Appendix M: MENTAL HEALTH COORDINATOR CHECKLIST

Perform only those actions appropriate to the situation

	MENTAL HEALTH COORDINATOR RESPONSE ACTIONS ***TO DO FIRST***
1	Report to Incident Manager; receive briefing on status and priorities.
2	Inform Logistics Section of logistic support needs: phone, email access, space.
3	Set up mental health briefing station.
4	Activate Mental Health Team; Assemble Mental Health Team and Team supplies.
5	Assign roles and duties.
6	Designate a site for Mental Health Team operations.
7	Determine need for additional mental health personnel. Request recall of clinic mental health staff, activation of contract mental health providers or augmentation through Operational Area or clinic consortium.
8	Gather information and conduct assessment.
9	Identify most affected patients, staff – refer to therapists for assessment and intervention.
10	Assign staff or outside agency professionals to various roles.
11	Direct waiting room children to parents and separate clients served as needed.
12	Inform staff of time and place of mental health briefing and update meetings.
13	Delegate monitoring of phones / crisis calls.
14	Provide mental health emergency response guidelines to clinic staff.

	MENTAL HEALTH COORDINATOR RESPONSE ACTIONS ***TO DO LATER OR AS A FOLLOW-UP***
1	Documentation and tracking
2	Draft announcements and updates for PIO to disseminate via e-mail messages or mailings / send letters to patients and staff.
3	Give info on grieving and other emotional issues.
4	Give info to staff on discussing the situation with patients.
5	Distribute counseling referral list.
6	Provide any other info necessary, as indicated by PIO.
7	Meet with patients / family / Staff.
8	Stand in for absent/affected staff.
9	Rumor Control – Monitor for rumors. Institute rumor control procedures.
10	Update staff on mental health situation status and services.
11	If there are staff fatalities, provide funeral information.
12	Identify clients/staff/patients requiring additional support
13	Debrief with site or operational area (county) and/or city Crisis Response Team
14	Provide informational material and resources
15	Amend Crisis Response procedures as necessary
16	Plan memorial
17	Monitor crisis anniversaries

Appendix N: Personal Protective Equipment (PPE)

Gloves

Wear disposable gloves when contact with visible blood and body fluids is anticipated. Gloves should also be worn when touching environmental surfaces and patient care articles visibly soiled with blood or body fluids. Gloves should be put on just prior to performing a patient care task that involves contact with blood or body fluids and removed immediately, without touching non-contaminated surfaces, when the task is complete. When performing multiple procedures on the same patient, gloves should be changed after contact with blood and body fluids that contain high concentrations of microorganisms (e.g., feces, wound drainage or oropharyngeal secretions) and before contact with a clean body site such as non-intact skin and vascular access sites.

Facial Protection

Wear disposable, fluid-resistant masks and eye shields (goggles with side-shields) or a face shield if the patient is coughing or when performing patient care tasks likely to generate splashing or spraying of blood and body fluids onto the mucous membranes of the face.

Gowns

Wear disposable, fluid-repelling gowns to protect skin and clothing when performing procedures likely to generate splashing or spraying of blood and body fluids. Plastic aprons may be worn for procedures likely to soil clothing but are unlikely to generate splashing or spraying of blood or body fluids (e.g., cleaning incontinent patients). The material composition of the gown should be appropriate to the amount of fluid penetration likely to be encountered. Remove soiled gowns after patient contact. Reusable cloth gowns may be used for patient contacts, if splashing or spraying of blood and body fluids is unlikely. Disposable or reusable gowns should be worn once and then discarded.

California Hospital Bioterrorism Response Planning Guide
California Department of Health Services

EPA Levels of Protection for Ensemble Components

Level A

Vapor protective suit (meets NFPA 1991)

Pressure-demand, full-face SCBA, inner chemical-resistant gloves, and chemical-resistant safety boots.

OPTIONAL: Cooling system, outer gloves, hard hat, and two-way radio communications system.

Protection Provided: Highest available level of respiratory, skin, and eye protection from solid, liquid, and gaseous chemicals.

Used When: The chemical(s) have been identified and pose high levels of hazards to respiratory system, skin, and eyes. Substances are present with known or suspected skin toxicity or carcinogenity. Operations must be conducted in confined or poorly ventilated areas.

Limitations : Protective clothing must resist permeation by the chemical or mixtures present. Ensemble items must allow integration without loss of performance.

Level B

Liquid splash protective suit (meets NFPA 1992). Pressure demand, full facepiece SCBA, inner chemical-resistant gloves, chemical-resistant safety boots, and hard hat.

OPTIONAL: Cooling system, outer gloves, and two-way radio communications system.

Protection Provided: Provides same level of respiratory protection as Level A, but less skin protection. Liquid splash protection, but no protection against chemical vapors or gases.

Used When: The chemical(s) have been identified but do not require a high level of skin protection. Initial site surveys are required until higher levels of hazards are identified. The primary hazards associated with site entry are from liquid and not vapor contact.

Limitations : Protective clothing items must resist penetration by the chemicals or mixtures present. Ensemble items must allow integration without loss of performance.

Level C - *Not Acceptable for Chemical Emergency Response*

Support Function Protective Garment (meets NFPA 1993). Full facepiece, air purifying, canister-equipped respirator, chemical-resistant gloves and safety boots, two-way radio communications system, and hard hat.

OPTIONAL: Face shield, and escape SCBA.

Protection Provided: Provides the same level of skin protection as Level B, but a lower level of respiratory protection. Liquid splash protection, but no protection against chemical vapors or gases.

Used When: Contact with site chemical(s) will not affect the skin. Air contaminants have been identified and concentrations measured. A respirator canister is available that can remove the contaminant. The site and its hazards have been completely characterized.

Limitations : Protective clothing items must resist penetration by the chemical or mixtures present. Chemical airborne concentration must be less than IDLH levels. The atmosphere must contain at least

19.5 % oxygen.
Level D - ***Not Acceptable for Chemical Emergency Response***   Coveralls, safety boots/shoes, safety glasses or chemical splash goggles.
OPTIONAL: Gloves, escape SCBA, and face shield.
Protection Provided: No respiratory protection, and minimal skin protection.
Used When: The atmosphere contains no known hazards. Work functions preclude splashes, immersion, potential for inhalation, or direct contact with hazard chemicals.
Limitations : This level should not be worn in the Hot Zone. The atmosphere must contain at least 19.5 % oxygen.

Fatah, Alim A., etal Guide for the Selection of Personal Protective Equipment for Emergency First Responders, Volume 1, National Institute of Justice Office of Science and Technology, Washington, DC, November 2002. p. 7
www.ncjrs.org/pdffiles1/nij/191520.pdf

Appendix O.1: PLANNING SECTION SITUATION REPORT [SITREP]

(Completed by Planning Section Chief / Submit to Incident Manager / Distribute to All EOC Sections)

DATE:	**TIME:**	**REPORT NO.**	**RPTG PERIOD**	**8 12 24**
PREPARED BY:		**INCIDENT:**		
SECTION CHF SHIFT 1:		**SECTION CHF SHIFT 2:**		

EOC ACTIVATION

ACTIVATION/DECLARATION	DATE/TIME	BY
EOC ACTIVATED		

DAMAGE ASSESSMENT SUMMARY [ASSESSMENT]

	ITEM	SOURCE	NUMBER
1A	**STAFF DEATHS**		
1B	**STAFF INJURIES**		

CATEGORY	EST. EMERGENCY COSTS	ESTIMATED REPAIR/ RESTORATION COSTS	SOURCE OF INFORMATION
MAIN CLINIC FACILITY			
OTHER BUILDINGS			
EQUIPMENT			
OTHER			

WEATHER SUMMARY - CURRENT CONDITIONS DATE/TIME

WEATHER STATUS:		**WEATHER FORECAST:**	
TEMPERATURE	**PRECIPITATION**	**TEMPERATURE**	**PRECIPITATION / WIND**
OTHER ENVIRONMENTAL CONDITIONS:			

STATUS SUMMARY OF RESPONSE TO PRIORITY PROBLEMS

PROBLEM	# COMPLETED	# IN-PROGRESS	# WAITING

STANDARD SITUATION REPORT [SITREP]

(Completed by EOC Section Chiefs / Submit to Planning and Intelligence Section)

SECTION / BRANCH / UNIT:

DATE:	**TIME:**	**REPORT NO.**	**RPTG PERIOD**	**8 12 24**
PREPARED BY:		**INCIDENT:**		
UNIT LEADER SHIFT 1:		**UNIT LEADER SHIFT 2:**		

RESOURCE STATUS SUMMARY

RESOURCES NOTES	**PERSONNEL**	**MEDICAL / SUPPLIES EQUIPMENT**	**OTHER (COMMUNICATIONS, IT, UTILITIES, ETC.)**
LOSSES			
CURRENTLY COMMITTED			
AVAILABLE NOW			
AVAILABLE IN TWO HOURS			
ASSISTANCE REQUESTED			

STAGING AREA LOCATION FOR RECEIPT OF PERSONNEL AND SUPPLIES:

SPECIAL NEEDS:

CASUALTIES / ILL

PROBLEM/LOCATION (BY PRIORITY)	**MAJOR**	**MINOR**	**CONTAMINATED**	**INFECTED / ISOLATED**	**WAITING TRANSPORT**
# CASUALTIES / ILL					
CURRENT CAPACITY					

PRIORITY PROBLEMS

PROBLEM/LOCATION (BY PRIORITY)	**PERSONNEL NEEDS**	**MEDICAL SUPPLY / EQUIPMENT NEEDS**	**OTHER RESOURCE NEEDS**
1.			
2.			
3.			
5.			

Appendix O.2: ACTION PLAN DEVELOPMENT

Action planning is an essential part of Incident Command System. Action planning is an effective management tool involving two essential items:

- A process to identify objectives, priorities and assignments related to emergency response or recovery actions.
- Plans which document the priorities, objectives, tasks and personnel assignments associated with meeting the objectives.

The procedures and forms in this Appendix provide a roadmap for the use of this important response tool. Even in the period immediately following a disaster, it is important to establish and communicate clear priorities and to track the completion of priority objectives. At this point, action plans can be verbal and cover very short time (e.g., two hour) time periods. In later phases of the response, written action plans for longer time periods provide effective tools for ensuring that all responders are addressing the organization's priority tasks.

EOC Action Planning Procedures
EOC Action planning is based on the use of an operational period. The length of the operational period for the EOC is determined by first establishing a set of objectives and priority actions that need to be performed and then establishing a reasonable time frame for accomplishing those actions. Generally, the actions requiring the longest time period will define the length of the operational period.

Typically, operational periods at the beginning of an emergency are short, sometimes only a few hours. As the emergency progresses, operational periods may be longer, but should not exceed twenty-four hours. Operational periods should not be confused with staffing patterns or shift change periods. They may be the same, but need not be.

The initial EOC Action Plan may be a verbal plan put together in the first hour after EOC activations. It is usually done by the EOC Incident Manager in concert with the Planning Section Chief and the Management Staff. Once the EOC is fully activated, EOC Action Plans should be written.

EOC Action Plans should not be complex or create a time-consuming process. The EOC Action Plan should generally cover the following elements:

- Listing of objectives to be accomplished (should be measurable).
- Statement of current priorities related to objectives.
- Statement of strategy to achieve the objectives. (Identify if there is more than one way to accomplish the objective, and which way is preferred.)
- Assignments and actions necessary to implement the strategy.
- Operational period designation - the time frame necessary to accomplish the actions.
- Organizational elements to be activated to support the assignments. (Also, later EOC Action Plans may list organizational elements that will be activated during or at the end of the period.)
- Logistical or other technical support required.

Focus of the EOC Action Plan

The focus of the EOC Action Plan should be on ***<Name of Clinic>*** issues. The plan sets overall objectives for the clinic EOC. Properly prepared, the EOC Action Plan becomes an essential input to the development of Section level action plans by other EOC Sections.

24 HOUR ACTION PLAN

FOR REPORTING PERIOD

FROM : ____:____ AM/PM **TO: ____:____ AM/PM**

NOTE: ACTIONS ASSIGNED HEREIN SHOULD BEGIN DURING THIS OPERATIONAL PERIOD AND UNITS SHOULD REPORT PROGRESS AT THE EOC BRIEFING AT _____: _____ AM/ PM.

TIME/DATE PREPARED:

PREPARED BY PLANNING SECTION CHIEF:	**DISTRIBUTION:** **All EOC Sections and Units** **Other**
APPROVED BY EOC INCIDENT MANAGER:	

INCIDENT OBJECTIVES	**DATE PREPARED:**	**TIME PREPARED:**
OPERATIONAL PERIOD FROM:	**TO:**	

1. GENERAL OBJECTIVES: (FROM MANAGEMENT STAFF)

WEATHER FORECAST FOR OPERATIONAL PERIOD: (FROM SITUATION STATUS UNIT LEADER)

SAFETY MESSAGE: (FROM SAFETY OFFICER)

ATTACHMENTS (CIRCLE IF ATTACHED)

- ORGANIZATION CHART
- CURRENT AREA SITUATION REPORT
- TASK ASSIGNMENTS
- CARE/SHELTER FACILITIES
- SPECIAL MEDICAL FACILITIES
- TRAFFIC AND STAGING AREA MAP

PREPARED BY (PLANNING SECTION CHIEF):	**APPROVED BY EOC INCIDENT MANAGER:**

MANAGEMENT STAFF TASKS FOR THIS OPERATING PERIOD		DATE/TIME:
SECTION/UNIT	**TASK**	**ASSIGNED TO**
EOC INCIDENT MANAGER TASKS		
SAFETY OFFICER TASKS		
PUBLIC INFORMATION OFFICER TASKS		

PLANNING SECTION TASKS FOR THIS OPERATING PERIOD		DATE/TIME:
SECTION/UNIT	**TASK**	**ASSIGNED TO**
PLANNING SECTION CHIEF TASKS		

OPERATIONS SECTION TASKS FOR THIS OPERATING PERIOD		DATE/TIME:
SECTION/UNIT	**TASK**	**ASSIGNED TO**
OPERATIONS SECTION CHIEF TASKS		
PRIORITY ISSUES:		
1.		
2.		
3.		
4.		
5.		
MEDICAL CARE TASKS		
MENTAL HEALTH TASKS		

LOGISTICS SECTION TASKS FOR THIS OPERATING PERIOD		DATE/TIME:
SECTION/UNIT	**TASK**	**ASSIGNED TO**
LOGISTICS SECTION CHIEF TASKS		
PRIORITIES ISSUES		
1.		
2.		
3.		
4.		
COMMUNICATIONS TASKS		
INFORMATION TECHNOLOGY TASKS		
MATERIALS & SUPPLY TASKS		
HUMAN RESOURCES TASKS		

FINANCE SECTION TASKS FOR THIS OPERATING PERIOD		**DATE/TIME:**
SECTION/UNIT	**TASK**	**ASSIGNED TO**
FINANCE SECTION CHIEF TASKS		
PRIORITY ISSUES:		
1.		
2.		
3.		
4.		

Appendix O.3: EMERGENCY OPERATIONS CENTER MESSAGE AND OTHER FORMS

Incoming Message Form
Employee Time Sheet
Activity Log
Notes Form

INCOMING MESSAGE CONTROL LOG
(Used by Communications to log in incoming messages before distribution)

Section (Name) _____

MSG #	INCIDENT	ACTION	INFO	INFO / NOTES

<Name of Clinic> Employee Time Sheet

Section / Unit: **Date:** **Submit copies to:** **Logistics / Human Resources**
Finance / Time Unit at end of Operational Period

Last Name	First Name	Position	Location	Date/Time IN	Date/Time OUT

ACTIVITY LOG

DATE/TIME	EVENT

Prepared by (please print): _____

NOTES

Name: _____

EVENT	NOTES

Appendix O.4: COST TRACKING AND FINANCE FORMS

EOC Forms Finance

FINANCE SITUATION REPORT [SITREP] (Filled out by FINANCE CHIEF)

DATE:	**TIME:**	**REPORT NO.**	**RPTG PERIOD**	**8 12 24**
PREPARED BY:		**INCIDENT:**		
SECTION CHIEF SHIFT 1:		**SECTION CHIEF SHIFT 2:**		

PURCHASES DURING THIS TIME PERIOD [COST UNIT]

BEGINNING BALANCE $

	ITEM	QTY	UNIT COST	PURCHASED FROM	TOTAL COST
1					
2					
3					
4					
5					
6					
9					
10					
11					
12					
13					
14					
15					

TOTAL PURCHASED TO DATE $

CLAIMS [CLAIMS UNIT]

NAME	DEPT.	NATURE OF CLAIM	DISPOSITION	EST. COST

TOTAL CLAIMS ESTIMATE $

FINANCE SECTION TASKS FOR THIS OPERATING PERIOD		**DATE/TIME:**
SECTION/UNIT	**TASK**	**ASSIGNED TO**
FINANCE SECTION CHIEF TASKS		
PRIORITY ISSUES:		
1.		
2.		
3.		
4.		

SIGNIFICANT EVENT LOG

EVENT: _____ NAME: _____ DOC POSITION:_____

DATE	TIME	NOTES

Appendix P

EMERGENCY OPERATIONS CENTER PROCEDURES

CONTENTS

Appendix P.1: ACTIVATION OF THE EMERGENCY RESPONSE TEAM / EMERGENCY OPERATIONS CENTER

WHO USES THIS GUIDE
Clinic Executive Director and the Incident Manager.

WHEN IS THE GUIDE USED
This guide is used whenever an event occurs which will threaten clinic patient and staff health and safety and/or will impact operations.

WHERE IS THE GUIDE TO BE USED
From wherever the clinic Executive Director or the EOC Incident Manager is located.

PURPOSE/OUTCOME
- To ensure that the Clinic ERT is activated in a timely manner. This ensures that the EOC can be operated effectively.
- To ensure that the Clinic ERT is aware of the events it must respond to and are ready to initiate their responsibilities upon arrival at the EOC.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	The Clinic Executive Director officially activates the EOP by assigning the Incident Manager to activate staff, the EOP, and the EOC (as needed).
	The Incident Manager evaluates whether other ERT staff are needed immediately, or later, and which key agencies must be notified.
	The Incident Manager ensures notification of staff (as needed for the event) to assist with the recovery operations (or the Incident Manager assigns this duty, but still must ensure it is completed).
	The Incident Manager may direct that outside organizations be called immediately for assistance or to fulfill notification requirements (Operational Area Medical / Health Coordinator, fire/EMS (911), building owner/facilities management, clinic consortium, corporate headquarters)
	The Incident Manager ensures that security is established at the entrance to the EOC and then establishes a sign-in process in order to verify who has arrived and when (step not required if no EOC is activated).
	All persons notified will be provided the same, short briefing of the events at hand, including: • What is the event • What is it threatening (staff, property, communications, data, fiscal operations, environment, general public) • What is being done and by whom (activation of ERT, EOC, recovery actions, etc.)

Appendix P.2: EOC ACTIVATION CRITERIA AND SETUP

WHO USES THIS GUIDE
The Clinic Executive Director and the Incident Manager (as assigned), and assigned staff.

WHEN IS THE GUIDE USED
This guide is used whenever an event occurs which will threaten staff health and safety and/or will interrupt operations. Once the decision to activate an EOC is made, then staff involved with set up of the EOC will use it. It will also be used by set up staff when there is a decision to activate an alternate EOC.

WHERE IS THE GUIDE TO BE USED
This guide should be used first wherever the Clinic Executive Director and the Incident Manager are located. Once a decision is made to activate an EOC, this guide will be used at the selected EOC site.

PURPOSE/OUTCOME
To ensure that the Clinic ERT activates an EOC in a timely manner as needed.
To ensure that the appropriate EOC staff are directed to perform set up so that the EOC will be ready.
To ensure that the correct EOC is activated, to ensure habitability and the safety of ERT staff.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	Make decision about EOC activation, location, and appropriate staffing.
	Assign staff to set up an EOC. Ensure security and safety are present to ensure safety of personnel, habitability, and secure operations.
	If using an alternate EOC, contact the alternate sites to ensure the space is available prior to sending staff.
	If not all ERT staff are activated, ensure all other ERT staff are made aware of which EOC is being activated in case they are called for service.
	Once the EOC site is proven safe to activate, direct complete activation.
	Contact operational area medical/health coordinator and other key stakeholders about the EOC activation and provide contact phone numbers once the EOC is operational (ready to function).
	Ensure that external safety, parking, and access is appropriate for the EOC operation.
	Direct the Safety Officer to continue habitability assessments, especially in highly variable and dangerous conditions (floods, fires, hazmat, civil disturbance, earthquake, etc.)
	The Incident Manager ensures that security is established at the entrance to the EOC and then establishes a sign-in process in order to verify who has arrived and when (step not required if no EOC is activated).

	All persons notified will be provided the same, short briefing of the events at hand, including: • What is the event • What is it threatening (staff, property, communications, data, fiscal operations, environment, general public) • What is being done and by whom (activation of ERT, EOC, recovery actions, etc.)

APPENDIX P.2 (cont): EOC HABITABILITY CONSIDERATIONS (Example)

NOTE: The size, location and resources / amenities of a clinic EOC will vary considerably among clinics. An EOC can operate successfully for short term responses in a relatively small space. Telephone service and electricity are critical and Internet access highly desirable. The EOC description that follows can be set up in a conference room as small as 150 square feet, especially if nearby offices can be converted for use by EOC personnel.

The Emergency Operations Center (EOC) is responsible for the centralized management of information, decision-making, resource support and resource application during an emergency. The clinic's EOP envisions up to 4 designated positions and 2 supporting personnel (alternates and support staff) to support Management and General Staff operations in the clinic's EOC. The purpose of the EOC is to provide a safe and secure facility from which the clinic can provide coordination, direction and control of resources in response and initial recovery from events that overwhelm the regular operations of the clinic. Emergency operations could be on for 12 – 24 hours initially depending on the severity of the event and the nature of the clinic's response.

Seismic and Natural Hazard Considerations

Ideally, the EOC facility should be able to a withstand likely seismic event and remain in service and should be located away from potential hazards such as falling objects (trees, power and light poles), floods, mud or land slide, threat of structure or wild land fire.

Environmental Controls

Heating, cooling and ventilation systems will provide comfort for employees.

Working Space

- Large conference room with center table able to allow 5 people to work comfortably. Clinic offices can be used for occasional meetings and as worksites for EOC Section Chiefs.

- Wall space should be available for large maps message and status boards (4' x 4' each). Alternatively, easels can be used to hold maps and flip charts to record information.

Access

- Should be ADA accessible, all entrances/exits. Direct exterior doors as well as interior access from "waiting room" or foyer area of building.

Restrooms

- Direct or immediate access to restroom facilities.

Computing and Communications

- 2 computer workstations with internet access and email.
- 2 telephone connections, one of which should be capable of use with a telephone that does not require electricity and that bypasses the clinic switchboard.
- 1 fax connection.
- Television at end of room for monitoring news reports during large-scale disasters.
- Radio monitoring capability, including HAM radio operations in a separate room.
- Large projection screen at one end of room (preferred).

Electric Service

- Adequate for 2 computers, printer, a copier, 1 faxes, video and audio equipment, and portable lighting. Additional capacity for unanticipated needs (new technology).
- Uninterruptible power supply for critical equipment. (UPS and/or back-up generator).

Kitchen

- Access to kitchen facilities with storage. (Water, microwave, refrigeration, long shelf life snack foods, etc.)

Lighting

- Overhead acceptable.

Security

- Storage areas where EOC supplies are kept should be locked to prevent intrusion, tampering and theft of materials and equipment. Fire detection and suppression systems must be present in accordance with code.

Support

- Adequate space for computing and communications technical support (equipment) within surrounding building.
- Parking for 10 vehicles nearby.

Appendix P.3: COMMAND AND CONTROL

WHO USES THIS GUIDE
The Incident Manager and Section Chiefs use this guide to help recognize the lines of authority and decision making that occurs through ICS during operational recovery. This is to be used as a planning and briefing document for the Incident Manager, and also for clarifying authorities that become confused during disaster operations.

WHEN IS THE GUIDE USED
This guide should be used whenever the Incident Manager is assigned his/her function and when they are ordered to open the EOC and activate staff. Once a decision is made to activate an EOC, this guide will be used to establish the authority and leadership actions of the Incident Manager.

WHERE IS THE GUIDE TO BE USED
This guide is used first wherever the Incident Manager is located.

PURPOSE/OUTCOME
- To ensure that the Clinic ERT understand who is in charge at all times.
- To ensure that the Incident Manager fulfill their roles of command over personnel actions, and control over resources, per the ICS model.
- To ensure that actions are taken in a timely manner to address operational recovery under the supervision of the Incident Manager and that resources are used effectively.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	Ensure that the Clinic Executive Director is aware the Incident Manager is in charge.
	Activate EOC staff in the positions designated under the EOP in accordance with the ICS structure, and as appropriate to support the needs of recovery.
	Ensure that a span of control is installed so that no person has more than 5-7 others reporting directly to their position.
	Establish security and safety controls over the EOC, and habitability monitoring.
	Establish a defined operational period for the EOC staff.
	Establish an Action Plan for the operational period with sound goals and objectives that are achievable. Section Chief's will be asked to provide regular updates.
	Ensure all EOC staff are provided an initial briefing on arrival, and follow up briefings on the status of the recovery and the Action Plan.
	Establish control over the Clinic resources needed for recovery operations.
	Establish lines of communications with other agencies and organizations so they know who is in charge, and who will replace the Incident Manager if not available.
	Control staffing levels, either expanding or demobilization.
	Direct deactivation, with approval of the Director.

Appendix P.4: COMMUNICATIONS

WHO USES THIS GUIDE
The Incident Manager and Section Chiefs use this guide. The Logistics Section Chief will take specific actions according to his/her responsibilities.

WHEN IS THE GUIDE USED
This guide should be used whenever the Incident Manager is overseeing the activation and set up of the EOC.

WHERE IS THE GUIDE TO BE USED
This guide should be used at the site of whichever EOC is being established or already operating.

PURPOSE/OUTCOME
- To ensure that the EOC recovery operations have reliable, redundant, and quality communications capability.
- To ensure that EOC staff in need of direct communications capabilities are provided those tools in a timely manner, or existing tools are repaired/repaired quickly.
- To ensure that inter-personal communications between staff and with outside contacts are efficient, accurate and consistent so that all participants are aware of key events.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	Direct that communications systems be established immediately, once habitability and security are provided for at the EOC being set up.
	Direct the Logistics Chief (if one is present) to direct the establishment of phones, computers, runners, status board keepers, and staff capable of timely repairs.
	Ensure that status boards for the event are established and posted with initial and continuing updates, and define the flow of intelligence to be used in the EOC.
	Establish a phone bank/call screener to direct incoming calls to correct EOC staff.
	Develop a contact/communications log for those who answer phones for the EOC for directing the calls to the correct EOC staff.
	Include the establishment of HAM communications as a recovery objective for the Action Plan.
	Ensure the current phones of key contact agencies are posted in the EOC.
	Establish a printed list of phone numbers in the EOC, along with outside key contacts, and distribute to all EOC staff.
	Establish times for phone conferences, and identify a bridge port and port size appropriate for the briefings.
	Establish protocols for crisis communications with the PIO.
	Establish communications with field personnel at habitat areas that are impacted to evaluate the need for closure or restricted access to the public.

Appendix P.5: INFORMATION AND INTELLIGENCE

WHO USES THIS GUIDE
The Incident Manager, Planning and Intelligence Section Chief, and PIO will use this guide.

WHEN IS THE GUIDE USED
This guide should be used whenever the EOC is operational and processing data.

WHERE IS THE GUIDE TO BE USED
This guide will be used in the operating EOC.

PURPOSE/OUTCOME
- To ensure that data coming into the EOC is converted to intelligence.
- To ensure that intelligence information is provided to EOC staff in a timely, concise manner.
- To ensure intelligence is processed properly prior to release to other staff outside the EOC, to external organizations, to the media and the public.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	Direct the Planning and Intelligence Section Chief to gather information related to recovery, and have it posted immediately once verified. Information includes: • Status of the threat • Status of other conditions impacting response or recovery (weather, power, resource shortages, etc.) • Status of supporting agencies and regulatory organizations tied to response/recovery • Status of staff, both at the EOC and elsewhere • Status of clinic facilities and the EOC, for recovery, or the need for relocation • News reports, reports from other agencies, rumor issues, Operational Area directives
	Ensure all data goes through a standard process for validation and verification.
	Ensure that raw information is process consistently to form intelligence, e.g.: • Compile • Analyze • Evaluate • Distribute
	1.
	Ensure that the PIO works closely with the Planning and Intelligence Section.
	Direct information release to the Incident Manager for final approval.

Appendix P.6: PUBLIC INFORMATION

WHO USES THIS GUIDE
The Incident Manager and the PIO.

WHEN IS THE GUIDE USED
This guide is used whenever there is information to be released to internal staff, external organizations, the media and the public

WHERE IS THE GUIDE TO BE USED
This guide is used in the EOC but also wherever the PIO is located (e.g., press briefings).

PURPOSE/OUTCOME
- To ensure that information released from the EOC is timely, concise and accurate.
- To ensure that the PIO gets full cooperation from EOC to gather intelligence.
- To ensure that the Incident Manager approves all official information prior to release.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	Perform an initial briefing of the PIO upon their arrival at the EOC.
	Ensure PIO provides regular briefings with Incident Manager on public information needs, and external information from the media of importance.
	Direct the Planning and Intelligence Section Chief to share information freely with the PIO, including Status Reports and the Action Plan.
	Direct other Section Chiefs to cooperate with the PIO.
	Coordinate press briefings with the Executive Director and the PIO.
	Ensure the PIO is following the Clinic public information policy.
	Approve all news releases prior to release.
	Ensure copies of all news releases are filed.
	Ensure radio, television, and print media are monitored by the PIO.
	Ensure all PIO materials are compiled for the critique and After Action Report.

MEDIA CONTACT FORM

(Submit completed form to PIO)

Date / Time	Initiated by Clinic	Media	Media Outlet	Reporter Name and contact information	Subject / Content	Follow-up Needed ? (Y/N)	Clinic Staff Interviewed

Appendix P.7: EOC RELOCATION

WHO USES THIS GUIDE
The Clinic Executive Director and the Incident Manager (as assigned), and the Logistics Section Chief.

WHEN IS THE GUIDE USED
This guide is used whenever an event occurs which threatens staff health and safety, or operability, in a currently operating EOC.

WHERE IS THE GUIDE TO BE USED
This guide will be used in an operating EOC.

PURPOSE/OUTCOME
- To ensure that the Clinic ERT continues operations in a safe and secure environment.
- To ensure that recovery operations can continue without major interruption.
- To ensure that an alternate EOC can be activated and set up in a timely manner.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	Identify the nature of the threat, including likelihood of impact, distance and time from impact, direction of threat, and current EOC location in relation to threat.
	Make decision about EOC relocation and announce to all EOC staff, while ensuring key stakeholders are aware of the decision.
	Send a scouting team to evaluate the alternate site.
	If no alternate is available try working in virtual mode from homes, or try other sites.
	Design a relocation plan after an alternate site is confirmed as: • Available (owner is not using or given to someone else for use) • Ready (facility is not full of storage, being remodeled, has wiring in place) • Habitable (facility has utilities, HVAC, water, restrooms, safe environment, etc.) • Reachable (roadways allow access to site, and security allows entry and exit)
	Develop safe routes to the site alternate site and send a set up team: • Security • Safety • Computer/Telecommunications Specialist
	Establish a movement time for remaining EOC staff, and communications enroute.
	When alternate EOC is operable, direct EOC Incident Manager to take charge.
	Forward all phones to new phone numbers in the alternate EOC.
	Assemble and identify staff before leaving and on arrival.
	Inform Operational Area when the move is complete and the alternate EOC is operational, and update key stakeholders of new location and phone numbers.

Appendix P.8: DEACTIVATION OF THE ERT AND EOC

WHO USES THIS GUIDE
Clinic Executive Director and the Incident Manager, with input from the Section Chiefs.

WHEN IS THE GUIDE USED
This guide is used whenever the EOC is operational and when conditions occur that no longer require the complete staffing that is in place, or the actual operation of an EOC.

WHERE IS THE GUIDE TO BE USED
From wherever the Clinic Executive Director or the Incident Manager is located.

PURPOSE/OUTCOME
- To ensure that the Clinic ERT and/or EOC is deactivated in a timely manner. This ensures that resources are used efficiently.
- To ensure that the Clinic ERT is aware of need to close their positions and log books properly in preparation for a critique and After Action Report.
- To ensure that the Incident Manager is acting by the Direction of the Clinic Executive Director and in accordance of the directions, if any, from the operational area.

STEPS TO ACHIEVE OUTCOME
Steps in this process are suggested in an order. Each situation is different, which may require skipping steps because of the impact of actual events. Check the box when completed.

	The Clinic Executive Director approves any and all deactivation of staff or recovery operations, including the closure of the EOC.
	The Incident Manager evaluates the need of ERT staff through regular communications and briefings with the EOC Section Chiefs. This includes Action Plan evaluations.
	The Incident Manager works to "right size" the recovery organization and to schedule a cleanup and resupply of the facility, as needed.
	The Incident Manager may reduce Section Chiefs and management staff in the following order, after instructing them to close their logs, and turnover key documents: 1. Operations Section 2. Liaison 3. Logistics Section 4. Planning and Intelligence Section 5. Finance and Administration and Administration Section 6. PIO 7. Security 8. Safety Officer
	The Incident Manager informs the Executive Director and operational area when the EOC is deactivated.
	The Incident Manager then compiles records and schedules a critique.

Appendix P.9: AFTER ACTION REPORT

AFTER ACTION REPORT QUESTIONNAIRE

Use of After-Action Reports

After-Action Reports serve the following important functions:

- A source for documentation of response activities.
- Identification of problems/successes during emergency operations.
- Analysis of the effectiveness of the components of the response organization.
- Description and definition of a plan of action for implementation of improvements.

The ICS approach to the use of After-Action Reports emphasizes the improvement of emergency management at all levels. It is important for all clinic staff to be encouraged to contribute to the after-action report process. Even staff who continued their day-to-day functions can provide useful information. The After-Action Report provides a vehicle for not only documenting system improvements, but also can, if desired, provide a work plan for how these improvements can be implemented.

It may be useful to coordinate the After-Action Report process when multiple agencies/divisions are involved in the same emergency. For example, an operational area may take the lead in coordinating the development of an After-Action Report which involves multiple count response agencies.

_____ DUE BY: _____
(Disaster Name)

Section A.

THIS FORM IS FOR THE <Name of Clinic>

Completed by _____ _____
Name (print) Division

_____
Phone Number

Section B.

QUESTION		YES	NO	N/A
1.	Were procedures established and in place for response to the disaster?			
2.	Were procedures used to organize initial and ongoing resources?			
3.	Was the ICS used to manage field response?			
4.	Were all ICS Sections used?			
6.	Was the EOC activated?			
7.	Was the EOC organized according to ICS?			
8.	Were sub-functions in the *EOC* assigned around the five *ICS* functions?			
9.	Were response personnel in the *EOC* trained?			
10.	Were action plans used in the *EOC*?			
11.	Was coordination performed with volunteer agencies (e.g., Red Cross)?			
12.	Was an Operational County EOC activated?			
13.	Was assistance requested and received?			
14.	Were the *EOC* assistance acquisition efforts coordinated?			
15.	Was communication established and maintained between operation centers?			
16.	Was public information disseminated according to procedure?			

Section C.

17. What response actions were taken by the clinic? Include such things as resource acquisition number of personnel, equipment and other resources.

18. As you responded, was there any part of *ICS* that did not work for your clinic? If so, how would/did you change the system to meet your needs?

19. As a result of your response to this incident, are any changes needed in your plans and procedures? If so, please explain.

Appendix Q: VOLUNTEER AND DONATION MANAGEMENT

Appendix Q.1: EMERGENCY PREPAREDNESS AND RESPONSE: VOLUNTEER POLICIES AND PROCEDURES

Introduction

This document is meant to provide a basic overview of federal and state law applicable to licensed non-profit clinics in California regarding participation of volunteers during emergency response. The overview may be used as a guideline for emergency response planning and not as a legal opinion about the particular risks and liabilities of individual clinics or other actors since these will vary depending on the facts of each situation.

During a public health emergency or regional disaster, the local disaster council and other emergency response participants may request assistance from community clinic or health center staff. Additionally, members of the community may respond to local needs by requesting to donate services and goods to the clinic. Clinic managers can prepare for both contingencies by incorporating policies regarding the use of volunteer responders into the emergency response plan as part of overall logistics planning.

Purpose

The purpose of instituting policies and procedures regarding deployment of volunteers or impressing volunteers into service is three-fold: 1) to provide a mechanism for smooth operations during a emergency or disaster; 2) to control risks through volunteer management in order to minimize legal liability, and 3) to prevent injury to staff and volunteers who are responding to emergencies and secondary injury to individuals who are emergency or disaster victims.

Policies

1. The clinic will establish procedures for the coordination of receipt of volunteer services and goods as part of the emergency response logistics plan.
2. The clinic will control risks to minimize liability for the services of volunteer medical professionals and other volunteers during emergency response though volunteer screening and training and by maintaining general liability insurance, workers' compensations insurance, and professional liability as appropriate.
3. To the extent possible, the clinic will clearly define duties for professional and lay volunteers during emergency response to minimize potential disputes as to whether a volunteer was acting within defined duties.
4. To the extent possible, the clinic will transfer risk through contractual and indemnification arrangements for the deployment of clinic staff and volunteers to other facilities and/or for the indemnification of volunteer health providers providing services on the clinic site.

Procedures

Clinics procedures for emergency response provide a mechanism for screening, credentialing, and training volunteers, reporting for volunteers service, assigning duties, and supervision of volunteers, handling donations, responding to requests by other entities for assistance.

Role of Volunteer Coordinator During Emergency Response Activation and Operation.

Under the supervision of the Logistic Section Chief, the Volunteer Coordinator will participate in all aspects of emergency response and recovery activity. In coordination with Incident Manager and Triage Leader, the Volunteer Coordinator will:

1. Pre-event:
   A. Develop written volunteer position descriptions as part of overall emergency response planning.
   B. Assist with development of curriculum and volunteer training.
   C. Through the local disaster council or local OES, update the list of registered disaster service workers quarterly.
   D. Maintain staff and community volunteer contact list.
   E. Understand classifications and limitation of duties of Disaster Service Workers.

2. During emergency response plan activation:
   A. Assess the need for volunteers at the clinic site and at any off-site care center or shelters operate by the clinics.
   B. Set up volunteer reporting station at clinic site or alternative site away from clinic.
   C. Check credentials of non-staff volunteers who are health professionals and persons authorized by the state OES to respond to disaster when reporting for duty.
   D. Assign to appropriate site/activity based on each volunteer's credentials.
   E. Orient volunteers to assigned duties.
   F. Assign tasks to convergent volunteers as appropriate.
   G. Keep volunteer roster and track assignments.
   H. Pursuant to a Memorandum of Understanding between the clinic and the local disaster council, or state or local OES authorizing such activity, impress volunteers into services as disaster service workers according to OES procedure.
   I. When possible assure appropriate supervision of volunteers.
   J. Communicate with other facilities in the local disaster council about need for volunteers.
   K. As requested or required by MOU, deploy volunteers to other organizations and facilities.
   L. Track receipt and disposition of donated goods and foodstuff.

Responding to requests for assistance.

Pre-event establish MOUs with local hospitals and/or local disaster councils for deployment of staff and equipment.

MOUs to include:
1. Credentialing obligations.
2. Staff assignments.
3. Reporting procedures.
4. Communications procedures.
5. Staff injury/incident reporting.
6. Indemnification clause.

Staff Volunteers.

1.Screening, credentialing, and defining duties.

A. Employees and contractors.
Incorporate into written employment agreements/contracts with each health care provider defining his/her duties and responsibilities in the event of a public health emergency or disaster.

B. Non-employees
1) Use volunteer position applications to ascertain volunteer background, skills, experience & risk factors
2) Review and screen volunteer applications
3) Institute written volunteer position descriptions to clearly specify volunteer roles and responsibilities (and limitations on those roles)

2. Training curriculum to include:
A. In-service education on emergency response procedures.
B. Participation in disaster drills.
C. Emergency triage procedures.
D. Use of equipment and supplies.
E. Compliance with HIPAA privacy and security regulations.
F. Informed consent procedures during an emergency.
G. Injury/incident reporting procedures.
H. Title 17, Section 2500 reporting requirements.
I. Procedure for reporting on and off for duty.

Pre-Event Community Volunteer Training.

In coordination with the local disaster council or local OES, clinic will solicit and train community volunteers for emergency response.
Training curriculum to include:
1) Reporting for duty.
2) Basic first aid.
3) Preventing worker injury.
4) Orientation to physical plant and equipment.
5) Registration process for disaster services workers.
6) Injury/incident reporting procedures.
7) Procedure for reporting on and off duty.

Classifications of emergency response volunteers

The classification of emergency response volunteers will determine the availability of statutory immunity and/or indemnification effecting the clinic's overall risk of liability for emergency response operations.

Staff volunteers. Staff volunteers are paid employees or contractors who may volunteer their services while off-duty during an emergency response operation. Staff volunteers may also include those who provide services to the clinic for no compensation and are already screened and credentialed by the clinic.

Staff volunteers may provider services at the clinic site or at an off-site location operated by the clinic. Staff volunteers may also be deployed by the clinic during emergency response operations to provide volunteer services for other organizations or health care entities, including participation in mass inoculation campaigns. Clinic staff, who are so registered or employed, may also be called away from the clinic operation to render emergency services as Disaster Service Workers or members of a Disaster Medical Assistance Team.

Non-staff volunteers. During an emergency response activation and operation, a clinic may find it necessary to impress into service volunteers who are not already members of the clinic staff. These unsolicited non-staff volunteers may be convergent volunteers who are laypersons or licensed professionals. Non-staff volunteers could also include Disaster Service Workers (DSWs) or members of a Disaster Medical Assistance Team (DMAT).

Convergent volunteers. Convergent volunteers, as defined in state regulation, are individuals that come forward to offer disaster response and recovery volunteer services, during a disaster event. Convergent volunteers are not persons impressed into service at the scene of an incident. However, convergent workers are eligible for workers' compensation benefits through the disaster service worker program, when they meet the requirements of the in accordance the regulations implementing the DSW program. At the election of the clinic's emergency response logistic chief, volunteers who are not registered as DSWs may be asked to leave the clinic site. Local authorities may arrest unregistered volunteers for refusing to do so.

Disaster Service Workers. In California, each persons who wishes to work as a volunteer in declared disaster areas must be registered as a Disaster Service Workers (DSW) through the state or local OES office pursuant to Title 19, California Code of Regulations §2573.1. The OES approves DSW applicants, approves emergency training programs, and issues identification cards to DSWs. California code section establishing the DSW program are found in the Government Code and the Labor Code. Authorized and registered DSW must carry identification when responding to an emergency.

DSW is legally defined and includes:
1) any persons registers with a disaster council, the Governor's OES., or a state agency granted authority to register DSWs;
2) public employees, except members of volunteer fire departments, employees performing disaster work that is outside the course and scope of their regular employment without pay;
3) any unregistered person pressed into services during a state of war emergency, a state of emergency or a local emergency by a person having authority to command the aid of civilians in the execution of his or her duties.

"Disaster service" means all activities authorized by and carried on pursuant to the California Emergency Services Act, including training necessary or proper to engage in such activities. Cal. Labor Code § 3211.93. "Disaster service" does not include any activities or functions performed by a person if the accredited disaster council with which that person is registered receives a fee or other compensation for the performance of those activities or functions by
that person. Cal. Labor Code § 3211.93(a).

DSW may be assigned to report to a clinic site; conversely, clinic personnel may be approved by OES as DSWs. DSWs are not compensated for their service.

The regulations governing DSW Program are found in the California Code of Regulations, Title 19, Division 2, Chapter 2, Subchapter 3, Section 2570 et.seq. There are several classifications of DSW and the limit of the duties of each classification is legally defined in Title 19 California Code of Regulations, §2572.1.

The OES is the state agency charged as the lead coordinating agency during a declared emergency. Each county has a local OES which acts as a coordinating agency that brings together local agencies to focus on unified response to disasters. The local OES Coordinator can provide information about how to properly identify OES-approved personnel for entry into disaster areas. An organization may maintain a Memorandum of Understanding with the local OES that specifically defines the role of the DSW in the event of an emergency. A disaster-related MOU is a legal agreement between the OES and a group or organizations that specifically defines the role(s) the group's OES-registered DSW may play during an emergency.

A disaster council is a local public agency which may register and direct activities of DSWs at the county or city level. It acts as an agent of the state with regard to the functions and policy of disaster services. Cal. Labor Code § 3211.9. Counties, cities and counties, and cities may create disaster councils by ordinance. Cal. Gov. Code § 8610. A disaster services council is accredited by the state OES. Cal. Gov Code§ 8612.

Role of Disaster Medical Assistance Teams (DMAT). The State of California currently has 5 level 1 DMATs- in Orange, Los Angeles, San Bernadino, San Francisco , San Diego- , a level III development team in Sacramento, and a Mental Health Specialty team in Southern California. A DMAT is voluntarily organized and composed of trained medical

professionals, allied health professionals and support personnel to provide emergency medical care and to augment local medical capabilities during times of disaster. In the event of a disaster, a team of about 35 will deploy as a unit to provide medical and health care to disaster victims. Each team operates under the umbrella of a sponsoring organization that maintains a Memorandum of Understanding with the Public Health Service.

DMATs operate under the authority of the National Disaster Medical System (NDMS), a section within the U.S. Department of Homeland Security, Federal Emergency Management Agency, Response Division, Operations Branch. The NDMS has the responsibility for managing and coordinating the Federal medical response to major emergencies and Federally declared disasters including natural disasters, technological disasters, major transportation accidents, and acts of terrorism including Weapons of Mass Destruction events .

DMATs are designed to respond rapidly to supplement local medical care until other federal or contract resources can be mobilized, or the situation resolves. DMATs deploy through Federal Coordinating Centers to disaster sites. DMATs bring adequate supplies and equipment to support themselves for a period of 72 hours while providing medical care at a fixed or temporary medical site. In mass casualty incidents the DMAT team's responsibilities include triaging patients, providing medical care, and preparing patients for evacuation. DMATS may also provide primary health care to augment the services of local providers. Deployment is voluntary. Clinic employees who are DMAT volunteers are not required by law to respond to a call for activation.

During deployment, DMAT volunteers DMATs are categorized according in four readiness levels:

Level 1.Fully deployable within 8 hours of notification and are self-sufficient for 72 hours with standardized equipment and supply sets to treat up to 250 patients per day.

Level 2. Lack sufficient equipment to make them self-sustaining but are able to deploy and replace a Level One team utilizing and supplementing their equipment which is left on site.

Level 3. Have local response capability only.

Level 4. Have a Memorandum of Understanding executed and are in some stage of development but have no response capability.

DMAT members are required to maintain appropriate certifications and licensure within their disciple. All States recognize the licenses and certifications of DMAT members when they are activated as Federal employees. DMAT members are paid while serving as part-time federal employees, have the protections of the Federal Tort Claims Acts for malpractice claims, and are entitled to the benefits of federal employees.

Legal Protections For Clinic Staff and Volunteers During Emergency Response

Federal and state laws provide certain protections for volunteers and organizations that use the services of volunteers. To minimize liability for participation of volunteers in emergency response operations, clinics should consider the available legal protections and various ways to maximize these. This provides a general overview of statutory immunity from liability and recommendations to increase liability protection.

Statutory Immunity for Certain Health Care Providers. California law provides immunity from liability for certain individual health care providers and facilities that render services during
any state of war emergency, a state of emergency, or a local emergency at the express or implied services request of any responsible state or local official or agency. Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist shall have no liability for any injury sustained by any person by reason of such services,
regardless of how or under what circumstances or by what cause such injuries are sustained except in the event of a willful act or omission. Cal. Gov.Code § 8659.

Section 8659 does not extend this broad immunity to community clinics and health centers for emergency response operation. However, such immunity is available to clinic staff and volunteers who are physicians, pharmacists, nurses, and dentists when involved in emergency response.

In addition, statutory immunity is extended to health care practitioner licensed in other states when responding to a state of emergency at the request of the Director of the Emergency Medical Services Authority. Cal. Business & Professions Code §900.

Clinics can reduce liability for activating emergency response operations by purchasing general liability insurance. Health centers that qualify for Federal Tort Claim Act (FTCA) coverage can specifically include emergency response operations in their approved scope of project. *See* discussion about FTCA coverage below.

Statutory Protections Provided by Good Samaritan Provisions. Clinic that sponsor, authorize, support, finance, or supervise the training of people, or certify those people, excluding physicians and surgeons, registered nurses, and licensed vocational nurses, in **emergency** medical services, are not liable by operation of law for any civil damages alleged to result from those training programs. Cal. Health & Safety Code § 1799.100.

Volunteers who, in good faith, render emergency care at the scene of an emergency are not liable for any civil damages resulting from any act or omission in the rendering of that care. However, the scene of an emergency does not include emergency departments and other places where medical care is usually offered. Cal. Health & Safety Code § 1799.102.

Therefore, volunteers who render emergency care on the clinic site are not protected from civil liability, and clinics that allow lay volunteers to render such care may also be liable, under the legal doctrine of respondeat superior, for the acts and omission of those volunteers. Clinics may choose to purchase liability insurance to cover the acts and omission of volunteers who render such emergency care.

Persons who, in good faith and without compensation, render emergency cardiopulmonary resuscitation (CPR) or renders emergency treatment by the use of an automated or automatic external defibrillator (AED) at the scene of an emergency are not liable for any civil damages resulting from acts or omissions in rendering emergency care. Organizations who provided the training for CPR or AED use are also not liable for civil damages. Cal. Civil Code §§ 1714.2 and 1714.21.

Immunity from Liability for DSWs. DSWs, acting within the scope of their official duties, enjoy immunity from liability for personal injury or property damages sustained by any duly enrolled or registered volunteer engaged in or training for emergency preparedness or relief activity, or by any unregistered person duly impressed into service during a state of war emergency, a state of emergency, or a local emergency and engaged in such service. Cal. Gov. Code § 8657. In addition, DSWs who perform disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency are not liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful. Cal. Civil Code § 1714.5.

Volunteer Protection Act of 1997. The Volunteer Protection Act of 1997 (hereafter referred to as VPA), P.L. 105-19, as found in Title 42, United State Codes, Sections 14501-14505, was enacted to limit the liability volunteers serving public and private not-for-profit organizations and government agencies. Except as to certain exceptions enumerated in the VPA, the VPA preempts state law except when the state provides additional protections from liability for volunteers or the state affirmatively elects non-applicability. California has provided no such additional protections or non-applicability provisions. The VPA applies to all volunteer, licensed health care providers acting within their scope of the duty within the organization, as well as other volunteers.

The VPA provides a defense to liability for harm, defined as physical, nonphysical, economic and non-economic losses, for acts or omission due to simple negligence of the volunteer, if the following criteria are met:

- the volunteer was acting within the scope of the volunteer's responsibilities at the time of the act or omission;
- if appropriate or required, the volunteer was properly licensed, certified, or authorized by the appropriate authorities for the activities performed;
- the harm was not caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by the volunteer; and

- the harm was not caused by the volunteer operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires the operator or owner of the vehicle of possess an operator's license or maintain insurance.

The VPA also limits punitive damages should a volunteer be found liable for conduct not protected by the Act.

The VPA does not:

- Protect the volunteers when conduct constitutes either a crime of violence (as defined in the U.S. Code), an act of international terrorism for which the volunteer has been convicted in any court; a hate crime (as defined in the U.S. Code); a sexual offense under state law for which the volunteer has been convicted in any court; a violation of federal or state civil right law, or when the volunteer was under the influence of alcohol or any drug at the time of the misconduct.
- Prohibit civil lawsuits against the volunteer, either by the organization or others.
- Transfer all liability for the volunteer's conduct to the organization.
- Prohibit lawsuits against the organization for the volunteer's conduct.

For the purpose of the VPA, a volunteer is defined as an individual performing services for a nonprofit organization or a governmental entity who does not receive compensation except for reasonable reimbursement for expenses, or any other thing of value in lieu of compensation in excess of $500 per year. The term "volunteer" include directors, officers, and trustees, as well as direct service providers.

The VPA prescribes several exceptions to volunteer liability protection. The following types of state laws will not be construed as inconsistent with the VPA and will not be preempted by the VPA:

- A state law that require a nonprofit organization or governmental entity to adhere to risk management procedures, including mandatory training of volunteers;
- A state law that make the organization liable for the acts or omissions of its volunteers to the same extent as an employer is liable for the acts or omissions of its employees;
- A state law that make a limitation of liability inapplicable if the civil action is brought by an officer or a state or local government pursuant to state or local law; and
- A state law that make a limitation of liability applicable only if the nonprofit organization or governmental entity provides a financially secure source of recovery for individuals who suffer harm as a result of actions taken by a volunteer on behalf of the organization or entity.

To date California has not passed specific statutes to limit volunteer liability protection. Because the VPA does not prohibit lawsuits against the organization for the volunteer's conduct, clinics are advised to continue appropriate liability insurance coverage for acts and omissions of officers, directors, and managers in obtaining volunteer services as well

as the acts and omission of the volunteers themselves in the performance of services while under the auspices of the clinic.

Coverage for Health Care Providers and Volunteers Under the Federal Tort Claims Act. The Federally Supported Health Centers Assistance Acts of (FSHCAA) of 1992 and 1995 established immunity from malpractice claims due to negligence for deemed health centers, their officers, directors, employees, and certain contractor under the Federal Tort Claims Act (FTCA) as found in 42 United State Code, Section 233, and implementing regulations at 42 CFR Part 6. FTCA coverage is available to health centers funded under Section 330 of the Public Health Service Act.

FTCA coverage is available for acts or omission by individual health care providers who are employees or contractors of a deemed health center when acting within the health center's approved scope of project and within the provider's scope of practice and while employed by the deemed health center. Health center employees are covered whether they work on a full or part-time basis. FTCA coverage is also available for part-time licensed or certified health care practitioners who are contractors providing services in the fields of family practice, general internal medicine, general pediatrics, or obstetrics and gynecology.

Volunteers who are not employees or contractors of the health centers are not covered under the FTCA. Although the acts or omissions of individual volunteer health care providers providing services within the scope of the health center's project are not be covered under FTCA, the health center itself is immune from liability for those acts or omissions.

Only acts and omissions related to the grant-supported activity of entities are covered. Acts and omission related to services provided to individuals who are not patients of a covered entity will only be covered if the federal Secretary of Health and Human Services determines that: (1) the provision of the services to such individuals benefits patients of the entity and general populations that could be served by the entity through community-wide intervention efforts within the communities served by such entity; (2) the provision of the services to such individuals facilitates the provision of services to patients of the entity; (3) such services are otherwise required to be provided to such individual under an employment contract or similar agreement between the entity and the covered individual. 42 CFR Section 6.6(d).

Services provided during emergency response, including those services provided by employees and contractor off-site, should be covered if they meet the elements of Section 6.6(d). Off-site care provided to health center patients is covered by the FTCA. In addition, FTCA is available for health center employees or contractors who voluntarily take hospital call and provide emergency room coverage if these activities are required by the hospital as a condition of obtaining hospital admitting privileges.

Where a health center contracts health center staff out to other organizations, generally the activity is covered under FTCA if the provider is an employee or contractor of the clinic,

the provider is paid by the health center, the services provided at the other site is within the health center's scope of project, the contract with the outside organization stipulates that if a malpractice claim is filed against the provider, the organization must release all necessary records to and cooperate in the defense of the claims. The FTCA does not cover indemnification by covered entities of other parties not covered by the FTCA.

Health centers and their employees and contractors are not covered under the FTCA for supervision of non-health center employees or contractors, services rendered to individuals who are not health center patients unless a patient-provider relationship is established by a triage activity, or supervision of local emergency systems.

Voluntary activities by health center employees and contractors, not within the health centers approved scope of project or within a health care providers scope of employment with the health center are not covered by the FTCA. For coverage of emergency response activities, a health center may include the activity in the health center's scope of project or include this as part of the scope of employment for individual covered providers. However, health centers should assess the necessity of this in light of statutory immunity afforded certain California providers.

42 USC Section 233(o) provides for FTCA coverage for volunteer services provided by health professionals at free clinics (commonly referred to as the "Medical Volunteers Act"). The provision does not take effect without an appropriation to authorize payment under the Act. To date Congress has made no such appropriation nor has the Secretary issued regulations to implement this section. Therefore, malpractice coverage for volunteer services provided by health professionals at free clinics is currently not available pursuant to the FTCA.

Health center coverage under FTCA must be deemed through an annual application process.
Covered health centers are advised to maintain deemed status under the new requirements for deeming under the FSHCAA. *See* BPHC PIN 2002-23. California health centers can contact the Region IX , FCTA Coordinator for more information. *See* http://bphc.hrsa.gov/risk/directory.

42 USC Section 233(p) was added by P.L. 107-296 § 304(c) in 2002. Section 233(p) provides FTCA coverage with respect to liability arising out of the administration of a countermeasure against smallpox during the effective period of a declaration by the Secretary of the federal Health and Human Services of an actual or potential bioterrorist incident or other actual or potential public health emergency. Liability coverage is available to covered entities and qualified persons who are licensed health professional or other individual authorized to administer smallpox inoculations under the law of the state where the vaccine is administered.
Health centers and health center employees and contractors who are defined as qualified persons are covered.

Indemnification By Local Public Entities for Volunteer Health Clinicians at Clinics. A city, county, city and county, or any other local public entity with authority to provide health care services may provide insurance or provide indemnity through self-insurance for medical or
other health-care tort claims against any person, licensed pursuant to Business & Professions Code, Division 2 or an initiative act referred to in those provisions, and who, in good faith and without compensation, renders voluntary care to low-income patients within the scope of his or her practice at a community clinic or free clinic that serves residents within the jurisdiction of the local public entity. However, such insurance or indemnity must not cover liability for which there is other insurance coverage in effect. Cal.Gov.Code § 990.9. A clinic may enter into an MOU with a local public entity to effect an indemnification arrangement pursuant to this section.

Workers' Compensation Coverage. Subject to certain limiting conditions, employers are liable for any injury sustained by his or her employees arising out of and in the course of the employment and for the death of any employee if the injury proximately causes death subject to certain conditions. Cal. Labor Code § 3600. Among other limitations, at the time of injury:

1) both the employer and the employee must be subject to the compensation provisions in the Workers' Compensation Act ;
2) the employee must be performing service growing out of and incidental to his or her employment and acting within the course of his or her employment, and
3) the injury must be proximately caused by the employment either with or without negligence.

The California Workers' Compensation Act (WCA) requires all employers to secure the payment of compensation through insurance or self-insurance. Cal. Labor Code § 3700. Generally, Workers' Compensation is the exclusive remedy for injury and/or death of an employee against any employer.

Any person rendering services for another, other than an independent contractor, or unless expressly excluded by the WCA, is presumed to be an employee. Cal. Labor Code § 3357. "Employee" is defined in Cal. Labor Code §§ 3351 and 3351.5.

The following are statutory exclusions from the WCA:

1) Licensed physicians and surgeons. A licensed physician who enters into a contract for the performance of health services on behalf of a licensed primary care clinic is presumed to be an independent contractor rather than an employee for the purposes of the WCA subject to proof that the physician is an employee. Cal. Labor Code § 2750.6.
Exception: When an employer has in his employment any person not included within the term "employee" as defined by the or a person not entitled to compensation under this division, such employer and such person employed by him may, by their joint election,

come under the WCA provisions in the manner prescribed by the Labor Code. Cal.Labor Code § 4150, et. seq.

2) Volunteers. Volunteers performing services for nonprofit organizations who receive no payment for the services are excluded from the definition of "employee" for the purposes of the WCA. Cal. Labor Code § 3352 (i).
Exception: The Board of Directors of a private, nonprofit organization in its discretion may declare that volunteers are deemed to be employees while performing services for the nonprofit for the purpose of the WCA. The declaration must be in writing and dated prior to the injury. The form of the writing is not prescribed by statute and may be in the form of a board resolution. The declaration may describe only certain volunteers. Cal. Labor Code § 3363.6

To minimize exposure to tort liability for the injury or injury- related death of any person who performs services for the clinic, clinics are advised to take full advantage of exceptions to WCA exclusions by taking affirmative action to include these service providers in their workers' compensation policies as allowed and prescribed by the Labor Code.

Coverage for DSWs. Full WCA coverage is available to registered and unregistered DSWs who incur injury or injury-related death while performing disaster service work. Disaster service workers registered by a disaster council while performing services under the general direction of the disaster council shall be entitled to all of the same benefits of this division as any other injured employee. An unregistered person impressed into performing service as a DSW during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties is also deemed to be a DSW and is entitled to the same benefits of the WCA as any other disaster service worker. Cal. Labor Code § 3600.6.

Liability for compensation for any injury or death arising out of, and in the course of, his or her activities as DSW is against the state, the disaster council with which the disaster service worker is registered, and the county or city which has empowered the disaster council to register and direct his or her activities. Cal. Labor Code §4351. DSWs are also eligible for state disability benefits if the injury sustained while performing disaster service work disables the DSW for more than three days.

Other Legal Protections for Clinics

Protection from Liability for Sheltering Disaster Victims or From Use of A Premise for Mass Care Centers. Clinics are shielded from liability by operation of law for any injuries sustained by any person while in or upon a building or premise owned or maintained by the clinic which have been designated as a shelter from destructive operations or attacks by enemies of the United States by any disaster council or any public office, body, or officer of this state or of the United States, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other

necessary facilities for mitigating the effects of a natural, manmade, or war-caused emergency.

Immunity from liability stands for injuries sustained as a result of the condition of building or premises, as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes.

There is no immunity from liability for willful acts of the owner or occupant of the building or premises or his servants, agents or employees against person who seek refuge, treatment, care, or assistance at the building or premise. Cal. Civil Code § 1714.5.

Protection from Liability for distribution of donated food. A nonprofit charitable organization or a food bank that, in good faith, receives and distributes food without charge that is fit for human consumption at the time it was distributed is not liable for an injury or death due to the food unless the injury or death is a direct result of the negligence, recklessness, or intentional misconduct of the organization. Cal. Civil Code § 1714.25.

Clinics should not accept donations for distribution of food stuff that is perishable, unwrapped, or out of its original packaging.

APPENDIX Q.2: VOLUNTEER ROSTER
(completed by Logistics Section – copy to Human Resources)

Date Time	Last Name	First Name	Prof Degree	Phone Contact	Address	Prof License # Picture Id	Assigned To

APPENDIX Q.3: DONATION TRACKING FORM
(completed form to Finance Section Chief)

Quantity	Item Description	Category	Donor	Donor Contact	Est Value	Disposition / Use

Appendix R: BIOTERRORISM AGENTS

Some Potential Biological Warfare Agents

*The information in this chart is not meant to be complete but to be a quick guide; please consult other references and expert opinion, and check drug dosages particularly for pregnancy and children. **Refer to County of Los Angeles Department of Health Services, Terrorism Agent Information and Treatment Guidelines for Clinicians and Hospitals, June 2003.** (aka "The Zebra Book")

Disease	Incub-ation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Anthrax (inhaled and cuta-neous)	2-6 days Range: 1 day to 8 weeks	**Inhalation**: Flu-like symptoms, nausea, vomiting, abdominal pain , fever, respiratory distress **Cutaneous**: initial itching papule; fever	**Inhalation**: fever, followed by abrupt onset of respiratory failure, confusion Widened mediastinum on chest X-ray (adenopathy), bloody pleural effusions, Atypical pneumonia **Cutaneous**: initial itching papule, 1-3 cm painless ulcer, then necrotic center; lymphadenopathy	Gram stain ("boxcar" shape) Gram positive bacilli in blood culture ELISA for toxin antibodies to help confirm Chest CT	Aerosol inhalation *No person-to-person transmission* Standard precautions	Mechanical ventilation Antibiotic therapy (inhalation) Ciprofloxacin 400 mg IV q 8-12 hr **OR** Doxycycline 200 mg IV initial, then 100 mg IV q 8-12 hr **PLUS** Rifampin 10 mg/kg/d po (up to 600 mg day) **OR** Clindamycin 1200-2400 mg/day IM or IV	Ciprofloxacin 500 mg or Doxycycline 100 mg po q 12 hr ~ 8 weeks Amoxicillin in pregnancy and children (if susceptible) Vaccine if available

Disease	Incub-ation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Botulism	12-72 hours Range: 2 hrs – 8 days	Difficulty swallowing or speaking (symmetrical cranial neuropathies) Symmetric descending weakness Respiratory dysfunction No sensory dysfunction No fever	Dilated or un-reactive pupils Drooping eyelids (ptosis) Double vision (diplopia) Slurred speech (dysarthria) Descending flaccid paralysis Intact mental state	Mouse bioassay in public health laboratories (5 – 7 days to conduct) ELISA for toxin	Aerosol inhalation Food ingestion *No person-to-person transmission* Standard precautions	Mechanical ventilation Parenteral nutrition Trivalent botulinum antitoxin available from State Health Departments and CDC	Experimental vaccine has been used in laboratory workers
Plague	1-3 days by inhalation	Sudden onset of fever, chills, headache, myalgia **Pneumonic:** cough, chest pain, dyspnea, fever **Bubonic**: painful lymph nodes	**Pneumonic:** Hemoptysis; radiographic pneumonia -- patchy, cavities, confluent consolidation, hemoptysis, cyanosis **Bubonic:** typically painful, enlarged lymph nodes in groin, axilla, and neck	Gram negative coccobacilli and bacilli in sputum, blood, CSF, or bubo aspirates (bipolar, closed "safety pin" shape on Wright, Wayson's stains) ELISA, DFA, PCR	*Person-to-person transmission in pneumonic forms* Droplet precautions until patient treated for at least three days	Streptomycin 30 mg/kg/day in two divided doses x 14 days Gentamicin 3-5 mg/kg/day IV/IM in q 8 hr dosage Tetracycline 2-4 g per day Ciprofloxacin 400 mg IV q 12 hr	Asymptomatic contacts or potentially exposed Doxycycline 100 mg po q 12 h Ciprofloxacin 500 mg po q 12 h Tetracycline 250 mg po q 6 hr **All x 7 days** Vaccine production discontinued
Tularemia "pneumonic"	3-5 days Range: 1-14 days	Fever, cough, chest tightness, pleuritic pain Hemoptysis rare	Community-acquired, atypical pneumonia Radiographic: bilateral patchy pneumonia with hilar adenopathy (pleural effusions like TB) Diffuse, varied skin rash May be rapidly fatal	Gram negative bacilli in blood culture on BYCE (Legionella) cysteine- or S-H-enhanced media Serologic testing to confirm: ELISA, microhemagglutination DFA for sputum or local discharge	Inhalation of agents *No person-to-person transmission but laboratory personnel at risk* Standard precautions	Streptomycin 30 mg/kg/day IM divided bid for 14 days Gentamicin 3-5 mg/kg/day IV in three equal divided doses x 10-14 days Ciprofloxacin possibly effective 400 mg IV q 12 hr (change to po after clinical improvement) x 10-14 day	Ciprofloxacin 500 mg po q 12 hr Doxycycline 100 mg po q 12 hr Tetracycline 250 mg po q 6 hr All x 2 wks Experimental live vaccine

Disease	Incub-ation	Symptoms	Signs	Diagnostic tests	Transmission and Precautions	Treatment (Adult dosage)	Prophylaxis
Smallpox	12-14 days Range:7-17 days	High fever and myalgia; itching; abdominal pain; delirium Rash on face, extremities, hands, feet; confused with chickenpox which has less uniform rash	Maculopapular then vesicular rash -- first on extremities (face, arms, palms, soles, oral mucosa) Rash with hard, firm pustules ("intradermal blisters") Rash is synchronous on various segments of the body	Electron microscopy of pustule content PCR Public health lab for confirmation Rule out chicken pox with DFA	*Person-to-person transmission* Airborne precautions Negative pressure Clothing and surface decontamination	Supportive care Vaccinate care givers Experimental: cidofovir (useful in animal studies)	Vaccination (vaccine available from CDC)

Department of Veteran's Affairs, Office of Quality and Performance

www.oqp.med.va.gov/cpg/BCR/G/Biocard_5_16_02dgs.doc

Appendix S: DAMAGE ASSESSMENT

Appendix S.1: DAMAGE ASSESSMENT FORMS AND INSTRUCTIONS

Damage Assessment is the estimation of the impact of an emergency and the dollar amount of repair, reconstruction or other remediation. When conducting a damage assessment, focus on the big picture. Avoid getting mired in detail and minimizing or exaggerating damages.

Preliminary Damage Assessment Survey
This is a form used to summarize and report damages to the Emergency Operations Center.

Damage - Protective Measures
Estimate the cost of emergency measures taken to protect life and property, e.g., sandbagging, warning flashers, etc.

Damage – Clinic Buildings
Estimate the cost to temporarily repair clinic buildings. Include costs of equipment, vehicles, and overtime. Also estimate the costs to restore facility to pre-disaster condition.

Submit completed forms to Planning Section Chief with copies to the Finance Section Chief.

DATE: _____ TIME: _____ CLINIC NAME: _____

PRELIMINARY DAMAGE SURVEY PHONE: _____

BUILDING NAME / LOCATION: _____

BUILDING / ITEM	DESCRIPTION OF DAMAGE	DMGED	DESTR	LIFE	URGNT	INFO ONLY	NOTES
Building Structure - outside [Wall(s)-doors-glass- and parking lot]							
Room / Areas – inside [Ceiling / doors / blocked routes]							
Natural Gas System – city							
Stored Water – facility							
Heating – [gas / electric]							
Venting							
Air Conditioning							
Elevators – occupants?							
Stairwells							
Fire Alarm System							
Emergency Call System							
Emergency Lighting							
Security System							
Telephone System							
Fire Sprinkler System							
Emergency Paging							

BUILDING / ITEM	DESCRIPTION OF DAMAGE	DMGED	DESTR	LIFE	URGNT	INFO ONLY	NOTES
System							
Infectious Waste Storage Area							
Lab Area – Chemical							
Refrigerators / Freezers – Dry Ice?							

PAGE _____ OF _____

PRELIMINARY DAMAGE SURVEY

This form is used to record and report the preliminary damage assessment.

DATE / TIME: Identify Date and Time form completed.

NAME / PHONE: Identify Name and Phone Number of individual completing or responsible for form.

FACILITY NAME: Name of facility damaged or best description of facility/location.

DAMAGED: Check block if property is damaged.

DESTROYED: Check block if property is destroyed.

LIFE: Check block if deaths have occurred at site.

URGENT: Check block if URGENT Operations Section attention is required at location.

INFO ONLY: Check block if information provided does not require action or future assessment.

NOTES: Can the businesses still operate (even at reduced capacity?)

DATE: _____ TIME: _____ **CLINIC NAME: _____**

DAMAGE/PROTECTIVE MEASURES **PHONE: _____**

LOCATION OR ADDRESS OF PROTECTIVE WORK	DESCRIPTION OF DAMAGE AND PROTECTIVE MEASURES	ESTIMATED COSTS			
		EQUIP	SUPP	PERS	SUB-TOTAL
Sub-Total This Category					
TOTAL THIS PAGE					

PAGE _____ OF _____

Damage - Protective Measures

Estimate the cost of emergency measures taken to protect life and property, e.g., sandbagging, warning flashers, demolition, decontamination etc.

DATE / TIME: Identify Date and Time form completed.

NAME / PHONE: Identify Name and Phone Number of individual completing or responsible for form.

LOCATION: Enter location of protective measures.

DESCRIPTION OF PROTECTIVE MEASURES: Enter description of protective measures.

ESTIMATED COSTS FOR EMERGENCY EXPENDITURES: Estimate the costs to include equipment, supplies, and personnel overtime.

DATE: _____ TIME: _____ **CLINIC BUILDING DAMAGE** **NAME: _____**

BUILDINGS **PHONE: _____**

NAME/ BUILDING ADDRESS	DESCRIPTION OF DAMAGE	ESTIMATED COST	
		EMERGENCY	PERMANENT
Sub-Total This Page			
TOTAL THIS CATEGORY			

PAGE _____ OF _____

Damage - Buildings

Estimate costs to temporarily open/repair buildings.

DATE / TIME: Identify Date and Time form completed.

NAME / PHONE: Identify Name and Phone Number of individual completing or responsible for form.

LOCATION: Enter location of public buildings damage.

DESCRIPTION OF BUILDING DAMAGE: Enter description of public buildings damage.

ESTIMATED COSTS FOR EMERGENCY EXPENDITURES: Estimate the costs to include equipment, vehicles, and overtime. Also estimate cost to replace to pre-disaster condition.

Appendix S.2: CLINIC DECISION TOOL FOR OPENING AND CLOSING

Indicate for each trigger item if it negatively impacts the ability of the clinic to remain open, if it encourages the clinic to remain open or if it is neutral or irrelevant. This tool is not meant to generate a score. Rather, it is intended to assist a clinic Executive Director to consider the full range of factors in making a decision to close or open the clinic for operations and the level of operations the clinic could support.

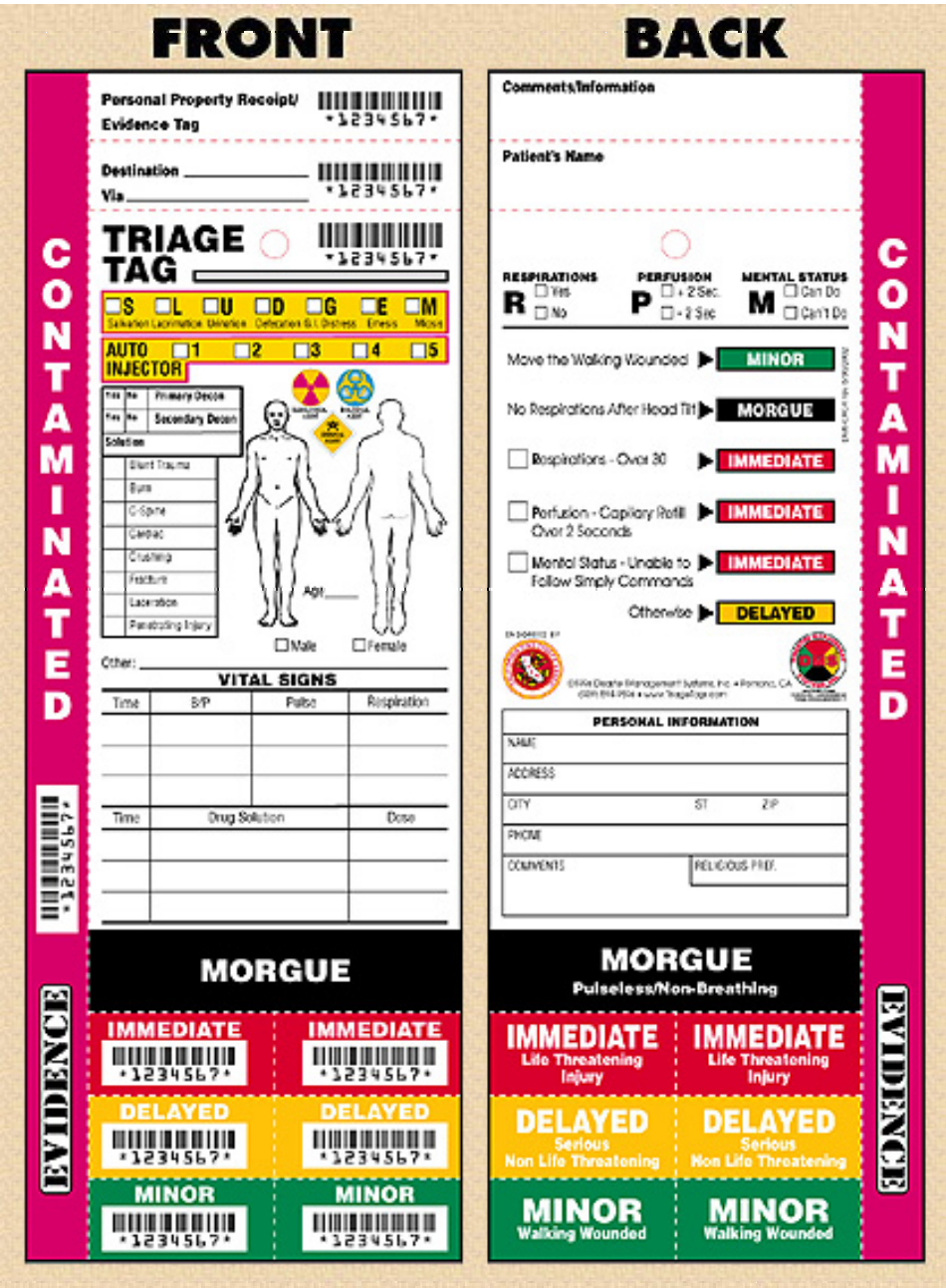
CLINIC DECISION TRIGGER POINTS FOR OPENING AND CLOSING	IMPACT ON CLINIC CAPABILITY				
	OPEN		NEUTRAL		CLOSE
FACILITY					
Permanent/Immediate loss of clinic facility					
Loss of clinic building for 1 day					
Loss of clinic for 1 hour or less					
Loss of clinic offices and patient care areas					
Loss of maintenance / building and grounds staff					
Earthquake – apparent structural damage					
Earthquake – suspected structural damage / unknown level of damage					
Earthquake – non-structural damage					
UTILITIES					
Loss of phones (landline and cellular)					
Loss of computer access for more than 1 day					
Loss of building heating/cooling for more than 1 day					

CLINIC DECISION TRIGGER POINTS FOR OPENING AND CLOSING	IMPACT ON CLINIC CAPABILITY				
	OPEN		**NEUTRAL**		**CLOSE**
Loss of utilities/power shortage					
STAFF					
Loss of Clinic management					
Loss of Medical / Nursing Director					
ENVIRONMENTAL CONDITIONS					
Street flooding cuts off clinic					
Levee failure: general flooding					
Earthquake damages roadways					
WMD / Hazmat release near clinic					
Loss of clinic budget – financial constraints					
Wild-land fire or major flood in a critical habitat area					
Transportation accident requires evacuation					
Violent weather					
INTERNAL / EXTERNAL VIOLENCE OR THREAT					
Terrorism threat/bomb threat					
Workplace violence					
Civil disorder nearby					

CLINIC DECISION TRIGGER POINTS FOR OPENING AND CLOSING	IMPACT ON CLINIC CAPABILITY				
	OPEN		**NEUTRAL**		**CLOSE**
Security intrusion					
GOVERNMENT ACTIONS					
Operational Area (County) declares disaster					
Governor proclaims a State of Emergency in Operational Area					
President Declares a disaster in area served by clinic					
State of War Declaration					
NEED FOR CLINIC RESPONSE					
Operational Area (County) requests clinic remain open without MOU					
Operational Area (County) requests clinic remain open with MOU					
Community Residents / Clients request open clinic					
Mass casualties nearby					
Surge of injured and ill					
Board of Directors directive					

Appendix T: CASUALTY CARE FORMS

Appendix T.1: CALIFORNIA FIRE CHIEF'S TRIAGE TAG



Appendix T2: PATIENT TRACKING FORM
(completed form to Medical Director)

Date/ Time	Patient Name	Pt. or Tag Number	Sex	Age	Destination	Released To	Triage Leader Initials

Appendix U: Emergency Preparedness and Response: Regulatory References for Licensed Community Clinics and Health Centers

The compendium provides references to select federal and state regulations applicable to emergency response planning.

Requirement for Disaster Planning Generally

Most health facilities in California are required by state law to have in place a plan or program for addressing disasters and/or mass casualties. Licensed primary care clinics and adult day health centers are subject to overlapping requirements for disaster planning as found in Title 22 of the California Code of Regulations, Sections 75057 and 78423, respectively. While the specific content of a clinic disaster program is not prescribed by state regulation, California law requires each licensed primary care clinic to adopt a written disaster program and instruct all clinic personnel in the disaster program requirement. *See* Title 22, CCR, Division 5, Chapter 7, Article 6, §75057.

Legal Obligation to Provide Emergency Response Services

Clinics and health centers may have a statutory or contractual obligation, or both, to provide services during a public health emergency or disaster. Where clinic resources are limited, a clinic's decision to keep the doors open during a public health emergency or natural disaster may rest on whether there is explicit legal obligation to do so. While there is no explicit requirement in federal or state law for community clinics and health centers to provide emergency response services, clinics may elect to do so as part of a local disaster council or OES. It is advised that the decision-making process and planning for emergency response include a legal risk assessment so that planning proceeds with the goal to maximize the clinic's ability to response to community needs with minimal risk.

A. Statutory Obligation to Provide Emergency Services.

1.Clinics receiving Public Health Service Act grants.

Health centers are required by federal law to provide, either through staff and supporting resources of the center or through contracts or cooperative arrangements, required primary care services for all residents of the area served by the center. Required primary care services include emergency medical services. 42 U.S.C. Section 254b.

2.Clinics receiving state grants.

Licensed clinics that receive a state grants-in-aid award may be required to provide essential primary care services to all persons impacted by any state of emergency or disaster. However, this does not create an obligation to provide emergency care services within the legal definition. California law requires certain licensed primary care clinics to: 1) provide nonelective, primary health care services to all persons who are impacted by any emergency or disaster as declared by the Governor and who present themselves for treatment at the clinic, and 2) utilize a sliding-fee scale based on income, including a zero payment option, when charging any person who presents for services and who is impacted by an emergency or disaster. California Health & Safety Code, Section 124450 requires that clinics funded by the seasonal agricultural and

migratory works (SAMW) program (Cal. Health & Safety Code Section 124550, et.seq.), the rural health services development program (Cal. Health & Safety Code Section 124600, et. seq.) or the expanded access to primary care (EAPC) program (Cal. Health & Safety Code Section 124900, et. seq.) comply with these requirements.

"Nonelective primary care services" is not defined in state statute**.** "Primary care services" "urgent care services " and "emergency services" are specifically defined in statute and are mutually exclusive. However, "nonelective primary care services" could be construed to include urgent care and emergency care services that are within the clinic's capacity.

Licensed clinics funded by the programs named in Section 124450 may be sanctioned under state law, including loss of funding and revocation of license, for failing to use a sliding-fee scale to determine the fees to be charges to any patient who presents as an emergency or disaster victim. Section 124450 does not provide a contingency for licensed clinics that are damaged or otherwise non-functional as a result of a disaster or emergency. However, the legal doctrine of impossibility under contracts law should excuse performance in the event that the clinic itself is damaged or incapacitated by a disaster.

California Grant-In-Aids programs for clinics do not explicitly require bioterrorism or emergency response policies and procedures as a condition of a grant award. (*See*, for example, *Expanded Access to Primary Care, Request for Application, Fiscal Years 2004-2007*.) Clinics that received state funding from sources other than the programs named in Section 124450 need not comply with Section 124450.

3. Emergency Medical Treatment and Labor Act (EMTALA).
EMTALA rules are found in Title 42 CFR, Parts 413,482, and 489. Generally the rules apply to hospitals, and not primary care clinics and health centers that do not have provider-based status. However, there is nothing in California law that would prevent clinics from rendering emergency services if a patient presents with an emergency medical condition and there are present medical personnel who are qualified to provide emergency medical care. However, "a clinic shall only provide those services for which it is organized, staffed, and equipped." Title 22 California Code of Regulations Section 75026 (c).

In addition, a clinic may not hold out to the public that it provides emergency medical services unless is satisfies the requirements of California Health & Safety Code Section 1798.175. However, nothing in Section 1798.175 prevents a clinic from advertising itself as, or otherwise holding itself out as, providing urgent, immediate, or prompt medical services. Regardless, a free-standing clinic that is not provider-based for the purposes of Medicare and holds itself out as an urgent care clinic would not be liable under EMTALA.

In the event of a public health emergency or local disaster that stresses the ability of local hospitals to provide emergency care, clinics may experience increased utilization if hospitals divert patients with non-emergency medical conditions to the clinics for diagnosis and treatment. Hospitals are required under EMTALA to provide "appropriate medical screening examination within the capability of the hospital's emergency department" for evaluation for an emergency medical condition, and provide any necessary stabilizing treatment or an appropriate transfer if an emergency medical condition is found. If the nature of the request for services is such that it is clear that the medical condition is not of an emergent nature, the hospital is required only to provide screening to determine that the individual does not have an emergency medical condition. A hospital could refer patients to a primary care clinic for evaluation and treatment of non-emergency conditions without violating EMTALA.

Primary care clinic licensing regulations as found in Title 22, California Code of Regulations, Section 75030, require written policies and procedures for the provision of handling emergencies and unusual occurrences and procedures for emergency consultation, and a list of physicians available for emergency consultation. All clinics are advised to prepare and implement emergency transfer protocols.

B. Contractual Obligation

A community clinic or health center may promise to provide health care services in the event of an public health emergency or natural disaster, either through a formal contractual agreement or through a Memorandum of Understanding with a local hospital, a local disaster council, or other entity. Except in the event where it is impossible or impractical to perform on the contract due to unforeseen events, as would be decided on a case-by-case basis, the clinic has a legal obligation to perform. Before taking on any contractual obligation to provide emergency response services, clinic management is advised to consider liability issues, whether the clinic has capacity to meet staffing and equipment requirements, and regulatory requirements that may hamper the clinic's ability to perform.

Select State Statutes and Regulations:

OBLIGATION OF CLINICS:

Cal. Health & Safety Code Section 124450.

(a) In any emergency or disaster, as declared by the Governor, clinics funded under the seasonal agricultural and migratory workers program provided for by Chapter 3 (commencing with Section 124550), the rural health services development program provided for by Chapter 5 (commencing with Section 124600) or the
expanded access to primary care program provided for by Article 2 (commencing with Section 124900) of Chapter 7 shall provide nonelective, primary health care services, utilizing a sliding-fee scale based on income, including a zero payment option, to all persons who are impacted by the emergency or disaster and who present themselves for treatment at the clinic.

(b) The department shall deny or recoup payment under Chapter 3 (commencing with Section 124550), Chapter 5 (commencing with Section 124600), and Article 2 (commencing with Section 124900) of Chapter 7, assess civil penalties, revoke or suspend the license of the clinic pursuant to Section 1229, or impose other sanctions or other penalties authorized by law, when the clinic charges patients for care and fails to utilize a sliding-fee scale based on income, including a zero-payment option, to determine the fees to be charged to any patient pursuant to subdivision (a).

(c) To the extent that the department enters into contracts or renews contracts with clinics identified in subdivision (b) on or after the effective date of this section, those contracts shall require clinics to utilize a sliding-fee scale based on income, including a zero-payment option, when determining fees to be assessed for patients.

GOOD SAMARITAN LAWS:

Cal. Health & Safety Code Section 1799.100.

In order to encourage local agencies and other organizations to train people in emergency medical services, no local agency, entity of state or local government, or other public or private organization which sponsors, authorizes, supports, finances, or supervises the training of people, or certifies those people, excluding physicians and surgeons, registered nurses, and licensed

vocational nurses, as defined, in emergency medical services, shall be liable for any civil damages alleged to result from those training programs.

Cal. Health & Safety Code Section 1799.102.

No person who in good faith, and not for compensation, renders emergency care at the scene of an emergency shall be liable for any civil damages resulting from any act or omission. The scene of an emergency shall not include emergency departments and other places where medical care is usually offered.

Cal. Civ. Code Section 1714.2.

(a) In order to encourage citizens to participate in emergency medical services training programs and to render emergency medical services to fellow citizens, no person who has completed a basic cardiopulmonary resuscitation course which complies with the standards adopted by the American Heart Association or the American Red Cross for cardiopulmonary resuscitation and emergency cardiac care, and who, in good faith, renders emergency cardiopulmonary resuscitation at the scene of an emergency shall be liable for any civil damages as a result of any acts or omissions by such person rendering the emergency care.

(b) This section shall not be construed to grant immunity from civil damages to any person whose conduct in rendering such emergency care constitutes gross negligence.

(c) In order to encourage local agencies and other organizations to train citizens in cardiopulmonary resuscitation techniques, no local agency, entity of state or local government, or other public or private organization which sponsors, authorizes, supports, finances, or supervises the training of citizens in cardiopulmonary resuscitation shall be liable for any civil damages alleged to result from such training programs.

(d) In order to encourage qualified individuals to instruct citizens in cardiopulmonary resuscitation, no person who is certified to instruct in cardiopulmonary resuscitation by either the American Heart Association or the American Red Cross shall be liable for any civil damages alleged to result from the acts or omissions of an individual who received instruction on cardiopulmonary resuscitation by that certified instructor.

(e) This section shall not be construed to grant immunity from civil damages to any person who renders such emergency care to an individual with the expectation of receiving compensation from the individual for providing the emergency care.

Cal. Civil Code Section 1714.21.

(a) For purposes of this section, the following definitions shall apply:

(1) "AED" or "defibrillator" means an automated or automatic external defibrillator.

(2) "CPR" means cardiopulmonary resuscitation.

(b) Any person who, in good faith and not for compensation, renders emergency care or treatment by the use of an AED at the scene of an emergency is not liable for any civil damages resulting from any acts or omissions in rendering the emergency care.

(c) A person or entity who provides CPR and AED training to a person who renders emergency care pursuant to subdivision (b) is not liable for any civil damages resulting from any acts or omissions of the person rendering the emergency care.

(d) A person or entity that acquires an AED for emergency use pursuant to this section is not liable for any civil damages resulting from any acts or omissions in the rendering of the emergency care by use of an AED, if that person or entity has complied with subdivision (b) of Section 1797.196 of the Health and Safety Code.

(e) A physician who is involved with the placement of an AED and any person or entity responsible for the site where an AED is located is not liable for any civil damages resulting from any acts or omissions of a person who renders emergency care pursuant to subdivision (b), if that

physician, person, or entity has complied with all of the requirements of Section 1797.196 of the Health and Safety Code that apply to that physician, person, or entity.

(f) The protections specified in this section do not apply in the case of personal injury or wrongful death that results from the gross negligence or willful or wanton misconduct of the person who renders emergency care or treatment by the use of an AED.

(g) Nothing in this section shall relieve a manufacturer, designer, developer, distributor, installer, or supplier of an AED or defibrillator of any liability under any applicable statute or rule of law.

WORKERS' COMPENSATION PROVISIONS:

Cal. Labor Code Section 2750.6.
There is a rebuttable presumption affecting the burden of proof that a physician and surgeon, licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who enters into a contract for the performance of health services on behalf of a licensed primary care clinic, as defined in paragraph (1) of subdivision (a) of Section 1204 of the Health and Safety Code, is an independent contractor rather than an employee. Nothing in this section shall authorize the employment of a physician and surgeon to provide professional services when the employment would violate any other provision of law.

Cal. Labor Code Section 3352.
"Employee" excludes the following:

(a) Any person defined in subdivision (d) of Section 3351 who is employed by his or her parent, spouse, or child.

(b) Any person performing services in return for aid or sustenance only, received from any religious, charitable, or relief organization.

(c) Any person holding an appointment as deputy clerk or deputy sheriff appointed for his or her own convenience, and who receives no compensation from the county or municipal corporation or from the citizens thereof for his or her services as the deputy. This exclusion is operative only as to employment by the county or municipal corporation and does not deprive any person so deputized from recourse against a private person employing him or her for injury occurring in the course of and arising out of the employment.

(d) Any person performing voluntary services at or for a recreational camp, hut, or lodge operated by a nonprofit organization, exempt from federal income tax under Section 101(6) of the Internal Revenue Code, of which he or she or a member of his or her family is a member and who receives no compensation for those services other than meals, lodging, or transportation.

(e) Any person performing voluntary service as a ski patrolman who receives no compensation for those services other than meals or lodging or the use of ski tow or ski lift facilities.

(f) Any person employed by a ski lift operator to work at a snow ski area who is relieved of and not performing any prescribed duties,while participating in recreational activities on his or her own initiative.

(g) Any person, other than a regular employee, participating in sports or athletics who receives no compensation for the participation other than the use of athletic equipment, uniforms, transportation, travel, meals, lodgings, or other expenses incidental thereto.

(h) Any person defined in subdivision (d) of Section 3351 who was employed by the employer to be held liable for less than 52 hours during the 90 calendar days immediately preceding the date of the injury for injuries, as defined in Section 5411, or during the 90 calendar days immediately preceding the date of the last employment in an occupation exposing the employee to the hazards of the disease or injury for injuries, as defined in Section 5412, or who earned less than one hundred dollars ($100) in wages from the employer during the 90 calendar days immediately preceding the date of the injury for injuries, as defined in Section 5411, or during the 90 calendar days immediately preceding the date of the last employment in an occupation

exposing the employee to the hazards of the disease or injury for injuries, as defined in Section 5412.

(i) Any person performing voluntary service for a public agency or a private, nonprofit organization who receives no remuneration for the services other than meals, transportation, lodging, or reimbursement for incidental expenses.

(j) Any person, other than a regular employee, performing officiating services relating to amateur sporting events sponsored by any public agency or private, nonprofit organization, who receives no remuneration for these services other than a stipend for each day of service no greater than the amount established by the Department of Personnel Administration as a per diem expense for employees or officers of the state. The stipend shall be presumed to cover incidental expenses involved in officiating, including, but not limited to, meals, transportation, lodging, rule books and courses, uniforms, and appropriate equipment.

(k) Any student participating as an athlete in amateur sporting events sponsored by any public agency, public or private nonprofit college, university or school, who receives no remuneration for the participation other than the use of athletic equipment, uniforms, transportation, travel, meals, lodgings, scholarships, grants-in-aid, or other expenses incidental thereto.

(l) Any law enforcement officer who is regularly employed by a local or state law enforcement agency in an adjoining state and who is deputized to work under the supervision of a California peace officer pursuant to paragraph (4) of subdivision (a) of Section 832.6 of the Penal Code.

(m) Any law enforcement officer who is regularly employed by the Oregon State Police, the Nevada Department of Motor Vehicles and Public Safety, or the Arizona Department of Public Safety and who is acting as a peace officer in this state pursuant to subdivision (a) of Section 830.32 of the Penal Code.

(n) Any person, other than a regular employee, performing services as a sports official for an entity sponsoring an intercollegiate or interscholastic sports event, or any person performing services as a sports official for a public agency, public entity, or a private nonprofit organization, which public agency, public entity, or private nonprofit organization sponsors an amateur sports event. For purposes of this subdivision, "sports official" includes an umpire, referee, judge, scorekeeper, timekeeper, or other person who is a neutral participant in a sports event.

Cal. Labor Code Section 3363.6.

(a) Notwithstanding Sections 3351, 3352, and 3357, a person who performs voluntary service without pay for a private, nonprofit organization, as designated and authorized by the board of directors of the organization, shall, when the board of directors of the organization, in its sole discretion, so declares in writing and prior to the injury, be deemed an employee of the organization for purposes of this division while performing such service.

(b) For purposes of this section, "voluntary service without pay" shall include the performance of services by a parent, without remuneration in cash, when rendered to a cooperative parent participation nursery school if such service is required as a condition of participation in the organization.

(c) For purposes of this section, "voluntary service without pay" shall include the performance of services by a person who receives no remuneration other than meals, transportation, lodging, or reimbursement for incidental expenses.

Cal. Labor Code Section 3600.6.

Disaster service workers registered by a disaster council while performing services under the general direction of the disaster council shall be entitled to all of the same benefits of this division as any other injured employee, except as provided by Chapter 10 (commencing with Section 4351) of Part 1. For purposes of this section, an unregistered person impressed into performing service as a disaster service worker during a state of war emergency, a state of emergency, or a local emergency by a person having authority to

command the aid of citizens in the execution of his or her duties shall also be deemed a disaster service worker and shall be entitled to the same benefits of this division as any other disaster service worker.

Cal. Labor Code Section 4150.
When an employer has in his employment any person not included within the term "employee" as defined by Article 2 of Chapter 2 of Part 1 of this division or a person not entitled to compensation under this division, such employer and such person employed by him may, by their joint election, come under the compensation provisions of this division in the manner hereinafter provided.

INDEMNIFICATION BY LOCAL PUBLIC ENTITIES FOR VOLUNTEER SERVICES AT CLINICS:

Government Code Section 990.9.
Any city, county, city and county, or any other local public entity with authority to provide health care services may provide insurance or provide indemnity through self-insurance for medical or other health-care tort claims against any person who, in good faith and without compensation, renders voluntary care to low-income patients within the scope of his or her practice at a community clinic or free clinic, as those terms are defined in subdivision (a) of Section 1204 of the Health and Safety Code, serving residents within the jurisdiction of the local public entity, and who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code or under an initiative act referred to in those provisions. However, the insurance or indemnity provided pursuant to this section shall not cover liability for which there is other insurance coverage in effect.

IMMUNITY FROM LIABILITY FOR DSWs:

Cal. Government Code Section 8657.
(a) Volunteers duly enrolled or registered with the Office of Emergency Services or any disaster council of any political subdivision, or unregistered persons duly impressed into service during a state of war emergency, a state of emergency, or a local emergency, in carrying out, complying with, or attempting to comply with, any order or regulation issued or promulgated pursuant to the provisions of this chapter or any local ordinance, or performing any of their authorized functions or duties or training for the performance of their authorized functions or duties, shall have the same degree of responsibility for their actions and enjoy the same immunities as officers and employees of the state and its political subdivisions performing similar work for their respective entities.

(b) No political subdivision or other public agency under any circumstances, nor the officers, employees, agents, or duly enrolled or registered volunteers thereof, or unregistered persons duly impressed into service during a state of war emergency, a state of emergency, or a local emergency, acting within the scope of their official duties under this chapter or any local ordinance shall be liable for personal injury or property damage sustained by any duly enrolled or registered volunteer engaged in or training for emergency preparedness or relief activity, or by any unregistered person duly impressed into service during a state of war emergency, a state of emergency, or a local emergency and engaged in such service. The foregoing shall not affect the right of any such person to receive benefits or compensation which may be specifically provided by the provisions of any federal or state statute nor shall it affect the right of any person to recover under the terms of any policy of insurance.

(c) The California Earthquake Prediction Evaluation Council, an advisory committee established pursuant to Section 8590 of this chapter, may advise the Governor of the existence of an earthquake or volcanic prediction having scientific validity. In its review, hearings, deliberations,

or other validation procedures, members of the council, jointly and severally, shall have the same degree of responsibility for their actions and enjoy the same immunities as officers and employees of the state and its political subdivisions engaged in similar work in their respective entities. Any person making a presentation to the council as part of the council's validation process, including presentation of a prediction for validation, shall be deemed a member of the council until the council has found the prediction to have or not have scientific validity.

HEALTH PROVIDER IMMUNITY FROM LIABILITY:

Cal. Government Code Section 8659.
Any physician or surgeon (whether licensed in this state or any other state), hospital, pharmacist, nurse, or dentist who renders services during any state of war emergency, a state of emergency, or a local emergency at the express or implied request of any responsible state or local official or agency shall have no liability for any injury sustained by any person by reason of such services, regardless of how or under what circumstances or by what cause such injuries are sustained; provided, however, that the immunity herein granted shall not apply in the event of a willful act or omission.

Cal. Business & Professions Code Section 900.
(a) Nothing in this division applies to a health care practitioner licensed in another state or territory of the United States who offers or provides health care for which he or she is licensed, if the health care is provided only during a state of emergency as defined in subdivision (b) of Section 8558 of the Government Code, which emergency overwhelms the response capabilities of California health care practitioners and only upon the request of the Director of the Emergency Medical Services Authority.

(b) The director shall be the medical control and shall designate the licensure and specialty health care practitioners required for the specific emergency and shall designate the areas to which they may be deployed.

(c) Health care practitioners shall provide, upon request, a valid copy of a professional license and a photograph identification issued by the state in which the practitioner holds licensure before being deployed by the director.

(d) Health care practitioners deployed pursuant to this chapter shall provide the appropriate California licensing authority with verification of licensure upon request.

(e) Health care practitioners providing health care pursuant to this chapter shall have immunity from liability for services rendered as specified in Section 8659 of the Government Code.

(f) For the purposes of this chapter, "health care practitioner" means any person who engages in acts which are the subject of licensure or regulation under this division or under any initiative act referred to in this division.

(g) For purposes of this chapter, "director" means the Director of the Emergency Medical Services Authority who shall have the powers specified in Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

SHELTERING DISASTER VICTIMS:

Cal. Civil Code Section 1714.5.
There shall be no liability on the part of one, including the State of California, county, city and county, city or any other political subdivision of the State of California, who owns or maintains any building or premises which have been designated as a shelter from destructive operations or attacks by enemies of the United States by any disaster council or any public office, body, or officer of this state or of the United States, or which have been designated or are used as mass care centers, first aid stations, temporary hospital annexes, or as other necessary facilities for

mitigating the effects of a natural, manmade, or war-caused emergency, for any injuries arising out of the use thereof for such purposes sustained by any person while in or upon said building or premises as a result of the condition of said building or premises or as a result of any act or omission, or in any way arising from the designation of such premises as a shelter, or the designation or use thereof as a mass care center, first aid station, temporary hospital annex, or other necessary facility for emergency purposes, except a willful act, of such owner or occupant or his servants, agents or employees when such person has entered or gone upon or into said building or premises for the purpose of seeking refuge, treatment, care, or assistance therein during destructive operations or attacks by enemies of the United States or during tests ordered by lawful authority or during a natural or manmade emergency.

No disaster service worker who is performing disaster services ordered by lawful authority during a state of war emergency, a state of emergency, or a local emergency, as such emergencies are defined in Section 8558 of the Government Code, shall be liable for civil damages on account of personal injury to or death of any person or damage to property resulting from any act or omission in the line of duty, except one that is willful.

DISTRIBUTION OF DONATED FOOD:

Cal. Civil Code Section 1714.25.

(a) Except for injury resulting from negligence or a willful act in the preparation or handling of donated food, no food facility that donates any food that is fit for human consumption at the time it was donated to a nonprofit charitable organization or a food bank shall be liable for any damage or injury resulting from the consumption of the donated food.

The immunity from civil liability provided by this subdivision applies regardless of compliance with any laws, regulations, or ordinances regulating the packaging or labeling of food, and regardless of compliance with any laws, regulations, or ordinances regulating the storage or handling of the food by the donee after the donation of the food.

(b) A nonprofit charitable organization or a food bank that, in good faith, receives and distributes food without charge that is fit for human consumption at the time it was distributed is not liable for an injury or death due to the food unless the injury or death is a direct result of the negligence, recklessness, or intentional misconduct of the organization.

(c) For the purposes of this section:

(1) "Nonprofit charitable organization" has the meaning defined in Section 114440 of the Health and Safety Code.

(2) "Food bank" has the meaning defined in Section 114445 of the Health and Safety Code.

CREATION OF LOCAL DISASTER COUNCILS:

Cal. Government Code Section 8610.

Counties, cities and counties, and cities may create disaster councils by ordinance. A disaster council shall develop plans for meeting any condition constituting a local emergency or state of emergency**,** including, but not limited to, earthquakes, natural or manmade disasters specific to that jurisdication, or state of war emergency; such plans shall provide for the effective mobilization of all of the resources within the political subdivision, both public and private. The disaster council shall supply a copy of any plans developed pursuant to this section to the Office of Emergency Services. The governing body of a county, city and county, or city may, in the ordinance or by resolution adopted pursuant to the ordinance, provide for the organization, powers and duties, divisions, services, and staff of the emergency organization. The governing body of a county, city and county, or city may, by ordinance or resolution, authorize public officers, employees, and registered volunteers to command the aid of citizens when necessary in the execution of their duties during a state of war emergency, a

state of emergency, or a local emergency.

Counties, cities and counties, and cities may enact ordinances and resolutions and either establish rules and regulations or authorize disaster councils to recommend to the director of the local emergency organization rules and regulations for dealing with local emergencies that can be adequately dealt with locally; and further may act to carry out mutual aid on a voluntary basis and, to this end, may enter into agreements.

CONDITIONS OF EMERGENCY UNDER THE CALIFORNIA EMERGENCY SERVICES ACT:

Cal. Government Code Section 8558. Three conditions or degrees of emergency are established by this chapter:

(a) "State of war emergency" means the condition which exists immediately, with or without a proclamation thereof by the Governor, whenever this state or nation is attacked by an enemy of the United States, or upon receipt by the state of a warning from the federal government indicating that such an enemy attack is probable or imminent.

(b) "State of emergency" means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by such conditions as air pollution, fire, flood, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake, complications resulting from the Year 2000 Problem, or other conditions, other than conditions resulting from a labor controversy or conditions causing a "state of war emergency," which, by reason of their magnitude, are or are likely to be beyond the control of the services, personnel, equipment, and facilities of any single county, city and county, or city and require the combined forces of a mutual aid region or regions to combat, or with respect to regulated energy utilities, a sudden and severe energy shortage requires extraordinary measures beyond the authority vested in the California Public Utilities Commission.

(c) "Local emergency" means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons and property within the territorial limits of a county, city and county, or city, caused by such conditions as air pollution, fire, flood, storm, epidemic, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, the Governor's warning of an earthquake or volcanic prediction, or an earthquake, complications resulting from the Year 2000 Problem, or other conditions, other than conditions resulting from a labor controversy, which are or are likely to be beyond the control of the services, personnel, equipment, and facilities of that political subdivision and require the combined forces of other political subdivisions to combat, or with respect to regulated energy utilities, a sudden and severe energy shortage requires extraordinary measures beyond the authority vested in the California Public Utilities Commission.

SUSPENSION OF REGULATIONS DURING A STATE OF EMERGENCY:

Cal Government Code Section 8571.

During a state of war emergency or a state of emergency the Governor may suspend any regulatory statute, or statute prescribing the procedure for conduct of state business, or the orders, rules, or regulations of any state agency, including subdivision (d) of Section 1253 of the Unemployment Insurance Code, where the Governor determines and declares that strict compliance with any statute, order, rule, or regulation would in any way prevent, hinder, or delay the mitigation of the effects of the emergency**.**

Cal. Civil Code Section 1714.6.

The violation of any statute or ordinance shall not establish negligence as a matter of law where the act or omission involved was required in order to comply with an order or

proclamation of any military commander who is authorized to issue such orders or proclamations; nor when the act or omission involved is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency
Services Act. No person shall be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with an order or proclamation of any military commander who is authorized to issue such orders or proclamations; nor shall any person be prosecuted for a violation of any statute or ordinance when violation of such statute or ordinance is required in order to comply with any regulation, directive, or order of the Governor promulgated under the California Emergency
Services Act. The provisions of this section shall apply to such acts or omissions whether occurring prior to or after the effective date of this section.

Title 22, California Code of Regulations, Division 5, Chapter 7. Primary Care Clinics

Article 3. Basic Services.
Section 75031. Basic-Services- Equipment and Supplies.
(a) Each clinic shall have equipment and supplies available to provide for the medical, dental or podiatric services offered and to meet the needs of the particular patients served.
(b) The clinic shall have equipment available for emergency treatment of patients. Such equipment shall be determined by the professional director and licensed nurse in accordance with the scope of services provided by the clinic. A list of such equipment and its location shall be posted.

Authority cited: Sections 208(a) and 1225, Health and Safety Code.
Reference: Section 1226, Health and Safety Code.

Article 6. Administration
Section 75047. Transfer Agreements.
(a)The clinic shall maintain written transfer agreements, which include provisions for communication and transportation, with one or more nearby hospitals and other inpatient health facilities as appropriate to meet medical emergencies. Essential personal, health and medical information shall either accompany the patient upon transfer or be transmitted immediately by telephone to the receiving facility.
(b) Clinics, except those providing abortion or birthing services, may request that the Department waive the requirement of (a). The clinic must demonstrate to the Department that all nearby hospitals and other inpatient health facilities, as appropriate to meet medical emergencies have refused to enter into transfer agreements.

Authority cited: Sections 208(a) and 1225, Health and Safety Code.
Reference: Section 1226, Health and Safety Code.

Section 75048. Service Agreements.
Written arrangements shall be made for obtaining all necessary diagnostic radiological, laboratory, therapeutic and other services which are prescribed by a person lawfully authorized to give such an order if such services are not provided in the clinic.

Authority cited: Sections 208(a) and 1225, Health and Safety Code.
Reference: Section 1226, Health and Safety Code.

Section 75049. Written Administrative Policies.

(a) Written administrative policies shall be established and implemented and shall be reviewed at least annually and revised as necessary.

(b) The policies shall include the following:

(1)Management and personnel policies which include job descriptions detailing the functions of each classification of employee or volunteer.

(2)Policies for acceptance of patients and termination of services shall include rate of charge for care, charges for outside services, limitation of services, cause for termination of services and refund policies applying to termination of services. These policies shall be made available to patients or their agents upon admission and upon request and shall be made available to the public upon request.

(3) Policies and procedures governing patient health records which are developed with assistance of a person skilled in record maintenance and preservation.

Authority cited: Sections 208(a) and 1225, Health and Safety Code.
Reference: Section 1226, Health and Safety Code.

Section 75050. Employees.

(a)The clinic shall recruit qualified personnel and provide initial orientation of new employees, a continuing in-service training program, and supervision designed to improve patient services and employee efficiency. Personnel shall be given training in infection control and emergency procedures consistent with the type of clinic and the services provided.

(b) The clinic shall provide a copy of the appropriate job description to each person employed or volunteering to work in the clinic.

Authority cited: Sections 208(a) and 1225, Health and Safety Code.
Reference: Section 1226, Health and Safety Code.

Section 75053. Unusual Occurrences.

Unusual Occurrences. Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of patients, personnel or visitors shall be reported by the facility within 24 hours either by telephone (and confirmed in writing) or by telegraph to the local health officer and the Department. An incident report shall be retained on file by the facility for one year. The facility shall furnish such other pertinent information related to such occurrences as the local health officer or the Department may require. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshal.

Authority cited: Sections 208(a) and 1225, Health and Safety Code.
Reference: Section 1226, Health and Safety Code.

Section 75057. Disaster Program.

(a) Each clinic shall adopt a written disaster program and all personnel shall be instructed in its requirements. A copy of the program shall be available in the clinic for review by the Department.

(b)The program shall provide plans for disasters occurring within the facility. The written program shall include at least the following:

(1)Administrative procedures, including designated authority, and personnel duty assignments. There shall be provisions for simulated fire drills at least semi-annually and records to indicate that such drills were conducted.

(2) Plans for evacuation of patients when necessary, including means of egress, methods of handling and transporting patients, and disposition and care of patients after removal.

(c) The program shall be reviewed annually, and updated as needed.

Authority cited: Sections 208(a) and 1225, Health and Safety Code. Reference: Section 1226, Health and Safety Code.

Chapter 10. Adult Day Health Centers.
Article 4. Administration.

Section 78423. Disaster Plan

(a) Each center shall have a plan for a disaster occurring within the center, or a local disaster occurring in the community.

(b) The plan shall be in writing and shall include:

(1) Designation of administrative authority and employee assignments.

(2) Plan for evacuation or relocation of participants, including:

(A) Means of evacuation.

(B) Transportation of participants when necessary.

(C) Supervision of participants after evacuation or relocation.

(D) Means for contacting local service agencies, such as fire department, law enforcement agencies and other disaster authorities of local government.

(3)Plan for reception of nonparticipants dislocated by disaster and emergencies occurring outside the center.

(c) Each employee shall be instructed in assigned duties. Instruction shall include employee and participant practice sessions. New employees shall be informed immediately of their disaster duties, as required in the plan.

(d) The disaster plan shall be conspicuously posted in the center and kept up to date, and shall be subject to annual review by the appropriate fire safety and disaster authorities of local government.

Disaster Service Worker Volunteer Program
Title 19, California Code of Regulations, Division 2, Chapter 2, Subchapter 3

Section 2570.1. Purpose

The Legislature has long provided a state-funded program of workers' compensation benefits for disaster service worker volunteers who contribute their services to protect the health and safety and preserve the lives and property of the people of the state. This program was established to protect such volunteers from financial loss as a result of injuries sustained while engaged in disaster service activities and to provide immunity from liability for such disaster service worker volunteers while providing disaster service.

Authority cited: Sections 8587 and 8580, Government Code. Reference: Section 8657, Government Code; and Sections 3211.9-3211.93a, Labor Code.

Section 2570.2. Definitions

(a)Disaster Service Worker.

(a) A disaster service worker is any person registered with a disaster council or the Governor's Office of Emergency Services, or a state agency granted authority to register disaster service

workers, for the purpose of engaging in disaster service pursuant to the California Emergency Services Act without pay or other consideration.
(2) Disaster service worker includes public employees, and also includes any unregistered person impressed into service during a state of war emergency, a state of emergency, or a local emergency by a person having authority to command the aid of citizens in the execution of his or her duties.
(3) Exclusion: Disaster service worker does not include any member registered as an active fire fighting member of any regularly organized volunteer fire department, having official recognition, and full or partial support of the county, city, town or district in which such fire department is located.
(b) Disaster Service.
(1) Disaster service means all activities authorized by and carried on pursuant to the California Emergency Services Act, including approved and documented training necessary or proper to engage in such activities.
(2) Exclusion. Disaster service does not include any activities or functions performed by a person if the disaster council with which the person is registered receives a fee or other compensation for the performance of that person's activities or functions.
(c)Training. For purposes of these regulations, training is a planned activity sponsored by a disaster council (or designated agency or authority) and may include classroom instruction, disaster drills or exercises, or related activities that are designed to enhance the disaster response skills (including safety) of the disaster service worker.
(d) Disaster Council. A disaster council is a public agency established by ordinance which is empowered to register and direct the activities of disaster service workers within the area of the county, city, city and county, or any part thereof. In this respect, the disaster council is acting as an instrument of the state in aid of carrying out general state government functions and policy with regard to disaster services.
(e) Accredited Disaster Council. A disaster council may become accredited through certification by the California Emergency Council, or the Governor when the Emergency Council is not meeting, when the disaster council agrees to follow and comply with the rules and regulations established by the Emergency Council pursuant to the provisions of the Emergency Services Act. Upon certification, and not before, the disaster council becomes an accredited disaster council. A disaster council remains accredited only while the certification of the California Emergency Council is in effect and is not revoked.
(f) Auxiliary Fire Fighter. An auxiliary fire fighter is a person recruited, registered and trained as a supplement or reserve for unusual fire emergencies or disaster situations. Workers' compensation benefits for auxiliary fire fighters may be provided by the state. An auxiliary fire fighter is not a “volunteer fire fighter,” who is a person recruited and trained to meet the day-to-day operational requirements of a fire department. Workers' compensation insurance premiums for the volunteer fire fighter are the responsibility of the local government or fire entity.
(g) Public Employee. All persons employed by the state or any county, city, city and county, state agency or public district, excluding aliens legally employed, are considered to be public employees.
(h) Convergent Volunteers. Convergent volunteers are individuals that come forward to offer disaster response and recovery volunteer services, during a disaster event. Convergent volunteers are not persons impressed into service at the scene of an incident.

Authority cited: Sections 8567 and 8580, Government Code. Reference: Sections 8581, 8610 and 8612, Government Code; and Sections 3100, 3211.9, 3211.91, 3211.93 and 3211.93a, Labor Code.

Section 2572.1. Classifications and General Duties

The various classifications of disaster service workers and the general duties of the members of each classification shall be limited to those described below:

(a) Animal Rescue, Care and Shelter. Veterinarians, veterinary support staff and animal handlers providing skills in the rescue, clinical treatment, and transportation of all animals, including but not limited to companion animals, livestock, poultry, fish, exhibition animals, zoo animals, laboratory and research animals, and wildlife; assisting in the procurement of shelters, equipment, and supplies; documenting arrival, sheltering, treatment, and discharge or placement of animals.

(b) Communications. Install, operate and maintain various communications systems and perform related service, to assist officials and individuals in the protection of life and property.

(c) Community Emergency Response Team Member. Under the direction of emergency personnel or a designated team leader, assist emergency units within their block, neighborhood, or other area assignment; survey area conditions; disseminate information; secure data desirable for emergency preparedness planning; report incidents; and generally assist officials and individuals in the protection of life and property.

(d) Finance and Administrative Staff. Perform executive, administrative, technical, financial and clerical functions for the emergency organization.

(e) Human Services. Assist in providing food, clothing, bedding, shelter, and rehabilitation aid; register evacuees to promote reuniting families and to support the needs of special populations; compile authoritative lists of deceased and missing persons; and other phases of emergency human services, such as maintaining morale and administering to the mental health, religious or spiritual needs of persons suffering from the effects of the disaster.

(f) Fire. As auxiliary fire fighters or auxiliary wildland fire fighters, assist regular fire fighting forces or fire protection agencies to fight fire, rescue persons, and save property; control forest or wildland fires or fire hazards; instruct residents in fire prevention and property defense methods, methods of detecting fire, and precautions to be observed in reducing fire hazards.

(1) For purposes of these regulations only, the ratios between auxiliary fire fighters, volunteer fire fighters, and paid fire fighters shall be one auxiliary for one volunteer and three volunteers for one paid fire fighter. The basis for applying these ratios is that the staffing of an engine company, truck company, or a squad shall not exceed six paid fire fighters, and a salvage and rescue company shall not exceed two paid fire fighters. A fire department that has no volunteer fire fighters is limited to three auxiliary fire fighters for each paid fire fighter in the companies and squads, staffed as above. These staffing standards are based on the number of first line (not reserve) apparatus operated by the fire department.

(2) When auxiliary fire fighters are registered with other than an established fire service organization; for example, auxiliary fire fighters in a county or city emergency management services organization, a total number of eligible auxiliary fire fighters shall be computed for that city or unincorporated area. The emergency management services organization is entitled to register auxiliary fire fighters not otherwise registered with other established fire service organizations, and to a number not to exceed the allowable total as indicated in Section 2572.1(f)(1), above.

(g) Laborer. Under the direction and supervision of the responding agency, performs general labor services and supports emergency operations.

(h) Law Enforcement. As Auxiliaries, assist law enforcement officers and agencies to protect life and property; maintain law and order; perform traffic control duties; guard buildings, bridges, factories, and other facilities; isolate and report unexploded ordnance.

(i) Logistics. Under the direction of the emergency organization, assist in procurement, warehousing, and release of supplies, equipment materials, or other resources. Assist in mobilization and utilization of public and private transportation resources required for the movement of persons, materials, and equipment.

(j) Medical and Environmental Health. Staff casualty stations, establish and operate medical and public health field units; assist in hospitals, out-patient clinics, and other medical and public health installations; maintain or restore environmental sanitation; assist in preserving the safety of food, milk, and water and preventing the spread of disease; perform laboratory analysis to detect

the presence and minimize the effects of nuclear, chemical, biological, radiological or other hazardous agents.

(k) Safety Assessment Inspector. Survey, evaluate and assess damaged facilities for continued occupancy or use; assist in emergency restoration of facilities for utilities, transportation, and other vital community services; and provide recommendations regarding shoring or stabilization of damaged or unsafe buildings or structures.

(*l*) Search and Rescue. Under the direction of the appropriate authority, perform search and rescue operations in one or more of several areas including: search and rescue; urban search and rescue; or mine and confined space rescue.

(m) Utilities. Assist utility personnel in the repair and restoration of public utilities damaged by disaster.

Authority cited: Sections 8587 and 8580, Government Code. Reference: Section 8580, Government Code.

Section 2572.2. Scope of Disaster Service Duties.

Each disaster service worker in any classification shall, without regard to a formal designation or assignment, be considered to be acting within the scope of disaster service duties while assisting any unit of the emergency organization or performing any act contributing to the protection of life or property, or mitigating the effects of an emergency or potential emergency either:

(a) under the authorization of a duly constituted superior in the emergency organization; or,

(b) under the supervision and direction of the American Red Cross while carrying out its programs in consonance with state and local statements of understanding, or in carrying out a mission assigned to that agency by a responsible state or local authority.

Authority cited: Sections 8567 and 8580, Government Code. Reference: Section 8580, Government Code.

Section 2573.3. Worker's Compensation Claims.

(a) Claims Packages. Worker's compensation claims for injuries sustained by disaster service workers while performing disaster service, shall be filed under the same authorities and guidelines as claims filed by paid employees. The claim shall include:

(1) the appropriate claim and employer's report of injury forms as prescribed by the State Compensation Insurance Fund;

(2) a written narrative account of the incident that may include witness statements; and,

(3) a copy of the claimant's current disaster service worker registration form indicating the loyalty oath or affirmation was administered.

(b) Convergent Volunteers. For purposes of obtaining workers' compensation benefits through the disaster service worker program, convergent volunteers will be eligible when the requirements of disaster service worker are met in accordance with these regulations.

Authority cited: Sections 8567 and 8580, Government Code. Reference: Section 3211.92 and 5400 et seq., Labor Code; and Section 3102, Government Code.