DHHS earthquake response plan

Annex to DHHS emergency operations plan

February 2026

Utah Department of
Health & Human
Services
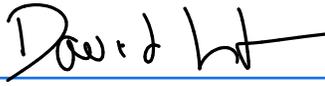
Table of contents

Earthquake response plan approval

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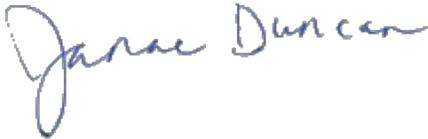
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Overview

Mission and purpose

This plan is primarily focused on the Department of Health and Human Services' (DHHS) role as the state's primary co-lead for emergency support functions (ESF) #6–mass care and the primary lead for #8–health and medical care during an earthquake that disrupts normal services in Utah. This plan correlates with the FEMA Region VIII Wasatch range earthquake response plan, which covers the duties of all ESF functions from local, state, and federal responders.

Scope

The DHHS earthquake response plan is an annex to the DHHS emergency operations plan (EOP). This plan may be activated for any magnitude earthquake in any part of the state if support from DHHS is needed. However, this plan focuses on the immediate response actions for DHHS following an earthquake along the Wasatch Front that disrupts normal operations. This plan is flexible and scalable, depending on the response needs. This plan does not seek to describe or dictate how any other agency will respond or operate in the aftermath of an earthquake. References to supporting agencies are made for the purpose of better inter-organizational coordination of the many entities involved in such a response.

Situation: earthquake scenario

This plan may be activated for an earthquake of any magnitude, if DHHS support is requested. The hazard profile described is just one possible scenario.

Hazard profile: 6.5 magnitude earthquake

The Utah Geological Survey has estimated there is a 50% probability of a rupture of 6.5 magnitude (M) or greater along one or more of the central segments of the Wasatch Fault within the next 50 years (Earthquake probabilities study). Figure 1, the HAZUS Map, demonstrates the impact of a rupture along the Salt Lake City segment of the Wasatch Fault. Accompanying modeling data provided by the Utah Division of Emergency Management describes the possible general effects, health severity, and infrastructure damage.

General effects
- Ground displacement up to 10 feet along fault lines.
- Extensive liquefaction damage from Ogden to Provo.
- 20.5 million tons of debris generated, 68% of which is concrete/steel.

Health severity
- Tens of thousands of people trapped in collapsed buildings.
- 3,100 immediate deaths.
- 42,000 injuries, 11,000 of which require hospitalization or immediate care.
- 89,000 households displaced, which is estimated to be about 267,000 persons and 35,000 pets. All of them will require evacuation, self-evacuate, or require shelter, feeding and hydration.
  - 55,000 people and 5,000 pets are expected to seek public shelter.
  - 267,000 people and 64,000 pets require feeding and hydration support, including those seeking public shelter.

Estimated Infrastructure damage/impacts
- 248,000 households lose power; power outages may last for 30 days or longer.
- Natural gas outages for weeks.
- Water and wastewater service outages for a prolonged period of time
- Limited in-state sources for fuel resupply for the duration of the response.
- Major disruptions in communications services.
- Major disruptions in transportation systems.
- Damaged and degraded local response infrastructure, including schools, police stations, fire stations, emergency operations centers (EOCs), and hospitals.

Figure 1. HAZUS modeling data for a 6.5M earthquake along the Wasatch Fault Salt Lake City Segment. Provided by Utah DEM, 2022.

Medical facilities status

The affected region, highlighted in Figure 1 as the Red Zone, has 32 acute care and critical access hospitals, 16 of which are designated trauma centers. All level I trauma facilities are located in Salt Lake County and will be affected by the quake (see Appendix D and Appendix E for more info). The closest functional level II and III trauma centers would likely be in Utah, Weber, and Cache counties. Hospital capacity will be overwhelmed statewide due to existing patients in addition to earthquake casualties. Patients will need to be evacuated to facilities in and out of state. There will be a need to bring in additional patient care capability. All hospitals should have at least 72 hours of generator capacity, and many have water purification capabilities, but do not have the ability to function without gas and water service or sufficient hospital staff.

Figure 2: Magnitude 6.5 or greater earthquake probabilities by fault.
Provided by Utah DEM, 2022.

Planning assumptions

The following assumptions provide the basis for the emergency response procedures outlined within this plan:

- Electronic communication, including phones and computers, may be inoperable immediately following the earthquake impacting many responders.
- Local organizations and agencies within the impacted jurisdiction have the initial and primary responsibility in the response, including triage, sheltering, and casualty distribution.
- Triage and treatment capabilities may be overwhelmed and impaired in the disaster area; it will be necessary to treat many injured disaster survivors in a reduced capability medical setting.
- Large numbers of people and animals may require sheltering.
- Access and functional needs populations may require additional and specialized assistance.
- Large-scale evacuations and shelter placements may occur (both organized and self-directed).
- Functioning healthcare facilities in the state may have a major role in the receipt and care of patients.
- All hospitals that provide emergency care may need to receive, stabilize, and hold trauma or specialty patients for an extended period.
- Transportation routes may be initially cut off or limited.
- Severe trauma patients may become clinically unstable, complicating transfer plans.
- Federal resources (e.g., ambulance contracts, National Disaster Medical Systems teams, sheltering assistance), though potentially available to assist, may not be available for the first 72 hours.
- It may be necessary to implement a Medical Operations Coordination Center (MOCC) to coordinate patient movement, resource allocation, and guide contingency strategies for all types of healthcare facilities.
- Normal patient treatment guidelines and protocols may need to be modified temporarily with contingency or crisis standards of care strategies in order to do the greatest good for the greatest number of patients.

Response goal and priorities

Goal

As the lead state agency for ESF #6 and ESF #8, the goal of DHHS following an earthquake is to support local public health, healthcare, and social services to save lives and ensure continuity of services to protect the health and well-being of all persons in the state.

Priorities

The goal will be achieved through the following priorities, described in more detail in the plan. Information sharing and employee safety are instrumental in safely achieving these goals.

1. **Life saving operations**—provide support for emergency medical services and healthcare system surge, as well as acquire and allocate critical resources.
2. **Life-sustaining operations**—provide support for mass sheltering operations, chronic medical care, public health, behavioral health, and environmental health services.
3. **Mass fatality operations**—provide support for decedent care, including: remains recovery, identification, and family assistance.

Concept of operations: the first 24 hours

This plan is primarily focused on DHHS roles in emergency management as the lead state agency for ESF #6–Mass Care and ESF #8–Health and Medical. Before these external response roles may be carried out, an adequate assessment of the impact of the earthquake on DHHS employees and facilities is needed to ensure responder safety and continuation of essential functions.

The focus of the DHHS response for the initial 24 hours following an earthquake is as follows:

1. Notify staff, assess earthquake impact, and activate response plans.
2. Establish a coordinated response.
3. Establish communications.
4. Begin medical support operations, activate the state MOCC, and request and prepare to receive pre-established federal resource deployments.

Notify, assess, and activate

Employee notifications

Although most DHHS employees and local partners will already be aware that an earthquake of high magnitude has occurred, the DHHS Office of Public Affairs and Education (PAE) in coordination with DHHS Executive Director's Office (EDO), will notify all DHHS staff of the emergency caused by the earthquake. DHHS' Office of Preparedness and Response (OPR) will provide initial incident situation reports and the DHHS Office of Administrative Services (OAS) will provide facility situation reports to PAE. Notifications will be sent using the Utah Notification and Information System (UNIS), if functional. UNIS alerts will provide details of the earthquake and any information available about the immediate impact to DHHS daily operations, such as temporary building closures and changes to job duties. Additional updates regarding working and building conditions will be provided to DHHS staff when possible and applicable via the UNIS system. Radio, satellite phones, or other means may be used if

UNIS is not immediately functional. Communication will follow procedures in the [DHHS Tactical interoperable emergency communication plan](#).

Staff assessment and evacuation

In order to effectively support response efforts and achieve goals and priorities, DHHS will work to account for all employees and their current status (i.e.: I am safe and well, I am safe and well but experiencing utility disruptions or have had to evacuate my location, or I am not safe and well). The incident manager and safety officer will work to mitigate risks for DHHS responders see the [Responder safety and health plan](#) for more information. Staff notifications and evacuations, if necessary, will occur as outlined in this plan, with additional detail in the [DHHS continuity of operations (COOP)](#) plan.

A status assessment of all DHHS staff will be completed as quickly as possible. All employees should be accounted for, including those in DHHS buildings when the incident occurred, at home, or elsewhere. For those at an alternate location, UNIS notifications are the most efficient way to communicate. UNIS messages ask employees to respond to a notification with their status. If UNIS is not functioning, leadership of each division or office, is responsible for accounting for their staff. Any employees with an emergency response role must be deemed fit to respond before they are activated in these duties.

DHHS facility assessments

In addition to staff well-being, an assessment of DHHS buildings is required before they may be used for any purpose. Building structural stability, hazardous conditions, and lack of essential services, such as power and water, must all be addressed before anyone will be allowed back into the buildings. If access is delayed for an extended period, DHHS leadership will direct staff to alternate locations. If evacuation is warranted, safe and immediate evacuation will occur according to established protocols. Refer to [DHHS COOP](#) for more information.

Plan activations and ICS structure

An earthquake along the Wasatch Fault that causes disruption to normal services will immediately trigger activation of this response plan. Such an event would also require activation of the overarching [DHHS EOP](#) and [DHHS COOP](#), which detail DHHS functions and outline how those of highest priority may be resumed as quickly as possible. The DHHS emergency response leadership will be the primary personnel designated to activate the earthquake response plan in conjunction with activation of the EOP. The following DHHS leaders or designees must be notified when this DHHS earthquake plan is activated:

- Executive director and deputy director(s)
- All division directors and deputy director(s)
- DHHS OPR director and staff
- DHHS PAE director

Other internal and external partners will be notified of the earthquake plan activation, including liaisons and representatives from local health departments (LHD), tribal partners, the Utah Division of Emergency Management (DEM), and the federal Health and Human Services (HHS) Region 8 emergency response coordinator.

Establish a coordinated response

DOC activation and incident command

The department operations center (DOC) will open immediately once the plan is activated. Staff will first conduct a rapid assessment of the Cannon Building DOC to make sure it is safe and functional; if not, an alternate location will be identified and activated. Simultaneously, the DHHS Incident Command System (ICS) will activate, responding in person, virtually, or through a hybrid model. While Figure 3 outlines the core ICS structure, additional roles may be added as required. DHHS executive leadership will approve the incident manager at the time of activation. For further details, refer to the [DHHS emergency operations plan (EOP)](#).

Figure 3 DHHS response organizational chart organization
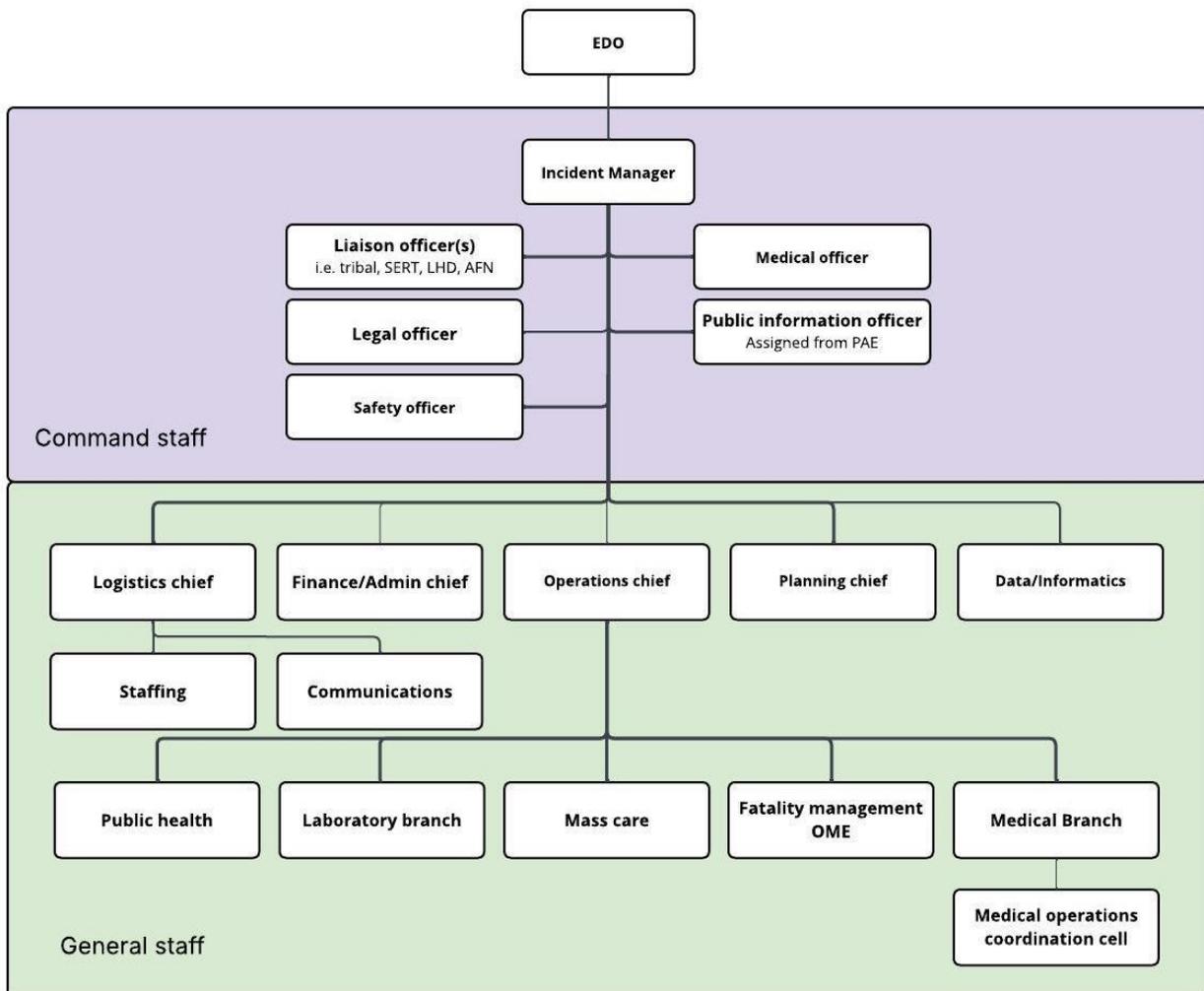
Local-led response

All disasters start and end locally. DHHS's response will be based on needs and requests from local partners, including local health departments and healthcare coalitions. If the earthquake is small enough in scale that local responders can handle it without external assistance, DHHS involvement will be limited to ensuring DHHS staff and building safety. This plan does not seek to describe or dictate how any other agency will respond or operate in the aftermath of an earthquake. References to supporting agencies are made for the purpose of better inter-organizational coordination of the many entities involved in such a response.

DEM-coordinated response

The overall response for the state will be coordinated by the Division of Emergency Management (DEM) via the state emergency operations center (SEOC), with DHHS staffing the ESF #6 and ESF #8 desks. The DHHS ICS structure will be adapted as needed to fit into the overarching response structure at the SEOC. In such a large response, the United States Federal Emergency Management Agency (FEMA) will be heavily involved to assist DEM in the overall response and recovery. In addition

to ESFs, FEMA uses "community lifelines" to assess and communicate status of services, interdependencies, and inform prioritization of response to ensure the continuous operation of critical business and government functions. See Appendix F for a chart with details about each community lifeline, including "food, water, and shelter" and "health and medical."

State elected officials/leadership
In such a large-scale incident, the Governor's Office and legislative branch will be involved in the response for the state, weighing in on key decisions, being involved in public information dissemination, and determining budget priorities. Working early to communicate ESF objectives, priorities, and efforts to gain input and approval will help reduce confusion and streamline response activities.

Federal response
HHS will send large numbers of support staff to be integrated into the DHHS ICS structure to support ESF #8 and coordinate federal resource deployment. In addition, FEMA and the United States Department of War (DOW) will deploy for other aspects of the response. Please see the "DHHS and HHS joint response" section of this plan for details to consider in the initial stages of mobilization and ICS structure implementation.

Establish communications and information sharing

Public information
Refer to the DHHS all hazards communications plan for detailed information on ensuring the public has correct, relevant and current information. Other helpful documents include the communication with vulnerable populations mission assignment, and the expanded public information support mission assignment.

Staff and response partners
It can be expected that typical communication methods may not be available immediately following an earthquake. Telephone lines, cell towers, and internet lines will be damaged, and functioning telecommunications infrastructure will be overwhelmed. Communication throughout the response will align with existing protocols. Communication will follow procedures in the DHHS tactical interoperable emergency communication plan.

Critical information sharing includes providing situational awareness for the SEOC, DHHS, and support agencies with critical incident information, including statewide hospital status and capacity, numbers of injured and deceased, resource coordination, numbers of displaced individuals, and standards of care in effect (i.e., if crisis standards of care have been implemented). Establishing information sharing with partners may include the following steps:
1. Determine viable/functioning communication equipment and pathways.
2. Re-establish communication with partners involved in the incident.
3. Establish a regular schedule for information sharing with both internal staff and

external partners.

The following flowchart depicts typical lines of communication with response partners to gain situational awareness, share information, and coordinate resources.

Response partner communication flowchart
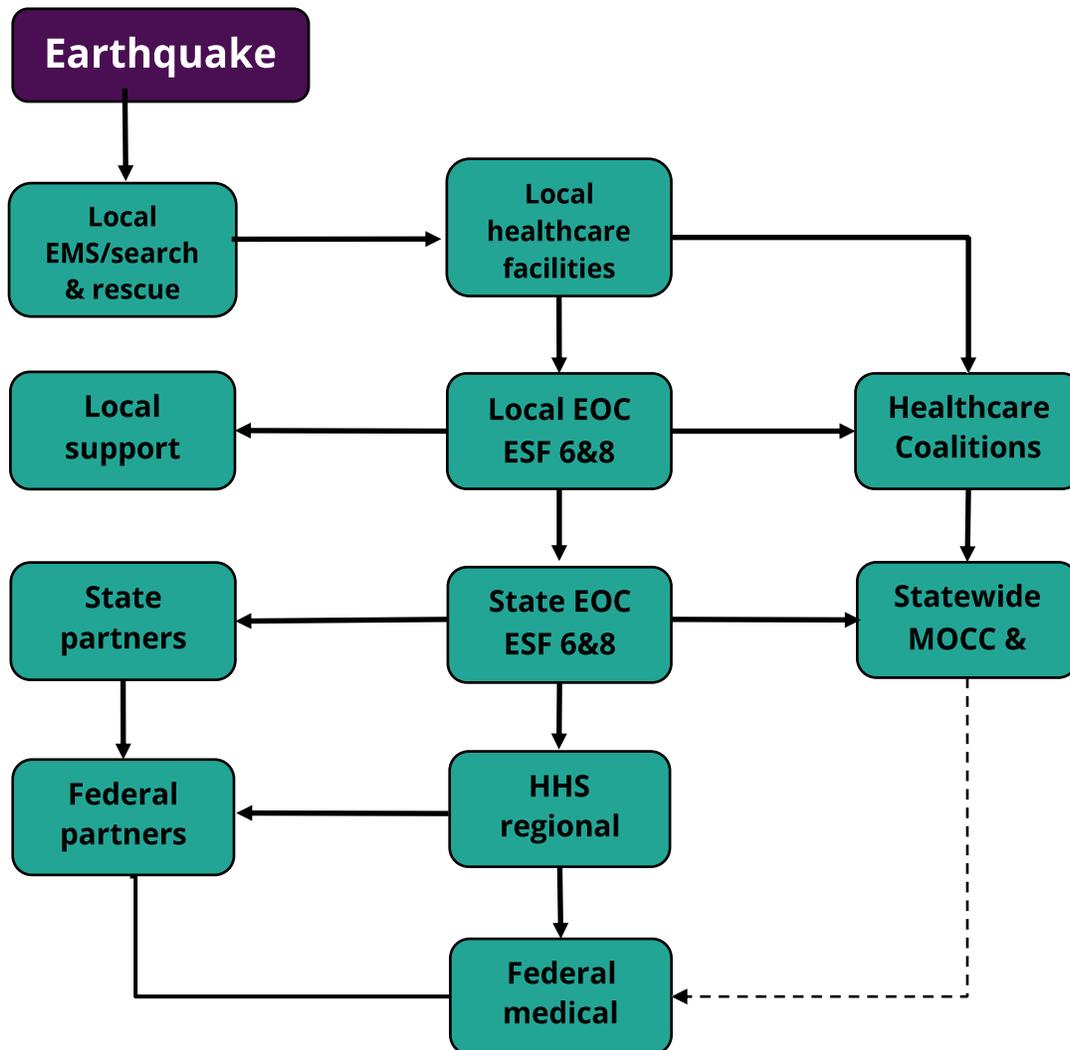
Begin life-saving support operations

Priority 1: Provide support to life-saving operations, including emergency medical services and healthcare system surge, as well as acquire and allocate critical resources.

Once communications have been established and situational awareness information is coming in, support of critical medical care should begin immediately. Tasks may include:
- Determine best estimates for numbers of injured and deceased, report to state leadership (DHHS, SEOC, Governor's office, etc.)
- Determine what DHHS assets need to be mobilized, and how (see Appendix C for asset list).
- Identify casualty collection points—communicate information to response partners and the public.
- Work with support agencies such as ESF 1–Transportation to ensure road clearing to healthcare facilities is a first priority.
- Coordinate with healthcare facilities for damage assessment reports and bed availability.
- Communicate with federal HHS regarding anticipated required federal medical assistance.
- Work with clinical subject matter experts (SMEs) to determine if crisis standards of care should be implemented.

Medical operations coordination cell (MOCC)

DHHS may establish a state MOCC to help coordinate healthcare services including casualty collection points, patient transfers (both in state and out of state), facility load-leveling, scarce resource allocation, and contingency strategies for all types of healthcare facilities to meet the goal of best possible patient outcomes after an earthquake.

MOCC representation may include:
- DHHS/LHDs
- UHA
- Healthcare systems
- EMS
- HCC

The MOCC works directly with hospital system leadership and transfer centers, and will assist with the following priority tasks within the first 24-48 hours after an earthquake, and beyond:
- Healthcare facility status (including damage and functionality assessments)
- Healthcare facility bed census (numbers of functional, staffed beds)
- Patient load leveling to facilities with available beds and appropriate level of care capabilities

An initial coordination call will be held as quickly as possible with all members of the MOCC for initial assessments and support needs. After these tasks have been established, the MOCC will assist with the following additional duties as needed:

- Resource request coordination, including field hospitals, supplies, medication, and staffing.
- Implement crisis standards of care.

For detailed information on the state MOCC, including organizational structure, process, and protocols, refer to the DHHS Medical operations coordination cell mission assignment.

State/federal joint response

Priority 1: Provide support to life-saving operations, including emergency medical services and healthcare system surge, as well as acquire and allocate critical resources.

Given the nature of the incident, the HHS Administration for Strategic Preparedness and Response (ASPR) will be involved in the response to a large-scale earthquake in Utah, when requested, to support the response in every way possible.

Staff
ASPR will be sending an immediate response team made up of Region VIII staff who are known to Utah DHHS and understand state and local capabilities and DHHS's public health and medical response plans in the initial and immediate phases of the event. Follow-on ESF #8 teams, including a larger footprint of the ASPR incident management team (IMT) will arrive in the state. The ASPR IMT's primary focus of incident management is to work closely and in conjunction with the state ESF #8 response team and assist with unmet public health and medical needs. Ultimately, the IMT will initiate appropriate planning, coordination, and delivery of resources to meet those needs. The IMT is scalable based on the incident.

The IMT is comprised of dedicated, experienced, and specially trained emergency management professionals, medical and public health planners and providers, and ASPR regional liaisons who are able to deploy on short notice to support all-hazards incident response activities or in support of pre-planned special events, as directed by the ASPR or designated representative.

Collectively, these individuals have expertise in the core NIMS-based functions (command and general staff positions), experience with specialized public health, medical planning, resource delivery, specific area knowledge, and professional relationships corresponding to the HHS region(s) where they are assigned.

As the state response structure is defined and state priorities determined, it will be vitally important to integrate IMT response staff with DHHS staff, to ensure a cohesive coordinated response. Federal ESF #8 response staff and the IMT can participate in multiple ways:
- Mission assessment and generation: In conjunction with state priorities and guidance, support development and prioritization of federal ESF #8 missions based on unmet and critical needs. Led by ASPR regional emergency coordinators (REC), the deputy rederal health coordinating official–mission generation (DFHCO-MG) and the federal health coordinating

official (FHCO).
- Mission execution: Oversees the execution of assigned missions. Leads the command and general staff and deploys specialized response teams and resources. Ensures tempo and operational planning of the federal ESF #8 response, can provide force multipliers to state DHHS response. Ensures deployed IMT staff and HHS operational teams have the necessary equipment and personnel to accomplish the mission; provides for the ongoing care, safety, sustenance, and lodging of deployed teams.
- Technical support: Provide technical expertise from across federal ESF #8 and HHS in addition to the larger federal interagency regarding policy, procedures, subject matter expertise, coordination, and decisional support.

Missions

Federal partners will work from pre-scripted mission assignments when possible, to speed the response efforts to get resources and staff moving where they need to be. However, direct assessment and analysis in partnership with the state is the best and most effective response approach. The ASPR mission generation team can expertly craft, in support of state intent, resource request forms and route the corresponding mission assignments through the emergency management system.

Space

ASPR command and control staff will be co-located with or near DHHS ICS staff. If the DHHS DOC is operational, the large conference room next to the DOC will be used.

Immediate, pre-established federal resource deployment

Upon occurrence of an earthquake in populous regions of Utah that overwhelms local and/or state capabilities, DHHS will begin immediate communications with the ASPR region 8 duty officer to assess the situation and request federal support. However, if communications are down and ASPR is unable to reach DHHS, they will assume that the state is overwhelmed and requires assistance. ASPR will deploy their regional immediate response team to the affected area. ASPR will also notify the IMT and ASPR leadership to begin pre-deployment of IMT staff and medical surge teams. Once they have arrived in Utah, the ASPR IMT will use best available situational awareness and state DHHS representation to determine where to deploy the assets initially and can adjust the placement, amount, and type of resources as more information and communication ability is acquired.

As the lead federal agency for ESF #8, ASPR can bring in ASPR internal expertise, such as medical surge teams, field medical stations/staffing, and mass fatality teams. Additionally, ASPR is supported by HHS and other federal ESF #8 support agencies and can reach out for assistance, on behalf of the state, to coordinate the federal response in these functional areas:
1. Assessment of public health and medical needs
2. Public health surveillance
3. Medical care personnel
4. Medical equipment and supplies

5. Patient movement
6. Hospital care
7. Outpatient services
8. Victim decontamination
9. Safety and security of human drugs, biologics, medical devices, veterinary drugs, etc.
10. Blood products and services
11. Food safety and security
12. Agriculture feed safety and security
13. Worker health and safety
14. All hazard consultation and technical assistance and support
15. Mental health and substance abuse care
16. Public health and medical information
17. Vector control
18. Potable water, wastewater, solid waste disposal, and other environmental health issues
19. Victim identification and mortuary services
20. Veterinary services
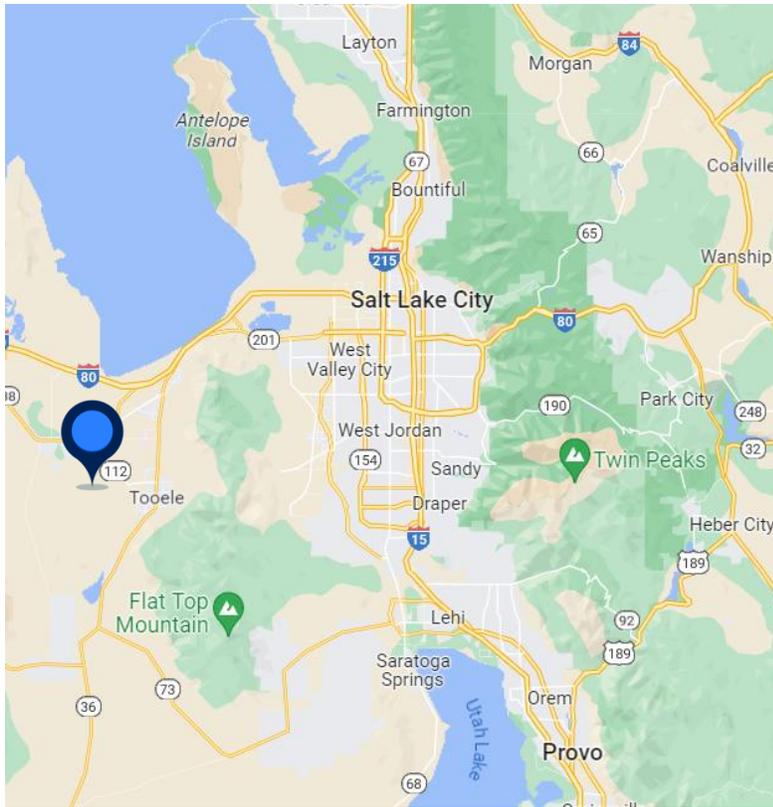21. Medical materiel, personnel, and technical assistance

It is anticipated that following a large-scale earthquake, HHS would immediately deploy as many as 6 federal medical stations. This resource has the capability to care for up to 250 patients, and includes medical equipment, pharmaceuticals, beds, cots, nursing stations, and personal protective equipment (PPE). This resource requires an indoor space of 15,000 to 40,000 square feet with wraparound services such as plumbing, electricity, restrooms, security, and climate control.

The preferred site for federal resource deployments is Utah MotorSports Campus, shown on the map in Figure 4. If this site is unavailable or unusable, a different site may be chosen from the additional potential sites listed and mapped in Appendix D. It is likely that resource staging and joint HHS/DHHS ESF #8 command and control would occur at one dedicated location. It is critical that a rapid site assessment be conducted prior to arrival of federal resources, to assess the impact of the earthquake and determine whether the site meets resource requirements. Rapid assessment reports should address building safety, access, and availability of water, power, and other wrap-around services.

Federal medical station example.
Figure 4: Primary federal resource deployment location

Table 1: Primary federal resource deployment location.

Type	Name	Location	Details/notes
Primary deployment site	Utah MotorSports Campus contact: 435-277-8000	512 Sheep Ln, Erda, UT 84074	• Open bay garages, massive parking lots gated/secured • On site fuel • Multi landing helipad area • Climate controlled garages • RV/trailer power hookups • Commercial kitchens throughout campus • Jumbotrons/banners/PA system and signage for entire location • Secured entry sites • Shower/restrooms located throughout • Proximity to Tooele airport and Walmart distribution center • Conference center for DOCs • 1 bridge from SLC to campus • 500 acres for staging • Close proximity to I-80

Concept of operations: the ongoing response

Life-saving operations

Priority 1: Provide support to life-saving operations, including emergency medical services and healthcare system surge, acquiring and allocating critical resources.

DHHS, with the assistance of the established state MOCC, will continue to support life-saving operations in the days and weeks following the earthquake, by supporting:
- Pre-hospital care, including the support of emergency medical services, casualty collection points, and patient evacuation/movement.
- Healthcare system surge, including support of facility assessments, requesting Emergency Management Assistance Compact (EMAC) or federal resources, patient movement, and providing guidance on implementing crisis standards of care.
- Medical logistics operations, including inbound state and federal ESF #8 assets, and health facility supply of critical equipment.

Appendix B and Appendix C provide in-state medical personnel, resources, vehicles, and healthcare facilities that will be used in life-saving operations.

Documents that may aid in the completion of these tasks include:
- Alternate care site mission assignment
- Medical supply acquisition mission assignment
- Supplemental hospital staffing mission assignment

Life-sustaining operations

Priority 2: Provide support to life-sustaining operations, including mass sheltering services, chronic medical care, public health, behavioral health, and environmental health services.

Once life-saving efforts are stabilized, focus shifts to life-sustaining services. DHHS will coordinate with internal and external partners to aid in the provision of these services.

Mass care
Provide support and services to those affected by the incident. Coordinate all mass care functions with the American Red Cross Utah Chapter and utilize partnerships with the Utah Voluntary Organizations Active in Disaster (VOAD).
- **Support mass sheltering operations**
  - Determine sheltering requirements
  - Coordinate with the American Red Cross to identify and maintain situational awareness of local jurisdiction-managed shelters and spontaneous shelters

- ○ Support local jurisdictions to establish and run medical needs shelters
- ○ Coordinate resources for shelter wraparound services, including potable water, restrooms, electricity, feeding, etc.
- ○ Monitor shelter residents to make sure health needs are addressed
- **Support mass feeding operations**
  - ○ Determine feeding requirements
  - ○ Coordinate with VOAD groups to establish and run feeding operations
- **Coordinate bulk distribution of disaster items**
  - ○ Coordinate distribution of donations and relief items
  - ○ Identify allocation and distribution strategies and locations
- **Coordinate mass evacuation and reunification**
  - ○ Coordinate with DEM, ESF 1 (transportation), and VOAD for evacuation of citizens/travelers and reunification of families
- **Assist in human services**
  - ○ Coordinate with individual assistance (ESF #8) to assist disaster victims seeking crisis counseling

Routine and chronic care

Support routine and chronic medical care for the general population, in shelters, for homebound individuals, and other settings, as necessary. Refer to the special considerations section of DHHS EOP for more guidance. The process includes:

- Establishing regular touch-base calls with representatives in the routine and chronic care field. Include home care services to understand issues, needs, and support that can be given.
- Working with the American Red Cross to determine issues, needs, and support to provide in shelters.
- Requesting and utilizing emPOWER data and working with local health departments to understand and how best to support individuals' needs and provide necessary care.

Behavioral health services

Support behavioral health services, including psychological first aid in shelters, clinics, and for responders. The process includes:

- Coordinate with the DHHS Office of Substance Use and Mental Health professionals to identify and meet the disaster crisis response needs.
- Ensure response workforce psychological safety and advocate for mental health resourcing—see the DHHS EOP personnel management and safety section.

Environmental health services

Support public and environmental health services, including: potable water, sanitation, disease control, and public risk communications. The process includes:

- Establish regular touch-base coordination with local health department environmental health directors to understand needs and issues in the public and in shelters.

- DHHS epidemiology teams will have a lead responsibility for disease control efforts in shelters and in the general public. The DHHS Infectious disease response plan and Informatics support mission assignment will aid in this response.

Special considerations

At-risk populations

Individuals with access and functional needs may have additional needs that must be considered in response and recovery after a disaster. These access and functional needs can be grouped into five categories referred to as C-MIST:

1. **C**ommunication—limited english proficiency, sign language, braille or aids needed to communicate, limited ability to hear announcements, see signs, or verbalize concerns.
2. **M**aintaining health—may require medications, supplies, services, equipment, infant/child care, or specific nutrition.
3. **I**ndependence—access to necessary mobility devices, assistive technology, vision and communication aids, and service animals.
4. **S**upport—caregiver assistance, memory or understanding, adaptation to new environments, trauma or abuse.
5. **T**ransportation—access to transportation, inability or restrictions to drive.

During a large-scale earthquake, DHHS will request access to identifiable information on Medicaid individuals who access durable medical equipment, such as oxygen or motorized wheelchairs through the emPOWER program. This information can greatly help first responders reach individuals who may need to evacuate or be considered for additional resources due to their medical needs.

The American Disability Act Best Practices Tool Kit for State and Local Governments includes the ADA and emergency shelters: Access for all in emergencies and disasters which may provide additional resources for supporting individuals with functional needs in a disaster.

Mass fatality operations

Priority 3: Provide support to mass fatality operations, including remains recovery, identification, and family assistance.

The deceased from an earthquake will be handled per state practice, and under the authority of the DHHS Office of the Medical Examiner.

- The medical examiner will define criteria for deaths to be recorded as a result of the earthquake. These deaths will not need medical examiner direct involvement, and may be handled locally.
- If there is any question as to the exact cause and manner of death for any victim, and/or if the victim does not fit the criteria provided for the earthquake incident, the medical examiner or designee will need to be engaged.

See the DHHS Mass fatality plan for detailed information.

Multi-agency coordination

Emergency Management Assistance Compact (EMAC)

During a governor-declared state of emergency, EMAC allows other states to send personnel, equipment, and commodities to help disaster relief efforts in the affected state. Through EMAC, states can also transfer services, such as shipping newborn blood tests from a disaster-impacted laboratory to a laboratory in another state. DHHS will coordinate with the SEOC for any resource requests that require the use of EMAC.

Figure 5: The EMAC process

| Pre-Event Preparation	Activation	Request and Offer	Mobilization, Response & Demobilization	Reimbursement
1. State emergency management works with resource providers to: • Develop internal procedures for implementing EMAC; • Identify deployable resources; • Validate and create cost estimates; and • Deliver training on deployment and reimbursement procedures.	2. A governor declares a state of emergency. 3. The Requesting State creates an event in the EMAC Operations System (EOS).	4. The Requesting State requests resources via EOS. 5. The Assisting State identifies deployable resource(s), estimates costs, and broadcasts an offer in EOS. 6. The Requesting State accepts or declines the offer.	7. Assisting State resources deploy from their home state and report to the location identified by the Requesting State. 8. Assisting State resources perform and complete mission and return home.	9. The Assisting State submits a reimbursement package to the Requesting State. 10. The Requesting State reimburses the Assisting State for all costs incurred during the deployment.

Local, state, tribal, and federal collaboration

All of the response functions fulfilled by DHHS can best be done with the support and coordination of partners. Local organizations and agencies within the impacted jurisdiction have the initial and primary responsibility in the response, including triage, sheltering, and casualty distribution. When local and/or tribal capacity is overwhelmed, the state ESF #8 team will provide as much assistance, coordination, and resources as possible. If assistance is required beyond the state and/or tribal level, the HHS regional emergency coordinator (REC) or a designee will provide regional/federal response assistance. The following steps outline the potential flow of activations and requests for a large-scale incident (including large-scale earthquake resulting in mass

casualties), in accordance with state laws governing response:

1. Local search and rescue efforts begin and local EMS responds to provide patient triage and distribution per existing protocols and typical "hub and spoke" procedures. Local receiving facilities notify LHDs and healthcare coalitions to assist with coordination and resource sharing as needed.
2. If local and/or tribal response agencies are overwhelmed, state assistance is requested from DHHS, directly or via the state EOC, and a state MOCC is activated to support in-state patient distribution and resource coordination.
3. If out-of-state assistance for patient care, trauma, specialty care bed availability, and/or resources is required, federal assistance will be activated. The state MOCC will work with federal and state partners for situational awareness, existing telemedicine programs, and appropriate patient transfer agencies to help facilitate appropriate transfer to regional patient beds for definitive care.

Figure 6: Escalation of an incident from local to state to federal response
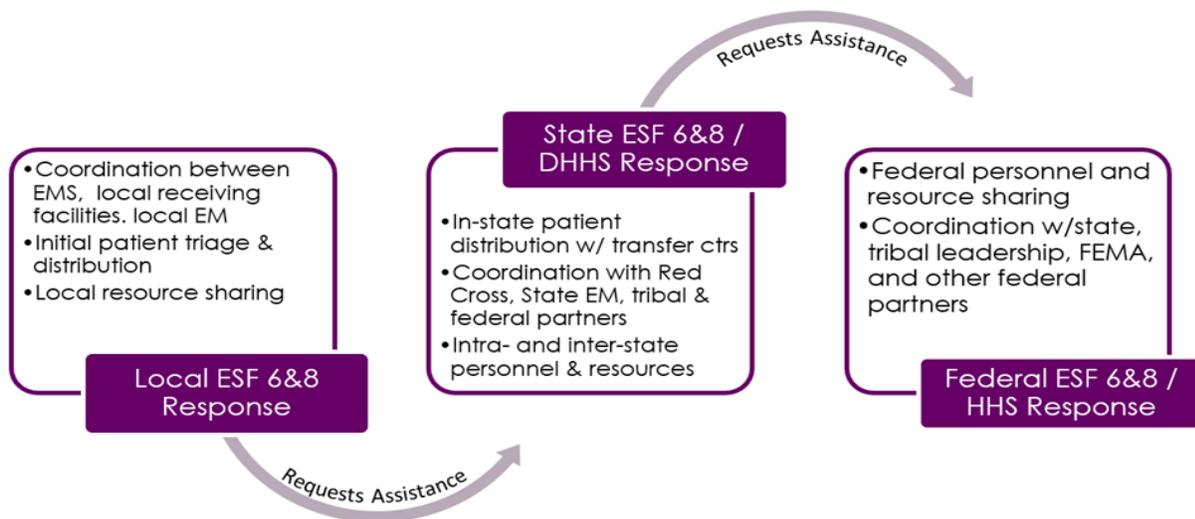
Response roles

Table 3: Local, state, and federal public health and medical response roles (suggested)

Partner	Response roles
EMS	• Triage/prioritize patients for movement to appropriate treatment locations via established mass casualty incident (MCI) protocols and medical control. • Rescue, transport, and distribute casualties to appropriate local facilities in accordance with established protocols.
Local health department	• Conduct a rapid health surveillance to identify injury patterns, disease outbreaks, and environmental health threats. • Monitor shelters, healthcare facilities, and impacted communities for communicable diseases, gastrointestinal illness, respiratory illness. • Support mortality surveillance and fatality management coordination. • Assess and address risks related to drinking water system, wastewater and sewage, food safety, solid waste, and debris. • Conduct health and safety inspections for emergency shelters and temporary food service operations. • Provide guidance on boil water advisories, safe cleanup, hazardous materials and debris handling. • Support behavioral health and psychological support of responders and the general public.
Healthcare coalition	• Request/mobilize any local coalition/regional caches of medical supplies. • Activate coalition coordination mechanisms and earthquake/disaster plans. • Coordinate with trauma experts, medical control, or the state MOCC to determine appropriate destinations for patients who cannot be accommodated in the local healthcare system. • Exchange information with state health & medical partners.

Hospitals	• Provide patient care.
	• Activate facility and regional surge capacity plans to accommodate the high volume of patients.
	• Coordinate with the state MOCC for real-time bed census, resources, and patient movement.
	Secondary roles:
	  • Assist with patient triage and movement.
	  • Tertiary facilities support care for trauma and pediatric patients via telephone or telemedicine and/or request support from the state MOCC.

DHHS	ESF #8 • Support local jurisdiction(s) with state-level coordination and requests for public health and medical assistance (e.g., state and federal declarations). • Activate medical operations cell coordination (MOCC) to maximize use of hospitals in the state for patient care. • Assure that patient triage, tracking, and transport needs are addressed. • Initiate EMAC requests for inter-state support for transportation, staff, or other logistics.

	● Make requests via HHS for federal medical assistance, including damage assessment teams, medical care teams, medical tents, equipment and supplies as needed.
	● Coordinate with DEM and HHS to determine staging locations for federal assets.
	● Provide situational awareness to all appropriate agencies.
	● Coordinate with DPS BEMS for ESF #8 EMS response efforts.
	● Conduct rapid health surveillance to identify injury patterns, disease outbreaks, environmental health threats.
	● Shelter and general public monitoring for disease spread.
	● Fatality management support.
	● Provide health guidance to the public and healthcare facilities.
	Secondary roles:
	    ● Liaison between local, state, and federal resources.
	    ● Serve as the primary point of contact for HHS.
	    ● In collaboration with state and regional partners, establish when the medical crisis has concluded, and federal/out-of-state healthcare resources are no longer needed.

DHHS, American Red Cross	ESF #6
	● Support local mass care operations (shelter, feeding operations, bulk distribution of emergency items, wraparound services).
	● Emergency assistance (family reunification, evacuation, sheltering, household pets and service animals, coordination of donated goods, voluntary agencies).
	● Housing services (rental assistance, repair, loan assistance, identification).
	● Human services (recovery of non-housing losses, food stamps, crisis counseling, disaster unemployment, disaster legal services, benefits).
	Secondary roles:
	    ● Support to ESF #8
	    ● Support to medical shelters

State MOCC	● Optimize patient distribution and healthcare capacity in coordination with transfer centers, particularly for trauma or other specialty care patients, and help determine appropriate patient destinations and transfers. ● Liaison with state and federal partners to help with out-of-state patient evacuation. ● Assist with the tracking of patient movement including arrival to destination facilities for in-state and out-of-state transfers. ● Facilitate exchange of patient transfer information between referring and receiving facilities once patients are matched to destinations. ● Coordinate resource and supply needs between healthcare systems. ● Maintain real-time situational awareness, including facility assessment reports, functionality, and bed availability at statewide hospitals.
Division of Emergency Management	Lead: ESF #5, #7, and #15. ● Coordinate overall activities of the state government for incident management and logistic support. ● Run the state emergency operations center with representation from all activated emergency support functions.

	● Ensure a coordinated response through combined efforts of local, state, federal, and private sector organizations. ● Provide centralized management of resource support requirements in support of state, tribal, and local governments.
UtahDepartment of Environmental Quality	ESF #10. ● Supports the state fire marshall with coordination and/or provision of support in response to actual or potential release of hazardous material. Secondary roles: ● Support ESF #6 and #8 to provide clean drinking water in mass shelters and field medical operations. ● Support for ESF #8 for biological and chemical analysis. ● Support for ESF #8 in waste collection.
Utah National Guard	ESF #16. ● Provision of military support. Secondary roles: ● Assist with ESF #8 transportation needs and road clearing. ● Provide of basic casualty care and medical assistance.
Federal Health and Human Services (HHS)	● Provide federal support to local and state activities as requested and authorized under the National Response Framework including supplies, staff, and transportation assistance through the federal health coordinating officer (FHCO) appointed to Utah for the incident. ● Coordinate approved use of deployable medical teams and assets, including National Disaster Medical System (NDMS) personnel and resources.

Deactivation and recovery

As the incident is stabilized, the DHHS ICS will continually assess, in coordination with local, state, regional, and federal partners—specifically those operating under ESF #6 (Mass Care, Emergency Assistance, Temporary Housing, and Human Services) and ESF #8 (Public Health and Medical Services)—when health, medical, and mass care response resources should be demobilized.

Triggers for demobilization include:

● **Decreased patient volume:** Medical surge requirements under ESF #8 have subsided.
● **Facility restoration:** Hospital functionality is at or near normal levels.
● **Risk reduction:** Behavioral and environmental health concerns have reduced significantly.
● **Infrastructure stability:** Mass care requirements under ESF #6 have transitioned to long-term solutions, and critical infrastructure can support essential activity.

The incident command structure will reduce and eventually fully deactivate; however, this may be a very long, ongoing process.

DHHS will support local recovery of public health, behavioral health, and healthcare services (primary

functions of ESF #8), as well as the transition of human services (under ESF #6), as determined by the needs and priorities of the community. Recovery coordination is separate but may operate concurrent to the disaster response.

DHHS will initiate an after-action review process with employees to solicit and compile analysis feedback regarding the effectiveness of ESF #6 and ESF #8 implementation. Identified gaps and areas of strength will be noted in the after-action report (AAR) and shared internally, with abbreviated or relevant information shared with pertinent external agencies and partners. Changes to plans and procedures, including this planning document and relevant ESF annexes, will be based on these identified gaps.

Plan maintenance

In collaboration with response personnel and partners, OPR takes the lead in maintaining this plan.
1. OPR will train response personnel and partners on this plan.
2. The plan will be evaluated using the Homeland Security Exercise and Evaluation Program guidelines and includes after-action reporting and improvement planning following real-world responses, drills, and exercises. The associated corrective actions, lessons learned, and best practices will be integrated as appropriate.
3. Plan revision will occur every 3 years, or more frequently to incorporate exercises or real-world event findings.
4. Plan revisions will undergo review and approval according to OPR policy.
5. Plan revision can be accomplished through email, virtual, or in-person meetings. Plan revision will include a new plan with an effective start date.

Change log

Document version	Location of change	Description	Changes made by
May 2025	Entire document	Edit of plan to more closely align with standardized response plan format	Mindy Colling

Appendix A: Acronyms

AAR   After action report
ASPR   Administration for Strategic Preparedness and Response
BEMS   Bureau of Emergency Medical Services
CAH   Critical access hospital
CMIST   Communication, Maintaining health, Independence, Support and Transportation
COOP   Continuity of operations plan
DEM   Division of Emergency Management
DFHCO-MG   Deputy federal health coordinating official–mission generation
DHHS   Utah Department of Health and Human Services
DOC   Department operations center
DOW   Department of War
ECU   Environmental containment unit
EDO   Executive Director's Office
EMAC   Emergency Management Assistance Compact
EMS   Emergency Medical Services
EOC   Emergency operations center
EOP   Emergency operations plan
ESF   Emergency support function
FEMA   Federal Emergency Management Agency
FHCO   Federal health coordinating officer
FMS   Federal medical station
HCC   Healthcare coalition
HHS   U. S. Department of Health and Human Services
ICS   Incident Command System
IMT   Incident Management Team
LHD   Local health department
MCI   Mass casualty incident
MOCC   Medical operations coordination cell
MRC   Medical Reserve Corps
NDMS   National Disaster Medical System
OAS   Office of Administrative Services
OME   Office of the Medical Examiner
OPR   Office of Preparedness and Response
PAE   Office of Public Affairs and Education
PPE   Personal protective equipment
REC   Regional emergency coordinator
SEOC   State emergency operations center

SERT	State emergency response seam
SNS/RSS	Strategic national stockpile/receipt, staging, and storing
UHA	Utah Hospital Association
UHERT	Utah Health Emergency Response team
UNIS	Utah Notification & Information System
UTNG	Utah National Guard
VOAD	Voluntary Organizations Active in Disaster
WebEOC	Web-based emergency coordination and resource fulfillment system

Appendix B: Utah medical teams and vehicles

The total numbers of equipment and personnel listed in the tables below may fluctuate over time. Numbers provided here are best estimates at the time of plan development and serve only as general guides for planning purposes.

Table 5: In-state medical response teams

Resource	Total #	Operated by	Description
Medical Reserve Corps (MRC)	~2550	Volunteer resource managed by local health departments	Volunteer medical and non medical professionals who are identified, credentialed, trained and prepared to help during a surge event. Note: These are local resources.
Utah Health Emergency Response Team (UHERT)	30-75	Utah Department of Health and Human Services	Self-sustaining, temporary, rapid response resource providing medical care in fixed or temporary sites. Medical personnel distributed regionally, with ability to quickly mobilize and treat hundreds of patients anywhere in the state. Support trailer contains supplies to sustain staff through the first 72 hours and beyond.
Utah National Guard medical unit	(Based on availability)	Utah National Guard	Utah National Guard medical unit * 3-4 dentists, 4-5 physicians, 3-4 physicians assistants * Ground transportation vehicles and road clearing equipment

Table 6: In-state medical response vehicles

Resource	Total #	Owned by	Description
Medical surge trailers	8	Utah Department of Health and Human Services	Designed to assist/augment basic emergency medical patient surges needed to respond to a mass casualty including hemorrhage control, airways, bandaging, splinting, and respiratory incidents. Medications or IV's are **not** included.
Ground ambulances	454	Gold Cross Ambulance Cities Counties Hospitals and other agencies	Medically equipped vehicle for providing first response care and transporting patients to hospitals/definitive care.
Air ambulances	30-50	University of Utah Hospital (AirMed) Intermountain Health (Life Flight) Classic Air Other agencies	There are 10 licensed air-ambulance providers in the state of Utah. They provide 24/7 air transport for trauma, burns, medical, pediatric, neonate, high-risk, OB, respiratory and cardiac assist device patients
Paratransit	(based on availability)	UTA Local transport Long-term care facilities	Buses, shuttles to move ambulatory patients

Appendix C: DHHS resources

DHHS preparedness resource catalog

The resources and assets currently held by the Utah Department of Health and Human Services are stored at the department's warehouse or in trailers prepositioned across the state. Any need for a state resource should be first requested through a local health department or regional healthcare coalition coordinator including pre-planned events, pre-Stafford Act emergencies, and during a declared emergency.

A list of current resources can be found here: DHHS Preparedness Resource Catalog.

Mass fatality supplies

Deployable assets owned by the Utah Department of Health and Human Services that may be used in mass fatality operations. **Note:** the total numbers of equipment and supplies listed in the tables below may fluctuate over time. Numbers provided here are best estimates at the time of plan development and serve only as general guides for planning purposes.

Table 7: DHHS-owned mass fatality resources

Resource	#	Location(s)	Description
Portable refrigerated morgue	1	Weber County Sheriff yard	53' insulated semi-trailer—self-contained refrigeration unit. Includes 14 (4) tray heavy duty rolling cadaver racks, 56 cadaver trays with cam straps, rear motion-controlled LED area and ramp lighting, power cable for interior lighting, crates, and straps.
Environmental containment units (ECUs)	30	Distributed to hospitals and coalitions across the state	Regionally pre-positioned equipment to protect sensitive healthcare environments/airborne contaminants/patient isolation. Includes HEPA filtering for one 2500 sq ft room, negative pressure HEPA corridors.
Environmental containment unit 2 system (ECU2)	3	Salt Lake City (DHHS Warehouse)	2 each large OA200V collapsible, portable units for corridors, allowing multiple ECU2 units to be combined. 3 each small MF100 collapsible, portable units for single room entry/exit anterooms.
BioSeal Mass Fatality Response Systems	6	Tooele, Weber, Washington counties	One re-closable container on pallet with tools needed to ensure absolute containment of whole or partial human/animal remains. Packaging for 1,500 adult bodies. Requires forklift and truck to move.
BioSeal portable systems	12	Salt Lake,Utah, Cache, Uintah, Sevier, andGrand counties	Case with power and tools for absolute containment of 12 adult bodies. Easily transportable.
Mass fatality recovery kits	4	Salt Lake City (DHHS Warehouse)	Supplies needed for mass fatality response supported by DHHS Office of the Medical Examiner.
Mass fatality trailer	1	Salt Lake City (DHHS Warehouse)	Towable trailer for deployable field site response; rakes, shovels, buckets, backboards, mega movers, safety glasses, work gloves, zip ties, tags and notepads.
PPE (personal protective equipment)	(based on availability)	Salt Lake City (DHHS Warehouse)	N95 and surgical masks, gloves, isolation gowns, face shields, protective coveralls
Support items cache	(based on availability)	Salt Lake City (DHHS Warehouse)	Generators, field toilets and sinks, cots, litters, blankets, radios, lighting, body bags, heaters, fans

Appendix D: Possible deployment locations

The following map and table show possible locations for federal medical station (FMS) deployments, joint HHS/DHHS ESF #8 operations, and other federal ESF #8 resource staging sites. Because FMS requires large open floor buildings, the locations indicated on the map with a "building" icon may be suitable for this resource, and/or for joint response operations. Other locations marked on the map, such as airports and large parking lots, may be of use in receiving and staging any additional large assets deployed by federal or regional partners. Hospitals are also noted on the map.

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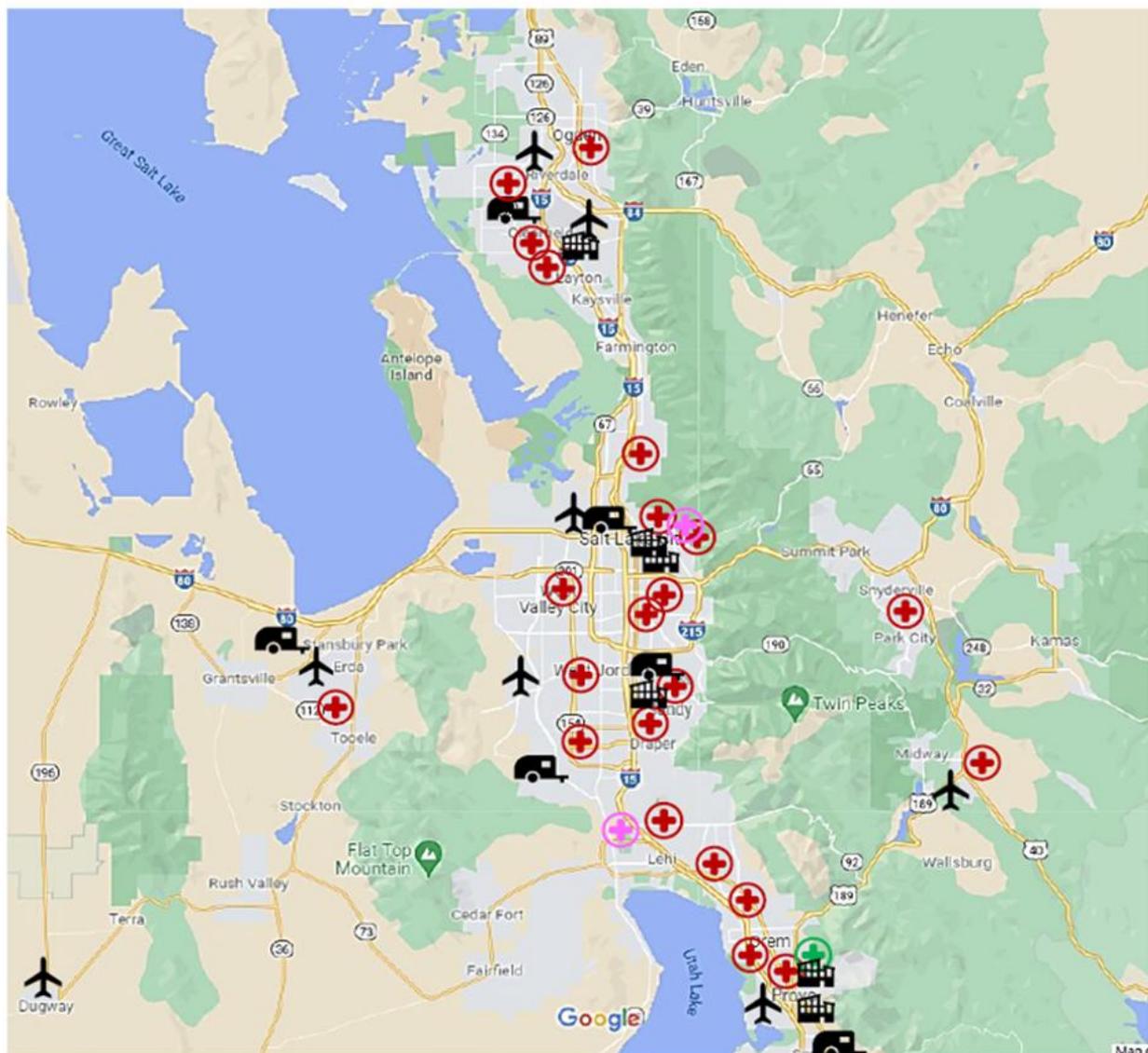
Table 8 : Possible federal resource deployment locations

| Type of space	Name and contact	Address	Description
Large outdoor parking lots—*may be suitable for tented operations*	Utah State Fairgrounds Contact: 801-538-8400	155 1000 W, Salt Lake City, UT 84116	Fenced, some buildings, lots of open space both dirt and paved, state-owned
	Real Soccer Stadium Contact: 844-732-5849	9256 S State St, Sandy, UT 84070	Large outdoor area with restrooms/plumbing, outdoor lighting
	Real Salt Lake Training Arena Contact: 385-434-3118	14787 Academy Pkwy, Herriman, UT 84096	Outdoor soccer stadium and school
	Freeport Center Contact: 801-825-9741	C-5, B St, Clearfield, UT 84016	Large manufacturing/distributing warehouses and parking lots
	Davis Convention Center Contact: 801-416-8888	1651 N 700 W, Layton, UT 84041	Large indoor conference area with several large rooms that can be partitioned or joined
Large open floor buildings—*may be suitable for indoor operations, such as FMS*	Salt Palace Convention Center Contact: (801) 565-4433	100 S W Temple St, Salt Lake City, UT 84101	Large indoor conference venue downtown
	Delta Center Arena Contact: 801-325-2000	301 S Temple, Salt Lake City, UT 84101	Large indoor basketball/concert venue
	Mountain America Expo Center Contact: (801) 565-4433	9575 State St, Sandy, UT 84070	Large, indoor exposition floor—can be partitioned. Also contracted for SNS/RSS operations.
	BYU Marriott Center Contact: 801-422-2981	Brigham Young University, E University Pkwy and, Campus Dr, Provo, UT 84604	Indoor college basketball arena
	Provo Convention Center Contact: General Manager (801) 370-3508	220 W Center St, Provo, UT 84601	Conference rooms, large and small
Airports—*may be suitable for winged mobile assets staging, patient evacuation*	Ogden-Hinckley Airport Contact: 801-629-8251	3909 Airport Rd, Ogden, UT 84405	Public, commercial service airport
	Hill Air Force Base Contact: (801)777-5201	7981 Georgia St, Hill AFB, UT 84056	Large, urban, military-owned
	Salt Lake City International Airport Contact: (801)575-2400	W Terminal Dr, Salt Lake City, UT 84122	Large, newly re-done airport near liquefaction zone
	South Valley Regional (Airport #2) Contact: (801) 556-4082	7365 South 4450 West, West Jordan, UT 84084	Small suburban airport adjacent to a military training field
	Provo Airport Contact: (801)852-6715	1331 Sky Way, Provo, UT 84601	Small suburban airport
	Dugway Army Airfield Contact: (435)831-5322	Dugway	Remote, military-owned, near proving grounds
	Heber Valley Airport Contact: (800)388-4445	630 S Airport Rd, Heber City, UT 84032	Private planes and jets

	Bolinder Field-Tooele Valley Airport Contact: (801)575-2400	4663 N Airport Rd, Erda, UT 84074	One primary runway

Hospitals May be suitable for tented operations (in parking lots) or for personnel and equipment		
Hospital name and contact	**Address**	**Trauma level**
Intermountain Medical Center Contact: 801-507-7000	5121 Cottonwood St, Murray, UT 84107	Trauma level I
Primary Children's Medical Center - SLC Campus Contact: 801-662-1000	100 Mario Capecchi Dr, Salt Lake City, UT 84113	Trauma level I
University of Utah Hospital Contact: 801-581-2745	50 Medical Dr N, Salt Lake City, UT 84132	Trauma level I
Primary Children's Medical Center - Lehi Campus	2250 North Miller Campus Drive,Lehi UT 84043	Trauma level II
McKay-Dee Hospital Center	4401 Harrison Blvd, Ogden, UT 84403	Trauma level II
Ogden Regional Medical Center	5475 S 500 E, Ogden, UT 84405	Trauma level II
St. George Regional Medical Center	1380 E Medical Center Dr, St. George, UT 84790	Trauma level II
St. Mark's Hospital	1200 E 3900 S, Millcreek, UT 84124	Trauma level II
Utah Valley Regional Medical Center	1034 N 500 W, Provo, UT 84604	Trauma level II
Holy Cross Hospital - Davis	1600 W Antelope Dr, Layton, UT 84041	Trauma level III
Holy Cross Hospital -Jordan Valley	3580 W 9000 S, West Jordan, UT 84088	Trauma level III
Holy Cross Hospital - Mountain Point Lehi	3000 Triumph Blvd, Lehi, UT 84043	Trauma level III
Holy Cross Hospital - West Valley	3460 S 4155 W #3460, West Valley City, UT 84120	Trauma level III
Lakeview Hospital	630 Medical Dr, Bountiful, UT 84010	Trauma level III
Layton Hospital	201 W Layton Pkwy, Layton, UT 84041	Trauma level III
Logan Regional Hospital	1400 N 500 E, Logan, UT 84341	Trauma level III
Timpanogos Regional Hospital	750 W 800 N, Orem 84057	Trauma level III
Alta View Hospital	9660 S 1300 E, Sandy, UT 84094	Trauma level IV
American Fork Hospital	170 N 1100 E, American Fork, UT 84003	Trauma level IV
Ashley Regional Medical Center	150 W 100 N, Vernal, UT 84078	Trauma level IV
Bear River Valley Hospital	905 N 1000 W, Tremonton, UT 84337	Trauma level IV
Brigham City Community Hospital	950 Medical Dr, Brigham City, UT 84302	Trauma level IV
Cache Valley Specialty Hospital	2380 N 400 E, North Logan, UT 84341	Trauma level IV
Castle View Hospital	300 Hospital Dr, Price, UT 84501	Trauma level IV
Cedar City Hospital	1303 N Main St, Cedar City, UT 84721	Trauma level IV
Central Valley Medical Center	48 W 1500 N, Nephi, UT 84648	Trauma level IV
Delta Community Hospital	126 White Sage Ave, Delta, UT 84624	Trauma level IV
Fillmore Hospital	674 UT-99, Fillmore, UT 84631	Trauma level IV

Garfield Memorial Hospital	200 N 400 E St, Panguitch, UT 84579	Trauma level IV
Heber Valley Hospital	454 East Medical Way, Heber City, UT 84032	Trauma level IV
LDS Hospital	8th Avenue, C St E, Salt Lake City, UT 84143	Trauma level IV
Mt. View Hospital	1000 E 100 N, Payson, UT 84651	Trauma level IV
Mt. West Medical Center	2055 N Main St, Tooele, UT 84074	Trauma level IV
Park City Hospital	900 Round Valley Dr, Park City, UT 84060	Trauma level IV
Riverton Hospital	3741 W 12600 S, Riverton, UT 84065	Trauma level IV
Sanpete Valley Hospital	1100 S Medical Dr, Mt Pleasant, UT 84647	Trauma level IV
Sevier Valley Hospital	1000 N. Main St, Richfield, UT 84701	Trauma level IV
Spanish Fork Hospital	765 E Market Place Dr, Spanish Fork, UT 84660	Trauma level IV

Appendix E: Trauma hospitals

Figure 9: Utah's hospitals by trauma designation and region.
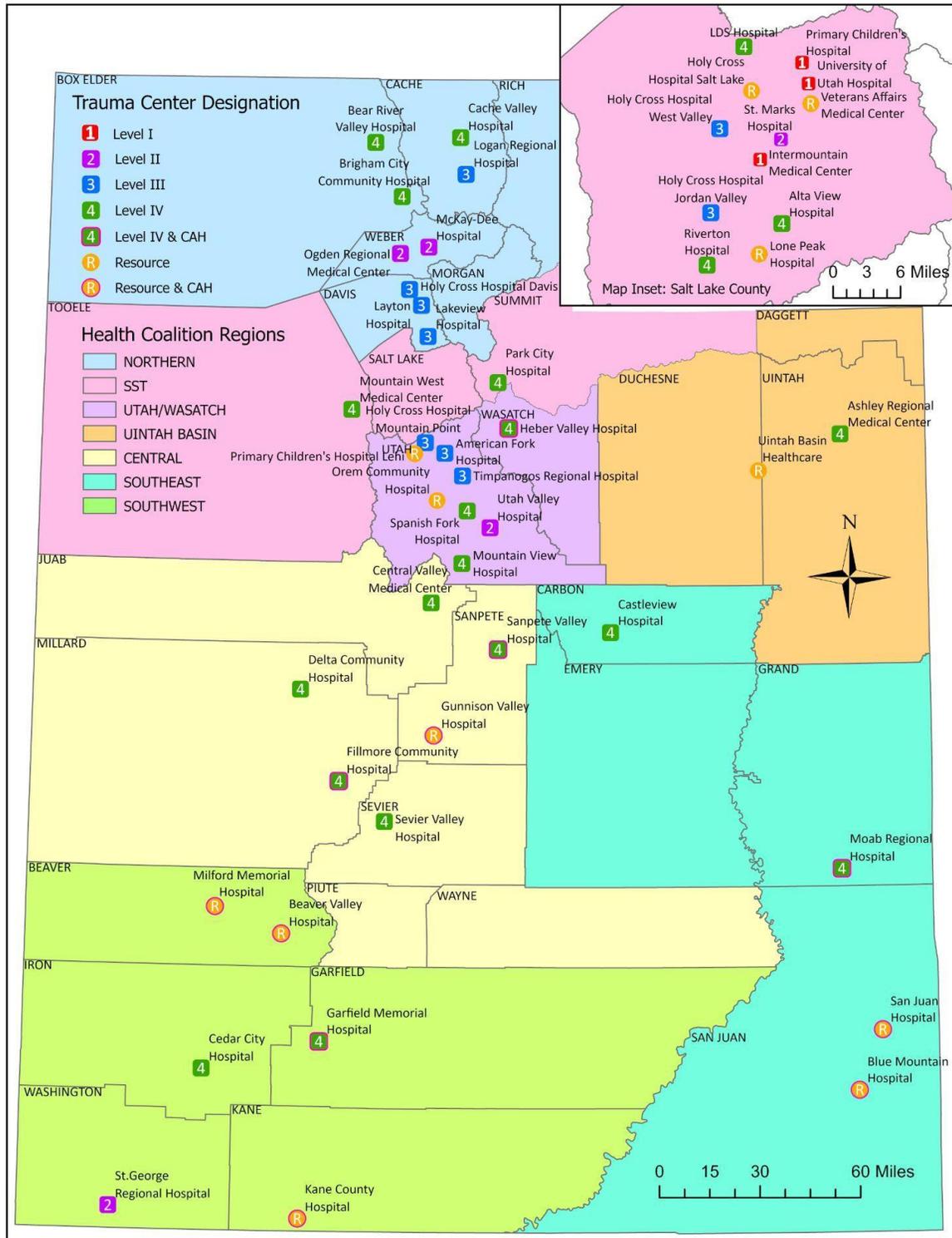
Appendix F: FEMA community lifelines

Figure 10: FEMA's Community lifelines concept