SHELTER MEDICAL GROUP REPORT: EVACUATION, CARE, AND SHELTERING OF THE MEDICALLY FRAGILE

CONTENTS

Table of Contents The Shelter Medical Report contains the following topics:

I. EXECUTIVE SUMMARY AND RECOMMENDATIONS

EXECUTIVE SUMMARY

The Medically Fragile

The first priority before, during and after a disaster is the health, safety and welfare of all people in the area affected by the event. The most vulnerable are people who cannot care for themselves because of pre-existing health conditions. These *medically fragile* individuals are dependent upon the existence of a controlled environment that includes the ongoing medical care by family members or medical professionals. The needs of this medically fragile population must be ensured in a disaster.

The Winter Storms of 1997

The Winter Storms of 1997 resulted in severe flooding throughout the State and the evacuation of over 150,000 people from their communities. This evacuation represented the single largest sustained movement of disaster victims in California and included the virtual abandonment of two entire rural counties. More than half of those evacuated sought emergency housing in local shelters.

Approximately one thousand of those evacuated consisted of medically fragile individuals from nursing homes, board and care facilities and home health care settings. Although these individuals required ongoing medical care and treatment, shelters were neither equipped nor staffed to provide this level of care. As shelter populations grew, available medical resources became overwhelmed, placing the medically fragile at risk.

Issues Identified

Out of this event came a surprising number of realizations regarding the variety and needs of the medically fragile community in a disaster. The issues presented by this disaster were both numerous and wide-ranging. Resolution of these issues clearly required the collective efforts of state

EXECUTIVE SUMMARY (Continued)

and local government and community-based organizations. Some of the issues identified include:

- Evacuation decision-making.
- Identifying appropriate destinations.
- Providing adequate and appropriate transportation.
- Ensuring medical support staff accompaniment.
- Ensuring availability of medical records, pharmaceuticals, medical equipment, supplies, bedding and environmental controls.
- Providing for dietary needs.
- Identifying continuing sources of financial coverage.
- Returning evacuees to the correct and appropriate facilities after the disaster.

Shelter Medical Group

In order to develop policy and guidance to address the needs of the medically fragile after an evacuation, the Shelter Medical Group (SMG) was formed. The SMG is an approved specialist committee serving as part of the Standardized Emergency Management System (SEMS) Technical Group. The committee is co-chaired by the Governor's Office of Emergency Services and the Emergency Medical Services Authority and consists of several state agencies (please see page 48 for complete listing) and the American Red Cross.

The mission of the SMG is to make recommendations to the Director of the State Office of Emergency Services that are consistent with statutorily required components of the California State Emergency Plan.

The SMG focused on three main areas:

1. Development of policy guidance for the evacuation and care of people who are medically fragile.
2. Development of strategies to ensure adequate staffing for medical treatment units/temporary infirmaries during an evacuation.

EXECUTIVE SUMMARY (Continued)

3. Identification of logistical requirements of the medically fragile.

This report recommends actions, which, if implemented, will improve state and local government and private sector preparedness and the ability to respond to the needs of the medically fragile during a disaster. The recommendations have been developed for statewide distribution to the health care community, state and local government, and the legislature.

Report Organization

The report is organized in accordance with the four phases of emergency management and includes recommendations that address (1) planning and preparedness, (2) response, (3) recovery, and (4) mitigation.

Recurring throughout the report are the following major themes:

1) the need for improved local private/public sector coordination,
2) the need to strengthen disaster plans,
3) the need to integrate the medically fragile into all levels of planning, and
4) the need to plan for self-sufficiency.

The report also provides guidance documents to assist local government and facility emergency planners in the development of effective evacuation and sheltering plans to ensure the ongoing health and safety of the medically fragile following a disaster.

Development of Plans

The information provided to the Shelter Medical Group by the various stakeholders prompted the development of specific recommendations to ensure that disaster plans are in place to address these needs of the medically fragile.

EXECUTIVE SUMMARY (Continued)

These plans should consider individuals who reside in medical and residential care facilities as well as individuals who live independently in the community. Additionally, counties should ensure the coordination of disaster plans at both the community and regional levels.

The following recommendations reflect the findings of the Shelter Medical Group. In addition, the Group has also included (in parentheses) those entities/organizations that have responsibility for implementation.

I. EXECUTIVE SUMMARY AND RECOMMENDATIONS

RECOMMENDATIONS

Planning and Preparedness

Regulatory Requirements for Disaster Planning

1. Develop legislation to require uniform language and emergency preparedness requirements for all medical and other residential care facilities. (DHS, DSS)

2. Develop and maintain a process and fee structure for the joint state/local review of disaster plans to ensure conformity with local emergency operations plans by all medical and residential care facilities. (Local Government, DHS, DSS)

3. Require all plans to include specific elements, as identified, such as plan development, coordination, roles and responsibilities, emergency equipment placement and operation, food, water, supplies, notification, transportation, patient tracking and record-keeping. (DHS, DSS)

Standardized Emergency Management System (SEMS)

4. Strengthen disaster planning coordination among public and private sector medical and residential care providers and community-based organizations. (OES, DHS, DSS)

Training and Exercises

5. Include disaster training and exercises in all staff training plans to enhance emergency response skills. (Care Providers)

6. Conduct regular disaster exercises in coordination with government agencies. (Care Providers)

RECOMMENDATIONS (Continued)

Response

Legal Authorities for Evacuation

7. The Incident Commander must work with the local health officer, EMS agency and affected facilities to determine if a decision to shelter in place is appropriate or to ensure that a mandatory evacuation order is carried out. (Incident Commander)

Decision to Evacuate vs. Sheltering in Place

8. Provide an evacuation and sheltering guidance document for medical and residential care providers. (See Appendix F)

Directing Medical Evacuees to Appropriate Destinations

9. Identify and establish a triage system and protocols. (Local Government, Care Providers)

10. Encourage coordination between the local government and community based organizations to develop a voluntary registration program. (OES)

11. Integrate the needs of the medically fragile into the emergency planning process. (Local Government, DHS, DSS, Care Providers)

12. Assess each patient's/resident's level of care requirements and designate the appropriate shelter type based on the level of medical services to be provided. (Care Providers)

13. Plan for the establishment of medical treatment units or temporary infirmaries. (Local Government)

RECOMMENDATIONS (Continued)

Transportation and Logistics Considerations

14. Identify the number and location of medically fragile persons located in the community that will require evacuation transportation. (Local Government, Care Providers)

15. Identify facilities that remain capable of sheltering the medically fragile following a disaster. (Local Government, Law Enforcement, DSS, DHS, OSHPD)

16. Survey and document the number and type of transportation assets available within their jurisdiction. (Local Government, Care Providers)

17. Establish agreements with private and commercial vendors to ensure the availability of identified transportation resources when needed to evacuate medically fragile individuals. (Local Government, Care Providers)

18. Develop plans and procedures that expedite the coordination and acquisition of transportation resources. (Local Government, Care Providers)

Support of Medical Evacuees: Staff, Records and Supplies

19. Determine medical treatment unit/temporary infirmary staffing needs and ensure ongoing 24-hour coverage. (Local Government)

20. Identify medical and pharmaceutical supplies necessary to supply medical treatment units/temporary infirmaries and develop agreements with potential vendors for supply and resupply. (Local Government)

RECOMMENDATIONS (Continued)

21. Develop an individual emergency evacuation document to assist facility staff in meeting each patient's medical care needs with little or no interruption. (Care Providers)

Recovery

Returning Evacuees

22. Develop plans to return medically fragile evacuees to appropriate care. (Care Providers, Local Government)

Reimbursement Process

23. Seek self-sufficiency through development of cost recovery plans with private insurers in lieu of relying on governmental reimbursement. (Care Providers)

24. Coordinate meetings with all levels of government, non-governmental organizations, and private entities to discuss and clarify cost recovery issues. (OES)

25. Keep clear, detailed documentation of all transactions or costs incurred as a result of efforts to provide services and/or resources to meet the needs of the affected population. (Care Providers, Public & Private Responders)

26. Develop a partnership with insurance companies to provide training and guidance to medical and residential care facilities in the development of response and recovery plans. (Local Government, Care Providers)

RECOMMENDATIONS (Continued)

Mitigation

Risk Factors for Medical and Residential Care Facilities

27. Identify potential technological and natural hazards that may affect medical and residential care facilities and develop specific plans to mitigate or minimize the risk posed by these hazards to the greatest extent possible. (Local Government, Care Providers)

II. INTRODUCTION

Purpose

The Shelter Medical Group was convened to establish policies and procedures to meet the medical needs of people who must move during disaster from their residence or care facilities to alternative locations.

Scope

This organization conducted all business and communications under the title of the Shelter Medical Group. This organization had the authority to perform its purpose as an approved specialist committee serving as part of the Standardized Emergency Management System's (SEMS) Technical Group. The Shelter Medical Group may continue to meet at the discretion of the SEMS Technical Group.

Intended Audience

The Shelter Medical Group developed this report for statewide distribution to the health care community, state and local government, and the legislature. The report is intended for use as a guide to improve current evacuation and sheltering practices and to reduce future adverse impacts on public health and safety during emergency evacuations of the medically fragile.

III. BACKGROUND

Historical Needs

During the Winter Storm flooding of 1997, over 150,000 Californians were evacuated from their communities, and more than half of these evacuees sought alternate housing in shelters. This was the single largest sustained movement of disaster victims in California and included the virtual abandonment of two entire rural counties.

Approximately one thousand of those evacuated were patients or residents from nursing homes, board and care facilities and home health care settings. These medically fragile individuals, in addition to their emergency sheltering needs, required a higher level of medical care than was available in general population shelters. As the shelters grew in population over the course of the emergency, so did the need for additional medical support.

The limited transportation, medical treatment, and sheltering capability for the medically fragile presented major challenges to government and other human service organizations in their efforts to accomplish a successful evacuation and sheltering operation.

Lessons Learned

State and local government was surprised at the variety and scope of issues related to the medically fragile. These issues included:

- Evacuation decision-making.
- Identifying appropriate destinations.
- Providing adequate and appropriate transportation.
- Ensuring medical support staff accompaniment.
- Ensuring availability of medical records, pharmaceuticals, medical equipment and supplies, appropriate bedding and environmental controls.
- Providing for dietary needs.
- Identifying continuing sources of financial coverage.
- Returning evacuees to the correct and appropriate facilities after the disaster.

III. BACKGROUND (Continued)

Shelter Medical Group

The Governor's Office of Emergency Services and the Emergency Medical Services Authority, in conjunction with other State Departments (please see page 48 for complete listing), formed the Shelter Medical Group in the wake of the 1997 Winter Storms and one of the largest evacuations in California history. This working body reports to the Standardized Emergency Management System Technical Group.

Mission

The Group's Charter was specific:

To establish policies and procedures to meet the medical needs of people who must move during disasters from their residence or care facilities to alternative locations. These recommendations will be presented to the SEMS Technical Group.

Because of the potential threat presented by the 1998 El Niño weather pattern, the Group guided the development of interim policy letters and informational bulletins that related to the evacuation of the medically fragile. These documents were designed to provide guidance to facilities and local emergency management agencies to enhance or modify their planning efforts and response programs. (See Appendix A - Interim Policy Letters and Informational Bulletins.)

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

Background

After considering the challenges presented by both the size and scope of the evacuation and sheltering issues, the Group decided to address each issue as it relates to the four recognized phases of emergency management:

1. Planning and preparedness
2. Response
3. Recovery
4. Mitigation

These issues were then sorted into related topics as they applied to the four phases.

Contents

The recommendations for each emergency management phase are found in the following sections:

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

PLANNING AND PREPAREDNESS

Contents

The recommendations for the planning and preparedness phase of emergency management are organized under the following topics:

Organization

Each of the topics listed above contain the following information:

1. Background
2. Implications
3. Recommendations

PLANNING AND PREPAREDNESS

Regulatory Requirements for Disaster Planning

Background

Statute (Health and Safety Code, § 1336.3) and the California Code of Regulations, Title 22, require each facility licensed by the Department of Health Services, Licensing and Certification Program, to adopt a written emergency preparedness plan and have the plan available to this state department by request. Title 22 Regulations also require Community Care facilities licensed by the California Department of Social Services (DSS) to have a written disaster and mass casualty plan and training for staff.

Although acute and most long-term care facilities are required to adopt a written emergency preparedness plan that is available for review by DHS, such plans do not require approval by the department. The regulations define both an "External Disaster and Mass Casualty" and a "Fire and Internal Disasters" plan which vary for each type of facility. Similarities in these plans include notification of personnel; patient transfer, relocation and discharge procedures; medical record and identification procedures for patients and casualties; location of equipment; and requirements for drills. The external plans must be reviewed and updated annually by the facility, with drills every six months. The internal disaster plans require quarterly drills.

Community Care facilities are required to have written disaster and mass casualty plans that are subject to review by DSS. These plans include general requirements for evacuation, exiting, transportation, relocation and requirement for drills. Disaster drills are to be conducted every six months. Administrators must be trained and certified by the Department as a condition of licensure.

Implications

While most facilities are required to have an emergency plan, the extent and detail of written plans varies widely by type of facility. Some facilities are only required to have an emergency plan, others are required to have separate plans

Regulatory Requirements for Disaster Planning (Continued)

for internal and external disasters. There are no consistent standards or general guidelines for emergency plans. Many plans are sadly lacking in the procedures required to implement them, which can result in inadequate coordination and confusion on all levels.

Even though the plans are subject to review by licensing agencies, this is done very sporadically. There is also no training or criteria for review of the plans by the evaluators. Although long-term health facility emergency plans are to be reviewed by the local disaster authorities for consistency with local emergency plans, there is no such requirement for acute-care or community care facilities. The local review is also done sporadically and there is no funding provided for this task.

Detailed plans, procedures, and knowledgeable staff decrease the potential for injury for the medically fragile if they must be moved quickly to other locations. Adequate planning and local coordination will help to ensure the safe evacuation and care of patients and residents during a disaster.

Recommendations

1. Develop legislation to require uniform language and emergency preparedness requirements for all medical and other residential care facilities. (DHS, DSS)

2. Develop and maintain a process and fee structure for the joint state/local review of disaster plans to ensure conformity with local emergency operations plans by all medical and residential care facilities. (Local Government, DHS, DSS)

This process should incorporate a coordinated review by county emergency management agencies, including fire and

Regulatory Requirements for Disaster Planning (Continued)

law enforcement, local Health Officer, local EMS agency, American Red Cross, and state agencies such as the Departments of Aging, Health Services, Social Services, the EMS Authority and other appropriate agencies. Appropriate funding should be provided to these agencies to carry out these duties.

3. Require all plans to include specific elements, as identified, such as plan development, coordination, roles and responsibilities, emergency equipment placement and operation, food, water, supplies, notification, transportation, patient tracking and record-keeping. (DHS, DSS)

All facility emergency plans should include the following elements:

- Consistency with the Standardized Emergency Management System (SEMS).
- Developed with input from the facility medical staff, administration, fire, safety, and other appropriate experts.
- The plan shall be reviewed at least annually and revised as necessary to ensure that the plan is current. All personnel shall be instructed in the requirements of the plan. There shall be evidence in the personnel files, or the orientation checklist, indicating that all new employees have been oriented to the plan and procedures at the beginning of their employment.
- Review and approval by the local disaster authority.
- The facility shall participate in all local and state disaster drills and test exercises when asked to do so by the local or state disaster or licensing agencies.

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

PLANNING AND PREPAREDNESS

Regulatory Requirements for Disaster Planning (Continued)

- A disaster drill shall be held by the facility at six-month intervals. There shall be a written report of the facility's participation in each drill or test exercise. Staff from all shifts shall participate in drills or test exercises.

- Threat/risk assessment.

- Disaster-specific procedures for events such as fires, floods, earthquakes, hazardous-materials spills, or other hazards likely to impact the facility.

- An emergency management structure that is consistent with the Incident Command System (ICS), such as the Hospital Emergency Incident Command System (HEICS).

- Evacuation procedures.

- Pre-determined relocation sites which are equipped to provide safe, temporary accommodation for patients/residents.

- Procedures for recalling off-duty personnel and assignment of personnel to specific tasks and responsibilities, either at the facility or to provide continuing care for patients/residents at alternate sites.

- Procedures for the conversion of all usable space into areas for patient observation or immediate care of emergency admissions.

- Information concerning the location of fire alarm boxes, fire extinguishers, fire-fighting equipment, utility shut off valves, and other emergency equipment.

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

PLANNING AND PREPAREDNESS

Regulatory Requirements for Disaster Planning
(Continued)

- Availability of basic supplies, including water, food, and essential medical and supportive materials capable of supporting patients and staff for at least 72 hours.

- Procedures for notifying emergency response agencies such as the fire department, law enforcement agency, local disaster authority, State regulatory agency, and other appropriate persons, including a list of names and telephone numbers.

- Procedures to transport patients/residents, including:

  --Identification of primary and alternate transportation resources.

  --Type of vehicles to be used.

  --Medical equipment and staff essential for movement of patients or residents.

- Procedures to track the location of evacuated patients/residents.

- Procedures to assure that all pertinent personal and medical information accompanies each patient/resident who is moved, transferred, discharged, or evacuated.

PLANNING AND PREPAREDNESS

The Standardized Emergency Management System (SEMS)

Background

The Standardized Emergency Management System (SEMS) is based upon the Incident Command System (ICS) adapted from the system originally developed by the Firefighting Resources of California Organized for Potential Emergencies (FIRESCOPE) program including those currently in use by state agencies. This system is also based on the Multi-Agency Coordination System (MACS) as developed by FIRESCOPE program, the operational area concept, and the Master Mutual Aid Agreement and related mutual aid systems. (See Appendix B - SEMS Organizational Levels and Functions.)

SEMS is intended to standardize response to emergencies involving multiple jurisdictions or multiple agencies. SEMS is intended to be flexible and adaptable to the needs of all emergency responders in California. SEMS requires that emergency response agencies use basic principles and components of emergency management including ICS, multi-agency or inter-agency coordination, the operational area concept, and established mutual aid systems. State agencies must use SEMS. Local government, including special districts, in California must use SEMS in order to be eligible for state funding of response-related personnel costs pursuant to activities identified in California Code of Regulations, Title 19, §2920, §2925, and §2930. Individual agency roles and responsibilities contained in existing laws or the state emergency plan are not superceded by these regulations.

Implications

There are no legal requirements for private sector organizations to use the SEMS structure in California. In addition, private organizations are unaware of the mutual aid regions used by government. These barriers add to the frustration of coordination between government authorities

The Standardized Emergency Management System (SEMS) (Continued)

and private medical resources and organizations. Some medical facilities are required to use SEMS during disaster response because they are operated under the authority of a county and/or city, and in some cases as a special district. Though some of the hospitals use an adapted form of the Incident Command System (part of the SEMS structural elements for field response) there are few connections statewide between the day-to-day operations of medical support for the medically fragile and government emergency management.

Recommendation

4. Strengthen disaster-planning coordination among public and private sector medical and residential healthcare providers and community based organizations. (OES, DHS, DSS)

The SEMS Maintenance System should work diligently to encourage stronger emergency management ties among local and state government, private sector medical and residential care operations, and community-based organizations.

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

PLANNING AND PREPAREDNESS

Training and Exercises

Background

To date, few comprehensive guidelines, standards or national criteria exist that establish minimum training requirements for emergency sheltering of the medically fragile. General disaster preparedness guidelines are available for both the public and private sector, but stop short of addressing the specific actions or procedures necessary to protect vulnerable populations during an emergency.

Implications

Inadequate training and exercises compromise public health and safety in many ways. Emergency responders are likely to make mistakes in one or more of the following ways:

- Poor decision making during fast-moving situations
- Inefficient use of resources
- Conflicts with community health facilities and organizations
- Non-existent, incorrect or incomplete communication
- Poor tracking and care of patients in transit and at shelters
- Poor facility recovery when it is time to restore normal services

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Recommendations

Training and exercising are the foundations of emergency management preparedness programs. When practiced regularly, a good training and exercise program helps to familiarize staff with disaster response plans and procedures, increases overall staff effectiveness during critical emergencies, mitigates death and injury, and limits the impact of the disaster on the community. (See Appendix C – Training Health Care Providers).

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

PLANNING AND PREPAREDNESS

Training and Exercises (Continued)

5. Include disaster training and exercises in all staff training plans to enhance emergency response skills. (Care Providers)

Ensuring that staff are trained to respond during disasters is a responsibility of management. However, if staff is to learn how to function effectively during a disaster, classroom training alone is not enough. Drills and exercises, when utilized in conjunction with classroom instruction, provide staff with challenging opportunities to practice what they have learned, enhance skills and thus optimize their performance during an emergency. Therefore, management is encouraged to adopt a regular, standardized approach to training staff that includes classroom training, drills and exercises and performance evaluation.

6. Conduct regular disaster exercises in coordination with government agencies. (Care Providers)

To ensure proper coordination of government services and resources, however, it is essential that plans are practiced and exercised as frequently as possible in conjunction with government agencies.

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

RESPONSE

Contents

The recommendations for the response phase of emergency management are organized under the following topics:

Organization

Each of the topics listed above contain the following information:

1. Background
2. Implications
3. Recommendations

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

RESPONSE

Legal Authorities for Evacuation

Background

It is the responsibility of county and/or city law enforcement agencies to implement evacuation orders when mandated by local officials. During the Storms of 1997, one acute care hospital refused to follow the local county order to evacuate the area. Even though the hospital was not subsequently flooded, this raised the issue of who had the ultimate authority to force evacuations.

Implications

There are several statutory sections that provide authority to force evacuation. (See Appendix D - Authority to Force Evacuation of Health and Community Care Facilities.) However, law enforcement agencies rarely, if ever, forcibly remove individuals from an evacuation area. In reality, the ultimate decision to evacuate medical and residential care facilities lies with the facility management. These decisions are usually made in response to a crisis and on fairly short notice. Guidelines suggested for local government in planning for and implementing an evacuation are provided in Appendix E - Government Level Evacuation Checklist.

If facility management chooses to ignore a mandatory evacuation order, the responsibility and liability for the safety of their residents remains with them. They are in violation of law and are ultimately responsible for any adverse outcomes their residents might experience. While the process of evacuation may subject patients to additional risk and cause economic disruption to a facility, the failure to evacuate may also present potentially grievous consequences.

Recommendation

7. The Incident Commander must work with the local health officer, EMS agency and affected facilities to determine if a decision to shelter in place is appropriate or to ensure that a mandatory evacuation order is carried out. (Incident Commander)

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

RESPONSE

Decision to Evacuate versus Sheltering in Place

Background

Every organization is potentially threatened by a variety of hazards, both known and unknown. These hazards should be identified in the organization's disaster plan along with appropriate response strategies, including evacuation procedures. For medical and residential care facilities, planning how, when and where to evacuate their patients/residents is an essential responsibility.

Implications

The problems encountered during the 1997 evacuations could have been avoided, or at least minimized, had there existed a primary, single-source document available to guide medical and residential care providers in planning for evacuation of their facilities. Although some level of disaster or emergency planning may have occurred, these plans did not necessarily include realistic evacuation procedures, resulting in critical delays in decision making.

Recommendation

8. Provide an evacuation and sheltering guidance document for medical and residential care providers. (see appendix F)

The Group prepared a guidance document to assist medical and residential care providers in planning for evacuations until other documents could be developed. This is provided in Appendix F - Risk Assessment and Evacuation Strategies.

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

RESPONSE

Directing Medical Evacuees to Appropriate Destinations

Background

During the Winter Storms of 1997, patients/residents evacuated from facilities and home care settings went to general population shelters. (With the exception of the county mental health facility, the option of evacuating to like facilities was rarely utilized.) At first, the evacuees were accompanied by facility staff to ensure continued medical care. However, as shelter populations grew, these shelters became overwhelmed and were unable to keep up with the demand for medical staff and resources.

During emergencies, general public shelters are the most prevalent. These shelters are only able to meet basic human needs and offer sleeping quarters, meals, sanitary facilities and basic first aid for minor injuries or illnesses. Access to these shelters is limited to persons who are basically healthy with no acute health care needs. These shelters will generally accept individuals who have brought their essential medications, supplies and/or equipment, and, if necessary, a caregiver to assist with their individual needs. Public Health, Red Cross, or community nurses are frequently available to provide medical triage and arrange for transfer to appropriate facilities for those whose needs exceed the level of care available in general or public shelters.

Implications

Managed care in California has resulted in an increasing number of patients being released early from hospitals to be treated at home by family members or by home health nursing services. Such patients may be ambulatory, bed-bound, confined to a wheelchair, require special medications or procedures (i.e., ventilators, oxygen, I-V, etc.), or have a chronic debilitating illness that inhibits their ability to perform one or more critical life functions. Although such medical conditions may not justify hospitalization in an acute care

RESPONSE

Directing Medical Evacuees to Appropriate Destinations (Continued)

facility, their care requirements exceed the basic first aid provided in general population shelters.

If specific measures are not taken to include the integration of medical care (between basic and acute care needs) in either the general public shelter as a temporary infirmary or as a separate medical treatment unit, future evacuations will not be able to provide for the continued, appropriate level of care required by the medically fragile.

Recommendations

9. Identify and establish a triage system and protocols. (Local Government, Care Providers)

The triage concept can help prevent the sheltering of the medically fragile in inappropriate facilities, better utilize scarce resources, and provide sheltering organizations with a better sense of what they can expect.

Each county should develop a triage system, including designated teams and protocols, to help determine whether people will be best suited for placement in a general public shelter, a medical treatment unit/temporary infirmary or a hospital. Counties are encouraged to obtain input from representatives from local agencies including emergency management, emergency medical services, American Red Cross chapter, the medical society and hospital association, home health and other services providers, and the County Health Officer.

During an evacuation, triage teams should be located at designated intake sites. When people begin to arrive, the team(s) would make an assessment, based on established criteria, and either refer them to the general public shelter, medical treatment unit/temporary infirmary, or arrange to transport them to a designated hospital.

Directing Medical Evacuees to Appropriate Destinations (Continued)

The triage team could also work with the county's registry for medically fragile persons. Cases could then be reviewed and a determination made as to where these individuals would best be served in a sheltering situation.

10. Encourage coordination between the local government and community based organizations to develop a voluntary registration program. (OES)

Article 5, Section 8589.6 of the California Emergency Services Act, encourages local government agencies or community based organizations to provide for the voluntary registration of residents within their jurisdiction who would need assistance.

In conjunction with government services providers and community-based organizations, local emergency management should coordinate the voluntary registration of people who will need assistance. In the event of a disaster or emergency requiring evacuation and/or sheltering of individuals, it is extremely beneficial to local authorities if they can quickly identify the medically fragile individuals in the community. These individuals will be specifically targeted for special outreach and educational efforts to encourage voluntary registration. The confidential nature of the medical treatment registry should be emphasized.

The form provided in Appendix G - Voluntary Registration Request for Medically Fragile Individuals will document the specific medical information pertinent to each evacuee and should be assembled into a county-wide database coded geographically. This information will assist local authorities in determining appropriate transportation and sheltering destinations. Also, the form pre-authorizes response agencies to enter an individual's home during post-disaster search and rescue activities. The Medically Fragile Registration program is voluntary and all registration documents are confidential.

RESPONSE

Directing Medical Evacuees to Appropriate Destinations (Continued)

11. Integrate the needs of the medically fragile into the emergency planning process. (Local Government, DHS, DSS, Care Providers)

Because floods and other natural and technological disasters will continue to threaten the displacement of large numbers of people from their homes and/or care facilities, it is essential that the medically fragile be appropriately integrated into the planning process. Evacuation plans should take into consideration the level of care required for each patient, the appropriate facility destination, and the method of transportation required.

Although the basic concern is the provision of medical care, the solution lies in the long term planning and involvement of the State, local government, county health and welfare departments, medical and health care organizations, emergency response planners, community organizations, the American Red Cross and others.

12. Assess each patient's/resident's level of care requirements and designate the appropriate shelter type based on the level of medical services to be provided. (Care Providers)

The medically fragile population encompasses a broad range of medical and behavioral conditions. Some evacuees may be eligible for discharge from a facility to their family, or to a general population shelter, while others will require a medical treatment unit/temporary infirmary. Still, there are some patients with extensive or critical medical conditions where only the services provided at a *like* facility or acute care hospital would be most appropriate.

The appropriateness of patient/resident placement should be based on the level of medical care required for each individual. Such levels are determined by the type and

Directing Medical Evacuees to Appropriate Destinations (Continued)

scope of medical aid required to maintain the individual's health or to accomplish day-to-day living requirements. Medical and residential care providers should, as part of their disaster planning efforts, seek to identify their patient/resident in accordance with these guidelines, determine the type of transportation required to a pre-determined type of alternate housing/sheltering destination. (See Appendix H - Patient/Resident Emergency Evacuation Destination Categories).

Once it has been decided to evacuate patients/residents from an unsafe area, emergency planners must then determine where to evacuate. The destination selected must be appropriate for the level of care required for each patient/resident. This could include, in priority order, one of the following:

- a *like* facility away from the threatened area
- a stand-alone medical treatment unit
- a general population shelter with a temporary infirmary
- a general population shelter

13. Plan for the establishment of medical treatment units or temporary infirmaries. (Local Government)

In conjunction with shelter providers (i.e., American Red Cross, Salvation Army, etc.), local government must plan for the establishment of independent medical treatment units or temporary infirmaries as a part of general public shelters. Both of these *ad hoc* facilities are designed to care for medically fragile individuals requiring a level of care beyond that available in public shelters. These medical treatment units or temporary infirmaries must be staffed and managed by local health authorities, staff from evacuating facilities, or other medical care personnel. Please refer to Appendix I–

RESPONSE

Directing Medical Evacuees to Appropriate Destinations (Continued)

Shelter Medical Operations Guidelines. See Appendix J for sample agreements between the American Red Cross and local health and mental health departments. (Appendix K - Adopt-a-Shelter Program also contains innovative ideas for developing shelters).

RESPONSE

Transportation and Logistics Considerations

Background

When an emergency occurs and an evacuation is ordered, most of the general population is able to transport themselves to safety. However, the mass movement of the medically fragile population will require the planning and coordination of local government and the medical/health community.

Implications

The medically fragile are dependent upon their care givers to plan for, manage, and provide appropriate transportation in an evacuation. This is true whether they are patients residing in a medical or residential care facility, or are receiving nursing care via services provided by a home health agency. The responsibility for crisis transportation planning rests mainly with local government. Without a disaster transportation plan for the medically fragile, these individuals may face tremendous risks during major disasters.

Recommendations

14. Identify the number and location of medically fragile located in the community that will require evacuation transportation. (Local Government, Care Providers)

Local officials should work with the medical/health community to identify the number and location of the medically fragile that could potentially require evacuation. When identifying potential populations, planners should also focus on geographic locations that may harbor potential hazards (i.e., flood plain, near rivers or streams, etc.).

Medical and residential care facilities should evaluate each patient/resident to assess their transportation needs should evacuation become necessary. Each individual should be designated as either ambulatory or non-ambulatory. Ideally, this kind of information would be documented on a special

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

Transportation and Logistics Considerations (Continued)

patient assessment record (see Appendix L - Health Passport) designed for emergency evacuation purposes. Also, the record should include medical treatments, equipment, appliances and/or medications that impact transportation needs. The patient's/resident's record should include transportation recommendations and should be available to management immediately upon the order to evacuate.

15. Identify facilities that remain capable of sheltering the medically fragile following a disaster. (Local Government, Law Enforcement, DSS, DHS, OSHPD)

16. Survey and document the number and type of transportation assets available within their jurisdiction. (Local Government, Care Providers)

Government planners and facility managers should identify and plan for those patients/residents that can be transported by bus, van or other vehicle, reserving the limited supply of ambulances for evacuating acutely ill/injured patients.

The listing of transportation assets should include the name of each company's authorized contact person(s), telephone numbers (regular and emergency numbers), the type of vehicles available (bus, van truck, etc.), the total number of each vehicle by type, passenger capacity and whether or not they are equipped with a lift for wheel chairs.

17. Establish agreements with private and commercial vendors to ensure the availability of identified transportation resources when needed to evacuate medically fragile individuals. (Local Government, Care Providers)

When transportation assets have been identified, it may be necessary to establish an agreement with each provider outlining potential needs, authorized agents, emergency contact numbers, method of payment and/or reimbursement, documentation, etc.

RESPONSE

Transportation and Logistics Considerations (Continued)

18. Develop plans and procedures that expedite the coordination and acquisition of transportation resources. (Local Government, Care Providers)

Plans and procedures should be developed to expedite communication between impacted facilities and the Health Officer (or other designated authority) at the local Emergency Operations Center, in order to coordinate information and transportation resource requests. As evacuation needs escalate, requests for transportation assets should be coordinated and prioritized at the local or operational area (OA) EOC.

RESPONSE

Support of Medical Evacuees: Staff, Records and Supplies

Background

The flooding of 1997 revealed significant gaps in planning and preparing for evacuated populations requiring medical care beyond the first aid level. The number of medical/health staff available to the shelters was inadequate as needs continued to increase. Relief staff had not been adequately planned for until those in need of replacement became exhausted and could no longer function.

Medical and other supplies were not available until shelter needs became critical and requests were forwarded to the State. Requested supplies ranged from egg-crate style mattresses to blankets and antacid medications. Similarly, the appropriate medications did not always accompany the evacuee, adding to their discomfort, increasing their health risks, and significantly adding to staff stress. Because of physical, mental or language deficiencies, some individuals were unable to communicate their needs to caretakers.

Implications

Due to the aging of the general population, trends in today's healthcare system, and ongoing threat of future disasters, government officials need to more adequately plan for the potential evacuation/sheltering needs for all segments of their community.

Recommendations

19. Determine medical treatment unit/temporary infirmary staffing needs and ensure ongoing 24-hour coverage. (Local Government)

Medical treatment units/temporary infirmaries should be staffed in sufficient numbers with the appropriate levels of expertise to ensure adequate medical coverage. Additionally, planning should include enough staff for at least one (or two) additional shift rotations to ensure caretakers are rested every 8 - 12 hours. (See Appendix I.)

RESPONSE

Support of Medical Evacuees: Staff, Records and Supplies (Continued)

20. Identify medical and pharmaceutical supplies necessary to supply medical treatment units/temporary infirmaries and develop agreements with potential vendors for supply and resupply. (Local Government)

Medical and pharmaceutical supplies should be identified and stocked in sufficient quantity to meet the needs of the potential evacuees. To aid facility planners in identifying the type and quantity of medical supplies, Appendix I has been provided as a resource. This listing identifies the medical and pharmaceutical supplies that most generally meet the needs of the medically fragile. Planners are urged to utilize this listing and to establish agreements with potential vendors or other suppliers to ensure that medical treatment units/infirmaries can continue to provide services to the medically fragile within their community.

21. Develop a special emergency evacuation document for each individual to ensure their medical care needs continue to be met with little or no interruption. (Care Providers)

Each individual's medical needs should be pre-identified before the disaster occurs and before emergency evacuation becomes necessary. Such advance planning should include 1) level of care category, 2) medications, 3) transportation options, and 4) appropriate shelter. This information should be documented and available when an evacuation is imminent. Having such information on hand eliminates confusion, saves time and aids staff in their efforts to meet the ongoing medical care needs of each individual patient/resident. An example of this type of document is provided in Appendix L.

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

RECOVERY

Contents

The recommendations for the recovery phase of emergency management are organized under the following topics:

Organization

Each of the topics listed above contain the following information:

1. Background
2. Implications
3. Recommendations

RECOVERY

Returning Evacuees

Background

When evacuation orders are lifted, the medically fragile evacuees must be returned to their homes, original care facilities, or alternate locations. While there were few reports of problems in 1997, the medically fragile face additional risks if their original care facility is damaged or unavailable.

Implication

In the usual post-disaster haste to return to 'normal' (i.e., the stability represented by family, home or care facility), the process of returning medically fragile evacuees to their point of origin (or, if damaged, alternate facilities) may be problematic, especially if this phase of planning has not been emphasized. Any deficiencies in one or more of the following areas could adversely impact the health and safety of the medically fragile evacuee:

- Assigning an inappropriate level of medical transportation.
- Misdirection to the wrong or inappropriate facility.
- Failure to provide or assign an attendant caregiver (when required).
- Failure to return the evacuee with their medical records, medications or other medical equipment.

22. Develop plans to return medically fragile evacuees to appropriate care. (Care Providers, Local Government)

Recommendation

This process can be accomplished more smoothly and efficiently if plans are developed in the same manner and with the same considerations used in planning for the initial evacuation. Following is a summary of some of the plan elements that should be included to effect a safe and appropriate return of evacuees after a disaster:

- Assess the health of the evacuee (fitness to travel, etc.).

RECOVERY

Returning Evacuees (Continued)

- Determine the appropriate destination for the evacuee.
  - return evacuee to original facility
  - transport to an alternate like facility (if facility of origin is damaged)
  - transport to a different type of facility
  - release or return to previous residence
  - release to alternate residence

- Determine appropriate level of medical transport (van, bus, ALS, BLS).

- Provide for attendant caregivers to accompany evacuees as necessary.

- Return evacuees with their medical records, medications, and medical equipment.

- Provide returning evacuees with mental health counseling.

- Coordinate with volunteer, community-based organizations and governmental agencies to provide outreach services (food, water, supplies, transportation, household chores, clothes, etc.) to medically fragile living at home.

RECOVERY

Reimbursement Process

Background

The need to recover costs incurred by private and public sector participants is a critical issue. Recovery issues could include repairing or replacing damaged facilities, returning evacuees to an appropriate facility, and cost recovery. This issue is complicated by the fact that most medical resources are owned by the private sector and many costs are not eligible for government reimbursement. Insurance companies can provide significant expertise in helping a facility plan for and recover from a disaster.

Implications

Costs recoverable through governmentally funded programs vary significantly depending upon the type of disaster, whether it be a federal, state or local declaration. Additionally, the costs eligible for governmental reimbursement may not adequately compensate medical care providers for the expenses incurred in responding to a disaster. This is confusing for private sector providers, especially when the day-to-day costs of their patients are covered by specific state and federal programs, and also by private insurers.

Recommendations

23. Seek self-sufficiency through development of cost recovery plans with private insurers in lieu of relying on governmental reimbursement. (Care Providers)

Care providers should develop an adequate cost recovery plan that provides for self-sufficiency and does not depend entirely upon governmental funding. Having adequate contingency plans in place will ensure maximum cost recovery. These plans should include documentation procedures that will allow for patient billing, appropriate business insurance coverage, and reimbursement agreements between facilities.

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

Reimbursement Process (Continued)

The Medi-Cal program is authorized to reimburse hospitals for acute care beds that must be used for skilled nursing because of a State of Emergency Proclamation issued by the Governor or Disaster Declaration issued by the President.

24. Coordinate meetings with all levels of government, community based organizations, and private entities to discuss and clarify cost recovery issues. (OES)

25. Keep clear, detailed documentation of all transactions or costs incurred as a result of efforts to provide services and/or resources to meet the needs of the affected population. (Care Providers, Public and Private Responders)

Accurate, complete and detailed records of all activities and costs resulting from the emergency are essential. Documentation should include:

- Staff hours
- Name of the facility/person requesting services/resources
- Type of service/resource requested
- Cost of service/resource requested
- Dates and times of each request
- Person taking the request
- Justification for the request
- Names of evacuees
- Evacuation departure and destination points
- Mileage, name of driver, vehicle license number
- Name of passengers transported
- Name of personnel/provider receiving individuals

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

RECOVERY

Reimbursement Process (Continued)

26. Develop partnerships with insurance companies to provide training and guidance to medical and residential care facilities in the development of response and recovery plans. (Local Government, Care Providers)

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

MITIGATION

Contents

The recommendations for the mitigation phase of emergency management are organized under the following topics:

Organization

Each of the topics listed above contain the following information:

1. Background
2. Implications
3. Recommendations

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

MITIGATION

Risk Factors for Medical and Residential Care Facilities

Background

In California's emergency management community, one of the most important lessons learned through a decade of disasters is the need for medical and residential care providers to identify the level of risk to their facilities and residents. This is particularly important when identifying and planning for hazards that may involve not only the facility, but the surrounding community as well.

Implications

Without a strategy for risk recognition and planning, facility managers may opt to make decisions based on their intuition or experience rather than through the use of carefully designed plans that have been backed up by regular training and exercises. Such reactive thinking, especially under the stress of an emergency in progress, can result in poor decision making, adversely affect staff and residents, and ultimately, the success or failure of the facility to respond during the disaster.

Recommendation

27. Identify potential technological and natural hazards that may affect medical and residential care facilities and develop specific plans to mitigate or minimize the risk posed by these hazards to the greatest extent possible. (Local Government, Care Providers)

Appendix F discusses some of the risks that may be faced by a facility. All facilities should survey and assess possible hazards (both natural and technological) in and adjacent to the property and take protective measures to increase their potential for a successful response to a disaster. Following are a few potential hazards to consider:

Natural Hazards:

- Flood zone near a river or lake (rain)
- Beachfront/coastal (tsunami, flooding, landslides)
- Earthquakes (near a fault line)

IV. ISSUES AND STRATEGIES FOR IMPROVEMENT

MITIGATION

Risk Factors for Medical and Residential Care Facilities (Continued)

- Forest or chaparral (fire season)
- Mudslides/landslides (rainy season)

Technological Hazards:

- Nuclear power plant
- Airport
- Other fuels (propane, gasoline, etc.)
- Power failures (any time)
- Toxic chemical and/or manufacturing plant
- Railway or highway (transportation of toxic materials)
- Structural hazards

V. GROUP MEMBERSHIP

Shelter Medical Group Members

The Shelter Medical Group is composed of representatives from a broad array of emergency management, medical, health and social service professionals. Group members include representatives from the following State Departments and the American Red Cross:

Governor's Office of Emergency Services (OES)
- John Passerello (co-chair)
- Rick Tobin
- Sharron Leaon
- Linda Pryor
- Brenna Carr

Emergency Medical Services Authority (EMSA)
- Jeffrey Rubin (co-chair)
- Sheila Keller

Department of Social Services (DSS)
- Shawn Ortiz
- Jefferson McCann
- Leo Riske
- Gary Levinson-Palmer

Department of Health Services (DHS)
- David Abbott
- Scott Lewis
- Ray Nikkel

Department of Rehabilitation (DOR)
- Les Treece-Sinclair

Office of Statewide Health Planning and Development (OSPHD)
- Delores Wilson

State Independent Living Council (SILC)
- Mike Collins

Department of Aging (DOA)
- Jim Christensen

GROUP MEMBERSHIP (Continued)

Department of Developmental Services (DDS)

- Patsy Van

Department of Mental Health (DMH)

- Linda Fain

American Red Cross (ARC)

- Dusty Bowenkamp

Stakeholders

The following professional organizations were identified as stakeholders and were invited to participate in the process:

- Assisted Living Provider Services
- Association for Minority Adolescents in Residential Care Homes
- California Advocates for Nursing Home Reform
- California Association of Area Agencies on Aging
- California Association for Health Services at Home
- California Association for Health
- California Assisted Living Facilities Association
- California Association of Health Facilities
- California Association of Health Maintenance Organizations
- California Association of Homes and Services for the Aging
- California Association of Long-Term Care Ombudsman
- California Association of Rehabilitation Facilities, Inc
- California Association of Residential Care Homes
- California Association of Social Rehabilitation Agencies
- California Conference of Local Health Department Nursing Directors
- California Conference of Local Health Officers
- California Emergency Services Association
- California Foundation of Independent Living Centers
- California Healthcare Association
- California Mental Health Directors Association
- California Pharmacists Association
- County Health Executives Association of California
- County Supervisors Association of California
- Community Residential Care Association of California
- EMS Administrators Association of California
- Estrella B. Manio and Associates

V. GROUP MEMBERSHIP (Continued)

- Health Care Education Resource Center

- National Senior Citizens Law Center
- The Salvation Army
- San Francisco Association of Residential Care Homes
- Society of California Care Home Operators
- State of California Welfare Director's Association
- Volunteers Active in Disasters

VI. REFERENCES

Statute

California Emergency Services Act, Chapter 7 of Division 1 of Title 2 of the Government Code

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Documents

Skilled Nursing Facility Evacuation Plan, San Joaquin County, (DRAFT- 1998)

Disaster Planning Guide for Medically Fragile Populations Requiring Special Needs Services, Tulare County, 1998

Home Health Disaster Planning Guide for Medically Fragile Populations Requiring Special Needs Services Served by Home Health Agencies, Tulare County (1998)

Responding to the Needs of People with Serious and Persistent Mental Illness in Times of Major Disaster, U.S. Department of Health and Human Services (1996)

Legal Guidelines for Flood Evacuation, Governor's Office of Emergency Services, Flood Emergency Action Team (1997)

The Authority and Responsibility of Health Officers in Emergencies and Disasters, Department of Health Services (1998)

The Disaster Preparedness Manual for the Aging Network, Administration on Aging (1995)

Hospital Emergency Incident Command System, San Mateo County EMS Agency (1998)

Disaster Preparedness for Persons with Disabilities, American Red Cross (1997)

Living and Lasting on Shaky Ground: Earthquake Preparedness for People With Disabilities, OES Earthquake Program and Independent Living Resource Center of San Francisco (1997)

VI. REFERENCES (Continued)

Disaster Preparedness for Persons with Disabilities, Improving California's Response, Department of Rehabilitation.(1997)

VII. APPENDICES

A. Interim Policy Letters & Bulletins
B. SEMS Organizational Levels & Functions
C. Training of Healthcare Providers
D. Authority to Force Evacuation of Health and Community Care Facilities
E. Government Level Evacuation Checklist
F. Risk Assessment and Evacuation Strategies
G. Voluntary Registration Request for Medically Fragile Individuals
H. Patient/Resident Emergency Evacuation Destination Categories
I. Shelter Medical Operations Guidelines
J. Model American Red Cross Agreements
K. Adopt-a-Shelter Program
L. Health Passport
M. Roles and Responsibilities
N. Terms and Definitions

APPENDIX - A

Following is the text from a letter from the State Department of Health Services to Health Care Facilities regarding preparedness for evacuation for the winter of 1997/98.

October 22, 1997

TO: ALL HEALTH CARE FACILITIES
HOME HEALTH AGENCIES

SUBJECT: SEVERE FALL AND WINTER STORMS

Experts are predicting severe fall and winter storms throughout the State of California this year due to El Niño and other weather conditions. You are requested to inspect your physical plant, especially the roof and drainage systems and, if necessary, make immediate repairs in order to minimize the potential iimpact on your residents and staff. If you are required to maintain an emergency power source, it must be fully tested and functional in order to insure availability in the event of a power outage.

Internal and external disaster plans should also be reviewed and revised as necessary. All external disaster plans must have been developed with assistance and advice of your local emergency management agency and may not conflict with county or community disaster plans (See attachment). It is also important to coordinate your plans with local Emergency Medical Services (EMS) and local health department, to ensure an effective response to an emergency . In addition, all staff must be trained and knowledgeable about your internal and external disaster plans and procedures.

Should you be required to evacuate, please ensure the following steps are taken:

- Evacuate residents, patients, and clients to other health facilities rather than general population centers. We highly recommend that you verify evacuation arrangements now with potential receiving facilities.

- In the event of facility evacuation, please notify your local emergency authority as well as the Department of Health Services (DHS), Licensing and Certification (L&C). The local emergency authority may be contacted through the county emergency telephone number. During normal business hours, please contact your local Department of Health Services, Licensing and Certification District Office. Outside normal business hours, or if the local DHS, L&C office in non-operational, please page the DHS, L&C duty officer at (916) 762-7333. If all other attempts fail, please telephone the Office of Emergency Services Warning Center at (916) 262-1621 and ask that the DHS duty officer be notified.

- If you are unable to evacuate to another health facility, and are forced to evacuate to an emergency shelter, call your local emergency management agency to determine which facility is most able to accommodate the special needs of your residents, patients, or clients.

- Regardless of the evacuation site, make sure that medications, medical care and personal information and/or other special diet information, and any supplies necessary for continuing care accompany the resident, patient, or client. Once you leave the facility, you may not bee able to return for anything until after the emergency has passed.

All storm related occurrences which threaten the welfare, safety, or health of patients, must be reported to your local Department of Health Services, Licensing and Certification duty officer, at pager number (916) 762-7333.

Thank you for your cooperation. If you have any questions, please contact your local Department of Health Services, Licensing and Certification District Office.

Sincerely,

[*Original signature on file*]
Brenda G. Klutz
Deputy Director

cc: District Administrators
District Managers
Local Emergency Management Agencies
County Health Officers
Shelter Medical Group
Dave Abbott, Chief
Department of Health Services
Emergency Preparedness Office
P.O. Box 942732 MS 396
Sacramento, CA 95814

Following is the text from the first newsletter (9/97) entitled "Just the Facts" as issued by the Shelter Medical Group:

Highlights
- **Actions Taken to Date**
- **Governor's Office of Emergency Services Performance**
- **Participating State Agency Information**

Inside
- **American Red Cross Activities**
- **Department of Social Services New**
- **Department of Mental Health Efforts**

"Just the Facts"

OES, EMSA, DHS, DSS, DMH, and ARC Update

Activities In Response to the January 1997 Floods

State OES Heavily Involved

Since the 1997 Winter Storms, the State Office of Emergency Services (OES) has been heavily involved in preparation for improving mass care and shelter operations. Currently staff from the OES Regions and the Planning & Technological Assistance Branch co-chair the statewide Care and Shelter

Red Cross Activities

Chapters throughout the state are currently working with local authorities to inspect potential shelters for accessibility for those with special medical needs. New shelter managers are being identified and trained in the Shelter Manager's Workshop and Mass Care Overview courses, to sensitize them to the varied needs of the community. Agreements for mutual assistance are being written and reviewed by several County Health Departments and local Red Cross chapters. These agreements identify the roles and responsibilities of each agency when American Red Cross shelters are operating. Additional American Red Cross and Public Health Nurses are being trained

Committee with the Department of Social Services (DSS) (the lead agency for mass care and shelter function in the State); they also co-chair the Shelter Medical Group with the Emergency Medical Services Authority (EMSA). The purpose of the Care & Shelter Committee is to develop an action plan for future operations, citing the capabilities, roles and responsibilities of state to support medical needs in shelters. Also, the Red Cross is deeply involved with DSS and OES in the development of an action plan for this winter's floods. All three agencies are working closely to solve sheltering issues faced by many California communities during the 1997 Winter storms.

Department of Social Services News

The DSS Community Care Licensing Division sent a memo to all licensed care facilities in the State requesting they update their disaster plans. They also suggested that all licensees have necessary medications, records, and equipment ready for evacuation. Once a facility is evacuated, residents and

agencies, private non-profit organizations, and federal Emergency Support Function (ESF) 6 in the support of Care & Shelter Operations for local government evacuations. The Shelter Medical Group project mission is to develop strategic recommendations for the evacuation and care of medically fragile populations.

employees may not be allowed back into the facility. Over the next year Community Care Licensing will be revising the requirements for care facility disaster plans.

Department of Mental Health Facts

The California Department of Mental Health (DMH), through technical assistance with County Mental Health Departments, is striving to ensure that the sheltering needs of mental health customers are met during mass care and shelter operations. They are planning for the provision of crisis counseling services to all evacuees at all shelters.

Emergency Medical Services Authority Takes Action

The Emergency Medical Services Authority (EMSA) is moving on several fronts to increase local and State preparedness in anticipation of a repeat of the January floods. EMSA, with the assistance of DHS, developed Local Health Officers disaster response guidelines and checklists. EMSA provides disaster medical response training and technical assistance as requested by counties and is supporting all six mutual aid regions in the development of inter-county cooperative disaster medical and health resource assistance agreements.

At the State level, EMSA is working to identify statewide providers of these necessary resources and is actively working with other State government agencies in this process. EMSA co-chairs the Shelter Medical Group with OES (see above) and is working with the American Red Cross to provide interim shelter medical planning guidance for ARC chapters and local government medical and health agencies.

Department of Health Services Takes Steps to Inform Licensees

Department of Health Services (DHS) Licensing and Certification has responsibility over all licensed health care facilities. An all facilities letter has been prepared to remind the facilities of their responsibilities in the time of disaster. The Department has worked with health facilities to ensure that, in the event of evacuation, they will transfer the medically fragile to a like facility, and not a general population disaster shelter. If necessary, the Department of Health Services is considering surging the capacity of other pre-designated health care facilities to accept the evacuated patients, residents or clients of the licensed health care facilities. These health care facilities have also been asked to coordinate their internal and external disaster plans with local government emergency authorities.
This will improve the overall resource coordination within the Operational Area of every county, and for the entire State, in accordance with Standardized Emergency Management system (SEMS) guidelines.

QUESTIONS?

If you have any questions about this newsletter, or the work of the Medical Shelter Group, please contact:

Jeff Rubin, Chief of Disaster Medical Services Division, Emergency Medical Services Authority (916) 322-4336

Rick Tobin, Plans Unit, State Office of Emergency Services (916)464-3282.

APPENDIX - A-2

Following is the text from the second newsletter (3/98) entitled "Just the Facts" as issued by the Shelter Medical Group:

Highlights
- **Governor's Office of Emergency Services Efforts**
- **Emergency Medical Services Authority Highlights**
- **Department of Health Services Plans & Projects**

Inside
- **Department of Social Services News**
- **Department of Mental Health Efforts**
- **American Red Cross Advancements**

"Just the Facts"

OES, EMSA, DHS, DSS, DMH, and ARC Update

Activities In Response to El Niño '98 Floods

State OES Heavily Involved

Since the El Niño '98 Floods struck California in February, the State Office of Emergency Services (OES) assisted in the coordination of mass care and shelter operations. It was evident that the concerted planning efforts of local government in the Operational Areas enhanced local sheltering capabilities. Though no formal reports have been developed by the Shelter Medical Group to date, the results of planning between state agencies in the Group was evident as state agencies supported mass care and shelter requests, as well as related medical support requests for medically fragile evacuees.

In addition, alliances were forged with the Fairs and Expositions Division of the California Department of Food and Agriculture. This assured timely access to large-scale sheltering facilities. The level of cooperation between the state agencies was invaluable in making the Standardized Emergency Management system a success in February.

Red Cross Activities

The American Red Cross (ARC) continues its close collaboration with many of the local governments, which has enhanced its ability to provide emergency housing for more than 3,300 individuals in 61 shelters throughout the State during the El Nino '98 Floods. Agreements are being signed between local chapters and health departments, clarifying roles and responsibilities in the provision of medical support to those considered medically fragile. This lead to many Public health nurses and mental health professionals assisting the American Red Cross in shelters and in outreach efforts.

The American Red Cross has also recently signed statewide agreements with Longs Drug Stores, Raley's Drug Stores and Shield Health Care. These agreements will enhance the ARC's ability to serve those affected by disaster.

Department of Social Services News

The California Department of Social Services (CDSS) response and recovery programs are helping Californians with temporary shelter and financial assistance. The Health and Welfare Agency's (HWA) Welfare Emergency Services Team (WEST), managed by CDSS, staffed the Care and Shelter branches of the Governor's Office of Emergency Services (OES) Regional Emergency Operations Centers (REOCs) in Oakland and Sacramento. The WEST was deployed from February 2 through February 28, 1998. Twelve members of the WEST were activated to help OES coordinate care and shelter operations conducted by the American Red Cross and local government agencies.

In the midst of the El Nino '98 Floods, CDSS' Director published and circulated to affected County Welfare Departments, large scale "evacuation protocols."

These protocols were developed over the last year by the

Standardized Emergency Management system (SEMS) Care and Shelter Specialist Committee.

Staff from the CDSS' Disaster Response Services Bureau's Emergency-Welfare Services (EWS) Unit also were sent to Lake County to help the County develop a care and shelter plan. Clearlake came within 18 inches of equaling its historical record of just over 13 feet above flood stage. About 600 persons, some medically and socially fragile, were affected. The mission to assist Lake County came at the request of the OES' Oakland REOC.

The CDSS' Individual and Family Grant Program (IFGP) also is receiving referrals from the Federal Emergency Management Agency (FEMA). As of March 2, 304 applicatoins have been referred to CDSS. To date, it is estimated that over 22,500 referrals from FEMA will be made to the IFGP.

Department of Mental Health Facts

Since early February, DMH coordinated with local county mental health, other state and federal agencies, the American Red Cross (ARC), the Salvation Army, other non-profit organizations, and the private sector to ensure that disaster-precipitated mental health needs are addressed for those impacted by El Nino '98 Floods. DMH provided oversight of county mental health coverage at shelters. Pre-disaster networking with the American Red Cross contributed to a cooperative effort in coordinating shelter mental health resources.

The Department also developed a telephone directory for crisis counseling referrals for all of the counties with disaster declarations.

Emergency Medical Services Authority Improves Planning

In the weeks prior to the El Nino '98 Floods, the EMS Authority compiled and distributed a compendium of planning documents and other strategies specific to finding solutions to meeting the needs of the medically fragile during evacuations. The compilation consisted of planning tools and documents from various committees and task forces as well as from the State of Florida. The package also contained some model agreements between counties and the American Red Cross, policy and advisory letters and other useful information. The EMS Authority sent this to local EMS agencies, local health officers, local emergency services coordinators, and regional disaster medical and health coordinators.

Additionally, the EMS Authority also concluded another task force focusing on the availability of medical and health resources (medical personnel, supplies, bed space, facilities, etc.) In other State agencies. This information was compiled and is on hand should there be a future need.

When El Niño finally unleashed its fury in early February, it prompted the EMS Authority to staff the Medical and Health Joint Operations Center (JEOC) over a three-day period. Although the storms saturated the State with record rainfall, and caused thousands of California residents to flee their homes, there were no significant medical implications to warrant continued EMS Authority staffing of the JEOC. However, the EMS Authority continues to monitor the El Niño phenomenon in the event future activation is necessary.

The EMS Authority's Home Page is being updated regularly to include a variety of disaster information concerning the current storms and the El Niño weather pattern.

Department of Health Services Takes Steps to Help Evacuees

The Department of health Services, Licensing and Certification program (L&C), issued two "all facilities" letters asking health facilities to prepare for possible flooding. Facilities were reminded to review and coordinate their plans with local emergency authorities.

The L&C also re-evaluated its role in health facility evacuation and transfer of patients and residents. L&C set goals to avoid placement of these populations in general purpose shelters. L&C also completed implementation training.

QUESTIONS?

If you have any questions about this newsletter, or the work of the Shelter Medical Group, please contact:

Jeff Rubin, Chief of Disaster medical Services Division, Emergency Medical Services Authority (916) 322-4336

Rick Tobin, Plans Unit, State Office of Emergency Services (916) 464-3282.

SEMS ORGANIZATIONAL LEVELS & FUNCTIONS

All emergency response agencies shall use the Standardized Emergency Management System (SEMS) in responding to, managing, and coordinating multiple agency or multiple jurisdiction incidents, whether single or multiple discipline.

There are five designated organizational levels within SEMS: Field, Local, Operational Area, Regional, and State. Each level is activated as needed.

- **Field** -- Commands emergency response personnel and resources to carry out tactical decisions and activities in direct response to an incident or threat.

- **Local** -- Manages and coordinates the overall emergency response and recovery activities within their jurisdiction.

- **Operational Area** -- Manages and/or coordinates information, resources, and priorities among local governments within the operational area and serves as the coordination and communication link between the local government level and the regional level.

- **Regional** -- Manages and coordinates information and resources among operational areas within the mutual aid region designated pursuant to Government Code §8600 and between the operational areas and the state level. This level along with the state level coordinates overall state agency support for emergency response activities.

- **State** -- Manages state resources in response to the emergency needs of the other levels, manages and coordinates mutual aid among the mutual aid regions and between the regional level and state level, and serves as the coordination and communication link with the federal disaster response system.

  Additionally, local government, operational area, regional, and state levels shall provide for all of the following functions within SEMS:

  - **Command/Management** -- for overall emergency policy and coordination through the joint efforts of governmental agencies and private organizations.

  - **Operations** -- for coordinating all jurisdictional operations in support of the response to the emergency through implementation of the organizational level's action plan.

  - **Planning/Intelligence** -- for collecting, evaluating, and disseminating information; developing the organizational level's action plan in coordination with the other functions; and maintaining documentation.

- **Logistics** -- for providing facilities, services, personnel, equipment, and materials.

- **Finance/Administration** -- for financial activities and administrative aspects not assigned to the other functions.

TRAINING OF HEALTHCARE PROVIDERS

Introduction

Training for healthcare providers should include emergency management roles, responsibilities and procedures. Staff training should also include orientation to the government's role in emergency management, including the authorities, responsibilities and functions of the local Emergency Operations Center, how to request/access medical and health resources, whom to contact for transportation and other logistical assets, when and where to evacuate medically fragile patients, etc. Facility staff should also be familiar with the different types of hazards their facility could potentially experience and how to respond in each event. They should also be knowledgeable of the various medical conditions and mobility impairments affecting their patients and know where/how to access the patient records for use during and after emergency evacuations.

Types of Training

Following is a summary of the different types of training available to enhance staff performance during a disaster response:

American Red Cross Training

The American Red Cross (ARC) offers a variety of training materials and courses for individual, family, organization, and business preparedness.

The Salvation Army

The local Salvation Army Corps Center may be contacted for information on their training and resource programs.

California Emergency Management Programs

The State of California has many emergency management training programs to assist the public and private sector in preparing for emergencies. The Governor's Office of Emergency Services offers many training courses through the California Specialized Training Institute. Training available includes a wide variety of emergency management courses for city, county and state government administrators as well as highly specialized courses geared for practicing law and fire professionals.

Federal Emergency Management Programs

The Federal Emergency Management Agency (FEMA) provides a variety of opportunities for continuing education as part of their Professional Training Program. Their methods of instruction include home study and classroom courses. Some are provided locally and conducted by either the California Specialized Training Institute, local college or other FEMA authorized institution.

Types of Exercises

A disaster exercise is an activity designed to simulate an organization's emergency response environment and to test the effectiveness of its disaster plan. Exercises provide excellent opportunities for staff to practice new or less frequently used skills/knowledge and to integrate with other response elements in the performance of their disaster roles. Exercises measure the ability of staff to respond to unusual events and to perform in an effective and predictable manner.

Exercises are the preferred method of testing an organization's disaster response plan -- *before* an emergency occurs. A well-executed exercise will reveal predictable flaws in the plan during exercise play and allow ample time to make necessary adjustments. When conducted regularly, exercises help to minimize confusion that often occurs during real emergencies when staff are suddenly challenged by situations that require them to function outside their normal day-to-day roles. Well-planned exercises, along with appropriate follow-ups, increase readiness, build team spirit and promote confidence among staff.

The four levels of exercises are characterized below:

1. **Drill**

   - are usually single-function
   - test a trained activity
   - provide the building blocks of needed skills
   - are based upon standard procedures

2. **Table-tops**

   - provide orientation and overview
   - involve collective problem solving
   - are scenario-driven
   - are methodical with fewer objectives
   - are valuable tools for learning about problem areas

3. **Functional**

- are scenario-driven
- involve many objectives
- are usually conducted in 'real time'
- use simulators to provide realism for participants
- are command post and EOC focused
- are management-oriented

4. **Full-scale**

are driven by well-developed scenario

- involve many objectives on all levels of response
- simulate actual disaster events
- involve 'real time' players and equipment
- contain special effects that add to realism (i.e., moulage, participant behaviors, rubble, etc.)
- require the highest level of training, organization, coordination and planning

Authority to Force Evacuation of Health and Community Care Facilities

Background

The authority to force the evacuation of health and community care facilities during an emergency or disaster was identified as an area that needed to be investigated after the winter floods of 1997. During these floods and the resulting evacuations, one acute care hospital refused to follow the local county order to evacuate the area. Even though the hospital was not subsequently flooded, this raised the issue of who had the ultimate authority to force evacuations.

A sub-committee of the Shelter Medical Group met with Roger Venturi, Supervising Deputy Attorney General, and discussed this issue at length. On August 4, 1997, Mr. Venturi provided the committee with his opinion (attached) that described three different means of imposing a mandatory evacuation.

Statutory Options:

(1) Penal Code §409.5 authorizes officers of the highway patrol, police departments, marshal's office or sheriff's office and certain other designated law enforcement officers to close an area whenever there is a menace to public health or safety. If the calamity creates an immediate menace to public health, the local health officer may close the area where the menace exists pursuant to the conditions set forth in this section.

(2) Government Code (GC) §§8558(c) and 8630 authorize the local governing body to declare a "state of local emergency" pursuant to the Emergency Services Act. When a "state of local emergency" has been declared, the local governing body may issue orders and regulations "necessary to provide for the protection of life and property". (GC § 8634). An order for mandatory evacuation would be authorized under that section. Failure to comply with any such order is a misdemeanor and subject to imprisonment for up to six months and/or a fine up to $1,000. (GC § 8665).

(3) The Governor may declare a "state of emergency" (GC § 8558(b) and 8625). During a "state of emergency" the Governor has complete authority over all state agencies and the right to exercise all police powers vested in the state, including the issuance of such orders and regulations as he deems necessary (GC §§ 8567, 8627, 8627.5, and 8628). He also may amend or rescind existing orders and regulations (GC § 8567) and suspend any regulatory statute, any statute prescribing the procedure for conducting state business, or the orders, rules or regulations of any state agency (GC § 8521). Local public officials and employees are required to render all possible assistance to the Governor and their

powers are subordinate to those of the Governor during a "state of emergency" (GC §8614). Thus, the Governor may assume responsibility for issuance of mandatory evacuation orders or abide by the mandatory evacuation orders issued by the affected political subdivision.

Discussion

Of the three options provided for mandating an evacuation, the Attorney General's office indicated that option (2) is used most often. This option authorizes the local governing body to declare a "state of local emergency" and to issue orders "necessary to provide for the protection of life and property." It is under this section that a local order for mandatory evacuation is authorized. The advantage of using this section is that local control and coordination are maintained. Failure to comply with such an order is a misdemeanor and subject to fines and/or imprisonment.

As these provisions apply to everyone in a mandatory evacuation area, including health and Community Care facilities, one question still remains: If health or community care facilities choose to defy such an order, could the Department of Health Services, Licensing and Certification (DHS/L&C) or the Department of Social Services, Community Care Licensing (DSS/CCL) force the facilities to evacuate? The answer is technically "yes"- in that California Code of Regulations (CCR), Title 22, requires facilities to comply with all local statutes and ordinances. Also, if the structural integrity or any major system of a hospital building is compromised and/or damaged to a degree that is unsafe to occupy under the provisions of Health and Safety Code §§ 129990 and 130025, the Office of Statewide Health Planning and Development (OSHPD) may order the building evacuated.

Notwithstanding statutory requirements, the reality is that decisions to evacuate health and community care facilities lie with the facility management and these decisions are usually made on short notice in response to a crisis. In the event management refuses to evacuate, the responsibility and liability for the safety of their residents remains with them. Evacuation orders issued by a state agency would be slower and may require the support of the local authorities for enforcement. During a disaster, local control and coordination by an emergency management authority is essential.

DHS Licensing and Certification requires that all health care facilities develop and maintain internal and external disaster plans in accordance with CCR, Title 22. These disaster plans are to be developed with input from the local emergency management authority and facility staff is to be trained on their implementation and use. DSS Community Care Licensing requires that all community care facilities develop disaster and mass casualty plans in accordance with CCR, Title 22. These disaster plans are subject to review by CCL. In times of disaster, these plans must be implemented and followed. If they are not followed, L&C or CCL could issue deficiencies or citations to the facility.

Facility management is responsible for the care and treatment of their residents. If they choose to ignore a mandatory evacuation order, they are in violation of law and are ultimately responsible for any adverse outcomes their residents might face. While evacuation presents risk to the patients and economic disruption to a facility, conversely, failure to evacuate presents potentially dire consequences. Good judgment must prevail in these circumstances.

The DHS Licensing and Certification and DSS Community Care Licensing district offices will lend their assistance whenever possible to help facilities relocate patients and residents in times of forced evacuation. This will include working with facility staff and local emergency response agencies to locate facilities of the same license category that are able to accept evacuated patients and residents.

Conclusion

Based on the review and study conducted by the Shelter Medical Group, it is believed that existing law is adequate to force facilities to evacuate but local authorities will determine the extent to which the evacuation order will be enforced. Ultimately, the facility management must use a "reasonable person approach" when evacuation is ordered. If health facility management should ignore an authorized, mandatory evacuation, they would then be subject to penal code violations and the potential for extreme fiscal liability.

APPENDIX - D-1

Following is the text of a letter responding to an inquiry by Ray Nikkel from Roger E. Venturi, then Supervising Deputy Attorney General concerning legal authorities governing evacuation of health care facilities:

August 4, 1997

Ray F. Nikkel, Chief
Field Training Unit
Department of Health Services
Licensing & Certification Program
1800 3rd Street, Suite 211
P.O. Box 942732
Sacramento, CA 94234-7320

Dear Ray:

As requested, I offer the following introduction of governing legal principles for your report:

We were asked to examine the legal authorities governing the evacuation of hospitals, acute care and other health care facilities. We have found three different means for imposing a mandatory evacuation:

(1) Penal Code section 409.5 authorizes officers of the highway patrol, police departments, marshal's office or sheriff's office and certain other designated law enforcement officers to close an area whenever there is a menace to public health or safety.

Although that section is often utilized during emergencies, it is unclear whether it may be used to remove persons who were within the area prior to it being ordered closed. Also, only those officers specifically named in that statute may enforce it.

(2) Although a local governing body has inherent police powers to protect the health and safety of its people, Government Code sections 8558, subdivision (c) and 8630 authorize thelocal governing body to declare a "state of local emergency" pursuant to the Emergency Services Act. When a "state or local emergency" has been declared the local governing body may issue orders and regulations "necessary to provide for the protection of life and property." (Gov. Code, § 8634.) An order for mandatory evacuation would be authorized under that section. Failure to comply with any such order is a misdemeanor and subject to imprisonment for up to six months and/or a fine of up to $1,000. (Gov. Code, § 8665.)

The advantage of this approach is that local control and coordination are maintained.

(3) The Governor may declare a "state of emergency." (Gov. Code, §§ 8558, subd. (b), 8625.) During a "state of emergency" the Governor has complete authority over all state agencies and the right to exercise all police powers vested in the state, including the issuance of such orders and regulations as he deems necessary. (Gov. Code, §§ 8567, 8627, 8627.5, 8628.) He also may amend or rescind existing orders and regulations (Gov. Code, § 8567) and suspend any regulatory statute, any statute prescribing the procedure for conducting state business, or the orders, rules or regulations of any state agency. (Gov. Code, § 8571). Local public officials and employees are required to render all possible assistance to the Governor and their powers are subordinate to those of the Governor during a "state of emergency." (Gov. Code, § 8614). The ordinances, orders and regulations of a political subdivision continue in effect during a state of emergency unless suspended or superseded by an order issued by the Governor. (Gov. Code, § 8614.) Thus, the Governor may assume responsibility for the issuance of mandatory evacuation orders or abide by the mandatory evacuation orders issued by the effected political subdivision.

If the latter two options, (2) and (3), are utilized, the Emergency Services Act confers increased immunities from liability. (Gov. Code, §§ 8544-8550.)

Sincerely,

DANIEL E. LUNGREN
Attorney General

[*Original signature on file*]
ROGER E. VENTURI, Supv.
Deputy Attorney General

GOVERNMENT EVACUATION CHECKLIST

1. Situation Assessment

- ❑ Determine type, size, and location of emergency
- ❑ Determine number of people affected
- ❑ Determine emergency assistance required, especially for vulnerable populations

2. Infrastructure Assessment

- ❑ Conduct infrastructure assessment (public and high-risk buildings)
  - ❑ transportation
  - ❑ communications
  - ❑ utilities

3. Evacuation

- ❑ Identify areas to be evacuated
- ❑ Identify transportation / roadways to be used
- ❑ Alert local law enforcement, California Highway Patrol, and CalTrans
- ❑ Identify vulnerable populations, including people from unique institutions to be evacuated

4. Alert and Warning / Notification

- ❑ Determine if thresholds for alert and warning have been reached
- ❑ Consider announcing precautionary warnings for vulnerable populations (hospitals, nursing homes/care facilities, schools, special event facilities, etc.)
- ❑ Identify whether the emergency affects life and property
- ❑ Activate public warning system: Emergency Alert System, including emergency digital information system (EDIS)
- ❑ Issue public advisory / notification
- ❑ Advise Operational Area (if city) / REOC (if county) of situation
- ❑ Advise affected jurisdictions, agencies, facilities of public evacuation

5. Initial Response

- ❑ Announce a precautionary warning for vulnerable populations
- ❑ Declare local emergency
- ❑ Issue local emergency orders/evacuation order
- ❑ Close affected areas

6. Public Information

- ❑ Issue precautionary warnings and instructions for vulnerable populations
- ❑ Issue evacuation instructions
- ❑ Issue news releases
- ❑ Issue press advisories

7. Mass Care and Shelter

- ❑ Identify sheltering needs and capabilities
  - ❑ activate/establish multi-jurisdictional agreements for care and shelter
  - ❑ activate existing agreements with American Red Cross, Salvation Army, community based organizations.
  - ❑ designate shelter areas
    - ❑ medical treatment unit/temporary infirmary
    - ❑ general public shelters

Risk Assessment and Evacuation Strategies

Introduction

Readiness for facility evacuation requires several stages of preparation and implementation. The entire process of assessing a facility's readiness to evacuate can be established by:

- Defining the authorities for evacuation in the community
- Defining a facility's legal responsibility and role regarding evacuation
- Assessing hazards and identifying risks that might require or complicate evacuation of a facility
- Developing strategies for evacuation of the facility, or supporting facilities that evacuate to a host facility
- Developing and implementing an evacuation/sheltering plan, operational procedures, training programs and drills
- Continual reevaluation of plan and procedures based upon drills and actual evacuations.

Defining Authorities and Responsibilities

The authorities and legal responsibility for evacuation, as discussed in Section IV and Appendix D of this Report, provide documentation and guidance for understanding evacuation directions in the community.

Assessing Facility Evacuation Risks

In order to develop evacuation strategies, facilities should first inspect their surrounding environments for hazards that pose further risk to evacuees and facility operations. Attention should be given to the following elements of evaluation:

♦ Hazard Analysis

There are many methods for identifying, evaluating and defining hazards that may affect a facility. Depending on facility location and size, hazards may require considerable expertise to identify properly. Hazards are not necessarily limited to natural events, but include technological risks ranging from chemical spills due to loss of utilities. Hazard analysis can be

provided by knowledgeable staff, software programs, and guidance from governmental emergency planners and consultants.

An additional tool in assessment is the use of "lessons learned" from similar incidents. Events that led to evacuation or shelter-in-place decisions can be pinpointed through data from associations, insurance companies and community emergency planners/responders. By evaluating information from sources like these, facilities are more likely to identify potential hazards.

- **Frequency**

To effectively identify the most likely evacuation scenarios, facilities must first qualify hazards and how often they occur. Frequency is not a stand-alone indicator, since a least likely scenario may have the largest impact.

- **Duration of Incident**

Each evacuation plan should consider how long a hazard would impact facility operations. An example is whether a chemical release will be of short or long duration.

- **Scope of Impact**

Plans for evacuation will depend upon how much of the facility is affected, for how long, and to what degree.

- **Destructive Potential to Life and Property**

To understand the type and length of evacuation, facility planners should know how much destruction is likely from the risk at hand. If a flood lasts for three weeks and covers the entire structure, patients may be transferred for months to other sites. A chemical release, however, may have little destructive impact on the facility structure, but result in severe risk to patients and staff.

- **Controllability**

Facility planners cannot control hazards but may be able to decrease associated risks by adequate planning.

- **Predictability**

Based on past history, some events may be predictable. The ability to reasonably predict events will assist in planning for evacuation. An example would include the building and grounds being routinely flooded during high-rainfall years.

- **Speed of Onset**

Every facility should have a method to quickly identify events that will create an immediate threat. In some cases, staff may have many days for planning and decision-making or have very little time to react. Lack of time to prepare can have a substantial impact on the health of patients and staff. Facility planners should find methods to provide early warning to staff for those events that can require evacuations within 2 hours of occurrence (e.g., earthquake, wildfire, dam break, bomb threat, etc.).

- **Length of Forewarning**

The longer you wait to take actions to respond to a disaster, the fewer options you will have to react successfully. Equipping facilities with appropriate warning systems will maximize the response time for evacuation or sheltering decisions. These may include weather radios that activate immediately upon a warning from the National Weather Service, an automated warning service provided by phone, or a warning siren from a nuclear power plant. Facility staff should also be trained to identify local sirens or messages provided on radio or television by the Emergency Alert System.

Developing Facility Protective Actions

There are several strategies for evacuation which include:

- Sheltering in place without moving clients
- Sheltering in place to a safe area on the same level
- Sheltering in place vertically (up or down)
- Evacuating just outside the facility
- Evacuating to a nearby like facility
- Evacuating to a distant like facility
- Evacuating to a shelter designated as a medical treatment unit (and originating facility continues to provide all staff and support services)
- Evacuating to a shelter designated as a medical treatment unit (and local health officials provide all staff and support services)
- Evacuating to a general public shelter with a temporary infirmary

NOTE: When considering movement of patients, whether within or outside the facility, facility planners must consider the inherent risk that the travel will impact the individual=s health.

- ***Sheltering in place without moving clients***

Depending on the degree of risk, facility staff may decide to remain in place because the threat may have less impact on client health and safety than a voluntary evacuation.

Example: A facility becomes aware of a chemical release that will affect it within a short period of time and local government advises staying indoors or evacuating the area. Evacuation could expose patients/residents to greater risks than sheltering in place.

- ***Sheltering in place to a safe area or refuge on the same level***

An evacuation may be necessary from one side of a building to another based on an approaching threat. Staff would be expected to identify the path and speed of the threat to ensure the timely movement of patients and critical equipment.

Example: An evacuation may be necessary from one side of a building to another based on an approaching or impending threat. Staff would be expected to identify the path and speed of the threat to ensure a timely movement of patients and critical equipment.

- ***Sheltering in place vertically (up or down)***

For fast-moving, short-duration events it may be necessary to move residents above or below the ground floor. This is usually done because time in which to respond to a serious hazard is extremely limited. Lower-level sheltering may be required for high wind scenarios or during threats from some man-made threat (e.g., a nearby impending explosion). Upper-level sheltering may be required for scenarios involving very fast-moving waters or during the release of ground-hugging chemicals in the immediate area.

Example: A two-story facility has a fall-out shelter in the basement. The National Weather Service has announced a tornado warning in the area. A staff member=s relative has already seen a funnel cloud touch down less than a mile from the facility. Staff should consider moving patients from the upper floor, and those near windows, to the security of the basement until the tornado warning has subsided.

- ***Evacuating just outside the facility***

There may be an internal emergency, which will require staff to evacuate patients from the building. This could be for an immediate problem or a long duration event. The evacuation plan should include locations where facility staff can perform an inventory of those who have left the building. The plan should also include contingencies for this occurring during inclement weather, and the possible need for further evacuation to nearby like facilities.

Example: Staff smells smoke in the facility and calls 9-1-1. They are directed to move patients out of the building. Upon authorization from the fire department, they return indoors.

- ***Evacuating to a nearby like facility***

Facilities with medically fragile residents should consider movement of patients/residents and staff to a nearby facility, with like capacity for care of patients/residents. This evacuation type might be considered during a voluntary or precautionary evacuation, and would definitely be appropriate during a mandatory evacuation order. It is critical that facilities have agreements with nearby *like* facilities to take clients. More than one facility should be identified, usually in opposite directions from the affected facility, in case the primary site is impacted by the same threat. Facilities should identify whether other medical and residential care facilities are also planning to use the same location to receive clients. In addition, plans should address accessible evacuation routes (depending on risks) and transportation logistics.

Example: Local government authorities have warned a facility that flood controls may fail within six hours. The facility has a high risk of being flooded within the next two days. Staff have been given adequate time to secure bed space and care at one of the predestinated like facilities. They have also been given time to arrange for transportation and verify a safe route for evacuation.

- ***Evacuating to a distant like facility***

Very serious conditions may require a facility to move all patients to a distant site. This can occur during regional events with massive impacts. Examples include events such as widespread flooding, earthquake, epidemic and civil unrest. This choice would be preferable to movement to a nearby medical shelter if the impact of the event will have a substantial duration (more than 3 or 4 days) and/or there are extensive equipment and personnel support needs for the care of the patients.

Example: A large earthquake has severely damaged a facility and staff determines that all *like* facilities with which they have agreements are also disabled and unable to receive additional patients.

- ***Evacuating to a shelter designated as a medical treatment unit (and originating facility continues to provide all staff and support services)***

A rapid onset of a disaster may severely limit evacuation and transfer options available to the local emergency authorities and facility. Under these conditions, the local disaster authority may instruct a facility to evacuate and transfer the entire operation to a temporary shelter (i.e., school gymnasium) and continue to provide all care and treatment. This option is desirable for short-term evacuations. However, depending on the duration of the event, this may be the first step before transferring patients to another *like* facility.

Example: A nearby river is at flood stage and threatens to break through containment levees. If this occurs, the nearby facility will be flooded. A lawful evacuation order has been issued and the facility has been directed to move all patients and staff to a school gymnasium on higher ground. Patients, staff, equipment and supplies must be transferred with the patients and the facility must be capable of maintaining operations for a minimum of 72 hours.

- ***Evacuating to a shelter designated as a medical treatment unit (and local health officials provide all staff and support services)***

When the scope of the disaster conditions are severe, facility planners may need to consider moving patients to a medical shelter before they can be moved to *like* facilities. Since they will have to be moved twice, this choice can create increased stress on patients, and the quality of care in the shelters may not be equal to the care available to them in the facility from which they are evacuating.

Example: An urban firestorm has burned down the neighborhood where a facility was located. Staff was able to evacuate all patients to a local community shelter for the medically fragile, but it has limited capabilities. Facility planners must arrange for movement of patients to a city that is in another county, as soon as the roads are passable and the fire threat is controlled.

- ***Evacuating to a general public shelter with a temporary infirmary***

In worst-case scenarios, facilities may have little choice but to evacuate to the nearest available general population shelter. This decision is made only when there is no other option available, and when there is an immediate peril to life and safety of clients if they are not immediately moved to the closest available shelter. The plan must recognize this as a temporary condition requiring immediate triage activities, in coordination with local government, to move the arriving patients to the closest like facility available, whether or not there exist any previous agreements.

Example: A massive earthquake has rendered a facility unsafe for occupation. Staff has used every method available to safely move the patients out of the building. The only available shelter is a school auditorium two miles away. There is a temporary infirmary as part of the general population shelter, with limited nursing staff, medical supplies and support. Facility staff will need to set up a working relationship with local government as soon as possible to arrange for the movement of the patients to a like facility.

Developing a Plan, Procedures, Training and Testing

To ensure that decisions about evacuation will be completed in a timely manner, a series of inter-related actions must be addressed.

- First, with input from local emergency services authority, facility planners should develop a succinct plan that describes their organization's evacuation policy, with basic information about who is in charge during evacuation, what the known risks and hazards are, and the expectations of staff and clients during and after evacuation. The plan should include agreements made with other facilities for evacuation support.

- Second, a specific checklist of actions should be developed into a brief, clearly written procedure for making decisions about evacuation and implementing those decisions.

- Third, staff must be trained around the plan and procedures, including a walk-through of the facility and its evacuation related sites and equipment. This should be part of a new employee's orientation training.

- Finally, the staff should be involved in, at a minimum, a tabletop evacuation exercise each year as part of the facility's licensure requirements.

Developing a Maintenance Process

Facility management should include an annex to the evacuation plan dealing with the maintenance of evacuation readiness. This should include plan and procedure revisions, training qualifications, facility readiness checklists, phone number verifications, and supplies and equipment inventory/replacement.

VOLUNTARY REGISTRATION REQUEST FOR MEDICALLY FRAGILE INDIVIDUALS

DATE:

Dear Citizen:

The Local Office of Emergency Services[1] maintains a Medically Fragile Registry for people who are medically fragile (MFR). In the event of a flood, earthquake, or other catastrophe, this department will attempt to provide medical sheltering and transportation. If you have a chronic medical condition, completion of the attached Questionnaire will allow us to assist you during an emergency. Please read this page carefully before signing up for the registry. When signed, please return it to the address indicated in the top left-hand corner. You may call the MFR Coordinator at: _____ for further information.

The medical information that you provide on the attached form will remain confidential. It will only be given to first response agencies associated with your emergency evacuation.

The level of care that this jurisdiction offers are: [Insert your jurisdiction's level of care here].

Please note that you are responsible for all costs associated with medical transportation (ambulance) and medical sheltering (nursing home, hospital, etc.).

You must be ready to evacuate when told to do so by emergency officials.

Pets are not allowed in most mass care shelters. To ensure their safety, arrangements for their evacuation should be made now. Ask your County Agriculture Commissioner about pet sheltering. Make sure that you have the following items on hand: current rabies and vaccination records, adequate food and water, and a properly tagged pet carrier.

When disasters occur, the demand for resources often exceeds local capability and may be unavailable. It is recommended that you pursue primary evacuation plans with family, friends, neighbors, church organizations, etc.

- Rely on local family members for your primary evacuation needs.

[1]Or any other local agency appropriate to provide this service, such as the local Departments of Health, Social Services, or Fire Protection District.

- Speak with your personal physician about your transportation and sheltering needs. If medical sheltering is essential, have your physician execute the necessary pre-admission procedures now.

- Talk to your friends and neighbors about providing you with evacuation transportation, forming a car pool or creating a buddy system. If you live in a mobile home park or condominium, inquire about your association's disaster plan.

VOLUNTARY REGISTRATION REQUEST FOR MEDICALLY FRAGILE INDIVIDUALS

_____ County
Office of Emergency Services
Medically Fragile Registry
[Mailing Address]
[City, CA, Zip Code]
[Telephone Number]

For Emergency Management Use Only:
MFR File Number:_____
Fire/EMS Agency:_____
Shelter Type:_____
Application Date:_____

----------DO NOT WRITE ABOVE THIS LINE----------

Name:_____ Spouse:_____Physical Address:_____ Apt/Lot:_____City:
Zip:_____ Phone:_____Mailing Address (if different than above):
Do you live in a mobile home? _____ If yes, what is the complex name?_____Are you a seasonal resident? _____ If yes, what months are you here?_____Date of Birth:
Social Security #:_____Check applicable medical disabilities:

❒ Legally Blind ❒ Deaf ❒ Terminal ❒ Contagious Disease

Specify other chronic medical disabilities:_____Are you:

❒ Self-ambulatory ❒ Ambulatory with Assist (walker, cane, arm)
❒ Confined to a wheelchair ❒ Non-ambulatory, bedridden

Check applicable special equipment that you are dependent on:

❒ Wheelchair ❒ Walker/Cane ❒ Crutches
❒ Life Support System ❒ Dialysis ❒ Insulin Dependent ❒ IV
❒ Oxygen: If yes, oxygen needed for __hours per day. Indicate liter flow:
Do you have a portable tank?
General Physician's Name: _____ Phone: _____Home Health Care Provider:_____ Phone:_____
Emergency Contact Person:_____ Phone:(____)_____Can you get to an evacuation shelter? _____ If no, check the appropriate transportation type needed?

❒ Standard Vehicle (bus, car) ❒ Wheelchair Equipped ❒ Ambulance

Will a caregiver accompany you to the evacuation shelter? _____ Relationship?_____Do you have a pet? _____ How many? _____ Have you made sheltering arrangements for them?

The information contained herein is true and correct to the best of my knowledge. I have read the information contained in this packet and I understand the limitation on the services and level of care available. I understand that assistance will be provided only for the duration of the emergency and that alternative arrangements should be made in advance in the event I am not able to return to my home. I also understand that I will be responsible for any charges and costs associated with hospital or other medical facility care or medical transportation. I grant permission to medical providers and transportation agencies and others as necessary to provide care and disclose any information necessary to respond to my needs. I understand that this registration is voluntary and hereby request registration in the Medically Fragile Registration Program.

_____ _____Registrant's
Signature Date

EMERGENCY EVACUATION DESTINATION CATEGORIES *for* MEDICALLY FRAGILE PATIENTS and RESIDENTS		
LEVEL OF CARE	***SHELTER TYPE***	***TRANSPORT TYPE***
LEVEL I ***Description:*** *Patients are usually transferred from in-patient medical treatment facilities and require a level of care only available in hospital or Extended Care Facility.* ***Examples***: ❑ Bedridden, totally dependent, difficulty swallowing ❑ Requires dialysis ❑ Ventilator-dependent ❑ Requires electrical equipment to sustain life ❑ Critical medications requiring daily or QOD lab monitoring ❑ Requires continuous IV therapy ❑ Terminally ill	Like Facility Hospital/ECF	ALS
LEVEL II ***Description:*** *Patients have no acute medical conditions but require medical monitoring, treatment or personal care beyond what is available in public shelters.* ***Examples*:** ❑ Bedridden, stable, able to swallow ❑ Wheelchair-bound requiring complete assistance ❑ Insulin-dependent diabetic unable to monitor own blood sugar or to self-inject ❑ Requires assistance with tube feedings ❑ Draining wounds requiring frequent sterile dressing changes ❑ Oxygen dependent; requires respiratory therapy or assistance with O_2 ❑ Incontinent; requires regular catheterization or bowel care	Medical Treatment Unit/Temporary Infirmary	BLS Wheelchair Van Car/Van/Bus
LEVEL III ***Description:*** *Patients are able to meet own needs or has reliable caretakers to assist with personal and/or medical care.* ***Examples*:** ❑ Independent; self-ambulating or with walker ❑ Wheelchair dependent; has own caretaker if needed ❑ Medically stable requiring minimal monitoring (i.e., blood pressure monitoring) ❑ O_2 dependent; has own supplies ❑ Medical conditions controlled by self-administered medications ❑ Is able to manage for 72 hours without treatment or replacement of medications/supplies/special equipment	ARC/ Public Shelter	Car/Van/Bus

SHELTER MEDICAL OPERATIONS GUIDELINES

I. DEFINITIONS

A. General Public Shelter

General public shelters are intended as safe havens for individuals and families who have been forced to leave their homes either due to an impending disaster or for short term emergency shelter after a disaster. General public shelters remain operational until evacuees can either return home or locate alternative safe housing.

General public shelters accept people with minor injuries or illnesses, or those with physical or emotional limitations, who do not require close monitoring, assistance, or equipment. Evacuees requiring skilled health or personal care will be referred to an appropriate health care facility or to a medical treatment unit/temporary infirmary. General public shelters cannot guarantee that there will be adequate medical or personal care staff or the necessary supplies or equipment for people who require such support.

B. Medical Treatment Unit/Temporary Infirmary

Medical treatment units are shelters intended to provide, to the extent practicable under emergency conditions, an environment in which medically fragile evacuees' current levels of health can be sustained. These facilities are staffed and supplied by the transferring agency and/or local health authorities and are administered by appropriate local governmental agencies in collaboration with the Red Cross or other sheltering agencies. Temporary infirmaries are portions of general public shelters intended to provide the same services. Local health authorities should determine the maximum population of medically fragile individuals that can be safely cared for in temporary infirmaries, and develop plans to open separate medical treatment units/shelters when the number of patients exceed the capability of the public shelter temporary infirmary.

Individuals who should be directed to a medical treatment unit or temporary infirmary for care include the following:

- People who require assistance with medical care or treatments, such as routine injections, IV therapy, wound care, in-dwelling drainage or feeding tubes, respiratory hygiene or who are dependent upon electrical medical devices.
- People who are unable to care for themselves and require personal care assistance for activities of daily living (ADLs) and do not have a caregiver present, or those whose mental status requires continuous monitoring and/or a secure environment.

II. MEDICAL TREATMENT UNIT/TEMPORARY INFIRMARY SITE SELECTION

A. Selection Process

When selecting sites appropriate for use as medical treatment units/temporary infirmaries, local government should work in conjunction with specific local and private agencies to ensure that medical, health, safety and other concerns are met. Representatives from the local health department, local emergency management, local school board(s), county/municipal engineering, building inspection, American Red Cross (ARC), and voluntary agencies should all participate in the site selection process.

Selected facilities should be (to the extent possible) compliant with the Americans with Disabilities Act (ADA), as this enables evacuees to be less dependent on staff and caregivers. Ramps, railings, easy-open doors, lowered water fountains and wash-basins, all assist the mobility-impaired to be more independent. All public buildings should be ADA compliant.

The California Department of Social Services has formed Care and Shelter Technical Assistance Teams to provide technical guidance and expertise to local governments concerning care and shelter requirements and responsibilities. For more information, local government is encouraged to contact the team assigned to their area.

B. Selection Criteria

The primary difference in requirements between general public shelters and medical treatment units/temporary infirmaries is the need for space for sleeping, medical equipment, medical supplies, and medical treatment areas, etc. Although the American Red Cross has established guidelines for selecting general public shelter sites, they do not address medical needs. However, local government, in conjunction with the ARC, should consider the following additional medical criteria:

- ❒ Sleeping/living space for medically fragile individuals should be calculated at approximately 60 - 80 sq ft per person to accommodate a 6' x 3' cot/mattress and a 2 - 3 foot wide perimeter.

- ❒ Extra space should be allocated for main aisle ways and should be wide enough to accommodate wheelchairs.

- ❒ Include space for two or three private examination rooms/areas.

- ❒ Pantry or storage space will be required for supplies.

- ❒ Refrigeration storage space will be required for certain pharmaceutical supplies.
- ❒ Water and sanitation systems should be in place and functioning.
- ❒ Adequate ongoing and backup electrical power.
- ❒ Each facility to be utilized as a medical treatment unit/temporary infirmary should be identified in the local emergency plan as having priority for restoration of electrical power by power suppliers.
- ❒ Should have reliable on site emergency power. Generators should be sized to fully accommodate all anticipated load requirements when the facility is fully staffed and functioning, independent of commercial electric power. Generators should have at least a 72-hour fuel supply.

III. STAFFING THE MEDICAL TREATMENT UNIT/TEMPORARY INFIRMARY

The following staffing recommendations are intended to provide evacuees with the minimum level of care.

A. Standards

- Medical/health professionals should only perform those duties consistent with their level of expertise and only according to their professional licensure/certification and allowable scope of practice.

B. Staffing Schedules

- Staff should not be scheduled to work for more than 12 hours in a 24-hour period.

C. Staffing Patterns

- The staffing pattern should be adjusted based on the actual number and needs of the medically fragile evacuees in the medical treatment unit/temporary infirmary.

D. Staffing Levels and Roles

1. MEDICAL MANAGEMENT

- ❒ An EMS Medical Director, Health Officer, or other designated medical manager or administrator should be available to provide overall medical management.

2. PHYSICIAN SERVICES

- ❒ A physician should be on site and have admitting privileges to at least one general hospital.

3. NURSING SERVICES

- ❒ A Registered Nurse should be on site to provide supervision and direction to caregivers.

4. CAREGIVERS

- ❒ Experienced caregivers include licensed and certified nursing staff, home health aides, paramedics, emergency medical technicians, medical/nursing students/trainees, personal care attendants, nursing aides and orderlies.

- ❒ Families of medically fragile evacuees should be allowed to stay with patients in the medical treatment unit/temporary infirmary, as they provide moral support and are often trained as caregivers.

5. MENTAL HEALTH PROFESSIONALS

- ❒ Mental health professionals capable of intervention and crisis counseling should be on site.

6. VOLUNTEERS

- ❒ The Red Cross encourages the recruitment of volunteers to assist with non-specialized tasks.

E. Staff-to-Patient Ratios

The staff-to-patient (medically fragile evacuee) ratios are recommended only as general guidance for planning purposes and should not be construed as mandatory. Furthermore, these ratios do not imply or guarantee that any jurisdiction has the available personnel resources, either employed or voluntary, to be able to staff medical treatment units/temporary infirmaries at the recommended levels. The acuity of the population or other factors may justify an increase or decrease in the type and number of staff present.

Suggested Staff-to-Patient Ratios
Each 12-hour Shift

Medical/Health Staffing	Shelter Population				
	35-40	41-80	81-120	121-160	161-200
❒ Medical Director	1	1	1	1	1
❒ Physician	1	2	3	4	4
❒ RN Supervisor	1	1	1	1	1
❒ RN/LVN	1	2	3	4	5
❒ Experienced Caregiver	3	6	9	12	15
❒ Mental Health	1	2	2	2	3
TOTAL	8	14	19	24	29

F. Staffing Resources

1. ESTABLISH A RESOURCE DIRECTORY

Develop a list of resources for medical personnel. Agencies with similar staffing resources which may be accessed include:

- local service providers to the aging
- home health agencies
- medical offices and clinics
- occupational health agencies
- managed care organizations
- ambulance companies
- hospitals and nursing homes
- nursing registries

When local staffing is unavailable, additional staff may be obtained through the State Emergency Management System. (Appendix B).

2. COMPENSATION, REIMBURSEMENT AND OTHER EXPENSES

Impacted counties must be prepared to pay for all costs associated with requests for emergency medical personnel. Personnel obtained from outside the area may also incur extra costs including travel and *per diem* expenses.

IV. MEDICAL SUPPLIES

A. Identify Supply Needs

A listing of suggested medical and general supplies necessary for establishing a medical treatment unit/temporary infirmary is included at the back of this document. Local government should review the suggested supply list and adopt or modify it as necessary to meet the needs of the county.

B. Develop a Resource Directory

❒ Maintain a resource directory with 24-hour emergency telephone numbers of vendors, suppliers, etc. and update it periodically.

❒ Develop contracts with local vendors, suppliers, and/or distributors to provide the variety and quantity of supplies needed, including resupply.

❒ When local supplies are exhausted, additional resources may be obtained through the State Emergency Management System. (Appendix B).

3. LOGISTICAL NEEDS

❒ Determine transportation and delivery methods.

❒ Determine storage and warehousing requirements.

❒ Determine the disposition of unused supplies following the emergency.

4. FINANCIAL RESPONSIBILITY

Impacted counties must be prepared to pay for all costs associated with requests for emergency medical supplies and equipment.

V. OBTAINING ADDITIONAL ASSISTANCE

A. Develop Cooperative Agreements

In coordination with the Regional Disaster Medical Health Coordinator (RDMHC), all counties within the OES mutual aid region should establish regional medical and health cooperative agreements. These agreements will help provide medical and health resources when local resources are depleted. Cooperative agreements document and establish procedures for the requisition, provision and payment of medical/health resources during an emergency.

B. Requesting Resources

When local medical/health resources are depleted, contact the County's Medical/Health Coordinator at the Operational Area Emergency Operations Center. The Medical/Health Coordinator can assist you in locating necessary resources from elsewhere within in the County, or request assistance from the region. The RDMHC will activate any regional cooperative agreements that may be in place and/or identify and coordinate resources from within the region, or, if necessary, request assistance from the State.

VI. SUGGESTED SUPPLIES FOR MEDICAL TREATMENT UNITS/SHELTERS: GENERAL AND MEDICAL

Following is a list of supplies to provide care and treatment to one hundred people for 3 days.

ITEM	DESCRIPTION	QUANTITY
Acetaminophen (non-aspirin)	adult	1 bottle (100 tablets)
Acetaminophen (non-aspirin)	pediatric	2 bottles (liquid)
Adhesive strips, plastic	assorted sizes	3 dozen
Adhesive tape	3" x 4" widths	2 rolls
Adhesive, non-allergic	assorted sizes	1 dozen
Airways		2
Alcohol, isopropyl	1 pint	1
Alcohol preps		2 dozen
Anaphylactic kit		1
Antacid, low sodium	tablets in box	2 boxes
Antibiotic ointment	tube	1
Antihistamines (tablets)	box	1
Antihistamines (liquid)	bottle	1
Antipruritic ointment	tube	1
Antiseptic	bottle	1
Applicator, cotton-tipped	6" long	2 dozen
Aromatic spirits of ammonia	breakable capsules	6
Aspirin, 5 grain	package of 2	100
Baby feeding bottles		1 dozen
Bandage gauze roller		1 dozen
Bedside commode		10
Betadine scrub solution	bottle	1
Bio-hazard waste bags	large	1 dozen
Blankets		100
Blood glucose strips	box	1

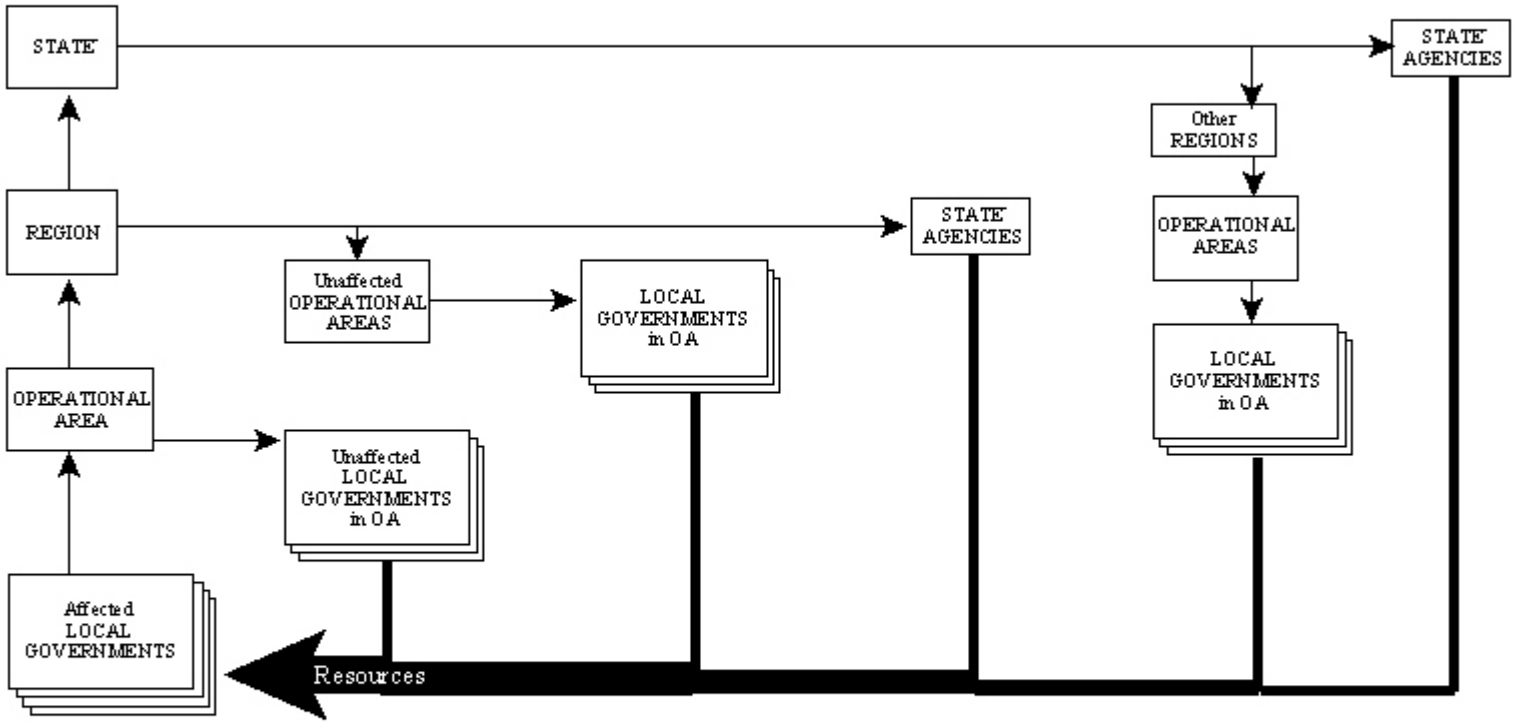
ITEM	DESCRIPTION	QUANTITY
Body lotion, moisturizing	bottle	3
Box or chest with lock to store medications		1
Bucket	2 gallon	2
Bug repellant, lotion	bottle	3
Calamine lotion	bottle	1
Can opener	manual	1
Chlorine bleach, liquid	1 quart	1
Collapsible water containers	1 gallon	10
Colostomy bags	box	1
Cotton balls	prepackaged	200
Diabetic diet		
Dialysis diet		
Diapers, baby, disposable	infant, med. & large	3 doz
Diapers, adult	prepackaged	
Dressing basin	small flat container	
Dressing adherent	assorted sizes	
Dust masks (facial)	disposable	20
Elastic bandage	3"	2
Emesis basin(s)		10
Eye pads	box	1
Face masks	disposable, for mouth to mouth resuscitation	
Facial tissues		2 boxes
Flashlight and batteries		1
Forceps or large tweezers		1
Formula, infant	powdered, liquid	2 cases
Gauze compresses, individually wrapped	3" x 3" or 4" x 4"	2 dozen
Gloves, plastic, non-sterile	disposable	6 dozen

ITEM	DESCRIPTION	QUANTITY
Gloves, plastic, sterile	disposable	6 dozen
Handi-wipes	disposable	1 case
Hydrogen peroxide	bottle	1
Hydrocortisone, .5% ointment	tube	1
Ipecac	bottle	1
Ice bag	disposable	1
Identification bracelets		100
Insulin syringes		
Instant ice	ice pack	2 dozen
Irrigation kit		1
Kaopectate	bottle	3
Lancing device		
Magic markers	permanent marker	1 dozen
Newspaper	(clean up messes)	
Obstetrical kit	disposable	1
Oxygen and tubing		
Paper cups	6 oz or 8 oz size	1 case
Paper towels		2 rolls
Petroleum	small tube	1
Pillows		100
Plastic bags	large	1 box
Safety pins	assorted sizes	2 dozen
Sanitary napkins	regular	2 dozen
Scissors	blunt	4 pair
Scouring powder		1 can
Sharps container		1
Soap	cake and liquid (antimicrobial)	
Soap substitute	bottle	2

ITEM	DESCRIPTION	QUANTITY
Soybean formula	can	1 case
Sphygmomanometer	adult cuff	1
Sphygmomanometer	pediatric	1
Spill kit		1
Splint or splinting device	arm, leg	1 package
Sterile water	gallon	1
Stethoscope		1
Sugar	cubes, package	
Sunscreen	SPF #15, bottle	3
Table salt	box	1
Throat lozenges	bag of 20	3
Tongue depressors		1 package
Tourniquet		1 package
Thermometer		10
Underpads (“blue” pads)		150
Urinary drainage and bag		1
Vinegar	bottle	1
Walker	walking assistance	2

Mutual Aid System Concept:
General Flow of Requests and Resources

APPENDIX - I
Shelter Medical Operations Guidelines



→ Resource Requests

OA - Operational Area

Notes: Local governments may request mutual aid directly from other local governments where local agreements exist.

Discipline-specific mutual aid systems may have procedures that provide additional methods of obtaining state resources.

Volunteer and private agencies may be involved at each level.

STATEMENT OF UNDERSTANDING

BETWEEN THE COUNTY OF _____ DEPARTMENT OF HEALTH SERVICES AND THE AMERICAN RED CROSS, _____ CHAPTER

I. Purpose

The purpose of this Statement of Understanding is to define the relationship between the County of _____ Department of Health Services and the American Red Cross, Chapter, in preparing for, and responding to the physical and emotional needs of individuals, groups, and families in disaster relief situations. This disaster relief and response may be met through the joint efforts of the_____ Department of Health Services and the American Red Cross.

II. Authorities

County government is responsible for the health care of its residents (California Health and Safety Code, Section 101025), including those special populations who fall beyond the scope of the American Red Cross, such as skilled nursing facilities, board and care homes, developmentally-delayed adults, congregate living situations, mental health residential-care sites, and technology-dependent persons.

The mission of the Department of Public Health is health promotion and primary prevention. Department of Health Services staff will participate pro-actively in preparation for disaster response and recovery in the community. During a disaster, Department of Health staff will work within established governmental guidelines, with adherence to the California Code of Regulations, Title 19, Division 2, Office of Emergency Services; and will be accountable for their disaster response activities.

By congressional charter dated January 5, 1905 (36 U.S.C.) and subsequent statutes (Public Law 93-288), the American Red Cross has been designated the nationwide lead agency through which the American people voluntarily extend assistance to individuals and families in need as a result of disaster. The American Red Cross does not have the power to surrender the mandate created by its charter. The legal status of the American Red Cross, as a unique instrumentality, has been confirmed by a unanimous decision of the U.S. Supreme Court in *Department of Employment v. United States, 385 U.S. 355 (1966)*. The American Red Cross mitigates suffering by meeting the urgent needs of victims and emergency workers immediately after a disaster has struck or in advance of a potential disaster.

Appropriate Federal, State, and local government agencies may, by contract or otherwise, accept and utilize the services and facilities of the Red Cross and may distribute through the Red Cross medicines, food, and other consumable supplies of emergency assistance.

The Red Cross recognizes that primary responsibility for the general health of a community in a disaster rests with the local public health authorities and medical, nursing, and health resources. Ill or injured persons normally look to their own physicians or to the usual community medical, nursing and health care facilities for the particular type of care needed. All Red Cross disaster health services activities, as part of the Red Cross disaster preparedness and relief program and as part of the community's emergency response system, supplement the existing community health care delivery system. Just as the Red Cross coordinates its overall disaster program, with the community's public safety and emergency service efforts, the Red Cross disaster health services efforts must be coordinated with those of the local health authorities and the medical and nursing communities. All activities and services provided by the Red Cross will be high quality and will conform to current professional standards.

III. AREAS OF AGREEMENT AND COOPERATION

The American Red Cross and the County of _____ Department of Health Services, agree to cooperate in the following areas of endeavor:

Cooperative utilization of volunteer and paid staff to meet the community's need. The Department of Health Services is responsible for the care of individuals who are sheltered and require medical care, special medical equipment and/or continuing medical surveillance. These individuals may either be transferred as soon as possible from a public shelter to an appropriate alternate facility or be cared for by the agency or individual normally responsible for pre-shelter caretaker duties, or the Department of Health Services in the temporary infirmary section of the shelter.

Transferral of all persons requiring a fully equipped and properly staffed facility will be a high priority and will be coordinated jointly by the Emergency Management Agency and the _____Health Department.

The American Red Cross, in cooperation with the Department of Health Services, will provide Health Services personnel in all designated Red Cross shelters. These Red Cross workers will be available for consultation with the Department of Health workers in the temporary infirmary section.

The Department of Health Services will:

- Provide consultation to the ARC shelter nurses regarding health assessments and referrals.
- Provide surveillance in cooperation with Environmental Health to all Red Cross shelters.
- Make Public Health Nursing personnel assignments to Red Cross shelters when mutual aid is requested through appropriate channels.
- Provide consultation and training on communicable disease control to shelter staff.
- Collaboration in training activities, research, and adherence to professional ethics.

The _____ Chapter of the American Red Cross will support the Health Department by offering American Red Cross Disaster Preparedness Training including, but not limited to:

- ARC Shelter Management
- Disaster health Services 1 & 2 for Public Health Nurses(PHN)
- ARC First Aid and CPR Courses
- Disaster Mental Health Services

Both agencies will collaborate to develop training which addresses the unique aspects of the two different agencies. Priorities will focus on:

- Coordination of health care activities
- PHN preparation for working in ARC shelters
- Tracking patients/clients back into communities
- Utilization of congregate Care Teams; shelter/community liaisons

Both agencies will participate in city/county disaster drills to enhance their understanding of roles and responsibilities.

Appropriate pre-event liaison and operational communications and coordination of services: Representatives of both agencies will participate in disaster planning meetings focusing on meeting the disaster-caused or aggravated physical and emotional needs of the community. Information to be included is:

- Table of organization
- Initiation of mutual aid
- Expected services

Both agencies agree to formulate and adopt Operational Response Plans to address and detail the operational policies and procedures to outline the cooperative efforts under this Statement of Understanding.

IV. PUBLICATION AND DISSEMINATION OF DIRECTIVES

Both agencies agree to jointly publish this agreement and to disseminate its content through appropriate methods and channels to its executive, managerial, and supervisorial staffs, any volunteer or paid staff providing disaster relief services, and as a basis of coordination with superior, affiliated, associated, or subservient units, departments, divisions, or organizations.

V. EFFECTIVE DATE, MODIFICATION, AND TERMINATION

This agreement shall become effective upon the execution by authorized individuals of both organizations. It must be ratified by appropriate authority within one year of its execution and may continue in force with or without subsequent modification or amendment until terminated. Modifications shall be by the same means as original execution, including the same obligations

of publication and dissemination of such modifications. Termination may be by either party to the other with a minimum of thirty calendar days' prior written notice.

This agreement shall not be construed to be an instrument of binding performance, contractual obligation, or any other form of enforceable instrument. It is designed to communicate the intentions of the two organizations to cooperate in various means, methods, and areas of endeavors.

SIGNATURES

AUTHORIZED BY:

_____(CEO) _____
_____Chapter, American Red Cross Date

_____(Exec. Dir.) _____
Medical Director, County of _____, Date
Dept. of Health Services

STATEMENT OF UNDERSTANDING

BETWEEN THE COUNTY OF _____ DEPARTMENT OF MENTAL HEALTH AND THE _____ COUNTY CHAPTER OF THE AMERICAN RED CROSS

I. PURPOSE

The purpose of this Statement of Understanding is to establish a working relationship between County of (county) Department of Mental Health, and the (chapter) County Chapter of the American Red Cross, hereafter referred to as Red Cross, to prepare for and coordinate disaster mental health services. Preparedness shall include the coordination and provision of disaster mental health training.

II. TYPES OF DISASTERS

Disasters are events that result in human suffering or create needs that cannot be alleviated without assistance. These events can be categorized as natural disasters (e.g., storms, floods, earthquakes, tidal waves, fires, etc.), technological disasters (transportation accidents, explosions, hazardous materials accidents, building collapses, etc.), health disasters (famines, pestilence, disease outbreaks) and social disasters (bombings, riots, wars).

III. MAJOR DISASTERS/OTHER DISASTERS

For the purpose of this Statement of Understanding, a "major disaster" is an event that has caused a local governing body (i.e., city or county) to declare a LOCAL emergency, the governor to declare a STATE OF EMERGENCY and/or the president to issue a FEDERAL DISASTER DECLARATION. This final presidential declaration is made when damage exceeds the resources and capability to respond of both local and state government as well as private relief organizations.

For the purpose of this document, "local disasters" are defined as emergencies or disasters in (county) County that do not meet the definition of a "major disaster." In "local disasters," the Red Cross shall evaluate whether the disaster meets Red Cross criteria for response. The Red Cross disaster mental health program is a supplement to community resources, and is not intended to take the place of appropriate community or corporate mental health programs. The Red Cross mental health function has primary responsibility for meeting the emotional needs of Red Cross workers, their families, and victims of disasters in Red Cross service delivery areas. If the situation does not meet Red Cross disaster response criteria, requests for mental health services may be referred to County of (county) Department of Mental Health or to other appropriate mental health resources. Examples of disasters that Red Cross routinely responds to include single or multiple-family fires. Examples of other events to which the Red Cross does not respond include small transportation accidents including automobile crashes, incidents involving workplace violence, or industrial accidents where there is definite corporate liability requiring referral to in-house or contracted employee assistance programs.

IV. DEFINITION OF SIZES OF DISASTERS

In order that the County of (county) Department of Mental Health and the Red Cross may work cooperatively with each other and without duplication of effort in providing disaster mental health services in the aftermath of both "major" and "local disasters," the organizations agree as follows:

A. Local Disasters: In "local disasters" which meet Red Cross disaster response criteria, the Red Cross shall be the coordinating agency in both the scheduling and provision of disaster mental health services. The Red Cross shall:

1. Identify, assign and schedule Red Cross disaster mental health professionals to provide disaster mental health services to people affected by the disaster, including survivors and Red Cross disaster workers, located in Red Cross shelters, service centers or other field operations.

2. Establish and maintain contact with the (county) County Department of Mental Health Disaster Coordinator and provide information including location of Red Cross operations, assessment of mental health needs, immediate plans for Red Cross operations and consult as needed.

3. If needed, request deployment of (county) County Department of Mental Health clinicians to supplement staffing of Red Cross mental health professionals at shelters, service centers or other field locations. This request shall be made through the (county) County Department of Mental Health Disaster Coordinator and shall be specific as to the number of clinicians requested, as well as the days and hours of coverage needed.

4. If county clinicians are deployed, provide for basic needs of same including space in which to work and access to telephones and other communication devices. When (county) County Department of Mental Health clinicians are deployed in "local disasters," the department shall:

    a. Provide salaries and benefits to staff assigned to Red Cross operations

    b. Ensure that department clinicians providing services in Red Cross locations display county-provided photo identification cards at all times

    c. Direct staff, upon arrival to and departure from Red Cross locations, to report to Red Cross disaster mental health supervisors and shelter or service center managers

d. Provide crisis counseling, defusing and information and referral services to people affected by disaster

B. Major Disasters: Following a county, gubernatorial or presidential declaration of a "major disaster," the shall become the coordinating agency in both the scheduling and provision of community disaster mental health services. In addition to the actions specified in 'c' above, the (county) County Department of Mental Health shall:

1. Assume responsibility for the coordination of disaster mental health services at various community locations;

2. Working collaboratively and consult with the Red Cross disaster mental health officer or designee to ensure adequate coverage of Red Cross shelters, service centers and other service delivery sites;

3. If necessary, request disaster mental health mutual aid approval from the State Office of Emergency Services (via the State Department of Mental Health) and coordinate with the other jurisdictions the scheduling and assignment of mutual aid clinicians;

4. Ensure that Department of Mental Health mutual aid clinicians working at Red Cross service delivery sites display county of origin photo identification cards at all times and coordinate their activities through the Department of Mental Health, and

5. Work with the Red Cross Disaster Mental Health administrative staff, and schedule Red Cross mental health professionals, as needed and available, to supplement the larger community mental health response effort.

C. The Red Cross shall:

1. Identify and assign Red Cross disaster mental health professionals to provide disaster mental health services to Red Cross staff and supplement the Department of Mental Health in the provision of services to people affected by disasters located in Red Cross shelters, service centers and other community locations as needed.

2. Recruit supplemental disaster mental health staff as needed through the Red Cross Disaster Services Human Resources System.

3. Provide the (county) County Department of Mental Health Disaster Coordinator with a Red Cross disaster mental health staff liaison to daily perform the following:

a. Provide information regarding Red Cross operation staffing changes, moves or relocations;
b. Provide information including the location of all Red Cross operations;
c. Provide assessment of mental health needs and diversity of population being served;
d. Plan and implement scheduling and site coverage issues;
e. Provide names and telephone numbers of Red Cross shelter and service center managers and Red Cross disaster mental health site supervisors; and,
f. Provide service delivery statistics including number of mental heath contacts.

4. Provide for basic needs of all disaster mental health clinicians coordinated by the Mental Health Department and deployed to Red Cross locations including space in which to work and access to telephones and other communication devices.

V. AIRLINE DISASTERS

According the Aviation Disaster Family Assistance Act of 1996 (United States Senate Bill S2161) signed September 30, 1996, the American Red Cross has been designated by the National Transportation and Safety Board (NTSB) as the responsible agency to coordinate the provision of mental health and counseling services to families of passengers involved in airline disasters where there is a significant loss of life.

VI. RESPECTIVE AGENCY RESPONSIBILITIES

A. In order to ensure services are provided which meet the intent of the law, the Red Cross shall:

1. Identify, assign and schedule appropriate Red Cross Disaster Mental Health professionals to provide emotional care and support to families at the site of the disaster, the family support center, point of departure and destination, as well as to those unable to travel to the site. These services will be provided in coordination with the disaster response team of the air carrier involved;

2. Ensure that an environment is provided in which families may grieve in private;

3. Communicate with the families as to the roles of the Red Cross, governmental agencies, and the air carriers involved with respect to the accident and post-accident activities;

4. Arrange for a suitable memorial service, in consultation with the families;

5. Contact all affected families periodically after the incident until it is determined that further assistance is no longer needed;

6. Establish and maintain contact with the (county) County Department of Mental Health Disaster Coordinator and provide information including location of Red Cross operations, assessment of needs, immediate plans for Red Cross operations, and areas which need mental health services that may be the responsibility of local jurisdictions (i.e. fire, police, rescue and recovery workers, witnesses, impacted community);

7. If county clinicians are deployed to supplement Red Cross disaster mental health at family support centers, ensure that basic needs for space in which to work, as well as access to telephones and other communications devices are provided;

8. Coordinate with local ministerial alliance to ensure either provision of, or referral to, spiritual counseling; and,

9. Ensure that all staff working with families receive appropriate mental health support including defusing and debriefing as needed and at end of shifts.

B. The (county) County Department of Mental Health will, upon request and as appropriate:

1. Ensure that all staff deployed to work with families are appropriately screened for suitability of assignment;

2. Ensure that staff clinicians providing services in Red Cross locations display county-provided, disaster-specific photo ID cards at all times as well as Red Cross photo ID if appropriate;

3. Direct staff, upon arrival and departure at assigned Red Cross locations, to report to Red Cross disaster mental health supervisors and site managers;

4. Ensure that all professional staff deployed agree to work specific shifts and schedules as agreed upon by the County Department of Mental Health services and Red Cross coordinators; and,

5. Provide crisis counseling, defusing, bereavement support, information and referral to families, and debriefing services as needed and requested to staff.

VII. PUBLICATION AND DISSEMINATION OF DIRECTIVES

Both agencies agree to jointly publish this agreement and to disseminate its content through appropriate methods and channels to its executive, managerial, and supervisorial staffs, any volunteer or paid staff providing disaster relief services, and as a basis of coordination with superior, affiliated, associated, or subservient units, departments, divisions, or organizations.

VIII. EFFECTIVE DATE, MODIFICATION, AND TERMINATION

This agreement shall become effective upon the execution by authorized individuals of both organizations. It must be ratified by appropriate authority within one year of its execution and may continue in force with or without subsequent modification or amendment until terminated. Modification shall be by the same means as original execution, including the same obligations of publication and dissemination of such modifications. Termination may be by either party to the other with a minimum of thirty calendar days prior written notice.

This agreement shall not be construed to be an instrument of binding performance, contractual obligation, or any other form of enforceable instrument. It is designed to communicate the intentions of the two organizations to cooperate in various means, methods, and areas of endeavors.

IX. SIGNATURES

AUTHORIZED BY:

_____(CEO)_____ _____
(chapter) County Chapter, American Red Cross Date

_____ _____
Director, (county) County Department of Mental Health Services Date

Adopt-A-Shelter Program

Adopting a medical treatment shelter means that a group or business agrees to supply either equipment or personnel to a medical treatment unit/shelter of their choice. Knowing ahead of time which shelters are already sponsored will enhance the ability of the local emergency management program to plan emergency shelters. This program ensures that the resources needed to open and maintain shelters are allocated and ready at any time.

General Population Shelter

Managers, nurses, logisticians, cooks, janitors, registrars, recreational/child care workers, interpreters (e.g. Hispanic, sign language), amateur radio personnel, and building managers are among the positions needed in a general shelter. In many instances, the residents of the shelter may assist in filling these positions.

Medical Treatment Units/Shelter

A medical treatment unit/shelter can be either a stand-alone shelter or a separate area within a general shelter. A medical treatment unit requires the same staffing as a general shelter and also requires additional staff to meet the advanced medical needs of the residents, as outlined in the staffing matrix in **Appendix - I: Medical Shelter Operations Guidelines.**

The additional staff and equipment needed in medical treatment units/shelters provide an opportunity to approach companies in the community to adopt shelters and supply them with their own equipment and/or personnel. Many of these companies (e.g. home health agencies and medical supply companies) deliver services to these individuals on a regular basis. Staff from any organization or company adopting a shelter should be allowed to have their families with them at the shelter. This may be viewed as an additional recruitment incentive.

Should additional staff be needed for a shelter, the adopt-a-shelter concept, if used by a service or civic organization, provides another avenue of support for both general and medical treatment units/shelters. The American Red Cross continues to recruit from various organizations for the management, operation, and supply of the shelters. There may also be other groups which have the ability and desire to work in either a medical treatment or general shelter. State and local government and the American Red Cross should work together to support community recruitment of all interested organizations and companies in the Adopt-A-Shelter Program.

EMERGENCY TELE-DIRECTORY

YUBA COUNTY:

Emergency Services (OES)	741-6254/6255
Sheriff/Coroner:	911/741-6331
Marysville Police:	741-6621
Wheatland Police:	633-2821
Health Dept.:	741-6366
Animal Control:	741-6478
Mental Health Services	822-7200
Crisis Line:	673-8255

SUTTER COUNTY:

Emergency Services (OES)	822-7370
Sheriff/Coroner:	911/822-7307
Yuba City Police:	822-4661
Health Dept.:	822-7225
Animal Shelter:	822-7375
Mental Health Services	822-7200
Crisis Line:	673-8255

MEDICAL CENTERS:

Rideout Emergency:	749-4511/4300
Peachtree Clinic:	749-3242
Sutter Co. Med. Clinic:	822-7215
DelNorte Clinic:	743-4611
Mental Health Services:	822-7200
Crisis Line:	673-9255

INDIVIDUAL INFORMATION

1. Take this Passport TO ALL MEDICAL VISITS for the doctor to review and update.
2. Keep this Health Passport with you as a record of your health care.
3. This information is personal and confidential.
4. Keep your Medi-Cal, Medi-Care, insurance and yellow Immunization Card with the Passport.
5. Schedule appointments for routine and follow-up care.

NAME:
ADDRESS:
TELEPHONE:
AGE:_____SEX:_____SS#

INSURANCE COMPANY / No:

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY:

Name:

Address:

Telephone:

HEALTH PASSPORT

FOR

_____

FROM

_____

ALLERGIES:

ALERTS:

HEALTH / SOCIAL SERVICES
Previously Provided by:

APPENDIX - L

AGENCY	(√)
Fremont/Rideout Emergency	
Sutter County Medical Clinic	
Peach Tree Clinic	
Del Norte Clinic	
Yuba Feather Medical Group	
Sutter Yuba Mental Health	

PHARMACY INFORMATION

Hospital / Clinic Last Visited:

Primary Care Physician:

Medications + Last Refill Date:

Pharmacy Used:

DATE & TIME	PROBLEM & ILLNESS	PHYSICIAN & MEDICATION

MEDICAL HISTORY

(*Include Dates*)

1. **Allergies:**
2. **Medications:**
3. **Serious Illness:**
4. **Hospitalization:**
5. **Psychiatric History:**
6. **Family History:**
7. **Special Needs:**

APPENDIX - L

ROLES & RESPONSIBILITIES

THE GOVERNOR'S OFFICE OF EMERGENCY SERVICES

Responsible for providing statewide leadership and coordination of the State's disaster response, including disaster planning, preparedness, mitigation, and recovery.

- Lead state agency responsible for statewide emergency and disaster planning, response, recovery, and mitigation
- Ensure the utilization of the Standardized Emergency Management System to assure state readiness for disaster preparedness, response, recovery, and mitigation
- Task appropriate State agencies to coordinate resources as needed to support a local disaster response.
- Coordinate response from the OES Regional Emergency Operations Center(s) and State Operations Center
- Use emergency operations centers to process local government and state agency requests, in coordination with FEMA, as needed

EMERGENCY MEDICAL SERVICES AUTHORITY

Plans for and provides statewide leadership during a disaster response involving mass casualties. Establishes policy and direction to assist local government in the event of a medical emergency that exceeds local and regional capability to respond.

- State medical preparedness and response management
- Strengthen local disaster response capabilities
- Liaison with federal disaster medical system
- Support local response
- Establish communication links with affected counties
- Assess disaster medical needs
- Coordinate the provision of medical resources to hospitals, clinics, nursing homes, shelters and field treatment sites

DEPARTMENT OF HEALTH SERVICES

Preserves, protects, and restores the health of the citizens in the disaster area through the provision, support, or restoration of public health and medical care services and programs. Helps to ensure that patients and residents are moved and relocated in the safest, most effective manner possible.

- Coordinate statewide public health assistance in support of local operations
- Conduct statutorily mandated response activities
- Support the EMS Authority in planning for and staffing the State Medical and Health Emergency Operations Center
- Enforcement of Title 22 regulations regarding health facilities development and review of disaster plans
- Facility implementation of disaster plans and notification of DHS, Licensing and Certification

- Plan in coordination with OES, EMSA and other departments
- Communication and liaison with OES, EMSA, local emergency authorities and other DHS programs and authorities
- Provide consultation and information to health facility staff and local emergency authorities regarding evacuation and relocation options
- During disasters, provide volunteer medical personnel for evacuation shelter staffing and other disaster relief

DEPARTMENT OF SOCIAL SERVICES

Develops and maintains California's disaster congregate care and shelter system and provide assistance to local government's mass care emergency response.

- Establish and train a statewide emergency services team
- Coordinate and strengthen a county's ability to meet their congregate mass care needs
- Program planning for compliance with the Americans with Disabilities Act
- Maintain CSU and UC Sheltering Partnership Program
- Maintain the Statement of Operational Relationship with the American Red Cross
- Provide technical assistance for the California Association of Information and Referral Systems
- Provide assistance to local government's mass care emergency response
- Provide representation at the State and Regional Emergency Operations Centers
- Coordination of the California Emergency Repatriation Program (CERP)

OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT (OSHPD)

Assures that hospitals are reasonably capable of providing services to the public after a disaster.

- Administer the provision of the Hospital Seismic Safety Act of 1983
- Enforce the California Building Standards Code - regulations for construction of health care facilities
- Plan review and approval of construction drawings as well as the observation of construction
- Assess acute care hospitals and skilled nursing facilities for structural, critical nonstructural and fire and safety issues
- Ensure rapid and correct safety inspection postings of facilities
- Provide information regarding facility status
- Expedite review, approval and permission of hospital repair and reconstruction
- Closure of all or portions of these facilities by OSHPD is a last resort and only if a threat to life safety exists
- Other inspections such as licensing and health may result in closure of a hospital regardless of OSHPD's assessment
- Local response officials, local structural engineers or health officials may post and evacuate a facility, however, OSHPD will inspect all facilities under their jurisdiction

DEPARTMENT OF MENTAL HEALTH

In support of local government, the Department of Mental Health is responsible for the statewide coordination of mental health services and resources necessary to meet the mental health needs of Californians after a disaster.

- State agency responsible for overseeing California's mental health system and statewide coordination of disaster mental health planning, response, and recovery (the responsibility for the provision of services is retained by the Counties)
- Liaison with county mental health officials and state and federal disaster staff
- Coordinate with private sector and other disaster agencies such as the American Red Cross
- Provide needs assessment assistance to local mental health programs
- Coordinate and monitor state mental health mutual aid assistance in support of local mental health efforts
- Secure federal disaster crisis counseling funding to ensure support of Substance Abuse and Mental Health Services Administration (SAMSA)
- Administer federal funded crisis counseling programs, including program and fiscal oversight through evaluation and monitoring of local programs
- In coordination with local mental health programs, provide disaster mental health education and information to general public and public officials

DEPARTMENT OF REHABILITATION

Assists Californian's with disabilities in obtaining and retaining employment and maximizing their ability to live independently.

- Lead agency responsible for assisting state government in responsibilities pertaining to the Americans with Disabilities Act
- Enter interagency agreements with state agencies for ADA plans and procedures
- Provide training and technical assistance to a broad range of individuals and organizations regarding physical accessibility for individuals with disabilities
- Provide technical assistance for disability planning
- Provide information regarding disability issues
- Assist agencies assisting ADA populations
- Provide headquarters support and field support as needed

STATE INDEPENDENT LIVING COUNCIL (SILC)

Maximizes opportunities for independence for persons with disabilities through advocacy and a system of independent living centers and services, and to fulfill the requirements of the federal Rehabilitation Act of 1973, as amended in 1992.

- Serve as a resource for the Governor, Legislature, and other state agencies concerning disability and independent living issues
- Work in conjunction with all other organizations that address the needs of people with disabilities
- Provide information to individuals, independent living centers and disability organizations regarding matters of public policy

- Joint development and signing the State Plan for Independent Living (SPIL)
- Review, monitor, and evaluate the implementation of the SPIL
- Extensive services including peer counseling, individual and systems advocacy, training in independent living skills, attendant referral, housing assistance, information, and referral, transportation, job development, equipment maintenance and evaluation, mobility training, sign language interpreter referral and communication assistance, technical assistance and access to the Internet.

DEPARTMENT OF AGING

Provides leadership in the Area Agencies on Aging and other providers in developing systems of home and community based services that maintain seniors 60 years of age or older in their own homes or at least restrictive homelike environment.

- In support of the Older Americans Act, the Department provides transportation, housing assistance, case management, home maker/chore, information and assistance, legal assistance, ombudsman, congregate nutrition, home-delivered meals, disease prevention and health promotion, and in-home services for frail older individuals
- Identify and assist seniors to assess immediate needs and loss
- Case management to assure seniors receive all services, grants and aid for which they are eligible
- Advocate on behalf of residents in long-term care facilities to effectively assert civil and human rights and resolve complaints
- May assist long-term care facilities in implementation of some agreed upon aspects of its disaster response plan
- Other disaster related services such as housing repairs, relocation expenses, and temporary shelter

AMERICAN RED CROSS (ARC)

Provides temporary mass care and sheltering to disaster victims who have been displaced from their homes.

Provides the following disaster relief services:

- Shelter, feeding and first aid to people affected by disaster
- May provide emergency replacement of medications and equipment if no other resources are available
- Shelter staffing with at least one nurse per shift, based on population and health of residents
- Mental health staff on all shifts as needed

In collaboration with local health agencies, the ARC

- Will provide medical staff to assess all incoming evacuees for health care needs
- If no special needs shelter is available, may provide an area for a medical treatment unit/temporary infirmary for those with special needs staffed by local health professionals or staff from evacuated facility

- Will refer people needed individual care or special equipment to alternate shelter staffed by local health authorities
- May request public health nurses to provide assistance to ARC as shelter nurses
- May request local medical facilities to set up temporary clinics outside ARC shelters to provide advanced medical treatment, as requested and available

TERMS & DEFINITIONS

ALS	Refers to ambulances and personnel trained and equipped to provide advanced life support care.
BLS	Refers to ambulances and personnel trained and equipped to provide basic life support care.
Care Giver	Someone who provides care to the medically fragile on a regular basis. This can be a family member or medical professional. May also be referred to as a Caretaker.
Care Provider	An individual or organization that provides medical and/or residential care services to the medically fragile.
Community Based Organizations	Organizations formed specifically for the purpose of providing or augmenting human services in the community, and staffed by volunteers and/or paid staff and operate as either a for-profit or non-profit organization.
Evacuation	The emergency movement of a population from a threatened or impacted location to a location of safety.
General Public Shelters	Alternative housing for evacuees who are not dependent upon ongoing medical care. General public shelters are neither equipped nor staffed to provide medical care beyond basic first aid.
Hazard	A source of danger. A hazard can be a specific object, structure, or situation (natural or technological) that may become a threat to life and/or property when exposed to, impacted upon, or affected by one or more outside causative event(s). (Example: a propane tank or other combustible exposed to fire or lightening).
Host Facility	An alternative facility that has agreed to receive patients/residents evacuated from medical and residential care facilities.
Hospital Emergency Incident Command System (HEICS)	Adapted from the Incident Command System, HEICS is an emergency management system designed specially for use in healthcare facilities during emergencies. HEICS facilitates organization, coordination, and communication among staff and other emergency response agencies and optimizes the effectiveness of medical staff and resources. *(The **HEICS** manual is available on the Emergency Medical Services Authority home page at* **www.emsa.ca.gov/dms_page.htm.** An introductory video is available and may be obtained by contacting the EMS Authority at (916) 322-4336.

Incident Command System (ICS)	Based on management by objectives and a component of the Standardized Emergency Management System, ICS is a method of organizing emergency response staff to ensure all response functions necessary for effective emergency management are appropriately staffed.
Incident Commander	This is field level ICS position that is assumed by the first responder arriving at the scene of an emergency. The Incident Commander directs the immediate response activities necessary to save life and/or property, requests assistance, and assigns others as they arrive on scene to perform specific functions. As more responders arrive, the duties of the Incident Commander may be relinquished to another responder having jurisdiction or a higher degree of skill or experience.
Intake Site	Identified by local government, a location or gathering point for evacuees where they are sorted (triaged) and, based on their medical needs, are referred to either a general public shelter, a medical treatment unit/temporary infirmary, or a health care facility.
Medically Fragile	People who need assistance to evacuate and are dependent upon family members or medical professionals for their ongoing medical care.
Medical Treatment Unit/Temporary Infirmary	Medical treatment units are shelters intended to provide, to the extent practicable under emergency conditions, an environment in which medically fragile evacuees' current levels of health can be sustained. These facilities are staffed and supplied by the transferring agency and/or local health authorities and are administered by appropriate local governmental agencies in collaboration with the Red Cross or other sheltering agencies. Temporary infirmaries are portions of general public shelters intended to provide the same services.
Mitigation	Specific and deliberate actions taken to reduce the probability that a hazard will become a threat. (i.e., using velcro or bolts to secure large objects, placing a guard strap or bar across shelves to keep toxic chemicals from spilling, etc.)
Mutual Aid	A statewide system of "neighbor helping neighbor" to provide/receive additional resources and/or services from one jurisdiction to meet the emergency needs of another. The system is based on the concept that the service will be returned at some future date.
Public & Private Responders	Any agency or organization providing emergency response relief or services.

Residential Care Facility	Any congregate living environment which houses five or more non-related people who are medically fragile and living together under the supervision of someone who is paid to care for them. This includes nursing homes, hospitals, adult congregate living facilities and group homes.
Risk	The probability that a hazard will become a threat to life and property. Risk is determined by assessing the hazard, its properties and destructive potential, and factoring these with the probability that a causative event (or events) will occur with sufficient force or impact (as demonstrated by historical and other data) to increase or compound the level of risk, or threat, of the hazard to life and property.
Service Provider	An organization that provides one or more services to the medically fragile population.
Standardized Emergency Management System (SEMS)	Established by State law and based on the Incident Command System, SEMS is a method of organizing staff to facilitate inter-agency coordination and communication and to ensure the expeditious acquisition and delivery of resources to the affected area. SEMS is required for all state and local agencies.
Threat	An indication of an impending event or action that could result in injury or damage.
Triage	A method of sorting casualties based on the extent of injury received. This method is used during emergencies when the number of casualties exceed available resources to care for them and determines the order in which they will receive treatment.