OES
CALIFORNIA
Governor's Office of Emergency Services

Clinic Disaster Plan Guidance

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Gray Davis
Governor

Dallas Jones
Director
Governor's Office of Emergency Services

Clinic Disaster Plan Guidance

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Governor's Office of Emergency Services
4671 Liberty Avenue
Los Alamitos, California 90720-5002
(562) 795-2900

Acknowledgements

Prepared and Edited by

Sonia Brown, BS, R.N.
Emergency Services Coordinator
Governor's Office of Emergency Services
Southern Region

Project Supervision

Deborah Steffen
Regional Administrator
Governor's Office of Emergency Services
Southern Region

Contributors

Nadja Christian
Emergency Services Coordinator
Governor's Office of Emergency Services
Coastal Region - Oakland

Mitchell Saruwatari
Project Manager
Kaiser Western Environmental Safety Services

Stuart Long
Regional Disaster Medical Health Specialist
Region VI, Emergency Medical Services

Reviewers

Cheryl Starling
Disaster Medical Specialist
Emergency Medical Services Authority

Gail Lockhart
Senior Emergency Services Coordinator
Governor's Office of Emergency Services
Planning and Technical Assistance Branch

Warren Lee
Disaster Assistance Program Specialists II
Governor's Office of Emergency Services
Disaster Assistance Program – South

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I. Forward

Major and catastrophic events such as earthquakes, fires, severe weather, terrorism, and tornadoes can, and do, occur. However, common emergencies such as power outages, patient overcrowding issues, public health epidemics, legislative changes in health care delivery and demographic shifts generate more routine dilemmas. Based on California's history, people in need of medical care during disasters will migrate to the nearest medical facility. Usually this is the neighborhood community clinic or hospital. As learned from the Northridge earthquake, many of these clinics soon become overburdened and overwhelmed with medical emergencies that they are not equipped to handle. Staff and services are quickly exhausted and individuals in need of medical treatment may be turned away. This document will assist in preparing the staff and facility to handle emergencies and disasters, and in the development of a plan.

Enclosed in this document are some of the issues for you to consider when developing a clinic plan. Much of the information in this document can be adapted to fit the unique needs of your facility. Although some of the recommendations are not statutorily required, your overall objectives should be to minimize injuries and fatalities of staff and clients, physical damage to your facility, and facilitate recovery efforts. We have also provided resource materials such as:

- supplemental forms- templates -for specific procedures
- an agency and organization resource list

Once you have completed your plan, it will need to be reviewed and updated on an annual basis, at the very minimum.

While you are required to comply with current law in having a written disaster plan under the California Code of Regulations, Title 22, Division 5, Section 78423 Disaster Plan, you will gain many other benefits such as protecting your staff and patients, building a stronger relationship with your community, and effectively communicating with local governmental response agencies such as law, fire, Office of Emergency Services (OES) and regulatory agencies. Additionally, using the **Hospital Emergency Incident Command System (HEICS)** has proven valuable in helping hospitals serve the community during a crisis and resume normal operations as soon as possible.

HEICS is an emergency management system, which employs a logical management structure, defined responsibilities, clear reporting channels, and a common nomenclature to help unify hospitals with other emergency responders. HEICS is predictable, has a flexible organizational chart, prioritized response checklists, accountability, improved documentation, common language and provides for cost effective emergency planning. Although HEICS has been developed for hospitals, there are clear advantages to all clinics using this particular emergency management system. Samples of the organizational chart and job action sheets are found in Appendix B1-B7.[1]

[1] For a complete copy of the HEICS manual, please visit the EMSA website at: www.emsa.ca.gov

II. Developing the Disaster/Emergency Plan

A. State Requirements for a Community Clinic

1. *Administrator/Command Staff or Designee*

The role of the administrator/command staff or designee is to:

- Execute (oversee) the development and implementation of the disaster plan including a description of how, when and by whom the place is activated.
- Assign staff duties and responsibilities based on job action sheets.
- Develop the criteria for and direct the evacuation[2] as well as transportation of staff, patients and visitors when indicated.
- Ensure the client's continuity of care/medical management including management of patient medications, medical records, patient tracking, and inter-facility communication with the relocation or alternative care site.
- Direct the overall response to the disaster/emergency.
- Ensure that drills and exercises are conducted semi-annually and records are maintained.[3]
- Evaluate the disaster program annually and update as needed including a description of how, when and who will perform the activity.

2. *Evacuation Plan*

The evacuation decision will be based on the damage assessment[4], which may include assessment of the following:

- Overall building survey internal and external (e.g. casualties, damage and operational status of the clinic).
- State of key utilities (e.g. water, sewer lines, gas and electricity).
- Presence and status of hazardous materials.
- Condition of equipment and all other materials.

To facilitate evacuation (partially or the entire facility), be sure to develop a plan that includes the following:

- Floor plan and map of exits with pre-established assembly sites outside the building.[5]
- Location and instructions on when and how to shut-off the utilities.
- Location of emergency equipment including fire extinguishers and first aid supplies.
- Priority evacuation plans for the injured or mobility impaired.
- Method of accounting for staff, patients and visitors.
- Directions on how to secure the clinic (e.g., access, traffic control, crowd control, etc.).
- Procedure for communicating the status of patients and staff to family and friends.

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[2] Please refer to Appendix A for a Patient Evacuation form.
[3] Please refer to Appendix J for a Fire or Disaster Drill/Exercise evaluation form.
[4] Please refer to Appendix C for a Damage Survey Report checklist.
[5] Please refer to Appendix D for a sample evacuation floor plan.

- Procedure for communicating to emergency response agencies the status of the clinic.
- A liaison with outside agencies or entities (e.g. volunteer organizations, ARC, OES, police, fire, news media).
- Establishing an alternative care site when the environment cannot support adequate patient care and treatment.
- A protocol for the transportation of both ambulatory and non-ambulatory patients, as necessary, to the alternative care site.
- Policies to transport patients and staff to the alternative care site.
- Optimum evacuation routes including alternates.
- A system to announce facility re-entry/terminate the evacuation order or implement alternate plan.
- A relocation site based on a *hazard vulnerability analysis*[6]and system to communicate the order to transport patients and staff to this site.

3. Transportation Plan

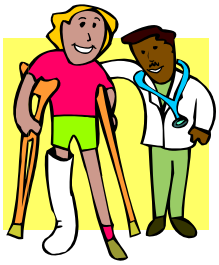
The following issues should be addressed in the transportation plan if an evacuation is necessary:

- Use of transportation companies and pre-arranged contracts for patient/staff transport following a disaster if necessary.
- Policies to ensure staff *never* transport patients in private vehicles.
- Instructions to patient's families, friends or neighbors to provide transportation.
- Insurance carriers policies regarding liability and insurance coverage if staff transport patients in an extreme emergency.

4. Medical Management

The following issues need to be addressed in the medical management of patients, staff and visitors if an evacuation is ordered:

- establish triage sites
- establish first aid stations
- assess the victims for the need for medical treatment
- provide medical services within the clinic's internal capabilities and resources
- establish a morgue based upon direction of your county coroner
- implement procedures for meeting the psychological needs of staff and patients through Critical Incident Stress Debriefing (CISD)[7]



[6] Please refer to Part B, Preparedness Section under "*hazard vulnerability analysis"* for more detail.
[7] Please refer to Part B, Recovery Section under "*meet the psychological needs of staff and patients*" for more detail.

B. Suggested Items to Include in the Disaster/Emergency Plan

The disaster plan is divided into four phases: hazard mitigation, preparedness, response and recovery. You will find issues under each stage that need to be addressed in the development of your facility's disaster plan prior to the event. It is important that you develop the plan jointly or in consultation with the local Office of Emergency Services, Emergency Medical Services (EMS), Department of Health Services, hospital planners and neighboring clinics.

1. Hazard Mitigation -

Hazard mitigation tends to be overlooked with respect to the other phases – preparedeness, response and recovery, but this phase will identify ways of minimizing future losses. A key tool of hazard mitigation is to conduct a *hazard vulnerability analysis*.[8] A Hazard Vulnerability Analysis is the identification of hazards and the direct and indirect effect these hazards may have on the facility.

a. Hazard Vulnerability Analysis

Assess the probability and potential impact of each emergency such as:

- civil unrest
- earthquakes[9]
- airline crash
- water supply contamination
- dam failures
- wildfire/urban fire
- hazardous materials (Haz Mat) incidents, which may be internal or external to your facility (e.g., transportation accidents or proximity to a facility that uses, produces, stores or transports hazardous materials)
- terrorism (e.g., chemical, biological, nuclear, radiological or explosives – CBNRE)
- severe weather (e.g., high temperatures, winter storms, wind storms, etc.)
- loss of utilities (i.e., water, power, telephones)

Research the types of disasters or emergencies that have occurred in the community in the past. Contact the local Office of Emergency Services and nearby hospital(s) for a list of emergencies that they have identified in their disaster/emergency plan.

Health-care providers, clinical laboratory personnel, and infection control professionals who notice illness patterns and diagnostic clues that might indicate an unusual infectious disease outbreak associated with intentional release of a biologic agent should report any clusters or findings to their local or state health department.

These are only examples; there may be many more hazards that may impact your facility. Consider emergencies that may occur within your facility as well as external to your facility in the surrounding community.

Hazard Mitigation or retrofitting measures are those a healthcare facility undertakes in attempting to "lessen the severity or impact a potential disaster or emergency may have on its

[8] For Hazard Vulnerability Analysis Tools, please refer to the following websites: www.ashe.org and Kaiser Permanente's interactive HVA tool, www.emsa.ca.gov/dms2/kp_hva.xls

[9] Please refer to Appendix F for instructions on "What to Do During the Shaking" in an earthquake.

operation". These measures are taken prior to disasters/emergencies to minimize the damage to the facility. One can mitigate *structurally* and *nonstructurally*.

b. Structural Mitigation

Structural mitigation is reinforcing, bracing, anchoring, bolting, strengthening or replacing any portion of the building that may become damaged and cause injury such as:

- exterior walls – (e.g., use a wind resistant design for tornados or windstorms)
- exterior doors – (e.g., non-combustible materials for wildfires or urban fires)
- exterior windows – (e.g., use shutters on windows for tornados or windstorms)
- foundation – (e.g., brace, anchor or bolt the facility for earthquakes)
- exterior columns/pilasters/corbels – (e.g., steel or concrete columns)
- roof – (e.g., use non-combustible materials for wildfires or urban fires)

c. Nonstructural Mitigation

Nonstructural mitigation reduces the threat to safety posed by the effects of earthquakes on such nonstructural elements as building contents, internal utility systems, interior glass and decorative architectural walls and ceilings.[10] These actions involve identifying nonstructural fixtures and equipment, which are vulnerable to an earthquake and which are either essential to continued operations or a threat to public safety.

Nonstructural mitigation is:

- Retrofit – refers to various methods for securing nonstructural items. Retrofitting methods are bracing, securing, tying down (tethers or leashes), bolting, anchoring, and so on.
- Replace – replacing the item with a new one that is resistant to the hazard.
- Relocate – moving items from a hazardous location to a non-hazardous one.
- Backup Plan – if there is concern that an essential service will be disrupted, provide for backup service – *it is planning for the consequences of failure*.

Nonstructural mitigation includes all contents of the structure that do not contribute to its structural integrity such as:

- s*ystems and elements* which are essential to the clinic operations
  - ✓ emergency power generating equipment - plumbing, HVAC
  - ✓ fire protection system - fire sprinklers and distribution lines, emergency water tank or reservoir
  - ✓ medical equipment - X-ray equipment, respirators and life support, refrigeration units to store pharmaceuticals and blood.
  - ✓ hazardous materials – restrain chemicals on shelves, containers stored on braced storage rack or tall stacks, gas tanks with flexible connections, gas tank legs anchored to a concrete footing or slab.
- *non-essential elements* whose failure could compromise clinic operations
  - ✓ suspended lights and ceilings

[10] Please refer to Appendix E for a checklist of recommended nonstructural mitigation actions for clinics.

- ✓ partitions
- ✓ interior doors
- ✓ furniture and contents - book shelves, file cabinets, etc.

2. Preparedness -

a. Disaster Plan

A well-written plan that has been tested will provide for an efficient systematic response to any type of a disaster or emergency.[11] The plan should:

- be functional, flexible and easy to implement
- be a permanent document and updated as needed
- be comprehensive - adaptable to disasters/emergencies whether natural or man-made that significantly disrupt the environment of care or the care and treatment. This is achieved by doing a hazard vulnerability analysis and identifying hazardous materials in each department.

The plan should also:

- include a statement of purpose, definition of terms, standard operating procedures
- chart the clinic's organizational structure for daily activities as well as for a disaster or emergency – additional roles of the administrator/command staff or designee should be addressed such as:
  - Assume the responsibility, as Incident Commander, for all lower level functions, which have not been specifically assigned to an individual.
  - Give notice to personnel when response measures are initiated.
  - Define and integrate the facility's role with community-wide response agencies (i.e., local Office of Emergency Services [OES], fire and law).
  - Notify external authorities of any disasters, emergencies or events impacting the facility's environment of care.
- have consistent procedures
- identify internal and external communications[12]
- identify the emergency operation center (EOC)

b. Hazardous Materials Management - Internal and External

Clinics may have various departments that store and/or handle hazardous materials. As such the potential for these materials to be released is significant. Each department should identify these materials and develop procedures for safely handling, containing and neutralizing them. Staff training should include, but not be limited to, location of hazardous materials, safe handling, proper notification procedures, proper evacuation procedures, potential risks, storage, containment, neutralization, decontamination techniques and medical management of victims. Many Federal, State and local statutes, regulation and ordinances govern the handling and storage of hazardous materials. It is important that clinics contact local Administering Agencies and/or their local Fire Departments to determine the level of and need for compliance.

[11] Please refer to Appendix G for typical emergency response actions.
[12] Please refer to Appendix H for internal and external communication resources.

Personnel should ***NOT*** attempt to handle spills or leaks themselves unless they have been trained, have the appropriate equipment and can safely and competently respond. Staff should respond to a Haz Mat event in a safe and competent manner, within the "awareness"[13] level:

⇒ **S**afety first, last and always,
⇒ safe **I**solation and Deny Entry - restrict building or area use accordingly; and
⇒ initiate **N**otifications…(**SIN**).

c. *Weapons of Mass Destruction (WMD)*

The threat of terrorism involving biological and chemical weapons is a realistic danger. The community relies on healthcare workers to help alleviate the suffering caused by these potentially devastating events by allocating needed medical resources and advice. Preparations for an event involving weapons of mass destruction – chemical, biological, nuclear, radiological or explosives (CBRNE) – should be based upon existing programs for handling hazardous materials. Comprehensive planning that focuses first and foremost on local preparedness and response capabilities with the local Office of Emergency Services, Department of Health Services, and hospital(s) is a fundamental step toward addressing these threats effectively. The consideration of different scenarios involving a CBRNE incident that may confront your facility or community in planning efforts, participation in education programs, training and local exercises, as well as the incorporation of these elements in your facility's disaster plan, will further increase the facility's ability to respond to such incidents.[14]

d. *Managing Volunteers*

Volunteers are a necessary part of any disaster plan but management of this resource is crucial. Spontaneous volunteers may:

- Be reactive in nature.
- Be unaware of the hazards involved in disaster work and may become injured as a result.
- Add to the population at risk.
- Present a liability to the local government.
- Be ineffective because they are not trained or are unfamiliar with response and recovery operations.
- Be unable to fully commit their time and effort to disaster assistance.

Management of volunteers may be done in the following way:

- Provide or refer to a Volunteer Management Training Workshop – county Office of Emergency Services may provide training.
- Set-up a Volunteer Reception Center for verification purposes and complete the designated forms. This center will provide for organization of the intake process.
- Maintain complete records for each volunteer.

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[13] Awareness definition: One likely to witness/discover a Haz Mat release and can initiate notifying authorities and take no further actions. [29 CFR 1910.120(q)(6)(i) & 8 CCR 5192(q)(6)(A)]

[14] Please refer to Appendix G1 – G7 for a quick reference guide for potential biological and chemical weapons agents and staff protection. Appendix G1 – G7 information compiled from USAMRIID, DoD, and OCJP.

e. Donations Management

Donations can quickly overwhelm the clinic especially when they are unsolicited. Coordination is accomplished by developing a plan prior to the emergency to handle receiving and distribution of the goods. Coordination of goods and donations may be done in the following way:

- Develop policies and procedures regarding accepting/receiving a particular donation– perishable, nonperishable, cash, etc. Cash should be documented properly and acknowledged. Distribution and disposal of goods and donations is the facility's responsibility. Develop a memorandum of understanding (MOU) with like facilities that will take these items.
- Develop a pre-identified list of needed goods and donations.
- Identify staging areas for collection of in-kind donations.

f. Training and Exercises

Training is achieved through exercising the clinic disaster plan without the stress of an actual disaster/emergency. This provides staff with the opportunity to become familiar with the plan and procedures, their roles and responsibilities and the information and skills required to perform their duties during an emergency. The following is a list of exercises:

- ***Table Top*** exercises provide a convenient and low-cost method designed to evaluate policy, plans, and procedures and resolve coordination and responsibilities. Such exercises are a good way to see if policies and procedures exist to handle certain issues. The table-top exercise is also an effective forum for strengthening the personal preparedness of staff *and* their families.

- ***Functional*** exercises are designed to test and evaluate the capability of an individual function (e.g., generator, communications system, EOC function, etc.). A functional exercise is a good method of testing and evaluating the clinic's capability of handling medical and evacuation issues, for example.

- ***Full-scale*** exercises simulate an actual emergency. They typically test the clinic's entire system - clinic disaster plan and staff - for handling an emergency.

In addition to training staff, exercises test the clinic disaster plan and allow for revisions and updates as necessary. Records must be maintained to verify that a drill/exercise was conducted.[15] It is important that post exercise evaluations be non-judgemental and individual criticism be avoided.[16]

3. Response

a. Emergency Operation Center (EOC)

The EOC is the key to successful response and recovery operations. It is the central location

[15]California Code of Regulations, Title 22, Section 70741(d) the disaster plan shall be rehearsed at least twice a year. There shall be a written report and evaluation of all drills.
[16]Please refer to Appendix I for a sample of a drill/exercise evaluation form.

where all activities are coordinated. Coordination of activities will ensure that all tasks are accomplished with little or no duplication of effort. A functional EOC should be:

- ☒ located in an area away from the center of activities
- ☒ stocked with adequate administrative supplies (e.g., copy of the disaster plan, frequently used telephone numbers, flip charts, walkie-talkies or alternate communication equipment, maps, marking pens, pens and pencils, paper, situation boards, facility floor plans showing egress, utility shut-offs, and location of fire extinguishers). You may decide to include more supplies to meet the needs of your facility.
- ☒ stocked with adequate emergency supplies (e.g., water, food, portable radio, first aid kit, flashlights and batteries, two-way radios, backup power). You may decide to include more supplies to meet the needs of your facility.

Explore sites for relocation in case the primary EOC becomes inoperable or unusable.

b. Organizational Chart

The organizational chart provides a structure that features the following characteristics:

- Assignment to a position ideally filled from top to bottom and by those who have been *pre-trained in more than one position*.
- Positions filled based on the size of the incident. For example, the larger the incident the more positions will need to be filled. In some instances, one person may need to fill more than one section. Job Action Sheets will facilitate the assignment of multiple positions.
- Job Action Sheets/checklists that guide and prioritize staff's response in their assigned position.

Samples of the organizational chart and some of the job action sheets within the *Incident Command System* (ICS) have been included. There are five primary functions within the ICS management structure - command, operations, planning and intelligence, logistics, and finance/administration.[17] The units under each section can be modified to meet the unique needs of your facility. ICS is a method for managing emergencies, which is widely used by emergency response agencies throughout the State of California. It is an essential element of the Standardized Emergency Management System (SEMS) and it is used in field applications. Although not all medical and health disciplines are mandated to participate in SEMS, in order to be eligible for any funding of response related costs under disaster assistance programs shall use SEMS. If the clinic is allied with a public organization, it will facilitate inclusion of the documentation of the damage sustained and costs incurred as accurately as possible. SEMS provides for an organized response to meet the demands of emergency incidents and larger disasters in a rapid and efficient manner. ICS is a practical method for dividing labor and responsibilities when responding to these events. ICS offers the following features:

- Common language to promote communication and facilitate outside assistance.
- Organizational structure that allows flexible response to specific emergencies.
- Predictable chain of command.

[17] Please refer to Appendix B1- B7 for samples of the organizational chart and job action sheets.

- Position accountability.
- Cost effective emergency planning.
- Documentation framework for improved accountability and cost recovery.

To ensure staff are ready to respond:

- Support the staff in the development of their own *family communication and preparedness plan* in order to minimize their anxiety regarding their family's well being.
- Provide essential *training and exercises.*

4. Recovery

Recovery operations can take longer than the emergency itself. Facilities that intend to survive the aftermath of a disaster need to *plan ahead* for rapid recovery. Planning ahead helps to ensure that services will continue throughout the course of a disaster with few disruptions.

Many clinics are the primary source of health care for the indigent and some social services, clinics must remain operational following an emergency and this is accomplished by planning. The goal of planning is to minimize financial losses caused by an emergency and to enable the facility to quickly provide the same efficient service as was provided prior to the incident. In order to recover costs related to the disaster, complete documentation including photographs of damage is essential. The documentation process must begin ***immediately*** **-** as soon as the shaking stops.

Like all businesses, each facility must attempt to provide for the resumption of business after a damaging emergency. As an external responder, the clinic will most likely provide billable medical care immediately after the earthquake strikes. However, it should be expected that computer systems will be down, patient record keeping may be compromised by the emergency and staffing levels will be unusual for a period of time. It should not be assumed that all costs will be recoverable unless steps are taken *before* the disaster to minimize risks to the facility's financial systems.

Business resumption issues to consider:

- Transfer critical functions to a department not affected by the disaster to ensure services are not disrupted.
- Relocate the facility's personnel to a predetermined alternative care site. Ensure that the alternative care site contains the necessary equipment for temporary operations.
- Restore the facility's operations to the normal condition prior to the disaster. There are times when this may not be economically feasible after an assessment of the damage and cost has been completed.

Recovery issues to consider:

- Structural and nonstructural damage to facilities
  - ⇒ contract in advance for a structural engineer to assess the structural integrity of the facility
  - ⇒ designate and train damage assessment teams to check on the nonstructural damage

⇒ provide teams with resources (e.g., appropriate forms for documentation, hard hats, work gloves, dust masks, flashlights, clipboards, tape, cameras, and communication capabilities)

- Inventory damage and/or loss

By becoming a customer prior to the emergency you will have several advantages such as:

- ◊ **pre-established standing order(s)**
- ◊ **the manufacturer will replenish damaged products**
- ◊ **the manufacturer will provide for emergency shipments to your facility or to the backup facility on record.**

⇒ maintain current lists, as well as a backup system, of equipment serial numbers, cost and dates acquired

⇒ develop a contract or memorandum of understanding (MOU) with vendors/suppliers or local pharmacies that fit the particular needs of the clinic for critical supplies such as pharmaceuticals, food and water, medical, etc.

⇒ seek local vendors or suppliers in the area

⇒ determine if the vendor/supplier has supplies in other areas or states in case their supplies become depleted or damaged

⇒ determine the anticipated turn around time for getting the supplies to the clinic if they are being transported from these other locations.

- Lost revenue through disruption of services
  - ⇒ develop a process for tracking expenses
  - ⇒ develop a "cost-to-date" incident financial status report
  - ⇒ develop plans for alternate billing
  - ⇒ develop an audit trail from response to cost recovery, especially *if* government assistance will be available
  - ⇒ develop a system for securing and protecting records, and a backup method (e.g., choose an alternate location outside the clinic's area of vulnerability)
  - ⇒ develop a procedure for notifying patients in the event relocation is necessary

- Personnel policies
  - ⇒ develop a procedure for the issuance of payroll
  - ⇒ consider the use of accrued vacation and paid time off as an alternate
  - ⇒ develop a policy for the release/retention of staff

- Meet the psychological needs of staff and patients
  - ⇒ develop procedures for Critical Incident Stress Debriefing (CISD). CISD is a process which assists personnel to mitigate the effects of stress associated with critical incidents. A critical incident is an extraordinary event that has the potential to overwhelm the normal coping mechanisms you use to deal with life on a regular basis. CISD may be provided by the local or county Department of Mental Health, clergy and social workers

A. Financial Recovery Sources

This section provides a general overview of the resources that may be available to your facility during and after a major disaster. Since each community is affected differently and may have unique needs after an emergency, or components of the program may change, some or all of the assistance outlined in this section may not be available.

- ***Public Assistance (FEMA/OES)***
  Assistance is available to applicants after a disaster occurs and a federal Disaster Declaration has been issued by the President. The Public Assistance Program[18] covers disaster related response and recovery costs. Under a federally declared disaster, OES administers the federal programs and works directly with local government, state agencies and ***private non-profit*** applicants such as medical facilities and outpatient centers. Unless the facility is private non-profit, it is not eligible for assistance under this program. However, before applying to FEMA/State, an application must first be submitted to the *Small Business Administration*.

  A private non-profit facility is eligible for emergency protective measures (i.e., emergency access such as provision of shelters or emergency care or provision of food, water, medicine, and other essential needs), and *may* be eligible for permanent repair work (i.e., repair or replacement of damaged elements restoring the damaged facility's):
  - **pre-disaster design**
  - **pre-disaster function**
  - **pre-disaster capacity.**

- ***Small Business Administration (SBA)***
  SBA provides *physical disaster loans* to businesses for repairing or replacing disaster damages to property owned by the business. This includes real estate, machinery, equipment, inventory and supplies. *Businesses and non-profit organizations of any size are eligible.*

- ***Federal Grant***
  Following a presidential disaster declaration, the Hazard Mitigation Grant Program[19] (HMGP) is activated. This program funds projects in the declared areas that are cost-effective and substantially reduce the risk of future damage, hardship, loss or suffering resulting from a major natural disaster. *State agencies, local governments and certain private non-profit (PNP) organizations, which own or operate facilities providing critical government services are eligible.*

- ***Insurance Carriers***
  Meet with insurance carriers to review all policies and understand the facility's coverage for relocation to another site, loss of supplies and equipment, and structural

[18] For additional information please visit the FEMA website at: www.fema.gov or the OES website www.oes.ca.gov

[19] Section 404 of the *Robert T. Stafford Disaster Relief* and *Emergency Assistance Act* of 1988 (P.L. 93-288) as amended.

and nonstructural damage to the facility. Determine the value of the insurance for the clinic. If you don't have coverage for floods or earthquakes, for example, evaluate if it is financially sound to acquire it. However, clinics located in special flood hazard areas must have flood insurance to be eligible for assistance. Any payments made by the insurance carrier will not be eligible for reimbursement under the state or federal programs but the eligible costs not covered by the insurance carrier such as the insurance deductible may be reimbursable.

APPENDIX

Patient Evacuation

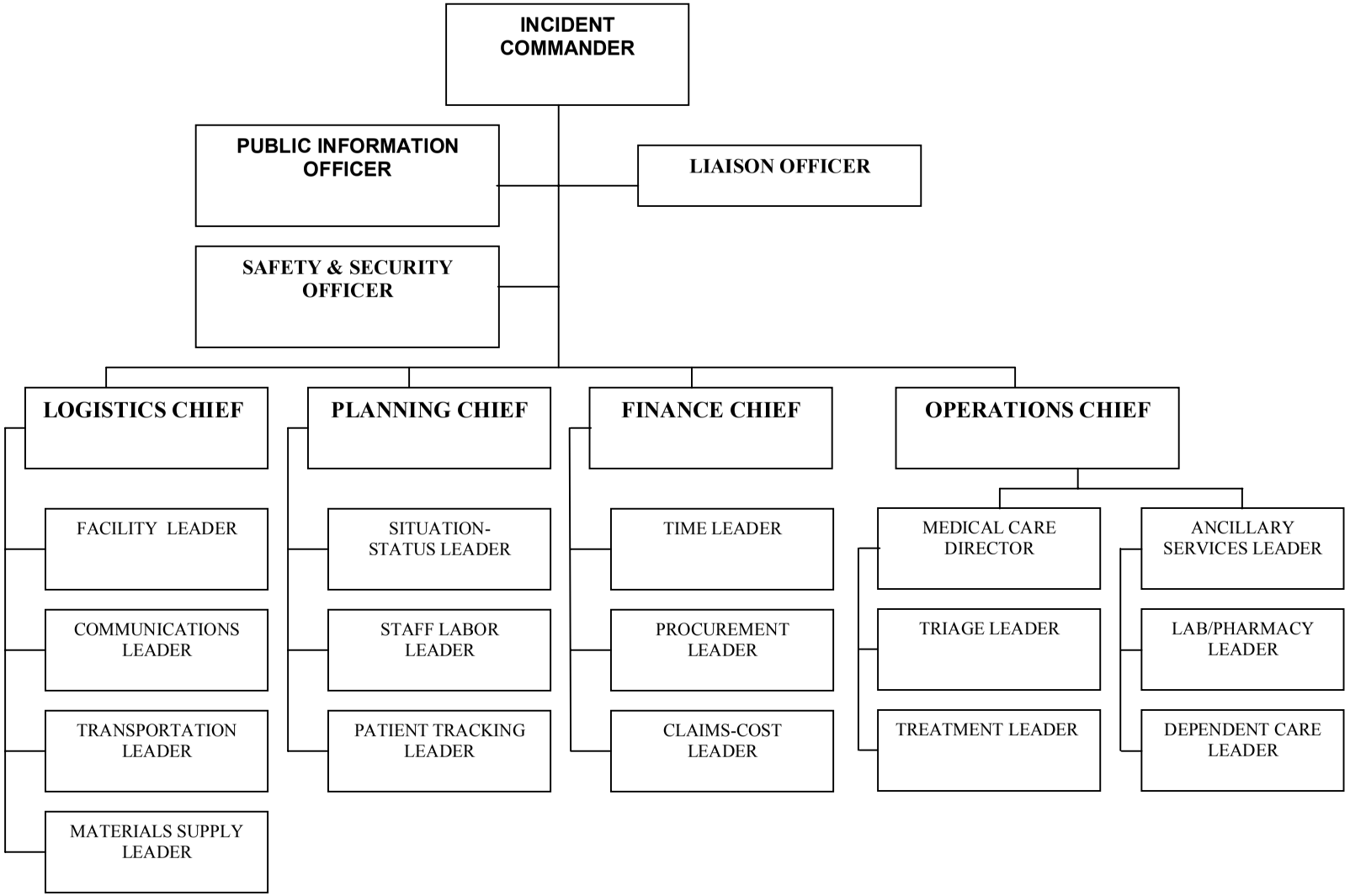
This form addresses the relocation of patients, staff and visitors and/or facility to other designated areas. (*This form can be modified to meet the evacuation criteria for your clinic*)

1. In case of emergency, contact: _____
(*contact depends on the type of emergency, e.g. fire, earthquake, etc.)*
at (_____) _____ or **9-1-1**.
2. In case of a service outage, clinic services can be found at (*neighboring clinic or acute care facility*): _____
3. _____ is responsible for determining when this facility is not
(administrator)
able to care for patients.
4. In the absence of the administrator, _____ is assigned the task of determining evacuation necessity.
5. Patient evacuation prioritization (triage) will be handled by _____.
(triage & treatment leader)
6. If patients are not going to be transported away from the site, they will be held at _____
(location)
_____.
7. If patients require transportation (*arranged by the transportation leader*) to an acute care facility, transportation will be arranged through _____
(local ambulance provider)
at (_____) _____or **9-1-1**.
8. Facilities (*neighboring clinic or acute care facility*) which are pre-approved to accept patients from this clinic are:
_____ (_____) _____
_____ (_____) _____
9. Staff will provide the patient with the following prior to leaving the clinic:
- ❑ Copy of medical record
- ❑ Medicines necessary for 48 hours of treatment
- ❑ Name/address of destination
- ❑ Patient emergency contact (i.e., family, friend, neighbor, etc.)

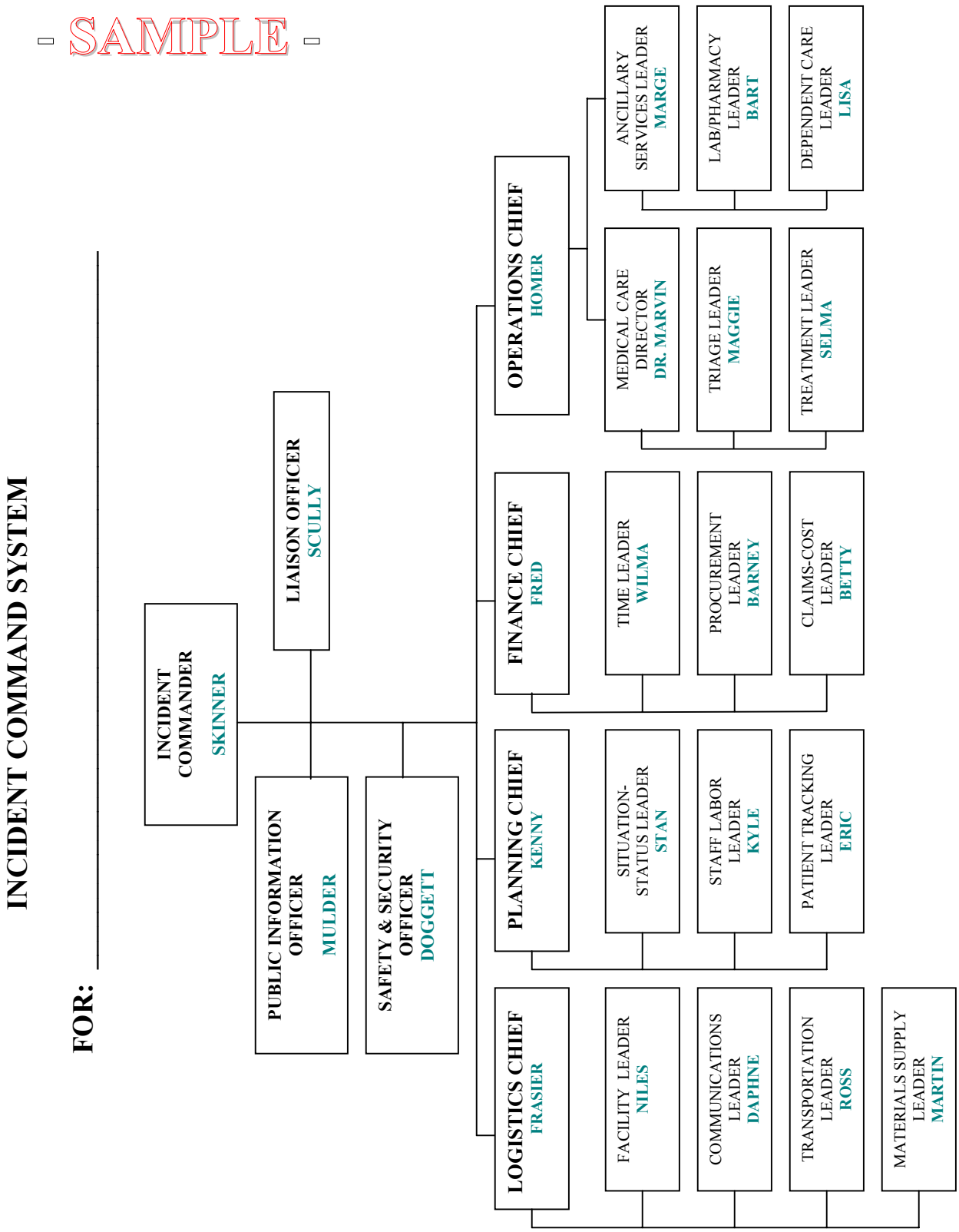
10. In the event that there is only minor damage causing the clinic to divert its patients, interim care will be administered at the following temporary location sites:
_____ (_____) _____
_____ (_____) _____
(temporary relocation site)
11. The following emergency attending physicians are authorized to serve in this clinic:
_____ _____
_____ _____
12. Each provider has a pre-approved purchase limit for use during an emergency or disaster. Supplies to maintain this clinic may be obtained from the following vendors with whom the clinic has pre-established agreements:
_____ (_____) _____
_____ (_____) _____
_____ (_____) _____

INCIDENT COMMAND SYSTEM

FOR: _____



- SAMPLE -


INCIDENT COMMAND SYSTEM
FOR: _____
INCIDENT COMMANDER
SKINNER
LIAISON OFFICER
SCULLY
PUBLIC INFORMATION OFFICER
MULDER
SAFETY & SECURITY OFFICER
DOGGETT
OPERATIONS CHIEF
HOMER
FINANCE CHIEF
FRED
PLANNING CHIEF
KENNY
LOGISTICS CHIEF
FRASIER
MEDICAL CARE DIRECTOR
DR. MARVIN
TRIAGE LEADER
MAGGIE
TREATMENT LEADER
SELMA
ANCILLARY SERVICES LEADER
MARGE
LAB/PHARMACY LEADER
BART
DEPENDENT CARE LEADER
LISA
TIME LEADER
WILMA
PROCUREMENT LEADER
BARNEY
CLAIMS-COST LEADER
BETTY
SITUATION-STATUS LEADER
STAN
STAFF LABOR LEADER
KYLE
PATIENT TRACKING LEADER
ERIC
FACILITY LEADER
NILES
COMMUNICATIONS LEADER
DAPHNE
TRANSPORTATION LEADER
ROSS
MATERIALS SUPPLY LEADER
MARTIN

INCIDENT COMMANDER

Mission: Organize and direct Emergency Operations Center (EOC). Give overall direction for clinic operations and if needed, authorize evacuation.

Immediate

____ Initiate the Incident Command System (ICS) by assuming role of Emergency Incident Commander.
____ Read this entire Job Action Sheet.
____ Put on position identification vest.
____ Appoint all Section Chiefs and the Medical Care Director positions.
____ Appoint Public Information Officer, Liaison Officer, and Safety and Security Officer; distribute Job Action Sheets. (May be pre-established.)
____ Announce a status/action plan meeting of all Section Chiefs and Medical Care Director to be held within 5 to 10 minutes.
____ Assign someone as Documentation Recorder/Aide.
____ Receive status report and discuss an initial action plan with Section Chiefs and Medical Care Director. Determine appropriate level of service during immediate aftermath.
____ Receive initial facility damage survey report from Logistics Chief, if applicable, evaluate the need for evacuation.
____ Obtain patient census and status from Planning Section Chief. Emphasize proactive actions within the Planning Section. Call for a clinic-wide projection report for 4, 8, 24 & 48 hours from time of incident onset. Adjust projections as necessary.
____ Assure that contact and resource information has been established with outside agencies through the Liaison Officer.

Intermediate

____ Authorize resources as needed or requested by Section Chiefs.
____ Designate routine briefings with Section Chiefs to receive status reports and update the action plan regarding the continuance and termination of the action plan.
____ Communicate status to chairperson of the Clinic Board of Directors or the designee.
____ Consult with Section Chiefs on needs for staff, physician, and volunteer responder food and shelter. Consider needs for dependents. Authorize plan of action.

Extended

____ Approve media releases submitted by PIO.
____ Observe all staff, volunteers and patients for signs of stress and inappropriate behavior. Provide for staff rest periods and relief.
____ Other concerns:

LOGISTICS SECTION CHIEF

Positioned Assigned To: _____

You Report To: _____ (Incident Commander)

Logistics Command Center: _____ Telephone: _____

Mission: Organize and direct those operations associated with maintenance of the physical environment, and adequate levels of food, shelter and supplies to support the medical objectives.

Immediate

____ Receive appointment from the Incident Commander.
____ Read this entire Job Action Sheet and review organizational chart.
____ Put on position identification vest.
____ Obtain briefing from Incident Commander.
____ Appoint Logistics Section Unit Leaders: Facilities Unit Leader, Communications Unit Leader, Transportation Unit Leader, and Materials Supply Unit Leader, distribute Job Action Sheets and vests. (May be pre-established.)
____ Brief unit leaders on current situation, outline action plan and designate time for next briefing.
____ Establish Logistics Section Center in proximity to EOC.

Intermediate

____ Obtain information and updates regularly from unit leaders and officers; maintain current status of all areas; pass status info to Situation-Status Unit Leader.
____ Communicate frequently with Incident Commander.
____ Obtain needed supplies with assistance of the Finance Section Chief, Communications Unit Leader and Liaison Officer.

Extended

____ Assure that all communications are copied to the Communications Unit Leader.
____ Document actions and decisions on a continual basis.
____ Observe all staff, volunteers and patients for signs of stress and inappropriate behavior.
____ Other concerns:

PLANNING SECTION CHIEF

Positioned Assigned To: _____

You Report To: _____ (Incident Commander)

Planning Command Center: _____ Telephone: _____

Mission: Organize and direct all aspects of Planning Section operations. Ensure the distribution of critical information/data. Compile scenario/resource projections from all section chiefs and effect long range planning. Document and distribute facility Action Plan.

Immediate

____ Receive appointment from Incident Commander.
____ Read this entire Job Action Sheet and review organizational chart.
____ Put on position identification vest.
____ Obtain briefing from Incident Commander.
____ Appoint Planning unit leaders: Situation - Status Unit Leader, Staff/Labor Unit Leader, Patient Tracking Unit Leader; distribute the corresponding Job Action Sheets and vests. (May be pre-established.)
____ Brief unit leaders after meeting with Incident Commander.
____ Provide for a Planning/Information Center.
____ Ensure the formulation and documentation of an incident-specific, facility Action Plan. Distribute copies to Incident Commander and all section chiefs.
____ Call for projection reports (Action Plan) from all Planning Section unit leaders and section chiefs for scenarios 4, 8, 24 & 48 hours from time of incident onset. Adjust time for receiving projection reports as necessary.
____ Instruct Situation - Status Unit Leader and staff to document/update status reports from all disaster section chiefs and unit leaders for use in decision making and for reference in post-disaster evaluation and recovery assistance applications.

Intermediate

____ Obtain briefings and updates as appropriate. Continue to update and distribute the facility Action Plan.
____ Schedule planning meetings to include Planning Section unit leaders, section chiefs and the Incident Commander for continued update of the facility Action Plan.

Extended

____ Continue to receive projected activity reports from section chiefs and Planning Section unit leaders at appropriate intervals.
____ Assure that all requests are routed/documented through the Communications
Unit Leader.
____ Observe all staff, volunteers and patients for signs of stress and inappropriate behavior.
____ Other concerns:

FINANCE SECTION CHIEF

Positioned Assigned To: _____

You Report To: _____ (Incident Commander)

Finance Command Center: _____ Telephone: _____

Mission: Monitor the utilization of financial assets. Oversee the acquisition of supplies and services necessary to carry out the hospital's medical mission. Supervise the documentation of expenditures relevant to the emergency incident.

Immediate

____ Receive appointment from Incident Commander.
____ Read this entire Job Action Sheet and review organizational chart.
____ Put on position identification vest.
____ Obtain briefing from Incident Commander.
____ Appoint Time Unit Leader, Procurement Unit Leader, Claims/Cost Unit Leader and distribute the corresponding Job Action Sheets and vests. (May be pre-established.)
____ Confer with Unit Leaders after meeting with Incident Commander; develop a section action plan.
____ Establish a Financial Section Operations Center. Ensure adequate documentation/recording personnel.

Intermediate

____ Develop a "cost-to-date" incident financial status report every eight hours summarizing financial data relative to personnel, supplies and miscellaneous expenses.
____ Obtain briefings and updates from Incident Commander as appropriate.
Relate pertinent financial status reports to appropriate chiefs and unit leaders.
____ Schedule planning meetings to discuss updating the section's incident action plan and termination procedures.

Extended

____ Assure that all requests for personnel or supplies are copied to the Communications Unit Leader in a timely manner.
____ Observe all staff, volunteers and patients for signs of stress and inappropriate behavior.
____ Other concerns:

OPERATIONS SECTION CHIEF

Positioned Assigned To: _____

You Report To: _____ (Incident Commander)

Operations Command Center: _____ Telephone: _____

Mission: Organize and direct aspects relating to the Operations Section. Carry out directives of the Incident Commander. Coordinate and supervise the Medical Services and Ancillary Services Subsections of the Operations Section.

Immediate

____ Receive appointment from Incident Commander.
____ Read this entire Job Action Sheet and review organizational chart on back.
____ Put on position identification vest.
____ Obtain briefing from Incident Commander.
____ Appoint Medical Care Director, and Ancillary Services and transfer the corresponding Job Action Sheets. (May be pre-established.)
____ Brief all Operations Section directors on current situation and develop the section's initial action plan. Designate time for next briefing.
____ Establish Operations Section Center in proximity to EOC.
____ Meet with the Medical Care Director to plan and project patient care needs.

Intermediate

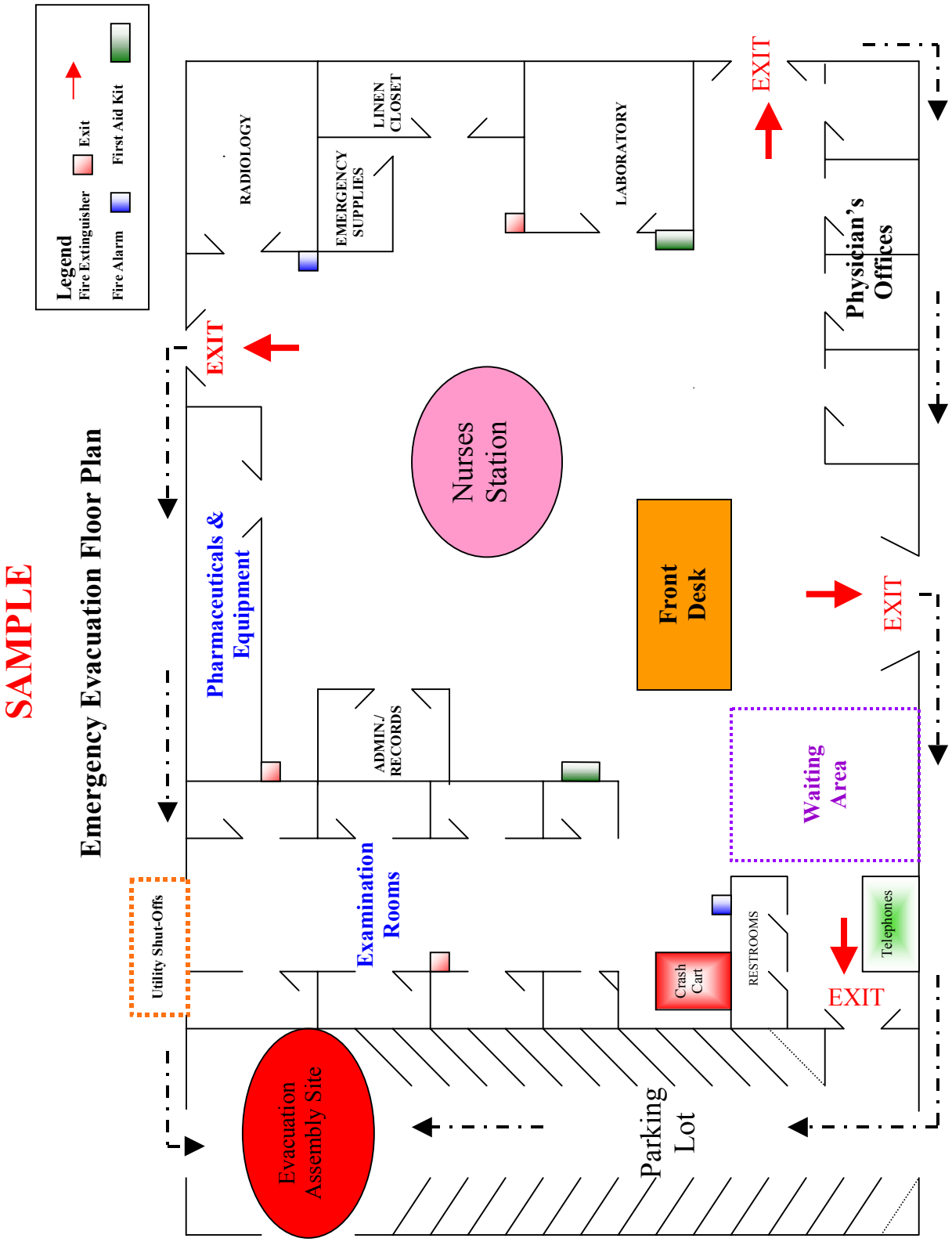
____ Designate times for briefings and updates with all Operations Section directors to develop/update section's action plan.
____ Ensure that the Medical Services and Ancillary Services Subsection are adequately staffed and supplied.
____ Brief the Incident Commander routinely on the status of the Operations Section.

Extended

____ Assure that all communications are copied to the Communications Unit Leader; document all actions and decisions.
____ Observe all staff, volunteers and patients for signs of stress and inappropriate behavior.
____ Other concerns:

DAMAGE SURVEY REPORT

Activity	Assignee	Target Completion Date	Date & Time Completed	Comments
Plan for the assessment of the following systems and areas immediately after an emergency or disaster.				
1. **Structural integrity of the clinic:** **a) Contact structural engineer on contract to report to the clinic.** **b) Check for unsafe areas such as weakened portions of the building that might fall, or unsafe stairs.**				
2. **Appoint and train a damage assessment team on each shift to evaluate items on this checklist. Supply the teams with hard hats, work gloves, flashlights, clipboards, tape, cameras, film and videotape, if possible.**				
3. **Elevators: doors, pulleys, chains, electrical systems.**				
4. **Electrical system: check for system integrity, electrical shorts, fire and downed power lines.**				
5. **Emergency generator: check for system integrity and function.**				
6. **Water: check for system integrity, availability and purity.**				
7. **HVAC system: check if functioning.**				
8. **Sewer system: check if functioning.**				
9. **Natural gas system: check for system integrity and availability.**				
10. **Fire.**				
11. **Hazardous materials: check for the presence of hazardous materials releases or spills.**				
12. **Access and exit routes: check for passage.**				


SAMPLE
Emergency Evacuation Floor Plan
Legend
Fire Extinguisher
Exit
Fire Alarm
First Aid Kit
RADIOLOGY
EMERGENCY SUPPLIES
LINEN CLOSET
LABORATORY
EXIT
Physician's Offices
EXIT
Pharmaceuticals & Equipment
Nurses Station
Front Desk
ADMIN./ RECORDS
Examination Rooms
Waiting Area
EXIT
Utility Shut-Offs
Crash Cart
RESTROOMS
Telephones
EXIT
Evacuation Assembly Site
Parking Lot

Structural vs. Nonstructural Hazard Mitigation

*The following is a **suggested** checklist (list is not all inclusive) of recommended structural and nonstructural mitigation actions for clinics:*

STRUCTURAL

_____ *Earthquakes* – anchor/brace (mobile home) or bolt the facility to its foundation and reinforce any portion of the exterior of the facility that may cause injury.

_____ *Floods and flashfloods* – elevate and reinforce the facility but ultimately avoid a floodplain location.

_____ *Landslide and mudflow* – build retaining walls on slopes. Build masonry walls to direct the mudflow around the facility. Bolt the foundation and reinforce the walls of the facility.

_____ *Tsunami* – elevate coastal facilities at risk. Although the strongest building can be damaged by a powerful tsunami.

_____ *Wildfire and urban fire* – use fire resistant materials (e.g., non-combustible roofing material) on the exterior of the facility.

_____ *Tornado* – follow local building codes to use a wind resistant design for your facility.

_____ *Dam failure* – reinforce and floodproof the facility.

NONSTRUCTURAL

_____ Brace light fixtures and other items that could fall or shake loose.

_____ Secure top and bottom of compressed gas cylinders with a safety chain.

_____ Store containers of hazardous materials on braced storage rack or tall stacks and restrain the containers with a restraining device such as metal or wire guardrails.

_____ Secure any desktop equipment such as computers, TV monitors, typewriters, printers, etc.

_____ Install shatter resistant protective film or blinds on windows to prevent glass from shattering onto people or install safety glass.

_____ Ensure that any equipment with piping be a flexible connection (e.g., gas pipes, water tanks, sprinkler piping, water heaters,

_____ Anchor any tall, unsecured furniture to the wall and/or to each other.

_____ Ensure that cabinets have positive catching latches.

_____ Secure suspended ceilings with diagonal bracing wires.

_____ Hang heavy objects away from workstations.

_____ Secure any larger equipment such as copiers or heavy machinery to the floor or use tethers and attach to the wall.

_____ Cross brace tall storage racks in both directions or, for racks significantly taller than wide, secure with anchor bolts connected to the concrete slab.

_____ Ensure the main breaker or fuse box and the utility meters elevated above the anticipated flood level of your facility to prevent damage.

_____ Secure one-of-a-kind equipment of high value from overturning or sliding.

What to Do During the Shaking…

Duck, Cover and Hold

DO

If inside...

☑ Stay there.

☑ Beware of projections on the under-surface of desks, tabletops and counters where you are seeking protection.

☑ Grasp table or desk legs so that furniture continues to provide overhead protection from falling items. If heavy furniture is not accessible, either take cover in corner of room with back against the wall seam and/or ***drop to floor.*** In either case, ***close eyes*** and ***protect head and neck by covering with arms.*** Try to avoid overhead light structures.

☑ Assist patient by having him/her turn to turn to side or stomach and protect the head with pillow **only if you are standing directly next to the patient when the shaking starts.**

If you are outside...**stay there**.

☒ Take shelter where items such as filing cabinets, crash carts, refrigerators and heavy shelf items can fall or move into you.

☒ Walk or run until the ground motion stops.

☒ Take shelter next to exterior walls, particularly if they are constructed of glass.

☒ Try to provide patient care until the ground motion stops.

☒ Try to exit down stairways.

☒ Stand in a doorway.

Biological Weapons (BW) Agent Characteristics

Disease	Trans-mit Man to Man	Infective Dose (Aerosol)	Incubation Period	Duration of Illness	Lethality (approx. case fatality rates)	Persistence of Organism	Vaccine Efficacy (aerosol exposure)
Anthrax	No (except cuta-neous)	8,000-50,000 spores	1-6 days	3-5 days (usually fatal if untreated)	High	Very stable - spores remain viable for > 40 years in soil	2 dose efficacy against up to 1,000 LD_{50} in monkeys
Brucellosis	No	10 -100 organisms	5-60 days (usually 1-2 months)	Weeks to months	<5% untreated	Very stable	No vaccine
Cholera	Rare	10-500 organisms	4 hours - 5 days (usually 2-3 days)	≥ 1 week	Low with treatment, high without	Unstable in aerosols & fresh water; stable in salt water	No data on aerosol
Glanders	Low	Assumed low	10-14 days via aerosol	Death in 7-10 days in septicemic form	> 50%	Very stable	No vaccine
Plague	High	100-500 organisms	2-3 days	1-6 days (usually fatal)	High unless treated within 12-24 hours	For up to 1 year in soil; 270 days in live tissue	3 doses not protective against 118 LD_{50} in monkeys
Q Fever	Rare	1-10 organisms	10-40 days	2-14 days	Very low	For months on wood and sand	94% protection against 3,500 LD_{50} in guinea pigs
Tularemia	No	10-50 organisms	2-10 days (average 3-5)	≥ 2 weeks	Moderate if untreated	For months in moist soil or other media	80% protection against 1-10 LD_{50}
Smallpox	High	Assumed low (10-100 organisms)	7-17 days (average 12)	4 weeks	High to moderate	Very stable	Vaccine protects against large doses in primates
Venezuelan Equine Encephalitis	Low	10-100 organisms	2-6 days	Days to weeks	Low	Relatively unstable	TC 83 protects against 30-500 LD_{50} in hamsters
Viral Hemorrhagic Fevers	Mod-erate	1-10 organisms	4-21 days	Death between 7-16 days	High for Zaire strain, moderate with Sudan	Relatively unstable - depends on agent	No vaccine
Botulinum	No	0.001 µg/kg is LD_{50} for type A	1-5 days	Death in 24-72 hours; lasts months if not lethal	High without respiratory support	For weeks in nonmoving water and food	3 dose efficacy 100% against 25-250 LD_{50} in primates
Ricin	No	3-5 µg/kg is LD_{50} in mice	18-24 hours	Days - death within 10-12 days for ingestion	High	Stable	No vaccine
Staphylococcal enterotoxin B	No	0.03 µg/person incapacitation	3-12 hours after inhalation	Hours	< 1%	Resistant to freezing	No vaccine
Tricothicene T-2 Mycotoxins	No	Moderate	2-4 hours	Days to months	Moderate	For years at room temperature	No vaccine

Biological Weapons Agents

DISEASE	SYMPTOMS	VACCINE	THERAPY (Rx)	PROPHYLAXIS (Px)	Comments
BACTERIA					
Anthrax	**Cutaneous**: 1-2 cm vesicles, painless necrotic ulcer with black eschar base, regional edema and lymphadenitis; **Inhalation**: nonspecific chest cold symptoms followed by respiratory distress (chest X-ray may show widening mediastinum with or without a bloody pleural effusion), fever, 50% of cases have hemorrhagic meningitis, shock or death; **Intestinal**: intense abdominal pain, bowel obstruction, sometimes rapidly developing ascities, dehydration, nausea, vomiting, bloody diarrhea, fever, blood poisoning, death (rare in humans)	Bioport vaccine (licensed) 0.5mL SC @ 0, 2, 4 wk, 6, 12, 18 mo then annual boosters	Ciprofloxacin 400mg IV q 12 h or Doxycycline 200mg IV, then 100mg IV q 12 h Penicillin 4 million units IV q 4 h	Ciprofloxacin 500mg PO bid x 4 wk If unvaccinated, begin initial doses of vaccine Doxycycline 100mg PO bid x 4 wk plus vaccination	Potential alternates for Rx: Gentamicin, Erythromycin, and Chloramphenicol PCN for sensitive organisms only
Brucellosis	Prolonged fever, headaches, profuse sweating, chills, joint and muscle pain, fatigue	No human vaccine available		Doxycycline 200mg/d PO plus Rifampin 600mg/d PO x 6 wk	Trimethoprim-sulfamethoxazole may be substituted for Rifampin; however, relapse may reach 30%
Cholera	Acute infectious gastrointestinal disease, vomiting, diarrhea, rapid loss of fluids, severe cramps, collapse	Wyeth-Ayerst Vaccine 2 doses 0.5mL IM or SC @ 0, 7-30 days, then boosters Q 6 months	Oral rehydration therapy during period of high fluid loss Tetracycline 500mg q 6 h x 3 d Doxycycline 300mg once, or 100mg q 12 h x 3 days Ciproflaxin 500mg q 12 h x 3 days Norfloxacin 400mg 12 h x 3 days	N/A	Vaccine not recommended for routine protection in endemic areas (50% efficacy, short term) Alternates for Rx: Erythromycin, Trimethoprim and Sulfamethoxazole, and Furazolidone Quinolones for tetra/doxy resistant strains

DISEASE	SYMPTOMS	VACCINE	THERAPY (Rx)	PROPHYLAXIS (Px)	Comments
Glanders	Large lesions, and ulcers in the skin, mucous membrane and viscera tissues **NOTE**: Although rare in humans, untreated cases are fatal and lethality for chronic cases can range from 50-70%	No vaccine available	Antibiotic regimens vary depending on localization and severity of disease - refer to text	Post-exposure prophylaxis may be tried with TMP-SMX	No large therapeutic human trials have been conducted owing to the rarity of naturally occurring disease.
Plague (**Bubonic:** infection of the lymph node; **Pneumonic**: infection of the lungs; **Septicemia:** generalized infection from bacteria escaping from the lymph node)	High fever, headache, myalgias, chills, headache, cough with bloody sputum, glandular swelling, pneumonia, hemorrhages in skin and mucous membranes possible, extreme lymph node pain	Greer inactivated vaccine (FDA licensed) is no longer available.	Streptomycin 30mg/kg/d IM in 2 divided doses x 10 – 14 d or Gentamicin 5mg/kg or IV once daily x 10 - 14 d or Ciprofloxacin 400mg IV q 12 h until clinically improved then 750mg PO bid for total of 10 –14 d Doxycycline 200mg IV then 100mg IV bid, until clinically improved then 100mg PO bid for total of 10-14 d	Doxycycline 100mg PO bid x 7 d or duration of exposure Ciprofloxacin 500mg PO bid x 7 d Tetracycline 500mg PO qid x 7 d	Chloramphenicol for plague meningitis is required 25mg/kg IV, then 15mg/kg qid x 14 d Alternate Rx: Trimethoprim-sulfamethoxazole
Q Fever	Sudden onset of influenza-like syndrome, with marked anorexia, fever (100-104°F), atypical pneumonia in 50% of cases, X-ray may reveal "ground glass" appearance, neck stiffness and CNS signs may also occur	IND 610 - inactivated whole cell vaccine given as single 0.5 ml s.c. injection	Tetracycline 500mg PO q 6 h x 5-7 d continued at least 2 d after afebrile Doxycycline 100mg PO q 12 h x 5-7 d continued at least 2 d after afebrile	Tetracycline 500mg PO qid x 5 d (start 8-12 d post-exposure) Tetracycline 500mg PO qid x 5 d (start 8-12 d post-exposure)	Currently testing vaccine to determine the necessity of skin testing prior to use.
Tularemia	**Inhalation**: sudden onset of chills, high fever, headache, muscle pain, myalgias, non-productive cough, pneumonia; **Ingestion** *or* **Inoculation**: painful and tender regional lympha-denopathy with or without cutaneous ulcers, **In all three forms**: pronounced inflammation and necrosis may occur in lymph nodes, lung, skin, conjunctiva, or oropharynx	IND – live attenuated vaccine: single 0.1ml dose by scarification	Streptomycin 7.5-10 mg/kg IM bidx10-14 d Gentamicin 3-5 mg/kg/d IV x 10-14 d Ciprofloxacin 400mg IV q 12h until improved, then 500 mg PO q 12 h for total of 10 - 14 d Ciprofloxacin 750mg PO q 12 h for 10 - 14 d	Doxycycline 100mg PO bid x 14 d Tetracycline 500mg PO qid x 14 d Ciprofloxacin 500mg PO q 12 h for 14 d	N/A

DISEASE	SYMPTOMS	VACCINE	THERAPY (Rx)	PROPHYLAXIS (Px)	Comments
VIRUSES					
Smallpox	Initial macules progress to papules, to postular vesicles, and scabs within 8-10 days; lesions are syndronous in their development **NOTE**: Highly contagious	Wyeth calf lymph vaccinia vaccine (licensed): 1 dose by scarification	No current medication other than supportive; Cidofovir (effective in vitro); animal studies ongoing	Vaccinia immune globulin 0.6mL/kg IM (within 3 d of exposure, best within 24 h)	Pre and post exposure vaccination recommended if > 3 years since last vaccine
Venezuelan Equine Encephalitis (VEE)	Severe headache, fever (104°F), rigors, photophobia, myalgias, nausea, vomiting, and diarrhea (these symptoms tend to last up to 3 d) followed by weakness and lethargy Small percentage develop CNS symptoms secondary to meningitis and encephalitis **NOTE**: Highly infectious	VEE DOD TC-83 live attenuated vaccine (IND): 0.5mL SC x1 dose VEE DOD C-84 (formalin inactivated TC-83) (IND): 0.5mL SC for up to 3 doses EEE inactivated (IND): 0.5mL SC at 0 & 28 d WEE inactivated (IND): 0.5 mL SC at 0, 7, and 28 d	Supportive therapy: analgesics and anticonvulsants prn; no antiviral medication exists	N/A	TC-83 reactogenic in 20%. No seroconversion in 20% Only effective against subtype C-84 vaccine used for non-responders to TC-83 EEE and WEE inactivated vaccines are poorly immunogenic Immunogenic. Multiple immunizations are required
Viral Hemorrhagic Fevers (VHF)	Initial high fever, myalgias, prostration, conjunctival injection, petechial hemorrhages, and hypotension; full-blown cases evolve in shock, generalized mucous membrane hemorrhage with respiratory involvement, hematopoietic, and CNS **NOTE**: Transmitted by contact with blood and body fluids with the highest risk of trans-mission is during the latter stages of the illness, which are characterized by vomiting, shock, diarrhea and hemorrhage	AHF Candid #1 vaccine (x-protection for BHF) (IND) RVF inactivated vaccine (IND)	Ribavirin (CCHF/Lassa) (IND) 30mg/kg IV initial dose; then 16mg/kg IV q 6 h x 4 d; then 8mg/kg IV q 8 h x 6 d Passive antibody for AHF, BHF, Lassa fever, and CCHF **NOTE**: Vaccine available only for yellow fever	N/A	Aggressive supportive care and management of hypotension (pulmonary overload) very important

DISEASE	SYMPTOMS	VACCINE	THERAPY (Rx)	PROPHYLAXIS (Px)	Comments
TOXINS **Botulinum (neurotoxin)**	Bulbar palsies first develop followed by skeletal muscles become weak, starting in upper body and moving downwards in a symmetrical fashion Symptoms progress acutely to respiratory failure in 24 h to 2 d **NOTE**: Not prone to person-to-person contact	DOD pentavalent toxoid for serotypes A - E (IND): 0.5 ml deep SC @ 0, 2 & 12 wk, then yearly boosters	DOD heptavalent equine despeciated antitoxin for serotypes A-G (IND): 1 vial (10mL) IV CDC trivalent equine antitoxin for serotypes A, B, E (licensed)	N/A	Skin test for hypersensitivity before equine antitoxin administration
Ricin (cytotoxin)	**Inhalation**: fever, chest tightness, cough, SOB, nausea, and joint pain within 4-8 h with airway necrosis and edema leading to death in 36-72 h **Ingestion**: raping onset of nausea, vomiting, severe diarrhea, and GI hemorrhage with necrosis of the liver, spleen, and kidneys with ensued shock and death in 3 d **Injection**: marked death of muscles and LNs near the site of injection along with multiple organ failure leading to death	No vaccine available	Inhalation: supportive therapy G-I: gastric lavage, super activated charcoal, cathartics	NA	No vaccine available
Staphylococcal enterotoxin B (cytotoxin)	**Inhalation**: 3-12 h sudden onset of high fever (103-104°F), headache, chills, myalgias, and nonproductive cough; larger doses cause severe SOB and chest pain **Ingestion**: nausea, vomiting, and diarrhea	No vaccine available	Ventilatory support for inhalation exposure	NA	N/A
Tricothecene T-2 mycotoxin (cytotoxin)	N/A	No vaccine available	N/A	Decontamination of clothing and skin	N/A

CHEMICAL WEAPONS AGENTS

Agent	Symptoms	Decontamination	Therapy
NERVE **Tabun (GA)** **Sarin (GB)** **Soman (GD)** **VX** (Most toxic agents)	**Vapor**: (low exposure) miosis, rhinorrhea, conjunctival injection, some degree of bronchoconstriction and bronchosecretions, and dyspnea; (high exposure) immediate loss of consciousness, seizures, apnea, and flaccid paralysis **Liquid**: (small amount) localized sweating, fasciculations, no miosis; (moderate amount) GI effects (nausea, vomiting and diarrhea), miosis uncommon; (large amount) sudden loss of consciousness, seizures, apnea, flaccid paralysis **Other symptoms**: *Cardiovascular* - bradyarrhythmias, heart block, tachyarrhythmias, and ventricular arrhythmias may occur *CNS* – acute severe symptoms include loss of consciousness, seizures, and apnea; mild effects include nervousness, fatigue, minor memory disturbances, irritability, and other psychological symptoms	Remove clothing Soap and water, sodium hypochlorite (bleach) diluted 1:10 then rinsed off with water	**Latent** exposure with no clinical symptoms: no treatment is needed, observe for 1 h with vapor, and 18 h for liquid or unknown exposure **Mild** exposure with symptoms of miosis (dim and/or blurred vision), rhinorrhea, SOB: one MARK I kit or Atropine 2mg IM/IV and 2-PAMCI 600 mg IM or 1gm IV Moderate exposure with above symptoms, but more severe, or vomiting and diarrhea: One MARK I kit or Atropine 2mg IM/IV and 2-PAMCI 600mg IM or 1gm IV and repeat 2mg Atropine at 5-10 minute intervals until agent effects diminish **Severe** exposure with above plus loss of consciousness, flaccid paralysis, respiratory distress, cyanosis, seizures, and severe effects in 2< organ systems: oxygen, bag mask, intubate after three MARK I kits or Atropine 6mg IM and 2-PAMCI 1800mg IM or 1gm 2-PAMCI IV repeated 2 x at hourly intervals, and repeat 2mg Atropine at 3-5 minute intervals until atropinized; Diazepam (seizures) 10mg IM or 5-10mg IV slowly NOTE: Atropine should not be given to an hypoxic patient Infant's and children's dose will vary from adult dose (please verify with drug handbook)
VESICANTS **Sulfur Mustard (blister agent)**	*Clinical effects do not begin for hours (2-48 h) after exposure* **Eyes**: mild conjunctivitis (small exposure), moderate/severe conjunctivitis (severe exposure), lid inflammation and edema, blepharospasm, and corneal roughening; corneal opacification, ulceration, or perforation (severe exposure or liquid) **Skin**: erythema followed by small vesicles which later coalesce to form blisters/bulla (size and depth depends on amount of exposure and if liquid or vapor), possible coagulation necrosis with liquid exposure **Airway**: damage to the mucosa or lining of the airways; epistaxis, sinus discomfort, and mild to moderate pharyngitis with a hacking cough (small exposure or initially after a larger); laryngitis and a productive cough (moderate exposure or later after a larger); dyspnea, productive cough, and possible hemorrhagic pulmonary edema (large exposure) **GI**: nausea and vomiting within first 24 h, and tissue destruction within 3-5 d	Remove clothing Soap and water, sodium hypochlorite (bleach) diluted 1:10 then rinsed off with water and must be done within minutes to prevent cellular damage and cross-contamination	No antidote **Eyes:** initial gentle irrigation with saline or water, then topical mydriatics, topical antibiotics, petroleum jelly on lid edges and topical steroids **Skin:** soothing creams or lotions, frequent irrigation followed by topical antibiotic, systemic analgesics, and don't overhydrate as would be done in a thermal burn **Airway:** steam inhalation, cough suppressants for mild symptoms, oxygen and PEEP or CPAP for severe airway effects, early intubation if severe upper airway involvement, bronchodilators as needed, and antibiotics after organism is identified

Agent	Symptoms	Decontamination	Therapy
continued… **Sulfur Mustard** (blister agent)	**Bone marrow:** stem cells damage, decreased, WBC, RBC, and platelets after 3-5 d		
Lewisite (blister agent)	Severe irritation to eyes, skin, and airways immediately on initial exposure **Skin:** greater skin damage than mustard **Lungs**: tissue necrosis, pseudomembranes **Cardiovascular**: increased capillary permeability leading volume depletion and hepatic and renal injury **Other symptoms**: vesicant effects similar to sulfur mustard	Remove clothing Soap and water, sodium hypochlorite (bleach) diluted 1:10 then rinsed off with water and must be done immediately after contamination to prevent further tissue damage	**Antidote:** British anti-Lewisite IM to reduce systemic effects
CYANIDE **Liquids -** **Hydrogen cyanide (AC)** **Cyanogen chloride (CK)** **Solids –** **Sodium, potassium, calcium**	**Low concentrations (non-lethal):** anxiety, hyperventilation, headache, dizziness, vomiting and flushed skin **High concentrations (inhalation)**: hyperpnea (15 sec), seizures (30 sec), breathing ceases (3-5 min), asystole followed by death (6-10 min)	Remove immediately from source of exposure, remove clothing Soap and water	**Conscious (breathing):** no antidote, administer oxygen, IV fluids (saline and sodium bicarbonate) **Unconscious (not breathing):** bag mask/ventilator with 100% oxygen, amyl nitrite perle via gauze bandage or bag mask/ventilator only until IV drugs can be given; sodium nitrite 300mg IV; sodium thiosulfate 12.5gm IV over 5 minutes NOTE: Infant's and children's dose will vary from adult dose (please verify with drug handbook)
PULMONARY INTOXICANTS **Phosgene**	Asymptomatic for 2-24 hr as it penetrates slowly down airways causing leakage of fluid into alveoli (up to 1 liter/hr), hacking cough (later with frothy sputum), SOB and non-cardiogenic pulmonary edema, and hypotension	Remove from source of exposure Soap and water	Supportive therapy; advance intensive care includes intubation, mechanical ventilator, and PEEP **NOTE**: Don't use diuretics; intubation and PEEP may be required
Chlorine	Significant irritation to eyes, and respiratory tract (cough, SOB, wheezing, chest pain and sputum production) followed within 12-24 hrs by cardiogenic pulmonary edema with sudden death usually due to severe hypoxia and cardiac arrest	Remove from source of exposure Remove clothing Flush skin and eyes with copious amounts of water	Supportive therapy; oxygen, cool mist, bronchodilators; advance care includes intubation, PEEP and bronchoscopy
RIOT CONTROL AGENTS **Mace ®** **Tear gas** **Capsicum (Pepper Spray)** **Adamsite**	**Eyes:** blepharospasm, tearing conjunctival injection, and redness **Upper airway:** can cause rhinorrhea, sneezing, and burning **Lower airway**: can cause a cough, SOB, and chest tightness; bronchospasm and wheezing can occur for hours after exposure **Skin**: burning and redness; severe dermatitis with erythema and blisters for 4-6 hrs after large exposure to Mace® and tear gas **Cardiovascular**: increased blood pressure and heart rate due to anxiety	Remove from the source to fresh air and remove any powder from clothing or remove clothing with care to avoid exposure to healthcare worker or reexposure to patient Eye irrigation With prolonged pain, use soap and water or carbonate and/or bicarbonate	Supportive therapy **Eyes**: irrigate with copious amounts of water or saline and remove impacted particles **Lungs**: bronchodilators or steroids for wheezing, may require oxygen **Skin**: delayed onset dermatitis due to large concentration exposure in high temperature and humidity use frequent irrigation and soothing ointments or creams NOTE: Adamsite does not cause skin irritation and Capsicum has less tendency to cause dermatitis

Personal Protective Equipment (PPE)
and
Decontamination (Staff Protection)

During a chemical, biological, nuclear, radiological or explosives (CBRNE) incident, healthcare workers must be protected from the risk of personal injury. Therefore they must be educated and trained in the use of personal protective equipment (PPE) and decontamination (staff protection).

PPE protects the skin, eyes and lungs of the staff. There are four levels of PPE and they are as follows:

- ⇒ **Level A** is required for exposures in the area of a release (the hot zone), if air concentrations exceed those that are immediately dangerous to life and health (IDLH). This level of protection mandates a self-contained breathing apparatus (SCBA), fully encapsulating, and is resistant to liquid and vapor penetration.
- ⇒ **Level B** is required for chemicals or substances that pose a potential inhalation hazard but requiring a lesser level of skin protection. Although this PPE ensemble offers less splash protection than Level A, when coupled with an SCBA or supplied air respirator (SAR), it provides adequate vapor protection. This is the minimum level of protection for personnel dealing with vapor-prone hazardous materials.
- ⇒ **Level C** should be used when the atmospheric contaminants (liquid and vapor) have been identified, (such as nerve or blister agents), concentrations measured and determined to be below a hazardous level, and an air-purifying respirator (along with an agent-specific filtering canister) is appropriate and available to remove the contaminants involved. An air-purifying respirator is one in which ambient air passes through a filter element or canister that removes gaseous or particulate contaminants. There are two basic types of air-purifying respirators - negative-pressure respirator that pulls ambient air across the filter by the user's inspiration, and a positive-pressure, powered air-purifying respirator (PAPR) with a blower that propels ambient air through a filter and into a mask.
- ⇒ **Level D** is selected when no respiratory protection and minimal skin protection is required, and the atmosphere contains no known hazard and work functions preclude splashes, immersion, or the potential for unexpected inhalation of, or contact with, hazardous levels of any chemicals. Minimum requirement is an escape mask for self-rescue. *This may suffice for a clinic.*

Decontamination is the physical removal of harmful substances from victims, equipment, and supplies. If you are not donning appropriate PPE and become contaminated either by direct contact with the substance or cross-contaminated by contact with the victim, activate decontamination procedures immediately. Decontamination can simply be done by first removing the clothing and using soap and water, or sodium hypochlorite (bleach) diluted 1:10 then rinsed off with water. There are some substances like riot control agents that may require the use of carbonate and/or bicarbonate. Always ensure that the victim has been decontaminated before entering your facility.

Typical Emergency Response Actions

- Establish an Incident Command System— *refer to the ICS Organization Chart*
  - ✓ Provides overall direction for the response
  - ✓ The Incident Commander should be ideally assumed by someone who has the authority to make life safety and financial decisions.
  - ✓ Initiates opening the Emergency Operation Center (EOC)
    - Needs to be in one area away from the center of activities and can be used to store disaster supplies, flashlights/batteries, portable radios, water, food, etc.
    - Staff will return with reports of damage, injuries, etc.
    - Flip charts, marking pens, maps to provide information regarding situation status and any other information relevant to the disaster.
- Assess if a building evacuation is required to a pre-established gathering place
- Conduct limited search and rescue
- Set up a triage site
- Set up a first aid station
- Establish a fatality collection area
  - ✓ How and by whom will family be contacted?
  - ✓ Where and how will bodies be held if morgue facilities are unstable or capacity is exceeded?
- Activate the clinic transportation plan
  - ✓ patients or staff may need to be transported to an acute care facility
- Determine communication capabilities
- Establish contact with local hospital if applicable
- Establish contact with local Office of Emergency Services, if applicable
- Conduct the damage assessment of the building if safe to do so
  - ✓ Assess the status of the facility
    - Check for obvious structural and nonstructural damage, hazardous material releases, fires and/or other related hazards
    - Mark doors with a large "**X**" to indicate that the room has been searched and evacuated
    - More severe damage will need to be assessed by a structural engineer
  - ✓ Assess the casualties
  - ✓ Assess the status of the utilities
  - ✓ Assess the inventory of equipment and supplies
    - Contact the local pharmacy, vendor or supplier in pre-established contracts to replenish the clinic's inventory
  - ✓ Assess potable water and food supplies

Communications Resources

Internal and External Equipment

The realistic clinic disaster plan will include many alternatives to telephones. The following list offers some suggestions for methods of communication.

1. Internal and/or External Options
   - Paper message system
   - Message Boards
   - Indoor Walkie-talkies with repeaters
   - Runners, bullhorns, signs, flyers/newsletter, barricades
   - External voice mail system ("access through 1-800 number) for employee messages
   - Battery backup for clinic switchboard and/or switch mechanism to hook up portable generator to PBX
   - Use existing clinic radio system (e.g., lab link radio car)
   - Develop list of direct dial telephone lines within the clinic that do not run through the switchboard (1 MB, DID lines)
   - E-mail over T-1 lines (use existing data lines)
   - Internal public address system (overhead speakers)
   - Cellular telephones (limitations in terms of open channels)

2. External Communications with Public Agencies and Community-at-Large

It is essential that the clinic be able to communicate with the local emergency response agency. To accomplish that, consideration should be given to the following systems:

   - Essential service telephone lines
   - Volunteer Licensed Amateur Radio Operators (HAM) and HAM packet systems
   - Computer based external communications systems (CHORAL, Internet-based systems)
   - Emergency Digital Information System (EDIS)
   - Commercial telephone system (i.e., public pay telephones)
   - Television and radio (provide essential real-time casualty and damage information)

3. Communication Tips
   - Provide supply of coins for public pay telephones
   - Cellular telephones must be kept charged
   - Remind staff to return receivers to the telephone base
   - Remind staff not to use clinic telephones, if they are functional, except for critical calls authorized by management
   - Train staff in the use of walkie-talkies. They need to understand that walkie-talkies are much like "party lines" and certain protocol in usage should be observed.

Fire or Disaster Drill/Exercise Evaluation Form

(Please keep a copy in your quality assurance/improvement report log and staff-training log.)

General Information

Date and time of drill/exercise: _____

Type of drill/exercise: _____
(fire, earthquake, bomb threat, flooding, etc.)

❒ Drill ❒ Table Top ❒ Functional ❒ Full-scale

Participating staff in the drill/exercise:

Staff Name	*Title and Department/Floor*

Exercise/Drill Goal

List the exercise/drill overall objectives (*measurable*):

Overall Objectives

List the exercise/drill section objectives (*measurable*):

Objectives	Section Responsible	Completion

Observations

Log of Event(s) and Action(s) Taken (*narrative*):

Log of Event(s)	Action(s) Taken	Time

Completion checklist:

_____ Patient and staff logs checked

_____ Emergency Supplies accessed

_____ Partial evacuation _____ Total evacuation

_____ Communications with other agencies and/or Office of Emergency Services:

(Describe who was contacted, why and the outcome)

Recommendations

Drill/Exercise Evaluation Recommendations

Explain what worked well: _____

Explain what needs improvement/corrective action: _____

Additional comments: _____

Plan for improvement/corrective action (*to be completed by clinic staff*): _____

Time the drill/exercise was completed: _____

Evaluation was completed by: _____
(name of person and title)

Agency Name: _____

Telephone number: (_____) _____

APPENDIX K

ORGANIZATION RESOURCES

California Primary Care Association 1215 K Street, Suite 700 Sacramento, CA 95814 Phone: (916) 440-8170 Fax: (916) 440-8172 www.cpca.org	**OES Inland Region – Fresno** 2550 Mariposa Mall Rm. B-181 Fresno, CA 93721 (559) 445-5672
California Specialized Training Institute (CSTI) P.O. Box 8123 San Luis Obispo, CA 93403-8123 (805) 549-3535	**OES Inland Region – Redding** 2395 N. Bechelli Lane Redding, CA 96002 (530) 224-4113
Department of Health Services 601 North 7th Street, MS 725 (916) 323-3675 www.dhs.ca.gov	**OES Coastal Region - Oakland** 1300 Clay Street, Suite 400 Oakland, CA 94612 (510) 286-0895
Emergency Medical Services Authority 1930 9th Street Sacramento, CA 95814 (916) 322-4336 www.emsa.ca.gov	**OES Southern Region Branch Headquarters** 4671 Liberty Avenue Los Alamitos, CA 90720 (562) 795-2900
Federal Emergency Management Agency (FEMA) Federal Center Plaza 500 C Street, S. W. Washington, D. C. 20472 (202) 566-1600 www.fema.gov	**OES Southern Region - San Diego** 1350 Front Street, Ste. 2041 San Diego, CA 92101 (619) 525-4287
Federal Emergency Management Agency Region IX Building 105 P.O. Box 29998 San Francisco, CA 94129 (415) 923-1800	**OES Disaster Field Office – South** 75 N. Fair Oaks Avenue, Fourth Floor Pasadena, CA 91103-3674 (626) 683-6800
Governor's Office of Emergency Services (OES) **Inland Region - Mather** P.O. Box 419047 Rancho Cordova, CA 95741-9047 (916) 262-1800 www.oes.ca.gov	**U. S. Small Business Administration (SBA)** Regional Office 455 Market Street, Ste. 2200 San Francisco, CA 94105 (415) 744-2118 www.sba.ca.gov

APPENDIX K

Operational Area (OA) Southern Region

Imperial Emergency Management Office Fire Department 2514 La Brucherie Road Imperial, CA 92251 (760) 355-1191	**San Bernardino** Emergency Services Office Fire Department 1743 West Miro Way Rialto, CA 92376 (909) 356-3998
Inyo Emergency Management Office P. O. Box 427 168 North Edwards Street Independence, CA 93526 (760) 878-0238	**San Diego** Office of Disaster Preparedness 5555 Overland Avenue, Bldg. 19 San Diego, CA 92123 (916) 565-3490
Los Angeles **O**ffice of Emergency Management 1275 North Eastern Avenue Los Angeles, CA 90063 (323) 980-2261	**San Luis Obispo** Office of Emergency Services County Government Center Room 370 San Luis Obispo, CA 93408 (805) 781-5011
Mono Office of Emergency Services P. O. Box 616 100 Bryant Street Bridgeport, CA 93517 (760) 934-8983	**Santa Barbara** Emergency Services Office Fire Department 4410 Cathedral Oaks Road Santa Barbara, CA 93110-1042 (805) 681-5526
Orange Emergency Management Office 2644 Santiago Canyon Road Silverado, CA 92676-9719 (714) 628-7055	**Ventura** Emergency Services Office County Government Center 800 South Victoria Avenue Ventura, CA 93009 (805) 654-2552
Riverside Office of Emergency Services P. O. Box 1412 4080 Lemon Street, Suite 8 Riverside, CA 92502-1412 (909) 955-4700	

Operational Area (OA) Coastal Region

Alameda Office of Emergency Services 4985 Broder Blvd. Dublin, CA 94568 (510) 803-7800	**Monterey** Office of Emergency Services 240 Church Street (Basement) Salinas, CA 93902 755-5120
Contra Costa Office of Emergency Services 333 2nd Street Martinez, CA 94553 (510) 646-4461	**Napa** **O**ffice of Emergency Services Room 310 1195 Third Street Napa, CA 94559 (707) 253-4421
Del Norte Office of Emergency Services 981 H Street, Suite 210 Crescent City, CA 95531 (707) 464-4191	**San Benito** Office of Emergency Services 481 - 4th Street Hollister, CA 95023 (408) 636-4004
Humboldt Office of Emergency Services Courthouse 825 Fifth Street Eureka, CA 95501 **(707) 445-7395**	**San Francisco** Mayor's Office of Emergency Services 1011 Turk Street, Room 103 San Francisco, CA 94102 (415) 558-2700
Lake Office of Emergency Services 333 2nd Street Lakeport, CA 95453 (707) 262-0862	**San Mateo** Office of Emergency Services 401 Marshall Street Redwood City, CA 95060 (650) 363-4790
Marin Office of Emergency Services 20 North San Pedro, Suite 2004 San Rafael, CA 94903 (415) 499-6584	**Santa Clara** Office of Emergency Services 55 W. Younger Avenue, Suite 435 San Jose, CA 95110-1721 (408) 299-3751
Mendocino Office of Emergency Services 175 S. School Street, Rm. 107 Ukiah, CA 95482 (707) 463-5630/1	**Santa Cruz** Office of Emergency Services 701 Ocean Street, Room 330 Santa Cruz, CA 95060 (408) 454-2210
Solano Office of Emergency Services 240 Church Street Salinas, CA 93902 (707) 421-6330	**Sonoma** Office of Emergency Services 2300 County Center Drive, #221-A Santa Rosa, CA 95403 (707) 527-1152

Operational Area (OA) Inland Region

Alpine County Office of Emergency Services P.O. Box 278 Markleeville, CA 96120 (530) 694-2231	**Kern** Office of Emergency Services 5642 Victor Road Bakersfield, CA 93308 (661) 391-7000
Amador Office of Emergency Services 108 Court Street Jackson, CA 95642 (209) 223-6384	**Kings** Office of Emergency Services 1400 W. Lacey Blvd. Hanford, CA 93230 (559) 582-3211
Butte Office of Emergency Services 25 County Center Drive Oroville, CA 95965 (530) 538-7373	**Lassen** Office of Emergency Services 220 So. Lassen Street, Suite #1 Susanville, CA 96130 (530) 257-6121
Calaveras Office of Emergency Services 891 Mountain Ranch Road San Andreas, Ca 95249 (209) 754-6303	**Madera** Office of Emergency Services 14143 Road 28 Madera, CA 93638 (559) 675-7792
Colusa Office of Emergency Services 929 Bridge Street Colusa, CA 95932 (530) 458-0230	**Mariposa** Office of Emergency Services 5082 Bullion Street Mariposa, CA 95338 (209) 966-4330
El Dorado Office of Emergency Services 300 Fair Lane Drive Placerville, CA 95667 (530) 621-5895	**Merced** Office of Emergency Services 735 Martin Luther King Jr. Way Merced, CA 95340 (209) 385-7548
Fresno Office of Emergency Services P.O. Box 11867 Fresno, CA 93775 (559) 445-3391	**Modoc** Office of Emergency Services P.O. Drawer 460 Alturas, CA 96101 (530) 233-4416
Glenn Office of Emergency Services 543 W. Oak Street Willows, CA 95988 (530) 934-6442	**Nevada** Office of Emergency Services 950 Maidu Avenue Nevada City, CA 95945 (530) 273-2238

Operational Area (OA) Inland Region, cont…

Placer Office of Emergency Services 2968 Richardson Drive Auburn, CA 95603 (530) 886-5300	**Sutter** Office of Emergency Services 1160 Civic Center Blvd. #E Yuba City, CA 95993 (530) 822-7370
Plumas Office of Emergency Services P.O. Box 916 Quincy, CA 95971 (530) 283-6332	**Tehama** Office of Emergency Services P.O. Box 729 Red Bluff, CA 96080 (530) 529- 7900
Sacramento Office of Emergency Services 711 G Street, Room 209 Sacramento, CA 95814 (916) 874-4670	**Trinity** Office of Emergency Services P.O. Box 1228 Weaverville, CA 96093 (530) 623-1227
San Joaquin Office of Emergency Services 222 E Weber Ave, Courthouse, Rm 610 Stockton, CA 95202 (209) 468-3962	**Tulare** Office of Emergency Services 5957 So. Mooney Blvd. Visalia, CA 93277 (559) 737-4660
Shasta Office of Emergency Services 1525 Court Street Redding, CA 96001 (530) 245-6059	**Tuolumne** Office of Emergency Services 2 South Green Street Sonora, CA 95370 (209) 533-5511
Sierra Office of Emergency Services P.O. Box 98 Downieville, CA 95936 (530) 289-2850	**Yolo** Office of Emergency Services 35 N. Cottonwood Street Woodland, CA 95695 (530) 666-8905
Siskiyou Office of Emergency Services 311 Lane Street Yreka, CA 96097 (530) 842-8379	**Yuba** Office of Emergency Services 215 - 5th Street Marysville, CA 95901 (530) 749-7520
Stanislaus Office of Emergency Services 929 Oakdale Road Modesto, CA 95355 (209) 525-4658	**Nevada** Office of Emergency Services 950 Maidu Avenue Nevada City, CA 95945 (530) 273-2238

For more information, please contact any of the following offices of the Governor's Office of Emergency Services:

Headquarters
Planning and Technical Assistance Branch
P.O. Box 419047
Rancho Cordova, CA 95741-9047
(916) 845-8731

Southern Region

Los Alamitos
4671 Liberty Avenue
Los Alamitos, CA 90720-5002
(562) 795-2900

San Diego
1350 Front Street, Suite 2041
San Diego, CA 92101
(619) 525-4287

Coastal Region
Oakland
1300 Clay Street, Suite 400
Oakland, CA 94612
(510) 286-0895

Inland Region
Mather
P.O. 419047
Rancho Cordova, CA 95741-9047
(916) 845-8470