medical Surge Capacity and Capability
NCTTRAC – North Central Texas Trauma Regional Advisory Council
POC – Point of Contact
RHMOC – Regional Health and Medical Operations Center
SITREPS – Situational Report
SMA – State Mission Assignment
SMOC – State Medical Operations Center
SOG – Standard Operating Guidelines
TSA-D – Trauma Service Area - D

Attachment A: List of Regional Emergency Contacts

HOSPITAL NAME	EMERGENCY MGT	EM OFFICE PHONE
Abilene Regional Medical Center	Tom Kinzler	325-428-1455
Anson General Hospital	Glenda Fuston	325-823-3231
Brownwood Regional Medical Center	Miranda Clemons	325-649-3317
Coleman County Medical Center	Harvey Ramirez	325-625-2135
Comanche County Medical Center	Kimberly Boyd	254-879-4900
Eastland Memorial Hospital	Laura Kay Pfeifer	254-631-5261
Fisher County Hospital	Randy Martin	325-735-2256
Haskell Memorial Hospital	Mary Belle Olson	940-864-2621
Hamlin Memorial Hospital	Amber Stoltz	325-576-3646
Hendrick Medical Center	Harold Turner	325-670-3357
Knox County Hospital District	Stephen Kuehler	940-657-3535
Mitchell County Hospital	Murray Hall	325-728-2693
Rolling Plains Memorial Hospital	Stephanie Leibowitz	325-235-1701
Stephens Memorial Hospital	Marty Dover	254-559-2251
Stonewall Memorial Hospital	Tim Boone	940-989-3551
Throckmorton County Memorial Hospital	Billy Boyd	940-849-2151
Abilene Behavioral Health	Tracy Noland	325-698-6600
Encompass Rehabilitation Hospital	Robert Krackenfels	325-793-7817
Comanche County EMS	Bryan Welch	254-879-4900
Sweetwater Fire and EMS	Grant Madden	325-235-4304
Eastland EMS	Gene Wright	254-488-1817
Abilene-Taylor County Public Health	Vincent Cantu	325-692-5600
Brownwood- Brown County Public Health	Pixie Clark	325-646-0554
Sweetwater-Nolan County Public Health	Sheila Ellison	325-235-5463

Attachment B: Regional Resource Request Flow Chart (In Development)

Attachment C: Regional Scarce Resource Request Flow Chart (In Development)

Attachment D: ICS Form 213RR

Resource Request (ICS 213 RR)

1. Incident Name:					**2. Date/Time**				**3. Resource Request Number:**	
Requestor	**4. Order** (Use additional forms when requesting different resource sources of supply.)**:**									
	Qty.	Kind	Type	Detailed Item Description: (Vital characteristics, brand, specs, experience, size, etc.)	Cost	**5. Resource Status**				
						Received by	Date/Time	Assigned to	Released to	Date/Time
	6. Requested Delivery/Reporting Location:									
	7. Suitable Substitutes and/or Suggested Sources:									
	8. Requested by Name/Position:			**9. Priority:** ☐ Urgent ☐ Routine ☐ Low		**10. Section Chief Approval:**				
Logistics	**11. Logistics Order Number:**					**12. Supplier Phone/Fax/Email:**				
	13. Name of Supplier/POC:									
	14. Notes:									
	15. Approval Signature of Auth Logistics Rep:					**16. Date/Time:**				
	17. Order placed by:									
Finance	**18. Reply/Comments from Finance:**									
	19. Finance Section Signature:					**20. Date/Time:**				
ICS 213 RR, Page 1										

ICS 213 RR, Adapted for FDA
Resource Request

Purpose. The Resource Request (ICS 213 RR) is utilized to order resources and track resource status.

Preparation. The ICS 213 RR is initiated by the resource requestor and initially approved by the appropriate Section Chief or Command Staff. The Logistics and Finance/Administration Sections also complete applicable sections of the form.

Distribution. This form is maintained in order to track resource status and assist with determining incident costs.

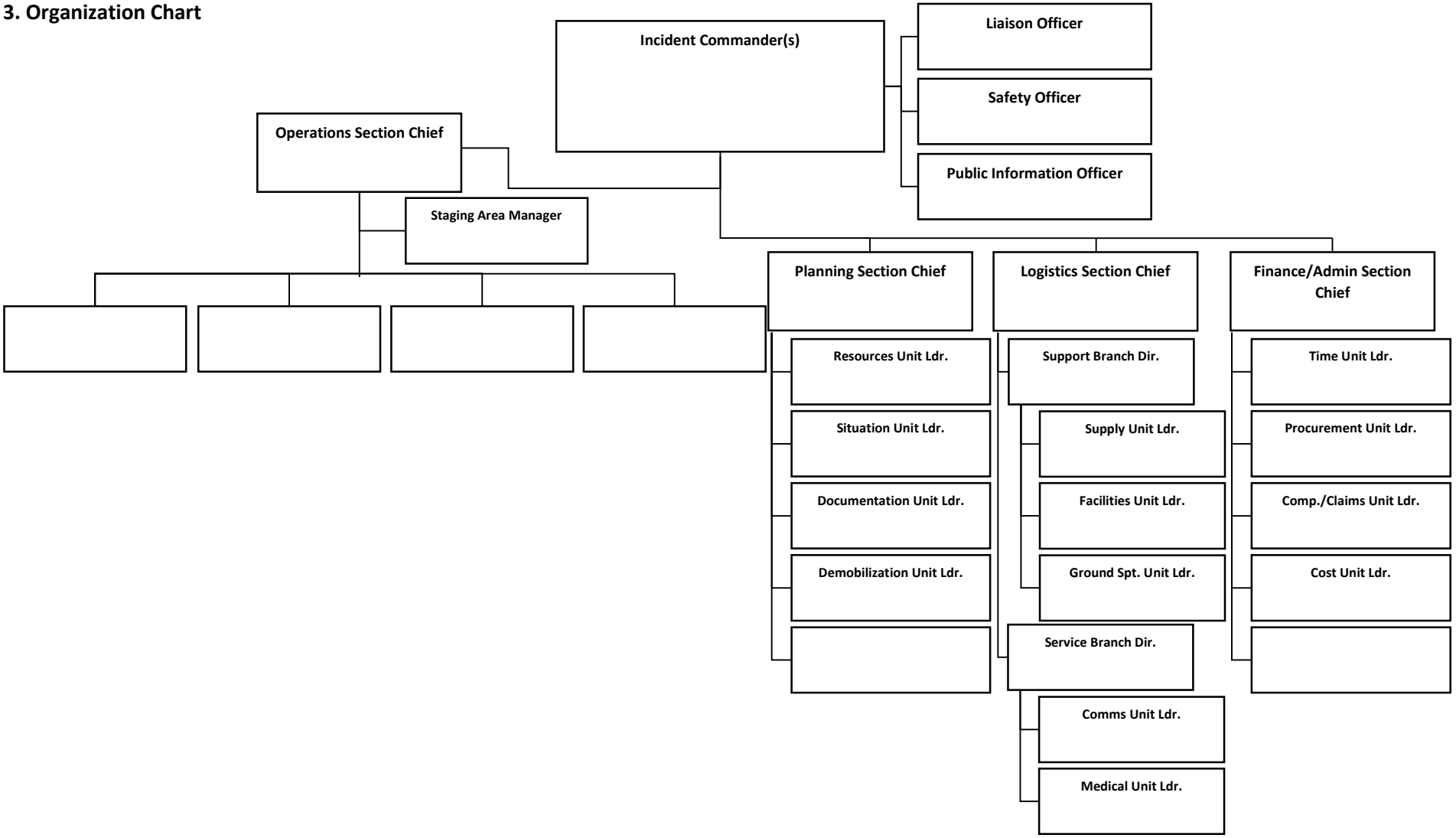
Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Date/Time**	Self-explanatory
3	**Resource Request #**	Self-explanatory
4	**Order**	Specify quantity, item description, cost. Complete resource status section after resource is received
5	**Resource Status**	Enter applicable resource status fields
6	**Requested Delivery/Reporting Location**	Enter location requested resource delivery/reporting location
7	**Suitable Substitutes and/or Suggested Sources**	Enter possible substitute items if exact requested resource is not available. Provide supplier information if known.
8	**Requested by Name/Position:**	Requestor's name and position
9	**Priority**	Select Urgent, Routine or Low priority
10	**Section Chief Approval**	Obtain appropriate Section Chief signature for request
11	**Logistics Order Number**	Enter Logistics Order Number if applicable
12	**Supplier Phone/Fax/Email**	Enter resource Supplier's phone/Fax/Email
13	**Name of Supplier/POC**	Enter name of resource supplier/POC
14	**Notes**	Any relevant notes regarding the request
15	**Approval Signature of Authorized Logistics Rep**	Enter approval signature of an authorized Logistics Section representative
16	**Date/Time**	Self-explanatory
17	**Order placed by**	Enter name of individual who places order for requested resource(s)
18	**Reply/Comments from Finance**	Any relevant notes regarding the request
19	**Finance Section Signature**	Enter approval signature of an authorized Finance/Admin Section representative
20	**Date/Time**	Self-explanatory

Updated by FDA 2/2011

Attachment E: ICS Form 207-E

1. Incident Name:	2. Operational Period:	Date From:	Date To:
		Time From:	Time To:

3. Organization Chart



ICS 207

Incident Organization Chart

Purpose. The Incident Organization Chart (ICS 207) provides a **visual wall chart** depicting the ICS organization position assignments for the incident. The ICS 207 is used to indicate what ICS organizational elements are currently activated and the names of personnel staffing each element. An actual organization will be event-specific. The size of the organization is dependent on the specifics and magnitude of the incident and is scalable and flexible. Personnel responsible for managing organizational positions are listed in each box as appropriate.

Preparation. The ICS 207 is prepared by the Resources Unit Leader and reviewed by the Incident Commander. Complete only the blocks where positions have been activated, and add additional blocks as needed, especially for Agency Representatives and all Operations Section organizational elements. For detailed information about positions, consult the NIMS ICS Field Operations Guide. The ICS 207 is intended to be used as a wall-size chart and printed on a plotter for better visibility. A chart is completed for each operational period, and updated when organizational changes occur.

Distribution. The ICS 207 is intended to be **wall mounted** at Incident Command Posts and other incident locations as needed, and is not intended to be part of the Incident Action Plan (IAP). All completed original forms must be given to the Documentation Unit.

Notes:

- The ICS 207 is intended to be **wall mounted** (printed on a plotter). Document size can be modified based on individual needs.
- Also available as 8½ x 14 (legal size) chart.
- ICS allows for organizational flexibility, so the Intelligence/Investigative Function can be embedded in several different places within the organizational structure.
- Use additional pages if more than three branches are activated. Additional pages can be added based on individual need (such as to distinguish more Division/Groups and Branches as they are activated).

Block Number	Block Title	Instructions
1	**Incident Name**	Print the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Organization Chart**	• Complete the incident organization chart. • For all individuals, use at least the first initial and last name. • List agency where it is appropriate, such as for Unified Commanders. • If there is a shift change during the specified operational period, list both names, separated by a
4	**Prepared by** • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

Attachment F: Management of Pediatric Patients Disaster Tool Kit (In Development)

Attachment G: Family Reception Services Guidelines (In Development)