

Tuolumne-Calaveras Health Care and Safety Coalition (HCSC) Chemical Surge Annex

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1. Introduction

The need to care for multiple patients exposed to chemicals is a rarely encountered but foreseeable consequence of potential hazards facing healthcare organizations in the Tuolumne/Calaveras operational areas. Compounding the problem is the very limited resources for care of chemical patients not only locally, but nationwide. These resources can be rapidly challenged in a mass chemical surge incident and the Tuolumne/Calaveras Healthcare and Safety Coalition (HCSC) may provide support through:

- 1) facilitating internal resource sharing and resource requests to external partners
- 2) information sharing among coalition members

1.1 Purpose

This annex to the Tuolumne/Calaveras Healthcare & Safety Coalition Health Emergency Preparedness and Response Plan (HEPReP) provides guidance to personnel supporting an incident in which the number and/or severity of patients exposed to Chemical material in the Tuolumne/Calaveras area has severely challenged the coalition's member organizations. Other attachments or annexes to the HEPReP may be utilized in conjunction with this document. As with any component of the HEPReP, this tool is intended to provide guidance only and does not substitute for the experience of the personnel responsible for making decisions at the time of the incident.

1.2 Scope

The HCSC authority is limited to the Governance Document and Participation Agreement signed by the members and does not supersede jurisdictional or agency responsibilities. This plan applies to all member organizations when an event occurs that is beyond the individual organization's ability to manage the response. This plan does not supersede or conflict with applicable laws and statutes. It is important to note that the Tuolumne-Calaveras Health Care and Safety Coalition is not a response entity. As such this plan is intended to increase the preparedness of the coalition to respond to a chemical surge event, in addition to documenting processes and procedures.

Members of the HCSC are trained in the Incident Command System (ICS) and are encouraged to utilize ICS when responding to events such as a chemical surge event.

1.3 Acknowledgments

This annex was developed during the 2023-2024 grant year to fulfill a grant requirement of the Hospital Preparedness Program (HPP). All coalition partners were invited to participate in the development of this annex. Participating agencies included:

- Tuolumne County Public Health
- Calaveras County Public Health
- Tuolumne County EMS Agency
- Adventist Health Sonora
- Mark Twain Medical Center
- Mountain Counties Emergency Medical Services Agency

1.4 Overview/Background of HCC and Situation

The Tuolumne-Calaveras Health Care and Safety Coalition includes the jurisdictions of Tuolumne County and Calaveras County. Health Care Coalitions have existed in each county for a number of years. Core coalition member requirements were introduced in 2017 and one of the new requirements was the participation of at least two acute care hospitals. For this reason, Tuolumne County and Calaveras County combined coalitions in 2017 with Tuolumne County taking the role of the “Lead Coalition” and Calaveras County taking the role of “Subcommittee Coalition.” While the combined Tuolumne-Calaveras Health Care and Safety Coalition plans, meets, trains, and exercises together, each county’s subcommittee of the coalition continues to operate within their own jurisdictions with individual grant and fiscal responsibilities.

Tuolumne and Calaveras Counties are both rural jurisdictions in the central Sierra Nevada range of California; Calaveras County borders Tuolumne County to the north. Each county has one acute care hospital: Mark Twain Medical Center (MTMC) in Calaveras and Adventist Health Sonora (AHS) in Tuolumne. In addition to the two hospitals and other healthcare organizations, the coalition includes public safety, non-governmental, faith-based, and educational partners, among others. Neither Adventist Health Sonora nor Mark Twain Medical Center have units dedicated to treating Acute Chemical Syndrome, although both hospitals can provide Emergency Department services to chemical patients.

Tuolumne and Calaveras Counties lie within the Medical Health Mutual Aid (MHMA) Region IV that includes the counties of Amador, Alpine, El Dorado, Nevada, Placer, Sacramento, San Joaquin, Stanislaus, and Yolo.

1.5 Assumptions

1. Several hazard etiologies are possible that could simultaneously generate large numbers of chemical victims in both counties.
2. Victims of these incidents may require decontamination from contact with chemicals.
3. Tuolumne/Calaveras Fire and/or EMS agencies would, in most foreseeable cases, be the lead agencies for field response to an incident of this nature.
4. Existing resources to treat chemical exposure in the State of California, and the country at large, are limited and have restricted ability to surge at any given point.
5. Transfers of chemical patients to appropriate treatments centers may need to be coordinated at the regional (or potentially state) level to prevent duplication of effort and to maximize efficiency of the process. This is in distinction to the everyday process in which individual facilities arrange transfer of their patients independently.
6. State and Federal resources, though typically available to assist, cannot be relied upon to mobilize and deploy for the first 24-72 hours.
7. Due to the nature of likely chemical events (terrorist attack/act of war), state and federal resources may be spread too thin across the state/nation for small, rural areas to receive assistance.
8. The success in executing any response plan is dependent upon the regular examination, revision, and training on the plan.

1.6 Definitions

- A. **Mass casualty incident:** Any incident generating patients that severely challenges or exceeds the current capabilities of the healthcare resources in Tuolumne/Calaveras.
- B. **MHOAC:** Medical Health Operational Area Coordinator

- C. **RDHMC:** Regional Disaster Medical/Health Coordinator
- D. **RDMHS:** Regional Disaster Medical/Health Specialist
- E. **OA:** Operational Area
- F. **DOC:** Department Operations Center
- G. **EOC:** Emergency Operations Center
- H. **Chemical dispersal device (CDD):** any device that causes the purposeful dissemination of chemical material over a large area using explosive or non-explosive means, with the goal of producing widespread contamination and psychological harm. An explosive CDD couples chemical material with conventional explosives; explosive CDDs are rare. A non-explosive CDD is a device or method for passive or active dispersion of chemical materials, which can be in the form of solids, aerosols, gases, or liquids. One example of a non-explosive CDD is a crop duster used to spread chemical aerosol.

1.7 Administrative Support

This plan, along with all other HCSC plans, will be reviewed and updated on a regular schedule. The agency primarily responsible for maintenance of this plan will be the Public Health department, specifically the HPP coordinator. The HPP coordinator will review this plan on an annual basis, identifying any gaps after exercises and real-world events, as well as ensuring any minor updates are performed. The HPP coordinator will make sure the most recent update is posted on the coalition's website (www.tuolumnehcsc.com) and all core member organizations receive a copy directly. If major updates are necessary to address identified gaps, a draft incorporating the proposed changes will be sent out to all coalition members for review/input. At a minimum, regardless of whether major updates become necessary, the plan will be sent out to all coalition members for review at least once per five-year grant cycle.

2. Concept of Operations

2.1 Activation

Some of the potential scenarios that would lead to a surge in chemical patients within either county include (but are not limited to):

1. Chemical incident at a fixed facility – The single most likely point of release of chemicals is from high school swimming pools with their large tanks of chlorine.
2. Terrorist attack – With no major population centers in either county, a terrorist attack utilizing a CDD or IND is unlikely, but not impossible. A terrorist group could decide to target rural towns and cities to show that nowhere is safe, rather than targeting large/dense population centers.

Any incident involving multiple patients exposed to potentially lethal doses of chemicals will likely immediately overwhelm the local healthcare system's capabilities. If there are multiple patients exposed to the chemical source, EMS will declare an MCI and begin requesting additional resources, following the county of occurrence's MCI protocols:

Tuolumne (<https://www.tuolumnecounty.ca.gov/DocumentCenter/View/16131/Policy-52000-MCI-Management>)

Calaveras (<https://www.mvems.org/policies/p900-county-specific-policies/515-928-40-amador-calaveras-mci-activation/file>).

2.2 Notifications

Initial notification of a chemical incident is most likely to be received by first responders through emergency dispatch following receipt of 911 calls from victims and onlookers at the site of an incident. Note that the initial reporting parties may not be aware of the chemical nature of the incident.

2.2.1 Notification of the MHOAC

The MHOAC of the county of occurrence will be notified as soon as possible, either by the Incident Commander (if an MCI has been declared) or by the responding agency's dispatch (if no MCI declared). The MHOAC will in turn notify the RDMHS, who will follow the relevant protocols to notify the appropriate State and Federal agencies.

2.2.2 Notification of Hospitals

The Incident Commander (or Transportation Group Supervisor, if assigned) is responsible for notifying the medical facility of any exposure or possible exposure to hazardous substances. Ideally, the notifications to the hospital should provide the medical facility with exposure information prior to victims' arrival at the medical facility, including as much of the following as possible:

- Type and nature of the incident
- Contact information of the notifying entity
- Approximate number and ages of victims
- Victim signs and symptoms
- Nature/degree of victim injury
- Type of chemical or other agent involved, if known
- Extent of victim decontamination occurring in the field
- Approximate time of EMS arrival
- Expected number of self-presenting patients

Upon notification of the hospital, hospitals will follow established internal processes and procedures to notify staff of the incident and activate appropriate response personnel.

2.2.3 Notification of HazMat response

As soon as the nature of the incident is determined to be chemicals, Dispatch will notify CalFire of the hazard (if they are not already aware). On-scene incident command will be handled by Sheriff's Office personnel, and containment efforts will be managed by CalFire. Dispatch will notify Environmental Health of the HazMat incident, and if the circumstances are appropriate, county OES and CalOES will also be notified. If additional HazMat resources are needed beyond what CalFire can supply, CalOES will be notified so mutual aid can be coordinated through that agency.

2.3 Roles and Responsibilities

The following table defines the roles of key local, coalition, and regional agencies responsible for chemical incident preparedness and response. All agencies listed below will respond in accordance with department/agency plans and policies.

Agency	Roles and Responsibilities
Local Fire District	• Fire department responsibilities may include the identification of materials, decontamination, bringing fires under control, and the containment of spills. • The fire department coordinates and notifies appropriate

	authorities to implement the safe removal of the product and may monitor the cleanup and decontamination of the site.
Local Law Enforcement	• Law enforcement duties may include securing the immediate area at the scene of the incident, rerouting traffic, public alerting, and limiting access to the area to emergency personnel only.
Local EMS Providers	• Local EMS providers will coordinate on-scene emergency medical care, transportation, and pre-hospital treatment for victims of a HazMat incident.
MHOAC	• The MHOAC Program maintains 24/7/365 capability to initiate emergency notifications, coordinate requests for medical and health assistance and/or resources, and obtain and distribute information to enhance situational awareness to medical and health stakeholders. • The MHOAC Duty Officer carries out the MHOAC Program duties such as serving as a single point of contact for local, OA, regional, and state agencies; potentially serving as the liaison between the HCSC, Health and Human Services Agency (HHSA), the EOC, and healthcare facilities; and achieves objectives in support of the DOC's and EOC's missions. • The MHOAC is also responsible for contacting the RDMHC/RDMHS to obtain mutual aid support from other OAs within the region or from state/federal medical and health resources if the HCSC is unable to meet the needs within the OA.

Agency	Roles and Responsibilities
Tuolumne/Calaveras Office of Emergency Services (OES)	• Depending upon the incident, other governmental agencies may be required to support containment, control, and recovery. These requests could include transportation, public works, equipment, specialized personnel, materials, and communications. The Incident Commander(s) may request such support directly or via the EOC. • If activated, the EOC will coordinate support from agencies within county government, the community, the private sector, and regional, state, and federal government entities. • If activated, the EOC will also lead public communications, establishing a Joint Information Center (JIC) if necessary. • Based upon incident needs, the EOC may establish and staff, in alignment with Mass Care Lead, community reception centers, evacuation centers, shelters, family reunification centers, and other facilities.
Hospitals	• Hospitals/health centers shall provide primary medical care to persons who are injured and/or exposed to

	chemicals, following decontamination protocols as appropriate. • In addition, should contaminated individuals arrive at hospitals independently, hospitals will decontaminate these patients.
Non-Acute Care Facilities	• To alleviate some pressure on the emergency department of the local hospital, outpatient providers such as Rapid Care clinics or Indian Health Clinics should consider increasing their hours of operation and/or offered services to provide alternative options for patients with less severe needs. Public messaging through local government agencies may be necessary to encourage these less severe patients to self-transport to these alternate sites if possible. • To help additional staffed beds to become available, the hospital may also transfer existing patients that are stable but still need care to local skilled nursing facilities (SNFs) or Indian Health Clinics, provided there are enough beds available at the receiving facility. <u>No chemical-exposed patients should be sent to the outpatient providers, under any circumstance.</u>
RDMHC/S	• The RDMHC/S Program is responsible for monitoring and acquiring medical and health resources during emergencies and is authorized to make and respond to requests for mutual aid from the MHOAC.

The following table defines the roles of key state and federal agencies responsible for chemical incident preparedness and response. All agencies listed below will respond in accordance with department/agency plans and policies.

Agency	Roles and Responsibilities
California Emergency Medical Services Agency (CalEMSA)	• CalEMSA develops general guidelines for the triage and handling of contaminated/exposed patients and assists with the development of general guidelines and promotion of training for personnel involved in a HazMat emergency medical response. • CalEMSA, in coordination with California Department of Healthcare Services (DHCS), jointly appoint a RDMHC, whose responsibilities include supporting the mutual aid requests of the MHOAC for disaster response within California mutual aid regions and providing mutual aid support to other areas of the state in support of the state medical response system. The RDMHC also serves as an information source to the state medical and health response system. • CalEMSA also identifies medical facilities capable of

	handling injured and contaminated persons; arranges for emergency procurement, storage, distribution, and handling of supplementary medical supplies and equipment in support of local government response; and identifies and coordinates procurement of medical assistance from other state departments, hospitals, and ambulance providers. • CalEMSA coordinates the evacuation of casualties from the affected area to definitive care facilities throughout and outside the state.
California Department of Public Health (CDPH)	• The CDPH Emergency Preparedness Office (EPO) coordinates overall emergency planning and preparedness efforts for the department. • The EPO oversees statewide public health disaster planning, maintains and manages the Medical and Health Coordination Center (MHCC), and coordinates planning for the SNS.
California Environmental Protection Agency (CalEPA)	• CalEPA Emergency Response Management Committee (ERMaC) coordinates preparedness for and responses to environmental emergencies in California under assigned statutory authorities. • ERMaC's mission is to manage public health and environmental consequences of emergency events through effective, coordinated agency-wide preparedness, response, recovery, and mitigation activities.

Agency	Roles and Responsibilities
California Office of Emergency Services (CalOES)	• CalOES provides specialized training in HazMat emergency response and assists local jurisdictions in preparing HazMat emergency response plans. • CalOES also operates the State Warning Center (SWC), including notification of HazMat emergencies to federal, state, and local agencies on a 24-hour, seven-day a week basis. • CalOES also develops procedures for, operates, and staffs the Regional Emergency Operations Center (REOC) and State Operations Center (SOC) • CalOES will be the primary agency for coordinating additional HazMat response resources once local/coalition/mutual aid resources have been exhausted.
Centers for Disease Control and Prevention (CDC)	• CDC can provide population triage, registration, tracking, and epidemiology support to enable effective patient triage and general tracking and flow through monitoring, as well as decontamination centers.
Department of Homeland Security	• DHS oversees the National Operations Center (NOC), which operates 24 hours a day, 365 days a year, and serves as the

(DHS)/Federal Emergency Management Agency (FEMA)	primary, national-level hub for situational awareness, a common operating picture, information fusion, information sharing, and executive communications. FEMA serves as the lead agency in the management of the Disaster Assistance Program in affected areas after a catastrophic HazMat emergency if requested by the Governor and declared by the President.
National Response Team (NRT)	The U.S. National Response Team provides technical assistance, resources, and coordination on preparedness, planning, response, and recovery activities for emergencies involving hazardous substances, pollutants and contaminants, oil, and Weapons of Mass Destruction (WMD) in natural and technological disasters and other environmental incidents of national significance.

2.4 Logistics

2.4.1 Mutual Aid

Tuolumne & Calaveras Counties have existing mutual aid agreements, allowing for easy sharing of EMS resources during an MCI. The HCSC will facilitate further mutual aid among the HCSC members (excluding EMS) as possible, specifically resource sharing.

No member facility will be expected to deplete their supplies, but each facility will be asked to spare as much as possible while maintaining operational capabilities.

If additional staffing is required by the primary receiving hospital, DHV/MRC volunteers will be deployed by Public Health.

2.4.2 Additional Resources

The MHOAC may, depending on incident parameters, initiate the process for requests for additional resources through the MHOAC system. This may include:

- Region IV assets: Additional beds and transportation assets; activation of MRC units or Hazmat Teams outside of Tuolumne/Calaveras.
- Cal OES assets: Additional beds, including patient transfers to facilities capable of bone marrow transplants; decontamination and/or transportation assets
- ASPR/National Disaster Medical System (NDMS):
 - Additional beds nationally
 - Additional equipment and supplies needed
 - Specialty related clinical management guidance (chemical burns, etc.)
 - Disaster Medical Assistance Teams (DMATs)

2.5 Special Considerations

2.5.1 Behavioral Health

Responding HCSC members (fire, EMS, law enforcement, hospital) can catalogue behavioral health needs anticipated in response to the incident and convey these to the MHOAC and/or the county of occurrence's Behavioral Health Department (as needed). Each county's

Behavioral Health Department should make efforts to have counselors available to patients, witnesses (particularly response staff), and families of patients.

2.5.2 In-hospital deaths

It is anticipated that hospital deaths occurring in Tuolumne or Calaveras County from the chemical incident will be handled by the county of occurrence's Coroner's Office for post-mortem processing. Individual facilities are expected to contact their Coroner's Office for individual cases. If the in-hospital deaths become excessive, the HCSC can assist with operational area-wide tracking of deaths (if requested), working with Tuolumne/Calaveras MHOAC to identify support needs for storage at the facilities, and petitioning for regulatory relief regarding storage of the deceased beyond 30 days (if Coroner's Office case load prevents timely removal from the healthcare facilities). Additionally, if the chemical incident becomes a mass fatality incident, "[Annex 13. Mass Fatality Plan](#)" of the [Tuolumne County HEPRP](#) will be activated and followed as appropriate.

2.6 Operations – Medical Care

2.6.1 Triage

Disaster triage is a method of quickly identifying victims who have life-threatening injuries and who also have the best chance of survival. Identification of such victims serves to direct other rescuers and health care providers to these patients first when they arrive on the scene. The use of disaster triage involves a change of thinking from everyday care to:

- High intensity care should go to the sickest patient doing the greatest good for greatest number.
- Identify victims with best chance of survival for immediate intervention focusing care on those with serious and critical injuries but who are salvageable.
- Identify victims at extremes of care by sorting those who are lightly injured and those who are so severely injured that they will not survive.
- Immediate treatment to only those victims that procedure or intervention may make difference in survival.
- Altered standards of care based on resource availability.

Disaster triage must be dynamic and fluid in its execution. Primary triage is done at the scene by first responders; the triage category is assigned rapidly and is based on physiologic parameters and survivability. Secondary triage occurs typically at the facility where the patient is transported. The initial triage assignments may change and evolve as the patient's condition changes so reassessment is crucial. It is essential that medical personnel prioritize transport and treatment based on level of injury and available resources.

2.6.2 Treatment

Transfers will be prioritized according to patient acuity. Specialty consultation may be obtained by the hospitals if they are temporarily caring for exposed patients to ensure the best care possible; potential resources include telemedicine consulting with facilities capable of or specializing in bone marrow transplants.

2.7 Transportation

Patients that need immediate transfer to a Trauma Center will be transported via air ambulance if available. If unavailable, patient will be transported via ground ambulance.

Additional emergency transportation may be available from regional partners but will likely not arrive for at least an hour after the incident occurs. Non-emergent transportation (evacuation, large scale non-urgent patient transport, etc.) may be provided by the transit agency of the county of occurrence.

2.8 Reunification

2.8.1 The Hospital Family Reunification Center (HFRC)

It is recommended that all hospitals have a plan in place to manage a surge of concerned family members, guardians, and friends that may present following a disaster, especially if large numbers of unaccompanied pediatric patients could be involved in the event. This is recommended because the volume of family members presenting to the hospital looking for their loved ones will typically overwhelm hospital lobbies and other care areas and could adversely affect clinical operations. This place where families and others may gather is often called a Hospital Family Reunification Center (HFRC). The HFRC is meant to:

- Provide a private and secure place for families to gather, receive, and provide information regarding loved ones who may have been involved in the incident
- Provide a secure area for these families away from the media and curiosity seekers.
- Facilitate efficient information sharing among hospitals and other response partners to support family reunification.
- Identify and support the psychosocial, spiritual, informational, medical, and logistical needs of family members to the best of the hospital's ability.
- Coordinate death notifications, when necessary.

Hospitals should consider locations in their facility that are best suited to effectively and respectfully establish a family reunification center. Some considerations to keep in mind are:

- Locate the HFRC away from the hospital Emergency Department and media staging sites.
- Ensure there is sufficient space to accommodate many individuals.
 - Adequate space facilitates communication between designated hospital personnel and family members.
- Provide nearby access to smaller rooms that may be used for confidential discussions, notifications, and provision of other support.
 - Distraught family members may need additional space; alcoves or additional rooms may help both psychologically and with security.
- Ensure the space has an area for food and beverage.
- Ensure restrooms are easily accessible.
- Ensure the space is accessible to patients and family members with considerations for access and functional needs.
- Ensure access to the HFRC can be controlled and security can be maintained within the site.

2.8.2 The Family Reunification Site

Once identification and verification of a patient and family is complete, there should be a separate area to facilitate the actual reunification of the family and patient. The physical place where patients are reunited with their families and/or legal caregivers should be located away from the HFRC if possible. This is to permit the reunification to occur in a safe, well-controlled area located well away from the noise and distractions of the other areas. The

family reunification site should allow for secure and simple departure from the hospital. Hospitals should also plan for reunification of patients who have been admitted to the hospital and for escorting of family members to other areas of the hospital.

Separation of the Family Reunification Site from the HFRC is also important to prevent creating additional trauma for families still waiting in the HFRC who are not yet reunited with their patient but who would otherwise be watching reunifications happening in front of them.

Families arriving at the hospital will be under a tremendous amount of stress and may have limited ability to process instructions or other information while they are looking for their patient. Therefore, staff members in the HFRC must have experience in helping people under stressful conditions. Hospital staffing may include, but are not limited to, the following departments:

- Security
- Social Work
- Nursing
- Chaplaincy
- Psychiatry or Psychology
- Pediatrics
- Family Medicine

The hospitals may also request support from non-hospital agencies such as Victim Witness or Behavioral Health.

Adventist Health Sonora has a draft Family Reunification Plan which includes a family reunification center procedure (includes a news media center checklist), set-up consideration checklist, contact list, phone operator call log, and a minor tracking form.

The Tuolumne County Sheriff's Office [Mass Fatality Plan](#) includes a Family Assistance Center section, which outlines roles and responsibilities, Family Assistance Center services, and activation of the center.

Mark Twain Medical Center does not have its own Family Reunification Plan; rather, they utilize the Calaveras County Patient Tracking and Reunification Plan. This plan includes patient tracking information, Family Reunification Task Force activation procedure, hospital switchboard procedure, a patient transportation summary worksheet, a patient destination worksheet, and an MCI patient directory.

Member organizations American Red Cross and Twain Harte Area CERT are both capable of assisting with family reunification services and will be asked to do so if time allows.

2.9 Deactivation and Recovery

Demobilization will proceed per MCI response plan(s) of the responding EMS agency and receiving hospital.

Reimbursement: The additional costs associated with treating patients from a chemical surge incident (HazMat teams, isolation area setup & supplies, etc.) can be expensive and may not be readily reimbursed by insurance and other payers. The HCSC will work with the Tuolumne/ Calaveras MHOAC to facilitate recuperation of costs incurred by member organizations to the full extent possible. This assistance can include:

- Facilitate data collection from healthcare organizations regarding non-reimbursed costs to advocate for State and/or Federal reimbursement.
- Convey instructions (as provided by Tuolumne/Calaveras MHOAC) to facilities regarding funding eligibility and application/documentation procedures
- Facilitate reimbursement to member organizations for resources shared with primary receiving facility.