ANNEX H

HEALTH
&
MEDICAL SERVICES

July 2019

Brazos County Interjurisdictional Emergency Management

Ver 2.1
8/06

APPROVAL & IMPLEMENTATION

Annex H

Health & Medical Services

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City of Wixon EM Coordinator — 7/18/19 Date

Monica Stark
Texas A&M University EM Coordinator — 7/18/19 Date

RECORD OF CHANGES

Annex H

Health & Medical Services

RECORD OF CHANGES

CHANGE #	DATE OF CHANGE	ENTERED BY	Date Entered
1	05/22/2017	Michele Meade	05/22/2017

ANNEX H

HEALTH & MEDICAL SERVICES

I. AUTHORITY

See Basic Plan, Section I.

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

II. PURPOSE

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

III. EXPLANATION OF TERMS

A. Acronyms

BCHD	Brazos County Health District
DDC	Disaster District Committee
DHS	Department of Homeland Security
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Services Team
EMC	Emergency Management Coordinator
DSHS	Department of State Health Services
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EOC	Emergency Operations or Operating Center
ICP	Incident Command Post
ICS	Incident Command System
NDMS	National Disaster Medical System
NIMS	National Incident Management System
PIO	Public Information Officer
SOPs	Standard Operating Procedures
TCEQ	Texas Commission for Environmental Quality

B. Definitions

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

2. Disaster Mortuary Services Team. A team of mortuary service and medical personnel that provide mortuary and victim identification services following major or catastrophic disasters.

3. Joint Information Center. A facility, established to coordinate all incident-related public information activities, authorized to release general medical and public health response information delivered by a recognized spokesperson from the public health and medical community.

4. National Disaster Medical System. A coordinated partnership between Department of Homeland Security (DHS), Department of Health and Human Services Commission, Department of Defense, and the Department of Veterans Affairs for the purpose of responding to the needs of victims of a public health emergency. Non-federal participants include major pharmaceutical companies and hospital suppliers, the National Foundation for Mortuary Care, and certain international disaster response and health organizations.

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

IV. SITUATION & ASSUMPTIONS

A. Situation

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

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

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

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

5. Medical and health care facilities that remain in operation and have the necessary utilities and staff could be overwhelmed by the "walking wounded" and seriously injured

victims transported to facilities in the aftermath of a disaster.

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

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

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

B. Assumptions

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

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

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

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

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

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

7. Some types of emergency situations, hurricanes, and floods may affect a large proportion of our county, making it difficult to obtain mutual aid from the usual sources.

8. Appropriate local, State, and possibly federal, tribal medical, public health officials, and organizations will coordinate to determine current medical and public assistance requirements.

V. CONCEPT OF OPERATIONS

A. General

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

2. The Brazos County Health District is the local agency primarily responsible for the day-to-day provision of many health and medical services for our community. Dr. Eric Wilke, through contract with the BCHD, serves as the Health Authority for our county. Dr. Seth Sullivan serves as Associate Health Authority. He will act as the Health Authority in the absence of Dr. Wilke.

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

4. Provisions must be made for the following:

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

B. Mental Health Services

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

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

C. Medical Services

1. Ambulance and Transportation

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

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

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

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

   d. If the emergency situation warrants, the EMT/paramedic will request, through the Incident Commander, additional ambulances.

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

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

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

2. Triage

   a. Medical supplies for providing advanced life support to trauma victims will be stored in a major rescue vehicle or trailer, or every responding service will bring a predetermined mass casualty supply package. Adequate supplies for treatment of victims requiring advanced life support will be stored in the rescue vehicle and mobilized to the scene of a mass casualty disaster.

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

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

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

e. The Triage Officer shall respond immediately to the scene of a local disaster. This person is responsible for the triage of patients, establishing priority of treatment and transportation. This person is also in charge of the care of patients awaiting transportation.

f. The EMS Transportation Officer is responsible for all ambulances and directs the loading and transportation of patients. This person acts as a liaison between the field and the hospitals.

g. Registered nurses and paramedics employed with local ambulance services and capable of providing advanced life support will respond immediately to the disaster site. They will work with the Triage Officer and apply their skills as required to disaster victims.

h. Equipment and medication for administrating advanced life support to trauma victims will be transported to the scene by the assigned rescue unit. Additional supplies will be obtained from local hospitals upon request.

i. Triage Priorities – Patients with the most severe injuries or conditions or injuries have priority for transportation and treatment over others as outlined:

1) Red Category – First Priority, most urgent

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

2) Yellow Category – Second Priority, Urgent

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

3) Green Category – Third Priority, Non-urgent

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

4) Black Category – Deceased, Non-urgent

D. Mortuary Services

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

2. When it appears an incident involves fatalities, the Incident Commander shall request the Communications Center make notifications to the Justice of the Peace and law enforcement requesting a response to the scene.

3. Law enforcement or the Justice of the Peace shall arrange for the transportation of bodies requiring autopsy or identification to morgues or suitable examination facilities. When mass fatalities have occurred, it may be necessary to establish a temporary morgue and holding facilities. Additional mortuary service assistance may be required.

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

E. Medical and Mortuary Assistance

1. Department of State Health Services (DSHS)

   When requested by local officials, the DSHS can provide health and medical advice and assistance during emergency situations from its various regional offices.

2. Disaster Medical Assistance Team (DMAT)

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

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

3. Disaster Mortuary Services Team (DMORT)

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

F. Damage Assessment

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

2. Water Supply Systems. In cooperation with Utility Departments, DSHS, and TCEQ have responsibility for evaluating damage to water treatment facilities following disaster occurrences. Because of system vulnerability to numerous forms of contamination and the impact which prolonged shutdown of water treatment facilities could have on public health and welfare, it is essential that rapid and accurate assessments of damage are completed. Accurate timely estimates for required repairs will permit the DSHS, TCEQ, and Utility Departments to identify appropriate interim measures such as rationing, expedient water treatment, or construction of temporary water delivery systems.

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

4. Medical Facilities. The Health Authority has primary responsibility for evaluating damage sustained by medical facilities in a disaster area. The hospitals and nursing homes in Brazos County will provide support in this activity. The facility administrator or his designee will gather initial damage reports and identify which patients must be removed pending repairs. This data will be provided to the lead facility to compile for the Health Authority's use.

G. Requesting External Assistance.

If health and medical problems resulting from an emergency situation cannot be resolved with local resources, those obtained pursuant to inter-local agreements, or resources obtained by the Resource Management staff in the EOC, local government may request medical or mortuary assistance from the State. The County Judge should make requests for such assistance to the DDC Chairperson in Bryan, TX. Cities must request assistance from their county before requesting assistance from the State.

H. Activities by Phases of Emergency Management

1. Prevention:

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

2. Preparedness:

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

3. Response:

   a. Conduct public information programs dealing with personal health and hygiene.
   b. Conduct disease control operations.
   c. Monitor sanitation activities.
   d. Ensure that supplies of potable water are available.
   e. Conduct environmental health activities regarding waste disposal, refuse, food and water control, and vector control.
   f. Begin the collection of vital statistics.

4. Recovery:

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

VI. ORGANIZATION & ASSIGNMENT REPONSIBILITIES

A. Organization

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

2. The Brazos County Health District functions as the local Health Authority. The Health Authority has primary responsibility for the health and medical services function and shall designate a Health Officer to plan and coordinate public health and medical services during emergency situations. The Health Officer or a designee shall serve as a member of the EOC Staff. Health and medical service response activities at an incident scene will be coordinated through the Incident Commander. Large-scale health and medical efforts shall be coordinated from the EOC.

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

B. Assignment of Responsibilities

1. General

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

   a. Designating and training representatives of their agency, to include NIMS and ICS training.
   b. Ensuring that appropriate SOPs are developed and maintained.
   c. Maintaining current notification procedures to insure trained personnel are available for extended emergency duty in the EOC and, as needed, in the field.

2. Emergency Functions

   Under the Brazos County Inter-Jurisdictional Emergency Management Plan, the Health Authority has primary responsibility to provide the following services in response to emergency situations:

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

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

C. Task Assignments

1. The Health Authority will:

   a. Designate a Health Officer to perform pre-emergency planning for emergency health

and medical services and coordinate such activities during major emergencies and disasters.

b. Provide qualified staff to support health and medical operations at the ICP and the EOC.

2. The Health Officer and Health Authority will coordinate:

   a. Emergency health and medical activities from the EOC when activated.
   b. Rapid assessments of health and medical needs.
   c. Efforts of local health and medical organizations activated for an emergency assessing their needs, obtain additional resources, and ensure that necessary services are provided.
   d. Emergency medical teams responding to a disaster to ensure the integration into the ICP at the disaster site.
   e. Neighboring community health and medical organizations on matters related to assistance from other jurisdictions.
   f. State and federal officials regarding state and federal assistance.
   g. Response units, such as DMAT.
   h. Screen individual health and medical volunteers obtaining positive identification and proof of licensure of volunteers.
   i. Location, procurement, screening, and allocation of health and medical supplies and resources, including human resources, required to support health and medical operations.
   j. Information to the news media on casualties and instructions to the public on dealing with public health problems through the PIO.
   k. The provision of laboratory services required in support of emergency health and medical services.
   l. Immunization campaigns or quarantines, if required.
   m. Inspections of foodstuffs, water, drugs, and other consumables that were exposed to the hazard.
   n. Inspections of damaged buildings for health hazards.
   o. Disposal of dead animals with the county and/or cities animal control agencies.
   p. Implementation of measures to prevent or control disease vectors such as flies, mosquitoes, and rodents.
   q. Preventive health services, including the control of communicable diseases such as influenza, particularly in shelters.
   r. Food handling and sanitation monitoring in emergency facilities.

3. Emergency Medical Services will:

   a. Respond to the scene with appropriate emergency medical personnel and equipment.
   b. Upon arrival at the scene, assume an appropriate role in the ICS. Initiate ICS if it has not been established and report to the EOC.
   c. Triage, stabilize, treat, and transport the injured.
   d. Coordinate with local and regional hospitals to ensure casualties are transported to the appropriate facilities.
   e. Establish and maintain field communications and coordination with other responding emergency teams (medical, fire, police, public works, etc.). Continue radio and/or telephone communications with hospitals.

f. Direct the activities of private, volunteer, and other emergency medical units, and of bystander volunteers, as needed.
g. Evacuate patients from affected hospitals and nursing homes, if necessary.

4. Hospitals will:

   a. Implement internal and/or external disaster plans.
   b. Advise the Health and medical services staff in the EOC of conditions at the facility and the number and type of available beds.
   c. Establish and maintain field and inter-facility medical communications.
   d. Provide medical guidance, as needed, to EMS.
   e. Coordinate with EMS, other facilities, and any medical response personnel at the scene to ensure the following is accomplished:
      1) Casualties are transported to the appropriate medical facility.
      2) Patients are distributed to hospitals both inside and outside the area based on severity and types of injuries, time and mode of transport, treatment capabilities, and bed capacity.
      3) Take into account special designations such as trauma centers and burn centers.
      4) Consider the use of clinics to treat less acute illnesses and injuries.
   f. Coordinate with local emergency responders to isolate and decontaminate incoming patients, if needed, to avoid the spread of chemical or bacterial agents to other patients and staff.
   g. Coordinate with other hospitals and with EMS on the evacuation of affected hospitals, if necessary. Evacuation provisions should specify where patients are to be taken.
   h. Depending on the situation, deploy medical personnel, supplies, and equipment to the disaster site(s) or retain them at the hospital for incoming patients.
   i. Establish and staff a reception and support center at each hospital for relatives and friends of disaster victims searching for their loved ones.
   j. Provide patient identification information to the American Red Cross upon request.

5. The Mental Health Authority will:

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

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

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

7. Law Enforcement will:

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

8. Mortuary Services will:

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

9. The Public Works Department(s), along with the Building & Grounds Department(s) will:

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

10. The Utility Department(s) will:

    Coordinate the restoration of utilities service to key medical facilities.

11. The Public Information Office (PIO) will:

    Working with the Joint Information Center (JIC), disseminate emergency public information provided by health and medical officials. The Health Officer has primary responsibility for the coordination of health & medical information intended for release through public media during emergency operations. Additional information on emergency public information procedures can be found in Annex I (Emergency Public Information).

VII. DIRECTION & CONTROL

A. General

1. The Health Officer, working as a staff member of the County emergency organization, supported by an appropriate network, shall direct and coordinate the efforts of local health and medical services and agencies, and organizations during major emergencies and disasters requiring an integrated response.

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

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

B. Incident Command System – EOC Interface

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

C. Disaster Area Medical Coordination

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

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

D. Line of Succession

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

1. County Health Authority
2. Assistant County Health Authority
3. Community Health Services Director, BCHD

VIII. READINESS LEVELS

A. Level IV: Normal Conditions

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

B. Level III: Increased Readiness:

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

C. Level II: High Readiness:

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

D. Level I: Maximum Readiness:

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

IX. ADMINISTRATION & SUPPORT

A. Reporting

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

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

B. Maintenance and Preservation of Records

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

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

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

C. Post Incident Review

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

D. Exercises

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

E. Resources

1. A list of local health & medical facilities is provided in Appendix 1.

2. A list of deployable health and medical response resources is provided in Annex M, Resource Management.

X. ANNEX DEVELOPMENT & MAINTENANCE

A. The Health Officer, with assistance from the EMC is responsible for developing and maintaining this annex. Recommended changes to this annex should be forwarded as needs become apparent.

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

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

XI. REFERENCES

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

B. Texas Department of State Health Services website: www.dshs.texas.gov

C. DSHS Public Health Region website: www.dshs.texas.gov/regions/. This site contains information on the counties served by the 11 DSHS Public Health Regions.

APPENDICES

Appendix 1 ..... Local Health & Medical Facilities

LOCAL HEALTH & MEDICAL FACILITIES

Accel at College Station, 1500 Medical Avenue, College Station 272-1000

112 Beds, long term acute care, Emergency Power- yes- Diesel-2 to 3 days

CapRock Hospital, 3134 Briarcrest Drive, Bryan 314- 2323

10 Licensed beds
9 ER beds
No ICU
MRI Scanner – No
CT Scanner – Yes
Dialysis Unit – No
Decontamination Shower that can be set up in the Ambulance Bay
ICU Unit – No
Operating Rooms – No
Minor Procedure Room – 1
Digital X-rays – Yes
Emergency Power for indefinite # hours (up to 72 hours w/o refueling)

CapRock ER Hospital, 948 William D. Fitch Parkway, College Station 314-2323

8 ER Beds

College Station Medical Center, 1604 Rock Prairie Road, College Station 764-5100

171 licensed beds
12 bed medical/surgical ICU
8 operating rooms (plus 2 cath labs)
MRI Scanner yes
CT Scanner yes
Dialysis Unit yes (area set up for dialysis)
Emergency Room - 29 acute care beds
No emergency rooms with integrated Decon Unit (# patients per hour)
have isolated units in ER, but would have to isolate ER from rest of hospital
Expedient outdoor decontamination unit
(can do 4 patients at one time - 20 mins/person)
13 isolation beds (1 in ER)
Emergency power for 158 hours

Christus DuBuis, 1600 Joseph Dr., Bryan 821-5000

30 beds, long term acute care

CHI St. Joseph Regional Health Center, 2801 Franciscan Drive, Bryan 776-3777

266 licensed beds
36 bed medical/surgical ICU
16 operating rooms
MRI Scanner yes
CT Scanner yes x2
Dialysis Unit 4 machines
Emergency Room – 28 treatment room beds
30 Isolation beds
Emergency power for indefinite # of hours (up to 60 hrs. w/o refueling, indefinite w/add'l fuel supply)

CHI St. Joseph Emergency, 4411 Highway 6 South, College Station 731-5231

9 ER Beds

Baylor Scott & White Hospital, 700 Scott & White Dr, College Station 207-0100

143 licensed beds
72 medical/surg beds
16 ICU beds
6 operating rooms
MRI Scanner yes
CT Scanner yes
Emergency Room
7 Isolation beds
Emergency generator backup

The Physicians Centre, 3131 University Drive East, Bryan 731-3100

16 licensed beds
No ICU
4 operating rooms and 2 minor procedure rooms
MRI Scanner - Yes
CT Scanner - Yes
Dialysis Unit - No
Emergency Room – 2 treatment areas. 24 hour MD coverage.
No emergency rooms with integrated decon units
No expedient outdoor decon unit
Emergency power for 24 hours

Physicians Premier ER, 2411 Boonville Road, Bryan 985-2641

11 Beds
MRI Scanner – No
CT Scanner - Yes
Ultra Sound – Yes
Dialysis Unit – No
ICU – No
Decontamination Area – No
Operating Room - No
Emergency Power - Yes – Natural Gas can run indefinite

1. Clinics

Brazos Valley Urgent Care, 2911 Texas Ave. South, College Station	764-2882
Integrity Urgent Care, 3201 University Dr. East, College Station	703-1832
Cap Rock Urgent Care, 1289 University Drive, College Station	314-2323
DaVita-Bryan Dialysis, 1640 Briarcrest Drive Ste. 100, Bryan 25 patients at a time; no emergency backup, (Divert Company is part Of DaVita and will bring Emergency generators to them if needed)	260-4908
DaVita Rock Prairie Dialysis, 1724 Birmingham Road, College Station 20 patients at a time; no emergency backup (Divert Company is part of DaVita and will bring them Emergency generators to them if needed)	704-6903
Health for All, Inc., 3030 East W 29th Street, Ste. 111, Bryan	774-4176
Liberty Dialysis, 2390 E. 29th St., Bryan 20 patients at a time, no emergency backup	314-1550
Liberty Dialysis, 3314 Longmire Dr., College Station 16 patients at a time, no emergency backup	314-1560
Texas A&M Physicians Family Medicine, 2900 E. 29th St, Ste 1010, Bryan	776-8440
Texas A&M Physicians Psychiatry, 8441 Riverside Pkwy., Clinic Bldg. 1, Ste.1400, Bryan	774-8200
Texas Avenue Medical Clinic, 1703 East 29th Street, Bryan	779-4756
Texas Brain & Spine Institute, 8441 Riverside Pkwy., Clinic Bldg. 1, Ste.4300, Bryan	776-8896
Scott & White Clinic, 1700 University Drive, College Station Walking wounded; no bed #'s: emergency power – 4hrs	691-3300
Scott & White Clinic, 800 Scott & White Drive, College Station	207-3300
Scott & White Clinic, 1296 Arrington Rd. Ste. 100, College Station	207-3636
Scott & White Clinic, 748 N. Earl Rudder Freeway, Bryan	207-3300
CHI St. Joseph Express, 4421 Hwy. 6 South, Ste. 100, College Station	731-5200
CHI St. Joseph Express, 2210 E. Villa Maria, Bryan	821-7629
Veterans Affairs Outpatient, 1651 Rock Prairie Rd, Ste. 100, College Station	680-0361

2. Nursing Homes, Assisted Living, and Independent Living

Arbor on the Brazos, 1103 Rock Prairie, College Station	694-2730
Bluebonnet House, 3901 Victoria Avenue, College Station 48 Beds; Assisted living facility; emergency power for 168+ hrs. Propane generator	693-9699
Broadmoor Place, 2601 East Villa Maria Road, Bryan 36 beds; emergency power backup; 3 hours for lighting only	823-4446
Carriage Inn, 4235 Booneville Rd, Bryan 85 rental apts. 1-2 pp/apt; independent living; No emergency power backup except for lighting	731-1300
Crestview Court Nursing Home; 2505 E. Villa Maria Rd, Bryan 48 Skilled nursing beds, 48 Assisted living beds, 18 Alzheimer's; Emergency power for 48 hrs (diesel)	774-9938
Crestview Place Apartments, 2503 East Villa Maria Road, Bryan 44 apt.; no emergency power backup	776-9294
Crestview Terrace Apartments, 2501 E. Villa Maria Road, Bryan 100 apt; no emergency power backup	776-9294
Crestview Unity Apartments, 2507 E. Villa Maria Road, Bryan 66 apt, no emergency power backup	776-9294
Esperanza Assisted Living, 1103 Rock Prairie, College Station 40 beds assisted living, 18 memory care beds	694-6496
Fortress Health and Rehab; 1105 Rock Prairie Rd., College Station 120 beds; emergency power for 72 hrs.	694-2200
Hudson Creek Care Center, 3850 Coppercrest, Bryan 66 beds, Assisted Living, emergency power Generator 4 hrs (Diesel)	774-0700
Isle of Watercrest, Assisted living, 4091 East Chester Drive, Bryan 84 Beds, Emergency Power, (Diesel) 56 hours runs continuous runs lighting and red plugs available	213-4850
Lampstand Health and Rehab., 2001 E. 29th St., Bryan 140 beds; emergency power for 24-48 hrs	822-6611
Magnified Health and Rehab; 1115 Anderson St., College Station 115 beds; emergency power for 24-48 hrs.	693-1515

Parc at Traditions, Assisted Living, 3095 Club Drive, Bryan 91 Independent Living Beds, Memory Care 24 Beds, 44 Assisted Living beds, Emergency Power (Diesel) 24 hours	213-4200
Park Place Assisted Living, 8733 North Hwy 6 North, Bryan 16 Beds; Emergency Power - No	778-3003
Sherwood Health Care, Inc., 2817 Kent Street, Bryan 126 beds; Assisted Living, emergency power for 24 hrs; (Diesel 1500 Gallons)	776-7521
St. Joseph Manor, 2333 Manor Drive, Bryan 81 beds, emergency power for 65 hrs @ 25% load; 40 hrs @ 50% shares power w/Manor Assisted Living & Rehab Center	821-7330
St. Joseph Manor Assisted Living, 2345 Manor Drive, Bryan 40 apartments; emergency power for 65 hrs. @ 25%; 40 hrs @ 50%	821-7330
St. Joseph Rehabilitation Center, 1600 Joseph, Bryan 30 beds; same as above	821-7500
The Langford, 1851 Carroll Fancher Way, College Station 72 Units, Independent Living, Emergency Power – 48 hours Diesel Assisted Living coming- not open as of 02/28/19	704-6600
Waldenbrooke Estates, 2410 Memorial Dr., Bryan 180 rental apts. 1-2 pp/apt; independent living; no emergency power backup except for lighting	774-1298
Watercrest, 3801 East Crest Drive, Bryan 204 Units, Independent Living, Emergency Power - No	703-7088