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Southeast Wyoming Healthcare Coalition

Chemical Annex

Southeast Wyoming Healthcare Coalition

Serving the citizens of Albany, Goshen, Laramie and Platte Counties

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**1. Introduction**

**1.1 Purpose**

This annex describes a coordinated healthcare response to a chemical emergency in which the number and severity of exposed or possibly exposed patients challenges the capability of HCC member facilities. The annex will outline specific incident and response protocols necessary to properly plan for, manage, and care for patients during a chemical emergency.

This Annex does not replace other county or local emergency operations plans or procedures, but rather builds upon the existing plans to provide additional healthcare response detail. The annex also does not replace the need to have separate chemical protocols, equipment, and training for each healthcare facility or EMS agency. This annex should ensure that during a chemical emergency:

1. Coalition members understand their roles and responsibilities for containing contamination, decontaminating patients, and providing patient care.
2. Resources within the coalition, and external to it, are documented and coalition members understand the timeframe for their activation and arrival.
3. Each healthcare facility and EMS agency has a plan, proper training, and necessary equipment to address the needs of patients impacted by a chemical incident, including the provision of dry and wet decontamination.
4. Sources of information regarding patient care are documented and available (e.g., job aids, technical expert reach back).
5. Emergency management and public health agencies understand the need for rapid communication to the public; the potential need for shelters where victims can perform self-decontamination (e.g., “dry” decontamination at a minimum) and additional locations for mass decontamination; the coordination of medical countermeasure deployment (e.g., CHEMPACK, Strategic National Stockpile [SNS]); and secondary transport coordination.

**1.2 Scope**

This section should be brief and include:

• Time Frame covered by the plan

• Geographic area covered by the plan (may refer to base plan)

• Involved coalition and jurisdictional partners (may refer to base plan, but also include nontraditional coalition partners who may only support the coalition during a chemical surge).

• Any necessary disclaimers about the plan (e.g., not to supersede authorities of the participating entities), jurisdictional requirements (e.g., SARA Title III), or acknowledgement of other dedicated community plans (e.g., Local Emergency Planning Committee (LEPC). This is especially important as a coalition may cross over jurisdictional boundaries when responding to a chemical emergency that includes multiple LEPCs. This section may also describe elements not addressed and refer the reader to other relevant documents, related considerations, or specialty annexes such as pediatric and burn surge.

**1.3 Overview/Background of HCC and Situation**

This section should include a general overview of the HCC and the community relative to a chemical emergency, including:

• Those potentially at higher risk during a chemical emergency (e.g., industrial/transportation workers, EMS/first responders) and vulnerable populations (e.g., long term care [LTC] facility residents, those with limited evacuation options or in close proximity to a fixed chemical risk, and pediatric patients).

• Areas at high risk of a chemical incident (e.g., industrial plants, research facilities, terrorism targets, and transportation hubs).

**1.4 Assumptions**

* Each facility or healthcare organization should understand expectations specific to them as part of the coalition, especially within the first minutes and hours of a large-scale chemical incident.
* Hospitals may need to shelter in place (or, less likely, evacuate) in response to a chemical release or plume.
* There should be an understanding of the general expectations for EMS and fire/rescue personnel during a chemical incident response that is appropriate to regional resources.
* Hospitals must have appropriate plans, PPE, and equipment to receive and decontaminate patients as self-referral is common.
* On-duty staff will need to quickly evaluate a large number of real versus possible exposures.
* Job aids will be needed to help initiate response, decontamination, and treatment guidance for these uncommon events.
* Specialty consultation (e.g poison control center, regional HAZMAT experts) will be needed quickly to provide specific Chemical Resources care recommendations for agent type and magnitude of release.
* Depending on the scale of the chemical incident, establishment of alternate decontamination or Planning with CBR Hazards screening locations may be required to assess low-risk patients and provide basic decontamination needs.
* There may not be an adequate local supply of specific countermeasures and antidotes for a large- scale chemical emergency.
* Health concerns, prolonged response requirements, fatigue, difficult work environments, and stress may contribute to behavioral health challenges among coalition members and the general public.
* Depending on the scale, severity, and type of chemical emergency, it may be necessary to contract private organizations to assist with large-scale containment and clean-up efforts.

**2. Concept of Operations**

**2.1 Activation**

This section should include information on the annex activation process (and levels, if relevant); the indicators and triggers that initiate the plan (including thresholds for notifying hospitals and EMS about a chemical release); and an outline of who is contacted to initiate a regional response, including how that is executed. These activation and notification sections should only detail the differences for a chemical incident versus a general disaster process or should otherwise refer to the base plan.

**2.2 Notifications**

This section should outline alerting and notification strategies specific to a chemical emergency. It should detail who will be notified, by whom, when, and how. Content should include information on specific communication systems, management processes, and/or notification/coordination strategies between the HCC, healthcare facilities, specialty facilities, and federal, state, local, tribal, or territorial agencies.

This section should also include any specific state or federal notifications that may need to be made (e.g., Wyoming Emergency Medical information regarding decontamination wash water runoff), and may also include who provides public Services Authority notifications about an incident and/or immediate actions.

Plans should consider what notification mechanisms are already in place, or what may be needed, to properly notify all responding agencies/organizations in a timely manner to ensure they take proper Incident Planning Guide protective measures.

**2.3 Roles and Responsibilities**

This section should define HCC, agency, and healthcare facility functions during a chemical emergency. It should include the role of any specialty response teams (e.g., HAZMAT, Civil Support Teams [CST) and Guide identify the lead agency coordinating the healthcare aspects of the response. The plan should specifically outline:

• The designated lead agency for a chemical emergency response.

• The agency that will operate community reception centers, or alternate care sites, should they be needed.

• The primary agency overseeing risk communication during an incident to ensure rapid public • The expectations of fire or other first responders to provide on-scene assessments and patient decontamination needs (e.g., dry and wet decontamination).

• The expectations of EMS regarding care of contaminated patients, medical countermeasure administration, patient distribution, and mutual aid for secondary transfers.

• The expectations of healthcare facilities, including their ability to provide decontamination.

• The agency/entity responsible for obtaining agent/treatment information and circulating to stakeholders.

• The state, or other, agencies that would have oversight or must be notified of a chemical incident

**2.4 Logistics**

This section should outline the available resources and potential logistics issues that may occur during a chemical incident, as well as discuss strategies for the HCC and member facilities to address these challenges. It should focus on when and how resources are requested and strategies for distribution.

The “space”, “staff”, and “supplies” sections are included for consistency with other annexes, however coalitions may wish to group these differently (e.g., by local resources versus regional/state, by decontamination versus treatment resources, or by EMS versus hospital). Consider if there will be designated facilities within the HCC that are expected to fulfill the majority of decontamination needs. Document available local, state, and interstate resources that can support a chemical incident response as well as their request process and response timeline. Ensure plans include:

• Available local assets.

• Resources for external support (including additional patient decontamination/containment materials, medical countermeasure/treatment supplies).

• Any detection equipment, chemical sampling/evaluation, and laboratory resources available for pre-hospital and hospital use.

• Contacts for clinical laboratories with chemical expertise.

**2.4.1 Space**

This section should briefly document regional hospital decontamination capabilities including the number of decontamination stations/showers (fixed or temporary) and estimated throughput per hour. This section should also briefly outline community decontamination capabilities, including mobile assets (e.g., fire/rescue), potential community sites for mass decontamination (including who controls and/or approves site use and activation), and may consider including additional information such as regional specialty resources for chemical burn care.

**2.4.2 Staff**

This section should outline the expectations for initial and supplemental hospital decontamination teams and staffing. The usual staffing augmentation plans should apply as per the base plan, including use of supplemental staff. SE WY Healthcare Coalition Chemical Emergency Surge Annex This section should also briefly outline fire/rescue assets that could support a hospital decontamination surge and include information on how they can be requested (if not occupied at the site). Consider including information on regional chemical information and response assets that may be needed (e.g., HAZMAT safety officers, toxicologists, poison control, industry hygienists, or CST). Consider how regional Hazardous Materials Safety Assistance Teams (HMSAT), the Agency for Toxic Substances and Disease Registry (ATSDR) emergency response teams, or environmental health agency assets can be integrated and/or utilized (if available).

**2.4.3 Supplies**

This section should summarize the equipment and resource expectations of member healthcare facilities relevant to a chemical incident, and coalition-level strategies to ensure adequate supply levels and availability. This section should include coalition-level resource inventory management strategies for accessing, mobilizing, storing, and distributing specialized supplies as relevant (e.g., CHEMPACK). This section should:

• Document baseline chemical PPE for EMS and hospitals in the coalition as appropriate per previously listed assumptions.

• Define baseline preparedness threshold levels of supplies for hospitals as appropriate (e.g., PPE, countermeasures) and/or list the locations and contents of hospital-based caches.

• Define baseline EMS agency supply expectations for HAZMAT response and patient treatment. • List current local or state countermeasure/stockpile data relevant to your area.

• Ensure stockpile/materials release, distribution, replenishment, and sharing policies are clear (e.g., who gets what, when, and how).

• Include plans and protocol for accessing and distributing CHEMPACK resources. Ensure the coalition is familiar with how to engage the state to make additional requests.

• Document additional decontamination supplies (e.g., dry decontamination kits, wet decontamination equipment, privacy shelters, containment materials).

**2.5 Operations Medical Care**

**2.5.1 Triage & Screening**

This section should reference any specific triage approaches for exposed, or possibly exposed, patients and outline expectations for hospital transport versus release-at-scene. Outline roles and responsibilities for on-scene evaluation and treatment by medical personnel.

• Discuss the expansion of response needs according to size/scale of the incident as well as thresholds for opening community screening sites and potential /prioritized locations.

• Highlight what medical information is needed (e.g., exposure level/duration/route, patient history, diagnostic data) to support decision-making. Note how information will be collected, documented, shared, and secured.

• Identify any tools and or technical resources that may be relied upon in the region for standard treatment and decontamination information (e.g., PRISM, ToxFAQs, ChemView, ChemResponder, CHEMM, WISER).

• Outline the basis for prioritizing patient decontamination, treatment, and transport (e.g., hazard type, exposure duration, route of exposure, or other trauma).

**2.5.2 Patient Care/ Management**

In this section describe the chemical emergency surge operations plans. Briefly summarize:

• The expectations for dry, gross, and technical decontamination pre-hospital and hospital.

• The role of EMS in the care of contaminated patients including countermeasure administration.

• The mechanisms and processes that will be used to track patients, their contamination status, and treatment provided.

• The expansion of decontamination operations relative to scope of the incident (e.g., transition to dry decontamination, the request/use of additional resources or techniques).

• Consider the potential need to move a large number of worried well (e.g., for screening/ decontamination)**.**

**2.5.3 Treatment**

This section should describe the coalition role in planning for and circulating treatment protocols for chemically exposed patients.

• Outline any regional coordination strategies with HAZMAT specialists, toxicologists, industry, local emergency planning council (LEPC) and other subject matter experts (SMEs).

• Summarize, or provide links to, available treatment recommendations for common/critical chemical exposures (that should be a common point of reference).

• Describe the process to provide agent information to hospitals from the field as well as any Emergencies mechanism for providing treatment recommendations to the hospitals.

**2.5.4 Safety & Control Measures**

This section should briefly summarize EMS and hospital expected safety and control measures during a chemical emergency. Plans should reference jurisdictional emergency management protocols as outlined, or Chemical in local emergency response plans. Community safety and control measures will reside with fire/HAZMAT, emergency management, and public health entities.

• Ensure compliance with OSHA Hazardous Waste Operations and Emergency Response Emergency Response Guidebook (HAZWOPER) standards (including training, establishment of control zones, hot/warm/cold zones, and use of PPE).

• Summarize expectations for management of wash water from decontamination operations (e.g., if allowing mass decontamination wash water to run down sanitary sewers who needs to be notified?)

• Briefly summarize plans for management of large amounts of victim clothing and belongings as well as large-scale disposal of contaminated waste from patient decontamination and care operations; address any state/local waste transportation/management regulations, include considerations for EMS agencies.

• Summarize or reference regional protocols for establishing zones of control for a chemical incident.

Summarize or reference expectations/plans for hospital control of spaces to direct ambulance and self-referred patients through the decontamination processes prior to facility entry, or to limit contamination after inadvertent facility entry.

**2.5.5 Fatality Management**

This section should address handling of chemically contaminated decedents, and:

• Include contingency plans for handling contaminated decedents as well as expectations for decontamination.

• Identify SMEs who can advise on decontamination and handling of contaminated decedents. • Include resources for decontamination of decedents and outline capabilities of the morgue to manage contaminated remains.

• Describe how information on decedent management will be circulated to hospitals and morgues.

**2.5.6 Transportation**

This section should refer to transport policies, plans and procedures, including transport of potentially contaminated patients and the mass movement of persons with significant chemical exposure but who have minimal current symptoms. The base plan for mutual aid and secondary transports should be referenced as needed. EMS should be integrated into the planning process to ensure understanding of capabilities and limitations during a chemical event (e.g., contaminated ambulance issues, roles and PPE, ability to support emergency responses and secondary transfers).

**2.5.7 Deactivation & Recovery**

This section should include considerations for facility clean-up, recovery of PPE, waste management, and clinical and incident documentation. The plan should define the specific coalition responsibilities and actions related to deactivation and participation in after-action reviews.

**2.6 Special Considerations**

**2.6.1 Behavioral Health**

This section should consider the HCC role in supporting short- and long-term, mental health needs after a chemical incident. It may reference base plans for behavioral health support.

**2.6.2 Pediatric & At Risk Populations**

This section should include special considerations specific to at-risk populations and individuals with special needs as required (e.g., children, communities of color, elderly populations, individuals with underlying physical and behavioral health conditions, persons experiencing access to care issues, people with limited English proficiency, individuals experiencing homelessness, and incarcerated individuals). The information included should:

• Ensure that coalition member organizations account for community members who could be more vulnerable during a chemical emergency.

• Consider the need for alternate communication and movement strategies regarding sheltering or evacuation orders for at-risk individuals (e.g., LTC facility residents) as well as during the decontamination process (e.g., each facility should have protocols in place for pediatric decontamination as well as for other at-risk populations).

• Summarize considerations specific to caring for pediatric cases including triage, age appropriate/assisted decontamination, specialty care, transport needs, or specialty resources/supplies.

• Consider preparing messages for communication with non-English speaking individuals during decontamination, and plan to engage with differing cultural groups. Facility plans should consider possible scenarios such as patient refusal to remove or surrender articles of clothing during the decontamination process for cultural reasons.

• Address the needs of at-risk populations when communicating critical actions (e.g., evacuation, shelter-in-place orders, when/where to seek care) and include use of multi-modal communication and language strategies.

**2.6.3 Communications**

This section should outline the entities responsible for disseminating timely, accurate, and consistent information (internally and externally) to partners and the public during a chemical incident. Provision of such messaging, education, and public health information about the event can help reduce a surge of worried well during a response.

Coalitions should:

• Refer to the base plan’s communication expectations and document specifically who will provide community messaging for evacuation/sheltering-in-place orders or when/where to seek care.

• Outline how these messages will be coordinated with SMEs and include who will communicate to hospitals about agent/plume information, treatment protocol, and such.

• Consider the best mechanism to clearly articulate to the public what they can and cannot do (e.g., an incident has occurred at this location, anyone within a 1-mile radius should…, and should not…).

• Have plans in place to maintain awareness of current conditions within the community and monitor multiple sources of information to identify and counter rumors/misinformation.

**2.6.4 Jurisdictional Special Considerations**

This section should outline any specific jurisdictional, demographic, and geographic based issues that could impact response and recovery efforts. (e.g., tribal, or territorial policies, and border control laws). Include specific state, local, tribal, or territorial community right-to-know laws, state OSHA rules, local fire codes, and the like that may govern the emergency response. If jurisdictional laws or rules/code are more stringent than the federal law, know which will take precedence.

**3. Appendices**

**3.1 Training & Exercises**

This appendix should include relevant baseline, or just-in-time training information, to support chemical incident care. Include jurisdictional level planning, training, and exercises/drills, as well as chemical specialty personnel. This section should address:

• Coalition training, exercise, and evaluation efforts to improve response capabilities to a chemical incident scenario. This may include safety, decontamination, screening, and triage training as well as toxidrome recognition and treatment.

• Requirements and resources for training on appropriate use of PPE; decontamination protocols; and safety of decontamination team members for pre-hospital and hospital personnel. (Note, the requirements outlined are per OSHA, The Joint Commission, and other authorities rather than HPP requirements).

• Exercise plans to coordinate patient management for a variety of chemical incident scenarios with differing levels of impact, to include vulnerable and at-risk populations.

**3.2 Legal Authorities**

This appendix should list any applicable legal authorities and regulatory information specific or relevant to chemical incidents; mass casualties and waste management; surveillance and population monitoring; and pertinent safety and control measures (e.g., evacuation or shelter-in-place procedures). This may refer the reader back to the all-hazard coalition response plan unless related issues are covered in this section. For example:

• What notifications are required under statute for hazardous materials/wash water disposal?

• Are first responders permitted to detain individuals that refuse decontamination?

• Are evacuation orders issued by the jurisdiction mandatory or voluntary?

• Is there a specific exemption that needs to be made for facilities where the risk of evacuation may exceed benefit (e.g., LTC facilities or hospital environments)?

**3.3 Additional Resources/References**

• [Hospital Patient Decontamination TC](https://asprtracie.hhs.gov/technical-resources/38/hospital-patient-decontamination/37#responder-health-and-safety)

• [Hospital Pharmacy Disaster Calculator](https://files.asprtracie.hhs.gov/documents/aspr-tracie-hospital-disaster-pharmacy-calculator.xlsx)

• [Hospital Surge Capacity/Immediate Bed Availability TC](https://asprtracie.hhs.gov/technical-resources/58/hospital-surge-capacity-and-immediate-bed-availability/0)

• [Incident Management TC](https://asprtracie.hhs.gov/technical-resources/14/incident-management/1)

• [Partnering with the Healthcare Supply Chain During Disasters](https://files.asprtracie.hhs.gov/documents/aspr-tracie-partnering-with-the-healthcare-supply-chain-during-disasters.pdf)

• [Pre-Hospital Patient Decontamination TC](https://asprtracie.hhs.gov/technical-resources/39/pre-hospital-patient-decontamination/37)