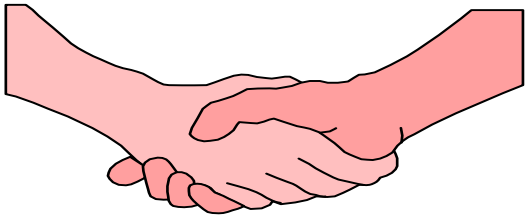
SHELTER MEDICAL GROUP TOOLKIT

LOCAL EMERGENCY PREPAREDNESS PLANNERS GUIDE FOR THE CARE AND SHELTERING OF THE MEDICALLY FRAGILE



PREPARED BY THE SHELTER MEDICAL GROUP

September 6, 2001

LOCAL EMERGENCY PREPAREDNESS PLANNING TOOLKIT

PURPOSE:
To provide guidelines for the local and regional implementation of sheltering and austere medical care delivery systems specifically for the medically fragile prior to and during a disaster. This "Tool Kit" was developed in full acknowledgment that *written plans, by themselves, cannot accomplish the work that needs to be done in this regard*. It must be part of a comprehensive disaster preparedness planning and implementation effort that conforms to the California Standardized Emergency Management System (SEMS). The nature of sheltering and caring for medically fragile populations is such that it cannot be accomplished without the collaborative, proactive action of many people and organizations across the spectrum of public, private, and non-profit organizations. We intend that this document provide a rudimentary set of guidelines that will further the goal of improved disaster preparedness for California's most medically fragile populations.

INTENDED AUDIENCE:
Those persons and organizations in local and regional California jurisdictions responsible for the care and sheltering of medically fragile populations before and during a disaster. This includes but is not limited to government emergency response agencies, residential care facilities, community-based organizations (CBO's) serving the medically fragile, American Red Cross chapters, the Salvation Army, and social and human services departments.

BACKGROUND:
In the wake of the winter storm flooding in 1997 that resulted in the evacuation of over 150,000 Californians, including several skilled nursing facilities, the Governor's Office of Emergency Services (OES) and the Emergency Medical Services Authority (EMSA) formed the Shelter Medical Group (SMG) Committee. The SMG is an approved specialist committee serving as part of the Standardized Emergency Management System (SEMS) Technical Group. The committee included representatives from most state agencies with responsibilities related to the medically fragile or the persons with disabilities community.

The SMG was convened to establish policies and procedures to meet the medical needs of people who must move during a disaster from their residence or care facilities to alternative locations. The SMG Report, released on February 18, 2000, contains extensive information for local emergency preparedness planners and health facilities in disaster planning, response, and recovery.

In October 2000, at the initiation of the State Emergency Medical Services Authority, the SMG was reconvened to develop a strategic plan to implement the SMG Report's recommendations. This Tool Kit is one product developed during that process.

CONCURRING AGENCIES:

Emergency Medical Services Authority
Governor's Office of Emergency Services
Department of Health Services
Department on Aging
Department of Social Services
Office of Statewide Planning & Development
The American Red Cross
The Salvation Army Western Territory
Local Government Representatives

USE OF THE TOOLKIT:

The original SMG report contained numerous appendices in support of the findings and recommendations identified in the report. The SMG has selected many of these appendices and included them in this toolkit as a resource to local emergency preparedness planners. The appendices should be used to assist in planning for the evacuation, care, and sheltering of medically fragile populations in disasters. A complete copy of the SMG report can be downloaded from the Emergency Medical Services website at www.emsa.ca.gov.

CONTENTS (with brief description):

1. **SEMS ORGANIZATIONAL LEVELS & FUNCTIONS (Appendix B)**
   - Basic overview of the use of the Standardized Emergency Management System (SEMS).

2. **TRAINING OF HEALTHCARE PROVIDERS (Appendix C)**
   - Includes types of emergency preparedness training available along with a description of the types of exercises necessary to train staff.

3. **GOVERNMENT EVACUATION CHECKLIST (Appendix E)**
   - Sample evacuation checklist to be used for the medically fragile by local government officials during an emergency or disaster.

4. **RISK ASSESSMENT AND EVACUATION STRATEGIES (Appendix F)**
   - Describes how health facilities should do a risk and hazard assessment in preparation for the development of evacuation strategies.

5. **VOLUNTARY REGISTRATION REQUEST INFORMATION (for the medically fragile) (Appendix G)**
   - Sample letter that explains the local registry program for medically fragile individuals.

6. **VOLUNTARY REGISTRATION REQUEST (for the medically fragile) (Appendix G-1)**
   - Sample registration form to be used by medically fragile individuals to sign up in the registry program.

7. **EMERGENCY EVACUATION DESTINATION CATEGORIES (for medically fragile patients and residents) (Appendix H)**
   - Provides triage guidelines to direct medically fragile patients and residents into three destination types, based on the level of care required. This section also provides recommendations on the type of ground transportation required.

8. **SHELTER MEDICAL OPERATIONS GUIDELINES (Appendix I)**
   - Provides detailed recommendations for setting up a medical treatment unit or temporary infirmary, including site selection, staffing, equipment, and supplies.

9. **MODEL STATEMENT OF UNDERSTANDING (between County Health Departments and the American Red Cross) (Appendix J)**
   - A sample agreement between the local health department and the American Red Cross for the provision of health and medical services following a disaster.

10. **MODEL STATEMENT OF UNDERSTANDING (between County Mental Health Departments and the American Red Cross) (Appendix J-1)**
    - A sample agreement between the local mental health department and the American Red Cross for the provision of mental health services following a disaster.

11. **ADOPT-A-SHELTER PROGRAM (Appendix K)**
    - Describes how a group or business may sponsor a medical shelter by supplying either equipment or personnel or both.

12. **HEALTH PASSPORT (Appendix L)**
    - A sample form, developed by Yuba and Sutter Counties, that can be modified for your jurisdiction and then completed and maintained by individuals with chronic medical problems. It establishes an up-to-date medical history that can be used by evacuated individuals to help ensure continuity of care.

REFERENCES:

1. Final version, State Shelter Medical Group Report, available at **http://www.emsa.ca.gov.**
2. Standardized Emergency Management System (SEMS) Regulations, Title 19, Division 2, Chapter 1, Sections 2400 – 2450, available at **http://www.oes.ca.gov**.

APPENDIX B

SEMS ORGANIZATIONAL LEVELS & FUNCTIONS

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

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

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

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

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

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

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

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

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

< **Operations** -- for coordinating all jurisdictional operations in support of the

response to the emergency through implementation of the organizational level's action plan.

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

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

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

APPENDIX C

TRAINING OF HEALTHCARE PROVIDERS

Introduction

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

Types of Training

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

American Red Cross Training

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

The Salvation Army

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

California Emergency Management Programs

The State of California has many emergency management training programs to assist the public and private sector in preparing for emergencies. The Governor's Office of Emergency Services offers many training courses through the California Specialized Training Institute. Training available includes a wide variety of emergency management

courses for city, county and state government administrators as well as highly specialized courses geared for practicing law and fire professionals.

Federal Emergency Management Programs

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

Types of Exercises

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

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

The four levels of exercises are characterized below:

1. **Drill**

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

2. **Table-tops**

    - provide orientation and overview
    - involve collective problem solving
    - are scenario-driven

- are methodical with fewer objectives
- are valuable tools for learning about problem areas

3. **Functional**

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

4. **Full-scale**

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

APPENDIX E

GOVERNMENT EVACUATION CHECKLIST

1. Situation Assessment

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

2. Infrastructure Assessment

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

3. Evacuation

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

4. Alert and Warning / Notification

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

5. Initial Response

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

6. Public Information

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

7. Mass Care and Shelter

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

APPENDIX F

RISK ASSESSMENT AND EVACUATION STRATEGIES

Introduction

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

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

Defining Authorities and Responsibilities

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

Assessing Facility Evacuation Risks

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

- **Hazard Analysis**

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

Knowledgeable staff, software programs, and guidance can provide hazard analysis from governmental emergency planners and consultants.

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

- **Frequency**

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

- **Duration of Incident**

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

- **Scope of Impact**

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

- **Destructive Potential to Life and Property**

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

- **Controllability**

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

- **Predictability**

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

- **Speed of Onset**

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

- **Length of Forewarning**

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

Developing Facility Protective Actions

There are several strategies for evacuation which include:

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

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

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

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

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

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

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

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

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

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

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

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

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

occurring during inclement weather, and the possible need for further evacuation to nearby like facilities.

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

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

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

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

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

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

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

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

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

the duration of the event, this may be the first step before transferring patients to another *like* facility.

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

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

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

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

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

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

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

Developing a Plan, Procedures, Training and Testing

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

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

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

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

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

Developing a Maintenance Process

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

APPENDIX G

VOLUNTARY REGISTRATION REQUEST
FOR
MEDICALLY FRAGILE INDIVIDUALS

DATE:

Dear Citizen:

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

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

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

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

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

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

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

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

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

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

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

APPENDIX G1

VOLUNTARY REGISTRATION REQUEST FOR MEDICALLY FRAGILE INDIVIDUALS

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

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

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

Name:_____ Spouse:_____Physical Address:_____ Apt/Lot:_____City: Zip:_____ Phone:_____Mailing Address (if different than above):

Do you live in a mobile home? _____ If yes, what is the complex name?_____Are you a seasonal resident? _____ If yes, what months are you here?_____Date of Birth:

Social Security #:_____Check applicable medical disabilities:

Legally Blind Deaf Terminal Contagious Disease

Specify other chronic medical disabilities:_____Are you:

Self-ambulatory Ambulatory with Assist (walker, cane, arm)

Confined to a wheelchair Non-ambulatory, bedridden

Check applicable special equipment that you are dependent on:

Wheelchair Walker/Cane Crutches

Life Support System Dialysis Insulin Dependent IV

Oxygen: If yes, oxygen needed for __hours per day. Indicate liter flow:

Do you have a portable tank?

General Physician's Name: _____ Phone: _____Home Health Care Provider:_____ Phone:_____

Emergency Contact Person:_____ Phone:(_____)_____Can you get to an evacuation shelter? _____ If no, check the appropriate transportation type needed?

Standard Vehicle (bus, car) Wheelchair Equipped Ambulance

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

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

_____

Registrant's Signature Date

Appendix H

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

APPENDIX I
SHELTER MEDICAL OPERATIONS GUIDELINES

I. DEFINITIONS

A. General Public Shelter

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

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

B. Medical Treatment Unit/Temporary Infirmary

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

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

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

II. MEDICAL TREATMENT UNIT/TEMPORARY INFIRMARY SITE SELECTION

A. Selection Process

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

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

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

B. Selection Criteria

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

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

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

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

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

III. STAFFING THE MEDICAL TREATMENT UNIT/TEMPORARY INFIRMARY

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

A. Standards

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

B. Staffing Schedules

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

C. Staffing Patterns

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

D. Staffing Levels and Roles

1. MEDICAL MANAGEMENT

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

2. PHYSICIAN SERVICES

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

3. NURSING SERVICES

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

4. CAREGIVERS

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

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

5. MENTAL HEALTH PROFESSIONALS

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

6. VOLUNTEERS

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

E. Staff-to-Patient Ratios

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

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

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

F. Staffing Resources

1. ESTABLISH A RESOURCE DIRECTORY

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

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

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

2. COMPENSATION, REIMBURSEMENT AND OTHER EXPENSES

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

IV. MEDICAL SUPPLIES

A. Identify Supply Needs

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

B. Develop a Resource Directory

- Maintain a resource directory with 24-hour emergency telephone numbers of vendors, suppliers, etc. and update it periodically.
- Develop contracts with local vendors, suppliers, and/or distributors to provide the variety and quantity of supplies needed, including resupply.
- When local supplies are exhausted, additional resources may be obtained through the State Emergency Management System. (Appendix B).

3. LOGISTICAL NEEDS

- Determine transportation and delivery methods.
- Determine storage and warehousing requirements.
- Determine the disposition of unused supplies following the emergency.

4. FINANCIAL RESPONSIBILITY

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

V. OBTAINING ADDITIONAL ASSISTANCE

A. Develop Cooperative Agreements

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

B. Requesting Resources

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

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

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

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

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

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

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

Appendix J

Statement of Understanding

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

I. Purpose

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

II. Authorities

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

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

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

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

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

III. AREAS OF AGREEMENT AND COOPERATION

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

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

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

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

The Department of Health Services will:

- Provide consultation to the ARC shelter nurses regarding health assessments and referrals.

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

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

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

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

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

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

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

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

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

IV. PUBLICATION AND DISSEMINATION OF DIRECTIVES

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

V. EFFECTIVE DATE, MODIFICATION, AND TERMINATION

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

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

SIGNATURES

AUTHORIZED BY:

_____ (CEO)
_____Chapter, American Red Cross Date: _____

_____ (Exec. Dir.)

Medical Director, County of _____,
Dept. of Health Services Date: _____

APPENDIX J-1

STATEMENT OF UNDERSTANDING

BETWEEN THE COUNTY OF _____ DEPARTMENT OF MENTAL HEALTH

AND THE

_____ COUNTY CHAPTER OF THE AMERICAN RED CROSS

I. PURPOSE

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

II. TYPES OF DISASTERS

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

III. MAJOR DISASTERS/OTHER DISASTERS

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

For the purpose of this document, “local disasters” are defined as emergencies or disasters in (county) County that do not meet the definition of a “major disaster.” In “local disasters,” the Red Cross shall evaluate whether the disaster meets Red Cross criteria for response. The Red Cross disaster mental health program is a supplement to community resources, and is not intended to take the place of appropriate community or corporate mental health programs. The Red Cross mental health function has primary responsibility for meeting the emotional needs of Red Cross workers, their families, and victims of disasters in Red Cross service delivery areas.
If the situation does not meet Red Cross disaster response criteria, requests for mental health services may be referred to County of (county) Department of Mental Health or to

other appropriate mental health resources. Examples of disasters that Red Cross routinely responds to include single or multiple-family fires. Examples of other events to which the Red Cross does not respond include small transportation accidents including automobile crashes, incidents involving workplace violence, or industrial accidents where there is definite corporate liability requiring referral to in-house or contracted employee assistance programs.

IV. DEFINITION OF SIZES OF DISASTERS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. The Red Cross shall:

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

other community locations as needed.

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

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

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

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

V. AIRLINE DISASTERS

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

VI. RESPECTIVE AGENCY RESPONSIBILITIES

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

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

carrier involved;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

VII. PUBLICATION AND DISSEMINATION OF DIRECTIVES

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

VIII. EFFECTIVE DATE, MODIFICATION, AND TERMINATION

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

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

IX. SIGNATURES

AUTHORIZED BY:

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

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

Appendix K

Adopt-A-Shelter Program

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

General Population Shelter

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

Medical Treatment Units/Shelter

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

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

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

Appendix L

EMERGENCY TELE-DIRECTORY

YUBA COUNTY:

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

SUTTER COUNTY:

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

MEDICAL CENTERS:

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

INDIVIDUAL INFORMATION

1. Take this Passport TO ALL MEDICAL VISITS for the doctor to review and update.

2. Keep this Health Passport with you as a record of your health care.

3. This information is personal and confidential.

4. Keep your Medi-Cal, Medi-Care, insurance and yellow Immunization Card with the Passport.

5. Schedule appointments for routine and follow-up care.

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

INSURANCE COMPANY / No:

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY:

Name:

Address:

Telephone:

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

PHARMACY INFORMATION

Hospital / Clinic Last Visited:

Primary Care Physician:

Medications + Last Refill Date:

Pharmacy Used:

DATE & TIME	PROBLEM & ILLNESS	PHYSICIAN & MEDICATION